



IEHP UM Subcommittee Approved Authorization Guideline			
<b>Guideline</b>	Allocation of Limited Critical Care Resources During a Public Health Emergency	<b>Guideline #</b>	UM_OTH 23
		<b>Original Effective Date</b>	7/17/20
<b>Section</b>	Other	<b>Revision Date</b>	02/17/23

### COVERAGE POLICY

For this guideline to be applicable, the following 3 criteria need to be present:

1. A public health emergency creates demand for critical care resources (e.g., ICU beds, ventilators, extracorporeal membrane oxygenation [ECMO]) that exceeds supply AND
2. Critical care capacity is, or will shortly be, overwhelmed despite taking all appropriate steps to increase surge capacity to care for critically ill patients AND
3. A regional authority has declared a public health emergency.

This guideline provides allocation criteria for distribution of critical care resources (bed, medication, equipment or other treatment) to determine whether ongoing provision of scarce critical care resources is justified for individual Members.

Allocation criteria is based on two considerations: saving lives and saving life-years. The criteria are to be applied to ensure access and individualized Member assessments to all Members while diminishing the effect of social inequities that lessen some Members' long-term life expectancy. All Members who meet medical indications for ICU beds and services will be assigned a priority score using a 1 to 8-point scale (lower score indicates higher predicted benefit from critical care) based on:

1. The likelihood of surviving to hospital discharge, using an objective measure of organ dysfunction and mortality risk the ICU such as the Sequential Organ Failure Assessment (SOFA) Score (See <https://www.mdcalc.com/sequential-organ-failure-assessment-sofa-score#use-cases> for a SOFA calculator)
2. The presence of underlying medical conditions that limit prognosis for near-term survival even if the Member survived the acute critical illness. Point score is assigned according to whether death is expected within one or five years despite successful treatment of acute illness.

Principle	Specification	Point System			
		1	2	3	4
Save lives	Prognosis for hospital survival (e.g., SOFA score)	SOFA score < 6	SOFA score 6-8	SOFA score 9-11	SOFA score ≥12
Save life-years	Prognosis for near-term survival	---	Death expected within 5 years despite successful treatment of acute illness	---	Death expected within 1 year despite successful treatment of acute illness

The scoring system would apply to all Members presenting with critical illness, not just those with the disease causing the public health emergency. For example, Members with respiratory failure not caused by pandemic illness would be subject to the same allocation guidelines.

Alternatively, scores can be used to create 3 priority categories based on the scoring system: high (1-3 points), intermediate (4-5 points) and low priority (6-8 points). High priority Members have the highest predicted benefit from critical care interventions and receive priority over the other 2 groups. Members in the intermediate group receive critical care resources if available after all Members in the high priority group have received the scarce critical care resource. The low priority group receives the scarce critical care resource after all Members in the high and intermediate groups have been allocated the scarce critical care resource.

#### OTHER CONSIDERATIONS

1. Priority in scoring can be given to Members who perform tasks vital to the public health response including the support of those who treat patients (maintenance staff would be considered as vital as physicians, nurses and technicians) and maintain social order. This could involve decreasing the calculated score or including this information as tiebreaker criterion.
2. Priority in scoring can also be given to Members who have had less opportunity to live through the stages of life. Younger Members would receive priority because they have had the least opportunity to live through life's stages, not due to social utility or intrinsic worth. Possible categories could be age 12-40, 41-60, 61-75 and older than 75 years of age. This could also be used as a tiebreaker criterion.
3. If there is still a tie after applying healthcare/public safety work and life-cycle considerations to scoring, calculated scores (rather than the category approach) should be used, with the lowest score receiving priority.
4. If a tie still exists after using the calculated score, a lottery can be used to break the tie.
5. Contraindication or exclusion criteria are not used because such measures are not necessary to accomplish the public health goal of achieving the most good for the patient population. This is accomplished through:
  - a. Access for all patients, regardless of age, disabilities or other factors.
  - b. Individualized assessments by clinicians based on best available objective medical evidence.
  - c. Avoidance of assessments based on presence of disabilities or other factors that could be perceived as discriminatory judgments based on stereotypes, quality of life or a person's worth.
  - d. Not incorporating a long-term life expectancy estimation in scoring which could unfairly disadvantage Members with a decreased long-term life expectancy from disabilities or diseases exacerbated by social inequities.
  - e. Instead, availability of the scarce resource determines allocation.
6. Members who are not assessed to receive an allotment of the critical care bed/service in limited supply will receive care that includes intensive symptom management and psychosocial support including palliative care.
7. Members who do and do not receive the limited critical care resource will be reassessed daily to determine if changes in resource availability or their clinical status warrant provision of the limited resource.

## COVERAGE LIMITATIONS AND EXCLUSIONS

1. The search for critical care resources will be suspended once **three (3) in network Providers** with availability of the resource have deemed the service **not medically indicated**, regardless of the allocation criteria score.
2. When all in network Provider availability has been exhausted, the search for critical care resources will be suspended after any one of the following occurs, regardless of the allocation criteria score:
  - a. **Two (2) out of network Providers** have deemed the service **not medically indicated** when the resource is available at their site.
  - b. **Three (3) out of network Providers** have indicated that they do not have available resources.
3. In general, search for critical care resources will not be pursued outside the state of California (limited to only California).
4. This section specifically pertains to **ECMO requests**. Due to the nature and severity of the underlying medical condition and the high risk of instability associated with the transport of these Members, the search for this resource will not extend beyond the following California counties: San Bernardino, Riverside, Imperial, San Diego, Orange, Los Angeles, Ventura, Santa Barbara, San Luis Obispo, and Kern.

## ADDITIONAL INFORMATION

1. Priority is given to Members:
  - a. More likely to survive with intensive care (save lives) over those less likely to survive.
  - b. Who do not have conditions in advanced stages that result in severely limited near-term prognosis even if recovered from the acute critical illness (save life-years).

## REFERENCES

1. Sequential Organ Failure Assessment (SOFA) Score. Accessed February 05, 2023. <https://www.mdcalc.com/sequential-organ-failure-assessment-sofa-score#why-use>
2. White, DB. A Model Hospital Policy for Allocating Scarce Critical Care Resources. University of Pittsburgh School of Medicine. Published March 23, 2020. Accessed February 05, 2023. [https://ccm.pitt.edu/sites/default/files/UnivPittsburgh\\_ModelHospitalResourcePolicy\\_2020\\_04\\_15.pdf](https://ccm.pitt.edu/sites/default/files/UnivPittsburgh_ModelHospitalResourcePolicy_2020_04_15.pdf)
3. White, DB, B. Lo. A Framework for Rationing Ventilators and Critical Care Beds During the COVID-19 Pandemic. *JAMA*. 2020;323(18):1773-1774. doi:10.1001/jama.2020.5046
4. Ezekiel J., Emanuel, MD, PhD, et al. Fair Allocation of Scarce Medical Resources in the Time of Covid-19. *NEJM*, May 21, 2020.

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