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Prospective, Exception-Based Utilization Management

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Executive Summary

Today is no ordinary time in healthcare. Health plan executives (plans) are facing relentless pressure to better manage costs while increasing access to care. With rising utilization and costs, members, employer groups, government entities and regulators are all demanding more affordable premiums. Larger provider organizations are driving tougher negotiations. Meanwhile, federal reform is requiring payers to expand member care by eliminating pre-existing condition and lifetime benefit limitations, adding “minimum” benefits, and including coverage for the uninsured.

Solutions to address these challenges must help rein in cost growth while improving collaboration with providers and ultimately, health outcomes. In the past, preauthorization and other aspects of utilization management (UM) were effective in reducing inappropriate services and managing medical costs. But traditional preauthorization lacks the speed, transparency and holistic approach necessary to maximize UM effectiveness.

The next level of UM is a prospective, exception-based model that greatly improves 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. Enabling the consistent application of clinical and coverage rules before inappropriate services are performed ensures timely, optimal care without the administrative costs or burden of traditional programs.

This paper details the challenges faced today using traditional authorization and discusses the advantages of a prospective, exception-based approach.

Where We Are Today

Plans are facing more pressure than ever to find innovative ways to reduce costs and improve quality of care. The grip is tightening on all sides: Healthcare costs and use continue rising at unsustainable rates. Employers, government regulators and members are demanding more affordable premiums. Larger provider groups are driving tougher negotiations. Meanwhile, reform is bringing waves of new mandates, creating even more cost pressures.

Specifically, plans are experiencing:

- An unsustainable rise in healthcare costs. While the nation's healthcare spending slowed in 2009 — increasing 4.0% compared with 4.7% in 2008 due to the recession — it is still the fastest growing portion of the economy. Key drivers include hospital, advanced imaging, surgery and pharmacy costs.
- Heavy pushback on premium rate increases. Traditionally, rate increases helped plans keep pace with medical inflation, but this is becoming a limited option. As part of healthcare reform, a new regulation in 2011 will require plans to publicly justify rate increases considered unreasonable — currently defined at 10% or more.
- A trend toward larger provider organizations. From 1996 to 1997, 41% of physicians were in solo or two-physician practices. By 2008, that figure declined to about 33%. Now, larger groups are pulling more leverage in contract negotiations. New models such as accountable care organizations and patient-centered medical homes will accelerate hospital and physician consolidation, further increasing their price leverage.
- New mandates driving higher medical and administrative spend. A prohibition on lifetime limits, restrictions on annual limits, first-dollar coverage for preventive services, extension of dependent coverage and new regulations on medical loss ratio are just a few of the mandates. While reform will help improve care for members, it has the potential to drive up costs for plans and impact how funds are arranged and allocated.

Solutions to drive down costs and improve access to care will depend on more effective and timely collaboration between plans and healthcare providers. In addition to enabling more effective plan-provider collaboration, plans will need to increase support for reform-driven, cost-sharing vehicles such as pay-for-performance plans, medical homes and accountable care organizations.

Rethinking Traditional Authorization

Traditionally, authorization and other UM efforts have made inroads into reducing inappropriate services and managing medical costs. But because these programs typically involve time-consuming, expensive manual effort by both plans and providers,

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providers are reluctant to participate, and the overall potential for financial impact is limited. According to McKesson research:

- More than 90% of authorizations require a phone call or faxed request
- Routine authorizations can take two days to two weeks to resolve
- The average cost of an authorization is \$20 to \$50 for providers, \$75 for plans
- The average cost per appeal is \$300

A heavily manual process, traditional authorization processes can't provide rich data on utilization and network use. This lack of insight hinders the development of policy and of effective, highly targeted provider interventions. Also, a traditional process lacks the coverage and complex reimbursement rules that clinicians must address as part of the process.

In addition, most would agree that traditional authorizations have been something plans value and physicians loathe, viewing them as an intrusive and unnecessary burden. This perception is worsened 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.

According to a study from the American Medical Association, about 64% of physicians surveyed have difficulty determining which tests, procedures and drugs require authorizations. About 63% wait several days for authorization responses on tests and procedures, and 13% wait more than a week.

In the same study, nearly all of the physicians surveyed report that eliminating authorization hassles is "very important" (78%) or "important" (17%). Seventy-five percent of the physicians believe automated authorizations would help them manage their patients' care more efficiently.

Historically, UM has pitted plans against physicians as they seek "permission" to practice medicine as they see fit. How can plans improve this dynamic to foster the effective, collaborative relationship demanded by the changing healthcare environment?

Introducing UM for Today's Healthcare

Based on McKesson's experience, health plan executives want to drive clinical and financial decision support to the provider at the point of care. The idea is to enhance clinical decision making with consistent, up-to-date evidence and comparative analysis — rather than just ensure that physicians get authorization to order or perform services. This more collaborative approach aligns plans and physicians in providing efficient, optimal care, helping members avoid clinically inappropriate, out-of-network or non-covered services that can delay or prevent the best care and increase costs.

A prospective, exception-based approach to UM that enables such collaboration is welcomed by providers, reduces overall costs and ultimately improves members' health. 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 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 plans from paying for unnecessary expenses and recovering them retrospectively, or worse,

never at all. Since prospective, exception-based UM automates most of the authorization process, plan clinical staff can focus on only the more complex “exceptions” that truly require their time and expertise.

A prospective UM approach frees up resources to:

- Reduce the turnaround time for complex reviews
- “In-source” currently outsourced tasks, leading to better control and better relations with providers
- Start new UM programs to address rapidly growing areas such as specialty pharmacy and molecular diagnostics
- Increase care management services to members with complex health concerns
- Increase membership without increasing staff

Understanding Principles of Prospective, Exception-based UM

The prospective, exception-based model succeeds because it allows plans to:

- **Identify outliers early on.** Research like the national survey of medical expenses by Atul Gwande, M.D. in 2009 found that certain providers drive a larger percentage of improper utilization than others. With fully automated authorizations, plans can identify provider-specific utilization trends early in the process and establish unique, automated interventions to address them.
- **Reward quality providers.** Some clients automate alternative quality contracts based on performance, and/or “gold card privileges” for providers whose practices are consistent with evidence-based medicine and other rules of medical appropriateness.
- **Provide flexible options.** Alternative approaches to authorization can streamline plan-provider collaboration, while educating providers on evidence-based clinical appropriateness. As a result, plans can enable behavior change without the intrusiveness of a permission-based process. One alternative is electronic notifications, which are one-way transactions from provider to plan indicating the intent to perform or order a medical service. Notifications enable plans to gather data to refine or target ongoing UM efforts. Less costly and invasive than authorizations, notifications provide powerful data to address an up-tick in utilization for a specific service or set of services before it impacts a 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 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 stakeholders, payers and providers become aligned in decision making. At the same time, it’s important to quickly see plan-specific rules without manual lookups and telephone calls.

Trading in Retrospective, Paper Workflows for Efficiency

Many of our clients seek a new approach to authorization after a change prompts them to take a fresh look at their operations, such as significant growth in imaging volume, a new policy or a new mandate.

A number of McKesson clients have implemented a prospective, exception-based approach using Clear Coverage™. This decision support platform incorporates evidence-based InterQual Criteria and plan-specific rules to automate clinical and coverage decision support, including authorization, at the point of care.

Clear Coverage and the InterQual Criteria within it identify:

- Whether the service is covered based on plan benefits
- Whether the service is covered based on medical appropriateness, considering InterQual clinical evidence and the patient's unique clinical scenario
- 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

Many plans have variable and complex authorization rules based on different product lines and contracts, and Clear Coverage can be customized to handle them easily and automatically. With a manual process, these variables can be challenging to administer for both providers and UM staff — just as medical claims processing was years ago. In fact, if claim payments were still managed manually, processing would be occurring at a crawl as many authorizations are today.

Clear Coverage has been proven to significantly reduce administrative spend by enabling UM staff to focus their attention on other UM activities that improve care and on the complicated "exceptions" that truly require their expertise. In addition, members avoid inappropriate and sometimes harmful services, such as exposure to radiation, which results in a direct reduction in medical spend.

Easing Provider Adoption

Providers grow to prefer automation since they receive immediate approval on up to 90% of requests. Requests pended for plan review — exceptions — are resolved much faster due to the common, automated framework used by both provider and plan. In addition, with InterQual Criteria, providers are receiving clinical appropriateness guidance based on widely accepted medical evidence.

To help providers ease into this new UM approach, many plans begin with only one type of service or with a small base of network physicians before rolling it out to others. To start out, plans may want to make the tool mandatory for a small number of physicians with the highest order volume, but then instantly approve all requests. Since Clear Coverage provides feedback on the appropriateness of services ordered, whether there are more appropriate alternatives and the best facilities to provide them, this strategy helps to educate physicians without involving a permission-based process.

A proactive, exception-based authorization model enables plans to provide extensive, encounter-specific information on clinical appropriateness and coverage, without impinging on the physician's ultimate decision, fostering a collaborative environment. Health plans that take this approach can evaluate what impact the tool has had on provider decision making. Did providers change or cancel their requests based on Clear Coverage recommendations? Then plans can use this information to decide how best to move forward.

Conclusion

Plans have always worked hard to help improve their members' health and manage costs. However, with increasing utilization, the continuous introduction of new technology, higher medical costs and the impact of healthcare reform, today's environment is "no ordinary time." Plan executives are facing relentless pressure from every direction to dramatically reduce costs and substantially improve quality of care.

Traditionally, the authorization process helped to ensure appropriate care. But today, the established approach lacks the transparent and collaborative engagement needed between plans and providers to succeed. It also doesn't fully leverage a plan's clinical staff time in driving higher quality of care to its members.

The next generation of UM is a prospective, exception-based approach. It combines innovative automation with payer-specific clinical and financial decision support, promoting optimal care at the right cost through a collaborative plan-provider model. This model enables health plan clinical staff to focus on only the complex exceptions that truly require their skills and expertise. A prospective, exception-based approach to UM goes beyond saving administrative costs. It helps to ensure consistent, evidence-based care by educating providers in real-time as they order treatment 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.

About the Author

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Mr. Zubiller is responsible for leading initiatives that advance McKesson's role in the realm of personalized medicine, decision support and molecular diagnostics. Before joining McKesson, he worked for a global strategy consulting firm in London and co-founded a spin-off from a leading Enterprise Resource Planning software and services vendor. He also founded and sold a boutique consulting practice for early stage technology companies, entrepreneurs and venture capitalists in the United States, the United Kingdom and India. Mr. Zubiller holds a Bachelor of Economics degree from the Wharton School and a Master of Business Administration degree from the London Business School, as well as a Management of Technology degree from the Berkeley College of Engineering and the Haas Business School.

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