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White Paper

Tammie Phillips, RN
Vice President of Business Consulting
McKesson Health Solutions

Utilization Management is Broken
Here's How to Fix It for a Value-Based World

It was the shot heard 'round the healthcare world. In January, Health and Human Services committed to making alternative payment 30% of Medicare reimbursement by 2016 and 50% by 2018. That was the moment, it could be argued, when the transition from fee-for-service to value-based models was transformed from a movement into a mandate.

The motivation for this goal is twofold: Improve the quality of care and reduce unnecessary cost. One of the ways we attempt to meet these goals is through utilization management (UM), an instrument the industry uses to try to deliver the right care at the right cost. But the current UM system, built for a fee-for-service world, is broken, disliked by providers and patients alike. We can't expect it to work with a modern mix of alternative payment models that require collaboration.

UM as we know it today positions providers and payers against each other. Providers end up resenting post-care decision approvals and payers get positioned as the "cost containment police." There's no place for such an adversarial relationship when delivering value-based care, which depends on shared risk. Payers need to engage providers in the process of cost savings and high-quality care.

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And trust must be part of the equation, something sorely lacking in the current UM system.

Value-based care also requires collaboration, yet during the claims process—the primary engagement between providers and payers—every step is transactional and sequential, not collaborative. We need to invert that. Providers should be ensuring medical appropriateness and considering issues of member benefits while care is being delivered. That's not happening in the main today.

Increasing Efficiency

It's no secret the U.S. healthcare system wastes billions on manual transactions and remediation, yet fails to consistently deliver high quality, evidence-based care. A study by the Journal of the American Board of Family Medicine[1] found the mean annual projected cost for preauthorization activities ranged from $2,161 to $3,430 per physician. A Health Affairs[2] study found nursing staff spent 13.1 hours per physician per week on preauthorization, far more than any other type of administrative interaction.

Is all this overhead producing results? A Kaiser Family Foundation study[3] reported, "the U.S. spends significantly more on healthcare than other nations, both on a per-capita basis and relative to its wealth." Moreover, U.S. spending on healthcare was 42% higher than Norway, the next highest per capita spender in the Kaiser study. Despite spending considerably more, U.S. healthcare system performance ranks last in comparison to other industrialized countries, according to the Commonwealth Fund[4].

We have a UM process. We have guidelines. We have evidence. But we're not using them effectively. Who wants to be admitted to a hospital if they don't have to? Who wants spine surgery if it's not warranted? Certainly providers and payers are conceptually aligned on what matters: Providers want to deliver the right care and payers want to pay for the right care.

> Providers and payers are conceptually aligned on what matters: **The Right Care**

When researchers run the numbers, however, it becomes clear that traditional UM isn't living up to its full potential.

That's the bad news. The good news: By employing a "new UM" process designed for a value-based world, payers can influence decisions as they're being made, streamline the administrative burden, and better engage providers in a collaborative relationship that supports value-based care.

A New, Real-Time Model

How do we get from a broken traditional UM system to a new UM system? Payers need a way to apply automation to authorization based on data—the latest medical evidence, provider utilization patterns, and value rankings—and do so in real-time with little to no burden on providers. Likewise, providers need to share information collaboratively with payers, and adjust when care patterns reveal insights on efficiency and patient outcome.

This new, real-time UM model that uses data to automate a lot of today's onerous processes helps ensure communication among stakeholders happens at the point of decision through the use of healthcare technology in the cloud. The model doesn't require a review of every transaction. Instead, it is exception-based, meaning the vast majority of approvals happen automatically and instantly. Only the exceptions—those transactions that can't be determined automatically based on clinical and business rules—are manually reviewed. The new UM model may also reward physicians who practice evidence-based care by giving them more freedom and dramatically reducing the administrative cost and burden.

Instead of the current manual authorization process, providers in the exception-based UM model can access a payer's clinical guidelines and payer rules automatically, informing their care decisions. A provider will get an immediate automated approval or denial, or be notified that a claim has been tagged for manual review.

The level of prior authorization required is based on how well a provider's practice patterns align with evidence-based practices. Payers can set looser requirements and lower hurdles for those providers who are frequently approved. Meanwhile, tighter requirements can be set for those providers who frequently request care that the evidence indicates is not medically necessary.

> The mean annual projected cost for preauthorization activities ranged from **$2,161 to $3,430 per physician**

Once authorization requests are being submitted consistently to the payer UM/CM (care management) system, the payer can query the database to see how often care decisions are being approved for any particular provider and identify outliers. The system uses data analytics to identify practice patterns and variations. Hopefully, over time, underperformers can be brought into alignment with the clinical guidelines and payer rules, further reducing the need for manual interventions.

Compare this new exception-based UM model to the current UM system, where payers and providers incur significant administrative costs and burden on prior authorizations that, in the end, are approved, often delaying patient care. In this new UM model, it can take just a few minutes to get an approval, instead of days or weeks. And once providers are practicing in line with evidence and a payer's policies, approval may become automatic or no longer required.

Collaborative vs. Transactional

When payers and providers can collaborate on care instead of being trapped in a transactional relationship, that's a true advancement. Prior authorization starts to look like a notification from the provider rather than a request for approval. The provider might spend 20 seconds on an authorization instead of hours, days, or weeks. Better still, the provider is no longer in the long-derided "Mother may I?" role.

In this new UM model, it can take **just a few minutes to get an approval,** instead of days or weeks

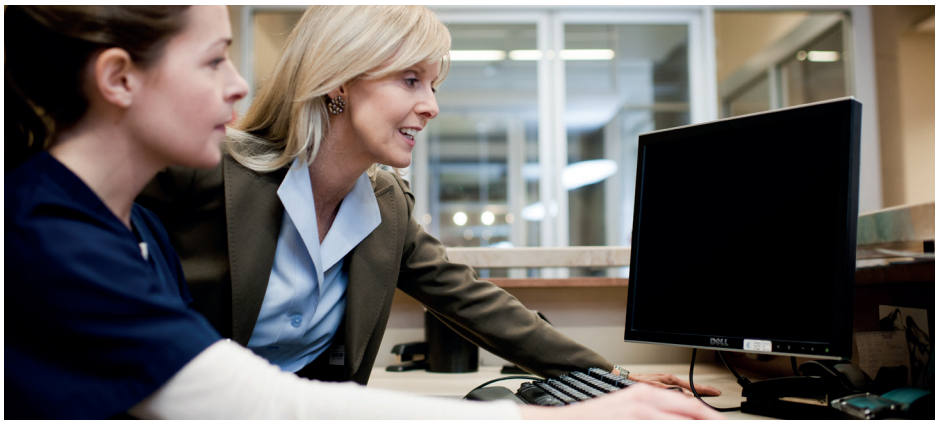
For payers, using exception-based UM can take an enormous load off the system, freeing staff to focus on those fewer providers causing waste or areas where there is great variation. Payers only touch transactions when they're pended for further review or when an intervention is required.

Why now for this exception-based UM model? Firstly, we finally have the technology available to make it happen. Cloud-based technology that combines contemporary connectivity with stakeholders' existing care management systems, payer portals, and IT infrastructure is now available. This cost-efficient, service-oriented "embrace and extend" approach quickly and easily connects a provider's and payer's workflow.

Secondly, the value-based care imperative. As the pace of the value-based payment transformation accelerates, the payer-provider relationship must be aligned and collaborative, and based on shared technology and shared information.

Payers need to trust that providers are practicing based on the medical evidence and reward them for it through an exception-based UM approach. Payers will have a more effective engagement program that facilitates genuine collaboration with their providers. And providers will be able to deliver quality care faster and for less cost.

The answer to UM's woes is a kinder, gentler approach that puts collaboration through automation at the forefront. This exception-based UM model is well-aligned to the future of reimbursement, and makes optimal use of the robust technical capabilities at our disposal today. It might well be one of the biggest steps we can take to help payers and providers meet CMS's ambitious value-based payment objectives and larger goal of a value-based healthcare system.



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McKesson Health Solutions

McKesson Corporation
275 Grove Street
Newton, MA 02466

www.mckesson.com
mhs@mckesson.com

Connect with us:

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