Utilization Management Takes on New Meaning, Requires Additional TLC Under Value-Based Care Models

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INTRODUCTION

In 1989, the Institute of Medicine defined utilization management as a "set of techniques used by or on behalf of purchasers of healthcare benefits to manage healthcare costs by influencing patient care decision-making through case-by-case assessment of the appropriateness of care prior to its provision." [1] The definition still holds true today but as time marches on, the meaning of utilization management (UM) has certainly taken on new connotations for healthcare organizations.

For many years, as the industry operated under fee-for-service models, UM was primarily viewed as a cost-cutting tool. However, as healthcare moves toward the full embrace of value-based care models — which reimburse care providers based on clinical outcomes achieved not just the quantity of services delivered — UM is being seen in a different light. Indeed, UM is increasingly leveraged as a means to not only manage costs but to ensure quality and manage risk as well.

"Utilization management ensures that medical necessity is evaluated against nationally recognized, evidence-based standards and decision support. So, health plans look at a request for service and then ensure that for a person's unique situation, diagnosis, and comorbid conditions, a particular service is medically necessary and appropriate. From a quality perspective, health plans can not only ensure they are containing costs by reigning in some of those extraneous services that were pervasive in a fee-for-service world but also ensure that care providers are delivering high quality care and that members are experiencing more positive outcomes and fewer complications," said Debbie Hill, MSN, RN, Sr. Director UM Product Applications at Medecision.

In addition, healthcare provider organizations, themselves, not only "receive" UM from health insurers, they are actually embracing UM as they take on risk under value-based care models. These organizations are leveraging UM as a key strategy of various population health initiatives, which focus on managing and improving care effectiveness across a defined group of patients. With these programs, UM is used to maintain the highest quality of care while reducing or eliminating care that is inefficient, wasteful or unnecessary.

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CONFLUENCE OF CHALLENGES

As UM takes on new meaning and increased importance under value-based care, though, healthcare organizations are apt to deal with various challenges such as:

Complying with standards. The Centers for Medicare and Medicaid Services (CMS) requires health insurers to leverage UM to assess care coordination, pharmacy prior authorization and quality improvement while also ensuring that members receive the appropriate quality and quantity of healthcare services at the appropriate time in a setting that is consistent with the medical care needs of the individual. More specifically, CMS requires healthcare organizations to report Part C Organization Determinations, Appeal, and Grievances (ODAG) and Part D Coverage Determinations, Appeals, and Grievances (CDAG) universes.

An organization determination is any decision made by a Medicare health plan regarding:

Authorization or payment for a healthcare item or service;

The amount a health plan requires an enrollee to pay for an item or service; or

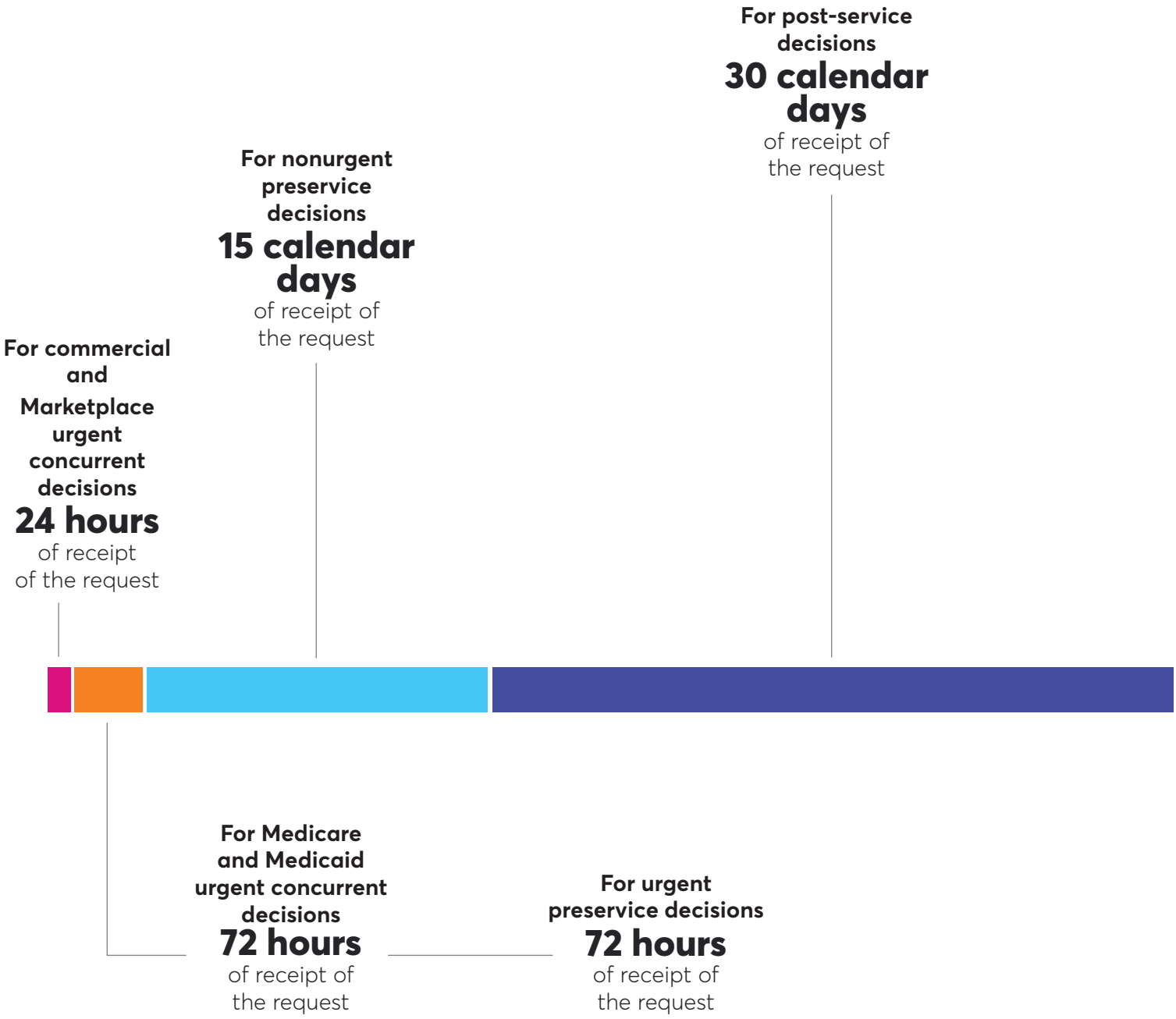
A limit on the quantity of items or services.[1]

Timeliness reviews are incorporated into CMS audit protocols (referred to as ODAG and CDAG) to validate the accuracy of data universes and to measure timeliness in each of the audit areas.

Utilization management timeliness requirements associated with responding to prior authorizations (see chart) are critical. If they are not met for any reason, requests can be appealed or plans can be reported for not being in compliance, which can put these plans at risk for penalties. The appeals or greviances allow members to follow up and potentially have their services approved but they must go through the steps of prior authorization first.

UTILIZATION MANAGEMENT TIMELINESS STANDARDS

The organization adheres to the following time frames for timeliness of non-behavioral healthcare UM decision making:



Source: NCQA Standards and Guidelines for the Accreditation of Health Plans for 2019 -Utilization Management.

To comply with these standards, healthcare organizations need to keep track of a myriad of variables, according to Hill. "CMS requires health organizations to report a variety of things. Was the requesting provider notified within the appropriate timeframe? Did they get the appropriate letter notification? Was verbal notification provided if a service was denied? Was the healthcare provider organization provided with the information that is needed to register an appeal on a denied service?" she said.

Compliance with these timeliness standards ensures that members have access to medical and pharmacy benefits and services — and are not being harmed due to delays in receiving such services. Health plans should be aware of the fact that timeliness has been a major finding for both medical and pharmacy cases in program audits. As such, properly reporting timeliness helps reduce a healthcare organization's risk of being audited by CMS.

While CMS standards provide a baseline for healthcare insurers and other organizations that are taking on risk under government programs, the National Committee for Quality Assurance (NCQA) adds to these standards by addressing the needs of commercial plans as well as policy and procedure requirements.

To comply with NCQA Utilization Management Accreditation standards, health plans need to:

Leverage fair and timely utilization evaluations that rely on objective, evidence-based criteria

Collect and use of relevant clinical information to make utilization management decisions

Ensure that qualified health professionals assess requests and make utilization management decisions

Support alignment with state requirements

Keeping tabs on changes. CMS reviews UM regulations each year, provides a notice and allows public comment on proposed updates to the regulations. These updates are then approved and typically are published in October. NCQA updates standards and guidelines once a year unless inconsistencies are discovered, which could potentially require additional clarifications to be made.

"With all the changes, there is a lot of grey area and that puts a lot of stress on utilization management departments. Because standards change, utilization managers then have to go back and figure out what has changed in reporting, what has changed for capturing data requirements, and what the standards bodies don't care about anymore and what they don't need prior authorizations for anymore," said Nannette Sloan, Vice President, Compliance at Medecision.

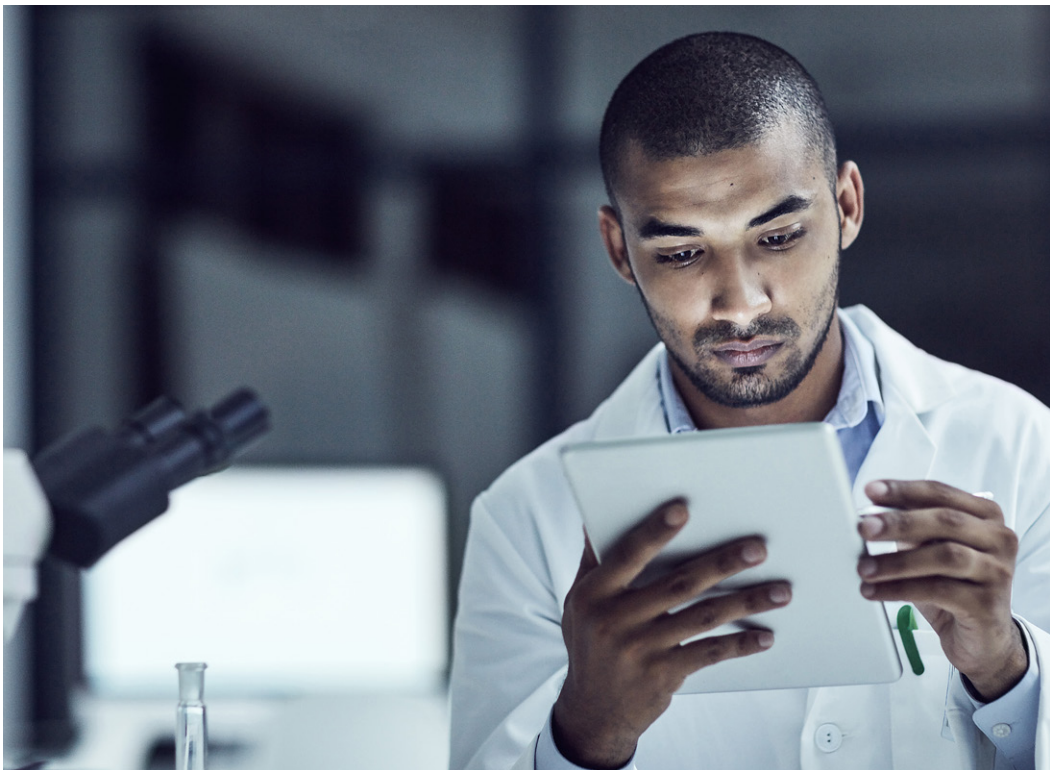
To help alleviate some of this burden, NCQA works closely with CMS to coordinate requirements and make it possible for health plans to monitor and report on information at once. This helps reduce the burden on the plans, as it can become extremely difficult to comply with and report on many standards.

Reconciling inconsistent UM practices across health plans. Utilization management is handled differently from plan to plan. Some plans, for instance, uses NCQA standards while other utilize URAC standards. Health plans, however, often need to consult with other health plans for peer review, if they do not have the expertise on staff to approve a specific service for a member or when seeking a second opinion to confirm if an approval or denial is appropriate. In addition, health plans often seek input from other plans to avoid any potential representation of bias toward either a service or a particular provider. For example, a requesting provider might also be part of the health plan as an ad hoc reviewer or as a member of the board.

"When health plans seek reviews from other plans, the requests are made in paper formats, which is really old school. Health plans are still notoriously faxing things, and we know if you fax, you could send the information to the automotive repair shop down in Chattahoochee, Georgia, and you don't know who's seeing somebody's medical information," Sloan warned.

Efficiently processing prior authorizations. The prior authorization process is especially troublesome for healthcare organizations. Consider the following: 69% of physicians find it difficult to determine whether a prescription or service requires prior authorization and 85% of physicians contend that prior authorization interferes with continuity of care, according to a survey conducted by the American Medical Association in 2018.[3]

Manual processes add to prior authorization frustrations. The following scenario illustrates the inefficiencies: Mr. Johnson visits Dr. Smith for chronic back pain and the doctor orders multiple services. With the manual authorization, the CT scan is denied as 30-day benefit limit is used; the pain management specialist that the patient is referred to is out of network; the diagnosis of back pain does not support nutritional counseling due to a bad CT code; and physical therapy benefits are limited by the Medicare plan to 5 visits in 30 days. Because the services cannot be provided, a follow-up visit with Dr. Smith will be required; Dr. Smith will need to update requests and wait for approval; and, perhaps most disconcerting, Mr. Johnson's chronic pain will continue untreated.



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AUTOMATION ADVANTAGES

The prior authorization process can be improved through automation, however. With an automated UM provided via a solution such as Medecision's Aerial®, the CT scan is completed at the hospital ER and Dr. Smith accesses results through a common EHR; the in-network pain management returns a list of providers and associated network costs; nutritional counseling systems indicate incorrect diagnosis-for-service match, so Dr. Smith updates the diagnosis and the referral is approved; and the preferred network physician therapy provider receives the approved 5 days request electronically.

In sum, the SaaS-based tool automates authorizations and referrals to drive compliance and reduce costs for health plans with substantial Medicare and Medicaid populations. What's more, the solution captures all of the information needed for reporting, so healthcare organizations can easily supply information to CMS and NCQA.

Indeed, with electronic UM solutions, healthcare organizations can:

Reduce out of network costs. By proactively managing and guiding members to in-network visits, health plans can more efficiently manage network leakage to control costs.

Manage CMS compliance, and mitigate audit penalties. An electronic system can improve reporting ability, eliminate incorrect documentation and missing or unrequested authorizations. In addition, electronic solutions that include dashboards can be used to proactively identify and then manage compliance issues in real time.

"Healthcare organizations don't want to go into, for instance, an NCQA accreditation cycle and have to figure out what they did wrong six months ago. It's better to monitor compliance on an ongoing basis, and, dashboards can help," Sloan said.

Drive member and provider experience/loyalty with reduced wait times. Because most authorizations can be auto-approved with an electronic solution, the overall approval process becomes much more efficient. As such, providers and patients experience reduced wait times — and increased satisfaction.

Improve outcomes by ensuring the right level of care for at-risk members. Since routine requests can be auto-approved, care managers can focus on authorizations for high-cost services, drugs or procedures to ensure the right level of care for at-risk members.

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BETTER YET

With all of these advantages, it's not surprising that "everybody thinks these electronic tools are the greatest thing since sliced bread. And in the payer world, I would agree," Sloan said. However, prior authorization processes could be improved even further through interoperability enhancements. Project Da Vinci, which aims to accelerate the adoption of HL7 Fast Healthcare Interoperability Resources (HL7® FHIR®) as the standard to support and integrate value-based care (VBC) data exchange across communities.[4] This interoperability standard could improve data exchange between insurers and providers.

"Project Da Vinci is one step above that great piece of bread. It's going to be the sourdough piece of that bread," Sloan noted.

With Project Da Vinci, business rules are applied to prior authorizations and, therefore, such requests can be streamlined even further. With a FHIR-based API, providers can discover in real-time specific payer requirements that may affect the ability to have certain services or devices covered by the responsible payer. In essence, Da Vinci supports "set and go" or the ability to build business rules for providers to ensure appropriate documentation is sent to support a request for services. The business rules then are activated each time a provider sends a request. Documentation is then seamlessly matched to the rule — and an automatic approval is sent, if warranted. As such, health plans and providers do not have to develop and deploy unique integration solutions.

Through the Da Vinci Project, health plans can reduce the administrative burdens inherent in working with providers on patient care, according to HL7 International CEO Charles Jaffe, MD, PhD.

"Streamlining preauthorization is a particularly high-value use case. It's an anathema for clinicians. Clinicians do their best to get preauthorized for every prescription or procedure, but the rules may be different for every payer, and they don't even know the criteria upon which that authorization is judged," Jaffe said. "When they care for the patient in the normal course of events, FHIR can enable a preauthorization algorithm to simply say 'yes, you can do that' or 'no, you haven't met these five criteria yet.' The burden and frustration of preauthorization is solved inherently."[5]

Using HL7 could also help track pre-authorizations that have been in the till for some time. "It could help so many providers not worry about calling and following up on where those 14 and greater days prior authorizations are. The pre-authorizations that really get lost are the ones that are not the urgent. The ones that are greater than 72 hours. A lot of times they sit there in the background until a provider calls the health plan and says that they never heard anything. The Da Vinci project really aims at cleaning that up, which is a great thing in coming from a compliance perspective," Sloan said.

Using these business rules developed via Project Da Vinci will result in a variety of benefits for all parties. Because health plans can provide faster prior authorization turnaround times, providers are apt to funnel more business to them. As such, health plans' Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores and Star ratings can improve. "It's a win-win and it helps everybody work smarter, not harder," Sloan concluded. And, in the final analysis, healthcare organizations can succeed under value-based care models by more expediently delivering high quality care, controlling costs and managing risk.

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