Because of new reform-driven medical loss ratio requirements, now more than ever health plans’ primary lever on profitability is to reduce administrative costs. Rethinking utilization management (UM) processes, especially those that require payer–provider collaboration, could provide excellent targets for health plans to reduce their administrative costs and inappropriate medical costs.

Preauthorization and other aspects of UM have been effective in reducing inappropriate services and managing medical costs. But the traditional preauthorization process is simply too high-touch and “low-tech.” Whereas claims are reviewed manually only in cases where there is an exception, nearly all UM requests include manual processing. We must begin to manage utilization by exception rather than by manual intervention and put systems in place that approve the vast majority of requests without touching them. This ensures sufficient focus on the 20% to 40% of cases that truly require review depending on the provider practice pattern and procedure specialty.

This next generation of UM uses a prospective, exception-based model that engages providers in a new way, greatly improving the impact of UM on costs while helping to ensure that the most appropriate care is consistently provided. This model facilitates real-time transparency with providers by leveraging automation and evidence-based medicine at the point of care, reducing the hassle that typically accompanies UM. It enables the consistent application of clinical and coverage rules before inappropriate services are performed and ensures timely, optimal care without the administrative costs or burden of traditional programs. This article details the challenges faced today using traditional authorization and discusses the advantages of this new prospective, exception-based approach to UM.

The Current State of Utilization Management

According to McKesson research:1

- More than 90% of authorizations require a phone call or faxed request
- Routine authorizations can take 2 days to 2 weeks to resolve
- The average cost of an authorization is $50 to $75 for providers and $75 to $100 for plans
- The average cost per appeal is $300.

Traditional authorization processes are unable to provide the rich data on utilization and network use that are required in today’s era of cost pressure and reform. This lack of insight hinders the development of policy and of effective, highly targeted provider interventions. Also, traditional approaches lack the coverage and complex reimbursement information for a provider to understand if a care procedure or service is covered.

Further complicating this is the antagonistic impact that UM has on payer–provider relationships. Although the traditional authorization process has been of value to health plans, physicians have typically viewed it as intrusive and burdensome. This perception is exacerbated when plans delegate authorization and other UM services to a third party, positioning that party as the “face” of the plan to its network physicians.

Although physicians lack the data and tools they need at the point of care to make efficient UM decisions, they are open to new approaches. According to a study from the American Medical Association,2 approximately 64% of physicians surveyed have difficulty determining which tests, procedures, and drugs require authorizations. Approximately 63% wait several days for authorization responses on tests and procedures, and 13% wait more than a week.2 In the same study, nearly all the physicians surveyed reported that eliminating traditional authorization hassles is very important (78%) or important (17%). Seventy-five percent of the surveyed physicians believed automated authorizations would help them manage their patients’ care more efficiently.2

When we look at the current state of UM, many physicians would agree that progress has been slow and payers and providers are not on the same page. UM remains much as it was more than 20 years ago, a process that health plans need and physicians still loathe. Traditional UM is perceived as pitting health plans against physicians as they seek permission to practice medicine as they see fit. How can plans take action to improve this dynamic and foster the type of effective, collaborative relationship demanded by the changing healthcare environment to significantly reduce administrative costs and enable better decision-making?

Next-Generation Utilization Management

Based on our experience, health plan executives are
looking to drive clinical and financial decision support to the provider at all points of care. They want to enhance clinical decision-making with consistent, up-to-date evidence and comparative analysis rather than simply ensure that physicians get authorizations for a care event. This more collaborative approach aligns plans and physicians to work together to provide efficient, optimal care and help members avoid clinically inappropriate, out-of-network or noncovered services that can delay or prevent the best care and increase costs.

A prospective, exception-based approach is welcomed by providers, reduces overall costs, and ultimately improves members’ health.1 This next generation of UM involves deploying real-time, fully automated decision support tools to the point of care, including widely accepted evidence-based clinical guidelines, combined with health plan coverage rules, before services are performed and expenses are incurred.

This approach ensures that members receive the right service at the right time in the right setting. It saves health plans from paying for unnecessary expenses and recovering them retrospectively or not at all.

This approach ensures that members receive the right service at the right time in the right setting. It saves health plans from paying for unnecessary expenses and recovering them retrospectively or not at all. Because prospective, exception-based UM automates most of the authorization process, the plan’s clinical staff can focus on only the more complex “exceptions” that truly require their time and expertise.

A prospective UM approach frees up the health plan resources to:

- Engage their providers in a new, transparent, collaborative way
- Reduce the turnaround time for complex reviews
- Insource currently outsourced tasks, leading to better control and consistency with providers
- Expand UM programs to address rapidly growing areas, such as specialty pharmacy and molecular diagnostics
- Increase touch where needed—in care management services to members with complex health conditions
- Scale as membership increases without increasing staff.

Reasons for the Model’s Success

The prospective, exception-based model succeeds because it allows plans to reap the following benefits.

- Identify outliers early on. Research, such as the 2009 national survey on medical expenses by Atul Gawande, MD, MPH, a general and endocrine surgeon at Brigham and Women’s Hospital and the Dana-Farber Cancer Institute in Boston, showed that certain providers drive a larger percentage of improper utilization than others.2 With fully automated authorizations, plans can identify provider-specific practice patterns and utilization trends early in the process and establish unique, automated interventions to address each provider or procedure individually.

- Reward quality providers. Automate new, alternative quality contracts based on performance, and/or “gold card privileges” for providers whose practices are consistent with evidence-based medicine, coverage policy, and other rules of medical appropriateness.

- Provide flexible options. Alternative approaches to in-depth authorization can streamline plan–provider collaboration, while educating providers on evidence-based clinical appropriateness. As a result, health plans can enable behavior change without the intrusiveness of a permission-based process. One alternative is electronic notifications, which are one-way transactions from the provider to the health plan, indicating intent to perform or to order a medical service. These transactions enable plans to gather data to refine or target ongoing UM efforts with reduced effort and time. Notifications are less costly and invasive than authorizations and provide powerful data to address an increase in utilization for a specific service before it impacts the plan’s bottom line.

- Drive more in-network activity. With physicians directing patients to the most appropriate facilities, point-of-care decision support tools can help providers ensure that procedures, care episodes, diagnostics, and other services are performed in-network.

- Drive alignment with providers while accommodating variation. By using widely accepted evidence-based clinical guidelines across care management, payers and providers become aligned in their decision-making and the performance is transparent. At the same time, it is important to quickly see plan-specific rules without manual lookups and telephone calls.

New Tools Enable Health Plans to Revise Their UM Approach

With the capabilities of new, innovative evidence-based decision support tools, health plans can reconsider traditional UM administration. These new decision management solutions provide the infrastructure needed to deploy prospective, exception-based UM, with a light footprint, including:

- Real-time, fully automated provider UM processes (eg, preauthorization)
Evidence-based clinical criteria that provide a common language to drive payer–provider collaboration
Condition-specific criteria that focus on the whole patient, including comorbidities and severity, requiring fewer case managers to intervene, and expediting the transition from retrospective to prospective care management.

In addition, the same UM tools used to support alignment and expense reduction can be leveraged as part of a bundled payment strategy. Specifically, real-time, point-of-care decision support provides the means to identify scenarios that would initiate a care episode and potentially provide integration to back-end bundled payment management. Thus, health plans will be able to address payment reform and leverage their investment in payer–provider UM collaboration tools to support bundled payment initiatives.

By implementing a prospective, exception-based UM decision support platform, health plans can identify:
- Whether a service is covered based on plan benefits
- Whether a service is covered based on medical appropriateness
- What alternative services are medically appropriate if the request is not recommended by clinical evidence
- Which in-network providers are optimal to perform the service
- What level of benefits apply
- Whether to use UM to trigger a care episode and corresponding bundled payment.

A Critical Solution for the Age of Healthcare Reform

Health plans have worked hard to help improve their members’ health and manage medical and administrative costs. However, with increasing utilization, the continuous introduction of new technology, higher medical costs, and the enormous impact of healthcare reforms, the pressure on health plans is unprecedented and daunting. Plan executives need to look at innovative approaches, such as prospective, exception-based utilization management, to dramatically reduce their administrative costs.

The next generation of UM is indeed a prospective, exception-based approach that combines innovative automation with payer-specific clinical and financial decision support. It addresses cornerstones of reform by promoting optimal care at the right cost through a collaborative plan–provider model. This model enables plans’ clinical staff to focus on only the complex exceptions that truly require their skills and expertise.

This new approach to UM is a powerful strategy in this age of healthcare reform for reducing administrative costs and inappropriate medical costs, while engaging providers in a new, collaborative, transparent way that focuses on cost-effective care performance. It helps to ensure consistent, evidence-based care by educating providers in real-time as they order treatments and diagnostics before services are performed and expenses are incurred. This approach also helps to ensure that patients consistently get the right treatments in the first place, eliminating waste in the system and ultimately improving overall healthcare and outcomes.

Author Disclosure Statement
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References