Advisory Board

RESEARCH

for the entire health care ecosystem

Health plan department series | Volume 1

Health Plan Utilization Management

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Key takeaways

- Often when people think of utilization management (UM), they think of prior authorizations. But UM departments have a wide range of responsibilities to maintain quality of care and manage spend.
- Tracking key performance indicators (KPIs) is critical to maintaining appropriate utilization and building a strong foundation to track provider adherence and utilization over time.
- UM departments rely heavily on partnerships with vendors. Some plans outsource more than half of their UM responsibilities, including management of specific benefits related to cardiology, musculoskeletal, durable medical equipment, and radiology.
- Health plans commonly develop UM criteria based on either MCG guidelines or Change Healthcare's InterQual guidelines. In turn, these guidelines inform what to cover (and not cover) and/or which prior authorizations to require.

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What do they do?

UM departments track and approve care utilization to manage medical spend and maintain high-quality care. For example, the plan can review a member's imaging claims to see if they are exceeding a safe level of radiation exposure by undergoing unnecessary exams.

Often when people think of utilization management, prior authorizations (PA) are at the forefront of their mind. Prior authorizations aren't merely the approval or denial of medical services. **PAs can involve certifying preadmissions and admissions, manual data review, appeals for denied services, and case management referrals.** While PAs are a core component of what utilization management departments do, they are not the only thing.

What UM departments do

- Prior authorizations
- Preadmission and admission certification
- Discharge planning
- Prospective, concurrent, and retrospective review
- Appeals
- Case management referrals
- Data review
- Length-of-stay monitoring
- Sites-of-care review
- Provider trainings
- Vendor management

In addition to overseeing the prior authorization process, UM staff manage spend through various mechanisms such as **monitoring the length of inpatient stays, shifting inpatient care to outpatient, informing members of payment responsibilities prior to completing medical procedures, and reviewing sites of care.** UM departments work to redirect members to less-intensive settings (for example, a PCP office instead of the emergency department) when appropriate, which is ideal for health plans and their members.

Other tasks UM leaders are responsible for include educating providers on medical policies and requirements, trending and reviewing historical claims data, fostering and improving relationships in their provider network, and managing vendors. UM staff spend a great deal of time streamlining policies to ensure accuracy and transparency to minimize surprises for consumers and providers.

What KPIs are tracked?

When it comes to key performance indicators (KPIs), utilization management departments track metrics for their wide range of responsibilities. The main KPIs that plans track for UM are:

Process measures

- Number of claims processed
- Approval and denial rates
- Percentage of appeals approved
- Claims turnaround time (TAT)
- Number of cases read by medical director
- Number of PAs reviewed per nurse

Outcomes measures

- Utilization rates compared to previous years
- Admissions per thousands
- Length-of-stay reduction
- Cost per day (inpatient stay)
- Readmission rate
- Total cost of care (TCOC)

Plans often benchmark these metrics to their own historical data. Many will also use benchmarking third-party data such as Milliman's or Sherlock's. The goal is not always to decrease these metrics. For example, plans don't want to have too many processed claims but also not too few—they want to be aligned with other competitor plans in their market.

Some may wonder why tracking certain metrics is necessary when prior authorization approval rates can be as high as 90% or greater. Plans have mentioned that the **sentinel effect, the tendency for people to improve their behavior when they're being monitored**, plays a role here.

Plans can measure the sentinel effect by tracking provider utilization after PA criteria are removed or after a provider is "gold carded." Gold carding exempts providers with a high approval track record from prior authorization requirements.

Additionally, even if 90% of PAs are approved, 10% are not. If we multiply this denial rate by thousands of beneficiaries, this becomes a sizable amount of inappropriate utilization from the plan's perspective.

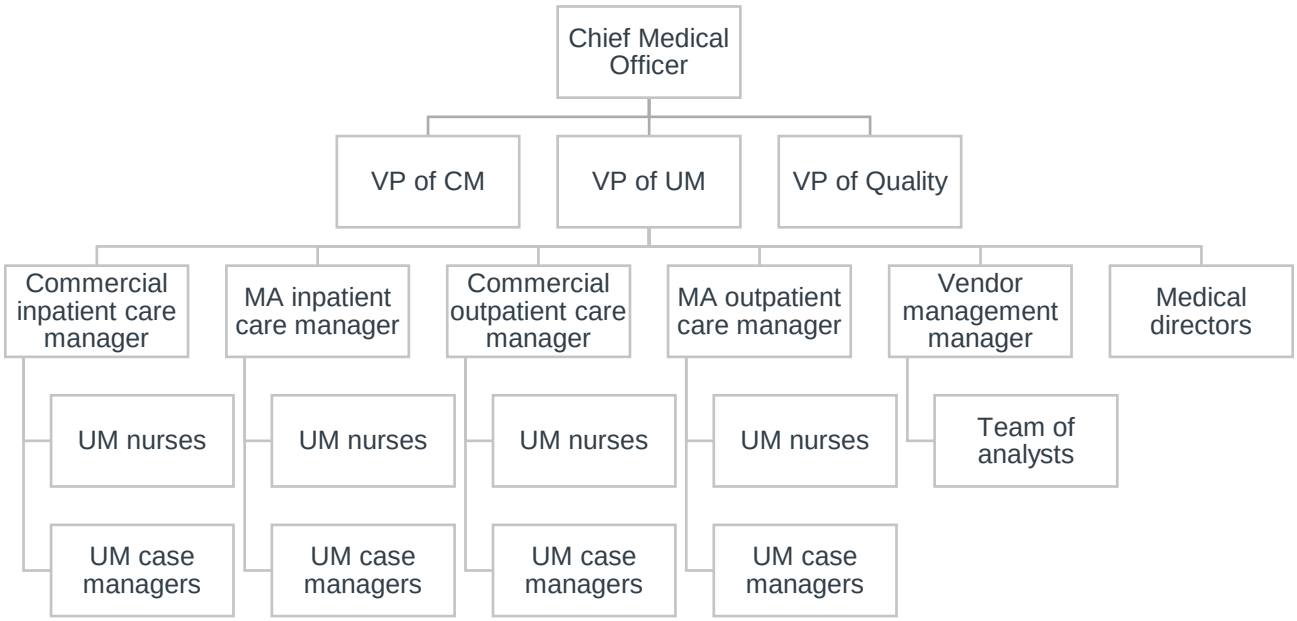
How are they organized?

Health plan UM departments usually employ hundreds of staff members with a range of responsibilities. As much as 40% to 60% of the department is made up of clinical staff, depending on the plan.

At the base of a plan's utilization management department are non-clinical staff who are responsible for collecting UM requests (from faxes or downloaded digitally), organizing the paperwork, and triaging it to the appropriate nurse for review. These UM case managers (also known as UM analysts or UM specialists) are paired with a clinical UM nurse—either 1:1 or in groups.

One step above, there are UM managers or supervisors who oversee groups of UM case managers and nurses. Also, there are various medical directors—these doctors review denials, unique cases, and have their own specialties.

Illustrative example of a plan's UM organizational structure



At the highest level, there is a director, VP, or SVP of utilization management. Many plans also have multiple directors and VPs, with the division varying by plan. For example, plans could divide leaders based on business line (commercial, MA, etc.), type of review (prior authorizations, post-service review, inpatient reviews, etc.), by responsibility (vendor management, inpatient care, outpatient care, operations, etc.), or some combination of the above.

These leaders then report up to an executive, usually the chief medical officer, who also oversees other clinical departments such as care management, quality improvement, and more.

The UM department often works closest with the care management team because members with high utilization can be referred for care management support. UM also works closely with the finance team to forecast spend trends and set goals, the medical policy team to create and adjust new UM criteria, and the pharmacy UM team since pharmacy UM is often managed by a separate team.

How do they work with vendors?

In addition to employed staff, based on our interviews, health plan UM departments outsource anywhere from 30% to 70% of their UM to outside vendors. Usually, smaller plans outsource more components because it costs a lot to hire specialized clinicians. For example, hiring a radiologist to oversee radiology UM could cost over $1 million including benefits, and this doesn't account for the whole team that would be required. **On pages 17, 18, and 19 of this report, we have included a list of the most common vendors cited by plan UM leaders during our interviews and the areas that these vendors specialize in.**

Plans start looking for vendors when utilization rates and medical spend are higher in a certain area than in previous years, or if they notice that other plans outsource an area of UM. Plans will then put out a request for proposals (RFP) to compare vendors. Some plans even have their internal department submit an informal RFP to decide between doing it in-house versus outsourcing to a vendor.

Vendors are increasingly offering outcomes-based contracts to make their RFP responses more competitive.

- Some are **pay-for-performance,** and payment is based on the vendor meeting pre-determined metrics. For example, a metric could be the appeals overturn rate because if this number is too high, it begs the question why were these requests denied in the first place.
- Another option is **PMPM or PMPY (per member per month/year) full-risk contracting** for a specific member population. This is challenging for some subspecialties if the members have multiple comorbidities.

- Some vendors guarantee a **discount on medical spend** from the past year. For example, if the plan spent $100 million on all physical therapy procedures with their in-house UM department or another vendor, this new vendor could guarantee a percentage discount from the $100 million base amount and keep additional savings as their payment.

Besides cost savings, here are some things that health plan UM departments look for in a vendor in the initial appraisal or when they renew:

- **Acting like a partner, rather than a point solution:** This was by far the most common answer we heard. Plans want a vendor that when presented with a problem, they say, “Let’s try to figure this out together,” rather than pointing out how it isn’t included in the contract or giving excuses for why certain metrics weren’t met in a quarter. One executive shared, “The best vendors are those you can’t tell don’t work at your plan until you see their email address.”

- **Seeing savings quickly:** While many vendors boast savings in three to five years, year over year (YOY) savings are ideal, especially in lines of business with fast member churn.

- **Easy implementation and short timeline:** The length of time to fully implement the solution is just as important as the length of time to see savings. Plans don’t want vendors to put the burden on them to implement and show success– saying, “Our solution can do X, but first we need the plan to provide Y and Z.”

- **Being progressive with technology:** Successful health plans use vendors to push where the plan may be lacking with outdated tech capabilities. Plans want to see that their vendors are nimble and applying the newest technologies. Furthermore, plans look for vendors that strategically invest in their futures so the vendor remains the best one to partner with in a decade.

- **Personalized, actionable data analysis:** Rather than just boasting data capabilities, plans want vendors to proactively share insightful next steps. For example, saying, “We ran the data and noticed that hospital X is never meeting Y criteria for prior authorizations so you should hold a training with them.”
- **Few to no internal complaints:** While cost savings may not show for years, health plans use satisfaction metrics as canaries in the coal mine. Plans track their employees’ complaints, member satisfaction scores from surveys, and sometimes external audits to decide if they want to switch vendors.

Three core characteristics

01

CHARACTERISTIC

UM leaders prioritize areas of spend that are expensive, variable, and inflectable

02

CHARACTERISTIC

Plans use a variety of methods to develop UM criteria and coverage rules

03

CHARACTERISTIC

Plans try to increase provider collaboration to reduce UM administrative burden

01 UM leaders prioritize areas of spend that are expensive, variable, and inflectable

We interviewed UM leaders across the country, and they identified the following categories as top priorities for managing spend.

Top categories of spend that plan UM departments are prioritizing

- Inpatient care
- Post-acute care
- Cardiology
- Orthopedics
- Musculoskeletal (MSK)
- Pharmacy
- Radiology and advanced imaging
- Physical therapy and occupational therapy
- Speech therapy
- End-stage renal disease (ESRD)
- Neonatal intensive care unit (NICU)

Many of these areas align with our analysis of highest-cost claims for the commercial line of business, but interestingly, it's not an exact duplicate. For example, immunizations are in the top 10 highest-cost claims (when aggregated) for the commercial line of business, but they are not in the top categories of spend that health plan UM departments are prioritizing because people are typically not overutilizing immunizations and immunizations can help manage medical spend in the long run by keeping members healthy.

Additionally, some areas can be **expensive** but not a UM priority depending on the plan's line of business/membership, how **variable** costs are in the specific area, and if the utilization is **inflectable.** For example, MSK care is highly variable—the same knee replacement surgery could cost tens of thousands more when done by one provider over another. And NICU utilization is highly inflectable—many cases of babies with NICU stays could have been prevented with appropriate prenatal care.

02 Plans use a variety of methods to develop UM criteria and coverage rules

Most health plans use **MCG guidelines or Change Healthcare's[1] InterQual guidelines** to develop UM criteria and decide what services to cover. Both are evidence-based clinical decision support solutions based on medical journal analyses and years of historic data. Which guidelines a health plan chooses typically depends on which is easier to implement with the plan's other technology platforms and their provider network's technology platforms.

Plans also keep a close eye on what their purchasers request. For example, plans use the **Centers for Medicare and Medicaid Services (CMS) policies** as a baseline for their own medical policies. This is true not only for Medicaid and Medicare Advantage lines of business, but also for commercial lines. Group insurance is unique because UM policies will consider the **employer's product design requests as well.**

But plans don't rely solely on clinical decision support vendors and purchasers, especially when they must make quick decision on newer therapies such as CAR-T therapies and genetic testing. There are two additional departments plan UM departments work with to make coverage decisions:

- **Data analysis department:** UM departments work closely with health plan data teams to analyze trends in claims data. Plans set up alerts if utilization is abnormally high for a certain procedure or in a certain region, and then create or adjust prior authorization protocols accordingly. This is also how plans determine if their utilization rates are "regular." Plans don't judge the success of their utilization management department by the number of PA denials. Rather, it's more important that utilization numbers are in the expected range (for example the number of admissions per 1,000 members).

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Plans can set up these acceptable ranges based on their own historic data, but most also use **Milliman benchmarks.** There are still some limitations because depending on benchmark definitions, plans may not be able to directly compare themselves with their peers.

- **Medical affairs department:** UM departments work closely with the medical affairs or medical policies team to decide PA criteria. These teams regularly review peer-reviewed medical journals for the most recent guidelines. They also continuously read what medical associations publish on new and up-and-coming therapies. Similarly, Blues plans monitor the Blues Association's UM guidelines to make sure they are aligned with the national association.

Sources plans use to determine UM criteria

- InterQual or MCG
- Trends in claims data
- Medical journals
- CMS rules
- Employer requests
- Associations
- Large, national plans
- Internal and external committees
- Providers in their network

Plans also rely on multiple committees when creating their UM criteria:

- **Committees of medical directors** often oversee changes in UM criteria. These committees bring together plan physicians with a variety of specialties. Many plans will also look at what the **large, national plans** are doing, since these plans often have a larger bench of medical experts to lean on.
- **Committees of health plan staff beyond the UM team** collaborate to approve UM criteria. These committees can include representatives from different teams including payment policy, claims, provider communications, care management, and network management.
- **Committees of providers from the plan's network** allow physicians who will have to request prior authorizations to participate in creating the PA rules. This is especially important for providers who are or are considering moving into downside risk. One health plan we interviewed had a provider committee consisting of half PCPs and half specialists.

03 Plans try to increase provider collaboration to reduce UM administrative burden

An American Medical Association (AMA) survey found that providers and their staff spent an average of two days a week on prior authorizations. **Both plans and providers want to reduce the amount of administrative burden caused by prior authorizations.** This is especially problematic now, because staffing shortages are impacting provider organizations at all levels. Reducing the administrative workload for provider offices is crucial to prevent burnout.

Below are five examples of ways plans are trying to improve collaboration with providers to improve UM processes:

88%

Of physicians describe PA burden as "high" or "extremely high"

41

The average number of PAs per physician, per week

Digitizing and automating prior authorizations

One of the things UM departments want most from providers is for them to submit PA requests through the health plan portal rather than by fax. Many provider offices still fax PA requests simply because it's easy – they just send all the documents they have. Inputting the relevant information into a portal takes time, and providers may work with 10 or more health plans, each with a different portal. In response, many plans are trying to improve the user interface of their portals. Plans are also encouraging providers to use their portals by giving immediate answers to PAs sent through the portal.

Source: "Measuring progress in improving prior authorization," American Medical Association, Prior Authorization Physician Survey Update | AMA (ama-assn.org); "2021 McKinsey Future of Work in Nursing Survey," McKinsey & Company, The US nursing workforce in 2021 | McKinsey

Collecting provider feedback to design UM processes

Health plans recognize that creating UM criteria in a vacuum will upset their network providers. Therefore, plans regularly ask providers for their feedback on UM criteria and processes through provider relations teams. Plans also use touchpoint meetings where they allow a board of providers to share their thoughts with plan UM leaders.

Training providers regularly on PA requirements

Providers are always asking plans—what *exactly* are you asking for with your UM criteria? What does my office need to submit for an approval? For example, if smoking cessation is required to approve a certain surgery, what specifically exemplifies smoking cessation (since this could vary by plan)? Plans have responded by trying to educate providers on changing UM criteria through various modes. Some plans offer a one-pager with checklists to help providers navigate medical policies. Others have regular meetings with provider offices to train them on what needs to be submitted for a PA.

Delegating UM to risk-bearing providers

Risk-bearing providers, especially those in downside risk, need visibility and control into utilization to manage medical spend. Some plans delegate UM to providers with full capitated risk. Plans also delegate UM to providers who aren't yet in downside risk to ease them into the responsibility. Plans want to make sure provider offices are prepared. Delegating UM to providers too soon might burn their desire to take on risk in the future.

Standardizing PA forms across health plans

PAs consume a lot of providers' time because each plan varies in form requirements and submission processes. Some plans (and state agencies) are trying to standardize PA forms so that regardless of the plan, the provider can fill in the same fields, in the same order. Unfortunately, this is easier said than done, since plans have different UM requirements based on membership, line of business, clinical guidance vendors, and employer-sponsored product requests.

Early stories

Below are some early stories of how plans are trying to improve their UM processes and prior authorization rules.

PA reduction stories

- **Pepper plan (pseudonym)** noticed that approximate length of stay (LOS) is available for physical conditions in national guidelines, but not for behavioral health (BH) conditions. The hypothesis was that they were approving shorter LOS for BH conditions, resulting in many more reviews for each admission. Pepper sifted through LOS by diagnosis using retrospective claims data to create approximate guidelines for themselves and successfully reduced the number of authorizations required to extend the LOS for BH conditions.
- **Highmark** completely removed PAs for 40 chemotherapy drugs if providers followed **standard clinical guidelines** set by the National Comprehensive Cancer Network (NCCN).
- **Health Plan of San Joaquin** considerably **reduced the number of codes requiring PA**. To ensure limited risk and exposure, HPSJ eliminated only codes that satisfied three criteria: low cost, high volume, and high approval rates.

Technology-based stories

- **BCBS South Carolina** invested in a new **PA tracker** in their mobile app and web portal which allows members to track the progress of their PA requests through various stages of the approval process.
- **L.A. Care** automatically approves PAs for specialty referrals if the PCP gets a **second opinion** from an in-network specialist through e-consults.

Value-based care stories

- **Independent Health Plan delegated PAs** to a provider practice—but only after supplying the practice with cost information for a drug class with wide cost variation.
- **Aetna** (and other insurers) have entered **performance-based agreements** with Novartis for Entresto, a high-cost drug that reduces the risk of heart failure. Novartis reimburses Aetna (and other insurers) based on rates of hospitalization and overall cost savings for the plan.

List of example vendors

While Advisory Board is vendor-agnostic, below is a list of some common vendors that plan UM leaders told us they like working with, in alphabetical order.

AIM Specialty Health

Specialty area: Radiology, cardiology, musculoskeletal

AIM is a platform that uses evidence-based clinical guidelines to provide real-time decision support. Their goal is to deliver cost savings across an ever-growing list of clinical domains.

American Specialty Health (ASH)

Specialty area: Musculoskeletal

ASH has a focus on musculoskeletal and health management programs to help plans improve their members' health. ASH provides a musculoskeletal provider network with more than 60,000 practitioners.

Avalon

Specialty area: Laboratory

Avalon helps health plans improve member care and reduce cost utilizing their expertise in lab data and analytics. Utilizing their network, Avalon helps plans lower test costs and reduce inappropriate laboratory testing.

Carecentrix

Specialty area: Home health

Carecentrix's main product is called HomeBridge, a whole-person, home-centered care coordination approach. Through their home health model, they have helped plans achieve as much as 35% in savings annually.

Evicore

Specialty area: Cardiology, musculoskeletal, post-acute care

The company provides benchmark data, clinical guidelines, and support for prior authorizations. The company uses proprietary analytics to assess over-utilization and unnecessary spend to help plans improve care and increase savings.

Landmark[1]

Specialty area: Care management

Landmark approaches care using the patient's personal health characteristics instead of historical utilization. Landmark provides whole patient care and has reduced hospital admissions by as much as 25%.

naviHealth[1]

Specialty area: Post-acute care

NaviHealth pairs in-market clinical support with predictive decision-support tools to increase patient satisfaction and reduce unnecessary spend. NaviHealth manages almost 10 million Medicare Advantage recipients.

New Directions

Specialty area: Behavioral health

New Directions partners with health plans to manage costs and continuum of care for medical care related to behavioral health. Using personalized solutions and social determinants of health, they help plans identify the right care.

Northwood

Specialty area: DME

Northwood is a diverse vendor, with the core of their offerings in durable medical equipment, prosthetics, orthotics, and medical supplies. Northwood partners with plans in pre-authorization, rent-to-purchase equipment, and appropriate care.

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OrthoNet

Specialty area: Orthopedics

OrthoNet manages orthopedic specialty benefits and helps payers deliver orthopedic care. Their musculoskeletal expertise assists plans with achieving cost-effective care and improved quality.

Turning Point

Specialty area: Musculoskeletal

Turning Point is a UM company with a broad reach across multiple clinical disciplines. Their business model identifies and removes high-cost and low-efficacy treatments.

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