REDEFINING UTILIZATION MANAGEMENT & PRIOR AUTHORIZATION:

LEVERAGING NON-DENIAL, COLLABORATIVE PROGRAMS TO IMPROVE OUTCOMES

HEALTHHELP®

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HEALTH PAYER INTELLIGENCE

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INTRODUCTION

Utilization management has been seen as a necessary evil—burdensome, denial-focused, and a major contributor to care delays despite its proven benefits of reducing healthcare spending and improving long-term patient outcomes—but it doesn't have to be.

Utilization management has evolved since its start after the adoption of managed care in the 1970s and the downward pressure to reduce costs through health maintenance organizations (HMOs) in the 1980s and 1990s.

The Centers for Medicare & Medicaid Services (CMS) and most private health insurers still leverage utilization management for that very purpose.[1] However, insurers have also learned that utilization management and its tools, such as prior authorization, can also improve quality of care, patient outcomes, and even member satisfaction.

Utilization management is therefore defined here as the integration of utilization review, risk management, and quality assurance to ensure appropriate use of resources while promoting high-quality care.

Prior authorizations are part of the prospective review process, requiring providers to submit requests for service or procedure approval before it is rendered. It is one way health insurers have been proactive about appropriation utilization of healthcare services in addition to concurrent reviews, which determine necessity of care during a hospital stay, and retrospective review, which is completed after care has been provided and typically after payment is made on the claim.

More generally, utilization management is also addressing one of healthcare's biggest problems: variation in clinical practice and waste. The US spends nearly twice as much on healthcare versus comparable countries[2] but about one-quarter of that spending is attributed to waste.[3] Clinical variation can lead to waste, adding to the major drivers of waste: failure of care delivery, failure of care coordination, and overtreatment or low-value care.

UTILIZATION MANAGEMENT HAS COME A LONG WAY SINCE ITS PRIMARY ROLE AS A COST CONTROL TOOL.

Utilization management has come a long way since its primary role as a cost control tool. But health insurers will need to overcome the challenges of prior authorizations and other management strategies for the healthcare system to realize the full benefits of new utilization management programs. Addressing these challenges will bring a next-generation approach to utilization management that uses a "non-denial" program to ensure not only appropriate but high-quality care.

[1]*Prior Authorization and Pre-Claim Review Initiatives*. CMS. (2020, August 31). https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives.

[2]Cox, C., & Kurani, N. (2020, September 28). *What drives health spending in the U.S. compared to other countries*. Peterson-KFF Health System Tracker. https://www.healthsystemtracker.org/brief/what-drives-health-spending-in-the-u-s-compared-to-other-countries/.

[3]Parekh, N., Rogstad, T. L., & Shrank, W. H. (2019). Waste in the US Health Care System. *JAMA*, 322(15). https://doi.org/10.1001/jama.2019.13978

OVERCOMING THE CHALLENGES OF PRIOR AUTHORIZATION

Provider perception is a major hurdle for utilization management success. A recent survey conducted by the American Medical Association (AMA) found that 94 percent of physician respondents reported delayed access to necessary care because of prior authorization. Ninety percent also said prior authorizations have a somewhat or significant negative impact on clinical outcomes.[4]

What's more, physicians are pointing the finger at health insurers. "You would think insurers would ease bureaucratic demands throughout a pandemic to ensure patients' access to timely, medically necessary care. Sadly, you would be wrong," AMA President Susan R. Bailey, MD, recently said in a press release.[5]

One major complaint from the AMA was that few health plans offer selective application of prior authorizations. In other words, only 11 percent of physicians contract with health plans that offer programs that exempt providers from prior authorizations based on past approval performance and adherence to evidence-based medicine.[6]

Selective application utilization management programs are generally supported by physicians because they reduce the burden of prior authorization, but they don't necessarily identify true high performers since they typically only base exemptions on prior authorization denial and approval rates. Larger provider organizations also have more resources to support prior authorization approval rates compared to smaller practices and those that treat underserved populations.

Another factor contributing to the negative perception of utilization management is a lack of clinical validity. AMA reports that 98 percent of health plans use peer-reviewed evidence-based studies when designing their prior authorization programs, yet almost one-third of physicians report that criteria are rarely or never evidence-based.[7]

ADDRESSING THESE CHALLENGES WILL BRING A NEXT-GENERATION APPROACH TO UTILIZATION MANAGEMENT THAT USES A "NON-DENIAL" PROGRAM TO ENSURE NOT ONLY APPROPRIATE BUT HIGH-QUALITY CARE.

"Non-denial" utilization management programs that emphasize achieving consensus through specialty peer collaboration over issuing denials, can overcome the challenges providers and payers experience with prior authorizations, utilization reviews, and quality assurance.

[4] *2020 AMA prior authorization (PA) physician survey.* AMA. (2021). https://www.ama-assn.org/system/files/2021-04/prior-authorization-survey.pdf.

[5] Physicians call on Congress to address prior authorization reform. (2021, May 14). *AMA.* https://www.ama-assn.org/press-center/press-releases/physicians-call-congress-address-prior-authorization-reform.

[6] *2020 AMA prior authorization (PA) physician survey.*

[7] Ibid.

SHIFTING THE FOCUS FROM DENIALS TO APPROVALS

Dr. Ronald Lopez had that negative view on utilization management when he was a practicing physician and practice owner.

“Because the perception of most providers is that if a health plan requires prior authorization or is doing utilization management, they are essentially denying my request or trying to find a way to deny my request,” Lopez says.

But that all changed when Lopez went into utilization management himself, formerly serving as Chief Medical Officer at a health plan and now as the Chief Medical Officer at HealthHelp.

“My view of utilization management was shaped by the idea that, in population health, you’re looking at the continuum of care to try to alter that care by preventing the need for care in the beginning,” Lopez shares. “So when you’re talking about chronic disease and taking the perspective that you want to promote health and prevention versus just dealing with the issues on a transactional basis as they develop.”

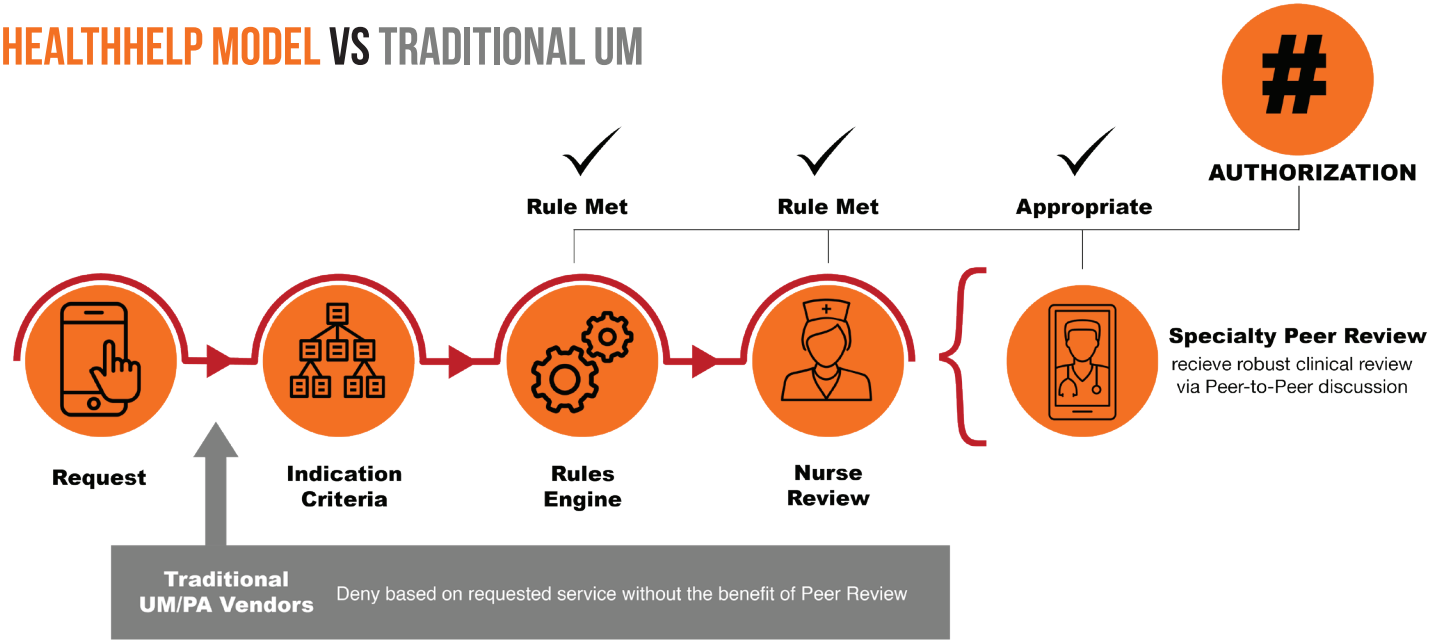
This new perspective helped to shape a new approach to utilization management that espouses a “non-denial” strategy based on education and collaboration to achieve physician consensus.

“Having previously worked under leadership that focused on that deny-for-any-reason perspective—and in those that have not—I’ve found that utilization management doesn’t have to be approached that way,” Lopez explains. “I always approach utilization management from the perspective of: I want to approve this.”

In order to transform utilization management from a denial tool to a collaborative program, a collaborative educational model that leverages

“In other utilization management models, what happens is a request doesn’t meet the criteria, so it gets denied and then only if the provider requests a peer-to-peer and it’s able to be scheduled is there a physician-to-physician interaction. In a model where physician-to-physician interaction is built in, nothing can get to the point that it’s not going to be approved until we have made attempts on our end to actually get that scheduled and have that conversation.”
— Dr. Ronald Lopez, HealthHelp Chief Medical Officer

HEALTHHELP MODEL VS TRADITIONAL UM



peer-to-peer reviews early and often is key. The model, according to Lopez, should engage with providers submitting requests for prior authorizations to go over evidence-based literature to determine if a requested service or procedure is appropriate and whether it will deliver a positive outcome for the patient.

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Peer-to-peer reviews tap the best and brightest in a specific specialty—from centers of excellence, academic medical centers, and other top-tier organizations—to determine the most appropriate service or procedure when an initial request and even a nurse-led review determines it is not. These physicians dive into a particular patient's case, conducting a chart review and delving into evidence-based literature and practice to make a judgment.

Sometimes patients fall into a gray area, Lopez states, that more traditional utilization management methods fail to see. But in the rare event they determine the service should be denied, the peer review physician will then work with the requesting provider to find a course of treatment that would achieve more desirable outcomes and get approved by the program.

This non-denial approach to utilization management addresses provider concerns about the clinical validity of prior authorizations while also preventing potentially harmful—even fatal—care delays.

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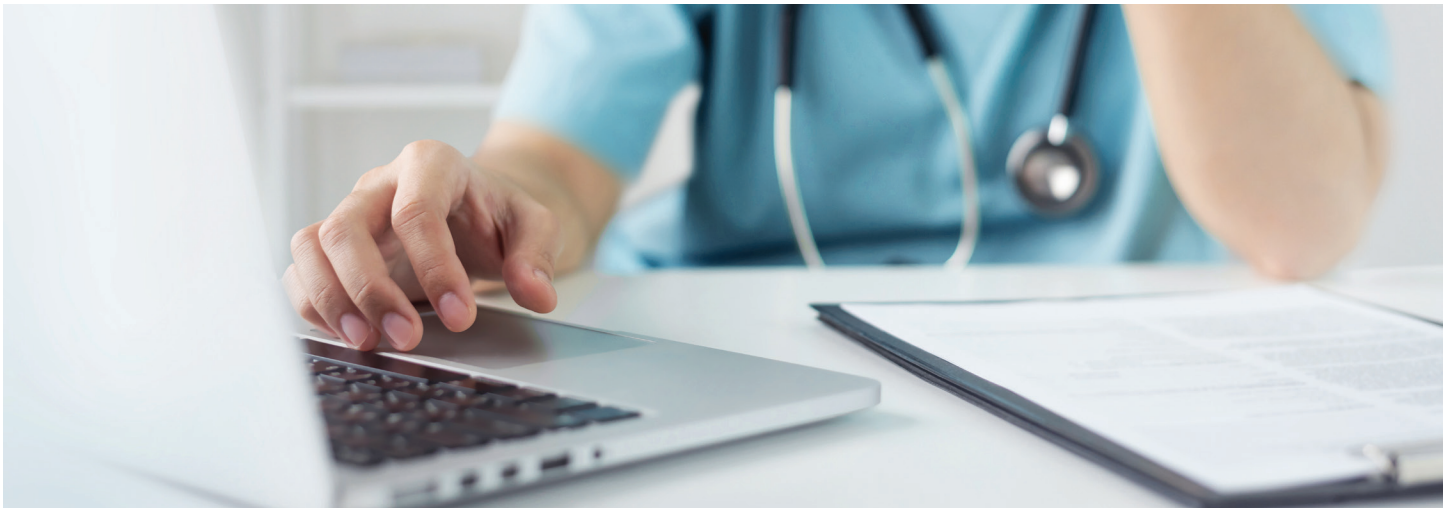
>
> *— Dr. Ronald Lopez, HealthHelp Chief Medical Officer*

"If something that should have been approved doesn't get approved, there's a delay in care," Lopez says. "That provider also has to go through an appeals process. There's extra work for that provider and a delay, both which ultimately affect the member. The value of our model is that we invest in the front-end to eliminate the chance that a request may not be approved."

The collaborative educational component of a collaborative program works to not only benefit the health plan and its contracted providers but really the member, Lopez states.



THE BENEFITS OF A COLLABORATIVE PROGRAM

Members are likely to push for more timely access to care in light of the recent COVID-19 pandemic. Research from Insights by Xtelligent Healthcare Media shows that 45 percent of over 300 surveyed healthcare stakeholders believe patients will demand more timely care after the pandemic, especially with the advancements made in telehealth and telephonic care. Respondents were also split on whether preventative or emergent needs would need to be addressed in a timelier manner.[8]

Implementing utilization management strategies that prevent care delays will be key to not only surviving but thriving in a post-pandemic world.

A non-denial program based on a collaborative educational model can help plans and providers deliver the right care at the right time at the right place—satisfying member demands for timely care and ensuring members always get the highest quality care.

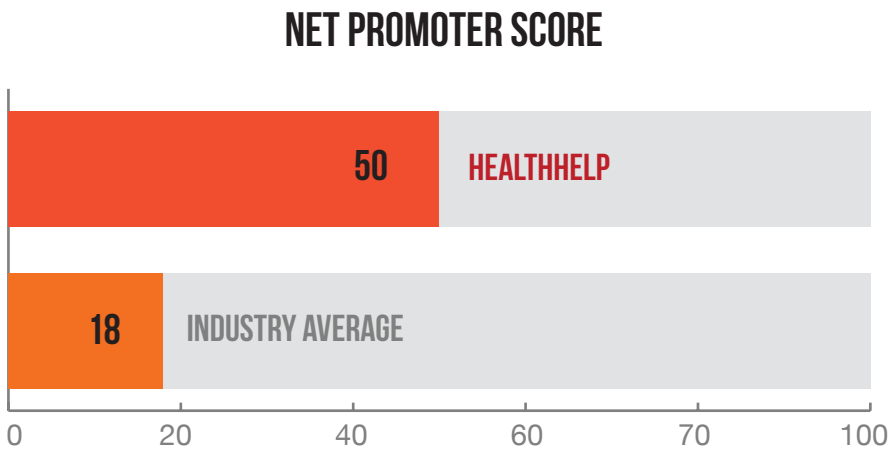
Beyond getting services and procedures approved as quickly as possible, these collaborative programs can impact a provider's practice patterns beyond just one case.

"When we're successfully providing evidence-based information and enabling the physician-to-physician interaction, it not only affects that particular request but it also affects how that physician practices in the future and what type of requests and what outcomes they have with future patients in the same situation," Lopez stated.

Collaborative programs are also evolving to influence not only one service within a member's healthcare journey, but their entire course of treatment. "We're moving toward programs designed as care pathways involving multiple areas that all work together," Lopez explains.

For example, HealthHelp has established a virtual tumor board (VTB) that identifies patients early in the disease process to provide advanced treatment planning for the entire episode of care as it relates to various cancer types. That episode may start with an imaging service to confirm diagnosis and at that point, the plan and the provider know a member has cancer.

"What we're doing is interacting with that physician—be it a member's primary care



[8] (2020). (rep.). *The Future of Healthcare Report: Move Beyond 2020.* Retrieved from https://www.xtelligentmedia.com/insights/future-of-healthcare-report

provider or medical oncologist—at that requesting time and interacting with them to define the treatment plan and discussing further care services during the episode," Lopez says. "We give them the information related to the best care pathways that is out there based on evidence and based on Center of Excellence treatment pathway that they may not have access to."

As a result, the collaborative educational component of collaborative programs "bridges the gap in care and that variation that occurs between places that affects outcomes," Lopez states. In fact, the non-denial approach aligns with the AMA's recommendation that utilization management programs include decision support to aid providers in selecting the most appropriate care pathways that reduce wasteful spending and assure quality and safety of patients.

There is more opportunity in the care pathway space for collaborative utilization management programs and to the benefit of all involved in a member's care. Health plans establish a clinically valid utilization management program that supports high-quality care without the bureaucratic back-and-forth of traditional models, while providers keep their autonomy and work with the most skilled physicians to determine the best care for their patients.

MEMBER CARE IS IMPROVED THROUGH COLLABORATIVE UTILIZATION MANAGEMENT PROGRAMS THAT LEVERAGE CLINICAL PATHWAYS.

All the while, members will receive appropriate care, saving both the system and themselves money, while also realizing better outcomes, safety, and satisfaction.

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HealthHelp, a WNS Company, is a leader in specialty benefits management. HealthHelp collaborates with payers and providers to improve patient safety and deliver quality care through an evidence-based, educative, and collaborative model, focused on improving outcomes, reducing healthcare costs, and reducing healthcare costs.