Comagine Health

Transforming Utilization Management to Achieve the Quadruple Aim: Better Patient Experience, Better Population Health, Lower Costs and Improved Provider Work Life

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About the Author

Dan Lessler, MD, MHA, FACP, is chief clinical officer for Comagine Health. He provides executive leadership and support on all clinical matters as well as leadership in linking the community-oriented, public health and health care delivery-focused work of Comagine Health as a means of improving population health.

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In his role as chief medical officer, Dr. Lessler led successful statewide efforts to reduce unnecessary emergency room visits, address the opioid public health crisis and create innovative value-based purchasing strategies. He also helped spearhead the integration of physical and behavioral health for managed care clients as the state moved to a whole-person approach to care.

Dr. Lessler worked in public hospital systems for more than two decades and is passionate about improving the coordination of medical care and social services for complex patients.

About Comagine Health

Comagine Health is a national, nonprofit health care consulting firm. We work collaboratively with patients, providers, payers and other stakeholders to reimagine, redesign and implement sustainable improvements in the health care system.

As a trusted, neutral party, we work in our communities to address key, complex health and health care delivery problems. In all our engagements and initiatives, we draw upon our expertise in quality improvement, care management, health information technology, analytics and research.

We invite our partners and communities to work with us to improve health and redesign the health care delivery system.

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Executive Summary

There has been and continues to be a compelling need to reduce the amount of low-value and potentially harmful care that is provided across the U.S. Since the 1970s, utilization management (UM) strategies that prospectively and retrospectively review appropriateness of care have driven health care payer decisions about whether to pay for care. However, the existing UM paradigm has become costly, burdensome to physicians and patients, and potentially harmful when it introduces unnecessary delays in care. On the other hand, jettisoning UM entirely would also be costly and expose patients to potential harm when they are subject to unnecessary care and associated avoidable risks. The answer is to transform UM into a data-driven, evidence-based, collaborative and transparent process that fully embraces the Quadruple Aim of better patient experience, better population health, lower costs and improved provider work life.

This white paper provides a blueprint for "next generation" UM that goes beyond ameliorating the immediate provider concerns about prior authorization (PA) to envision a model that is embraced by all stakeholders and effectively promotes the goals of the Quadruple Aim.

Introduction

As much as the practicing medical community recoils at the thought of PA, the need to address inappropriate and unnecessary medical care remains paramount. In 2012, Berwick and Hackbarth estimated the cost to society of overtreatment to be between $158 billion and $226 billion.[1] A 2019 update to this estimate approximated the cost of overtreatment or low-value care to be between $75.7 billion and $101.2 billion.[2] (The latter study used more conservative cost assumptions that likely explain most of the discrepancy between the two estimates.) Other similar data suggests that low-value care contributes substantially to health care costs. For example, the Washington Health Alliance — a regional health improvement collaborative based in Seattle — estimated that between 2014 and 2017, $703 million was spent in Washington state on low-value care.[3]

While the intent of PA is to improve care and lower cost, the PA industry has been criticized for creating unnecessary delays in care, placing undue burden on providers and patients, and lacking transparency in terms of PA guidelines and their supporting evidence. Moreover, while there is some evidence to suggest that PA reduces health care costs, there is very little published data that describes the impact of PA on outcomes.[4] Due to increased attention of the medical community to structural causes of health disparities, concerns about the impacts of PA on health equity have also been raised.[5]

Regulatory Efforts to Improve PA

The impact of PA on health care delivery has not escaped the attention of regulatory bodies such as the Center for Medicare and Medicaid Services (CMS) and state legislatures. In December 2021, CMS announced new policies regarding the conduct of PA.[6] Several state legislatures have passed laws to assure a minimal level of performance by organizations performing PA as well as maximal turnaround times for adjudication of PA decisions.

The proposed CMS rule, scheduled to go into effect Jan. 1, 2023, includes requirements related to data sharing, interoperability, timeliness and transparency policies. It will give patients and providers access to patient data and enable them to track the status of PA requests with a payer by building on CMS' previously adopted Interoperability and Patient Access rule, which requires payers to include information about a patient's pending

and active PA decisions so patients can have a better understanding of the PA process and its impact on their care. The proposed rule also requires payers to:

- Render urgent PA decisions within 72 hours
- Render standard PA decisions within seven days
- Provide a specific reason for a denial
- Provide data on metrics, including the percentage of PA requests approved, denied and approved after appeal

The new rule will specifically impact payers that the agency regulates, including Medicaid managed care plans, state Medicaid agencies, CHIP agencies and CHIP managed care entities, and issuers of qualified health plans on the federally facilitated exchanges. Notably, the rule will not impact Medicare Advantage Plans.

Professional Organization Efforts to Improve PA

Physician professional organizations such as the American Medical Association (AMA)[7] and the American College of Cardiology (ACC)[8] have given voice to provider concerns about the conduct of PA. They have also made recommendations that are consistent with but go considerably further than the proposed CMS rule. In fact, in 2017 the AMA, along with a group of 16 other health care industry organizations, published 21 recommended principles for the conduct of PA.[9] In 2018, the AMA, America's Health Insurance Plans (AHIP), the American Hospital Association (AHA), the American Pharmacists Association (APhA), Blue Cross Blue Shield Association (BCBSA) and Medical Group Management Association (MGMA) agreed to jointly pursue a smaller set of principles and standards that include:

- Selective application of PA such that providers who consistently adhere to UM guidelines would not be subject to PA review (a process referred to as "gold carding")
- PA program review and volume adjustment that assures PA reviews apply best evidence and appropriately target overuse and misuse
- Transparency and communication regarding PA requirements to ensure timeliness and minimize delays in the PA process
- Continuity of patient care such that authorizations for patient care under one plan transfer to any subsequent plan that the patient enrolls in
- Automation to improve transparency and efficiency[10]

AHIP has indicated that its membership sees the biggest opportunity for improving PA programs in automating the PA process. At the same time, however, AHIP has expressed concern that providers not using electronic health records (EHRs) enabled for electronic PA limits the current reach of automation.[11] And yet, for the broad-based use of electronic PA to occur, the Office of the National Coordinator for Health Information Technology (ONC) has recognized the need for electronic PA EHR certification criteria to accelerate the use of electronic PA.[12] Such standardization could take years and may inhibit the expansion of electronic PA in the short term.

There is agreement in the health care community, as demonstrated in a joint statement from AMA and AHIP and emphasized by CMS' recent rulemaking, on a core set of principles that will drive PA vendors toward automation, interoperability, forward-facing criteria, data-driven targeting of PA services and gold carding. However, even

when all these strategies are implemented, PA will still be limited in its scope and effectiveness, and unable to fully embrace and contribute to achieving the Quadruple Aim: Better patient experience, better population health, lower costs and improved provider work life.

Fulfilling the Quadruple Aim

Currently, PA focuses on individual transactions: A provider submits clinical information and requests authorization for a service or procedure that is ultimately approved or denied. And as noted above, efforts to improve PA focus on making this transactional process as efficient as possible through automation, better targeting of services to be reviewed, gold carding and so on. When care is denied, assuming that all clinical data has been submitted and considered relative to guidelines supported by the best available scientific evidence, then it is likely the proposed care does not align with evidence-based criteria. However, only when PA is incorporated into a broader conceptual model of UM grounded in the principles of data-driven quality improvement (QI), population health management and health equity can it enable true progress toward the Quadruple Aim. Successful implementation of an expanded model of UM requires robust data and sophisticated analytics; data, transparency, measurement, feedback and collaboration are all foundational to this model.

Understanding patterns of PA decisions, especially denied requests and attendant rationale, can inform broader QI efforts that aim to better align community practice with best evidence. For certain services and/or procedures, denial rates across all requesting providers may be relatively high, suggesting a gap in knowledge with respect to best evidence. When this is the case, then PA would point providers toward best practice and could be incorporated into collaborative QI efforts to improve clinical outcomes. Alternatively, PA denials may demonstrate geographic, hospital or health system variation, suggesting the need for more targeted interventions.

Mitigating Health Disparities

Recently, concerns have been raised about the potential for the PA process itself to introduce inequity in access to care. It is possible, for example, that clinicians at health care organizations serving many low-income and disenfranchised patients — such as Federally Qualified Health Centers — have far less time to advocate on behalf of patients when a PA request is initially denied than those who serve more affluent and privileged populations. The appeals process is an essential part of PA: It helps assure that clinicians and patients can present information and clinical context that sometimes leads to overturning an initial decision to deny a procedure. However, clinicians working in resource constrained settings may be unable to devote the time and resources necessary to avail themselves and their patients of this important process. If this is the case, then PA may adversely affect health equity and introduce or exacerbate disparities. For this reason, it is important to collect and analyze data on race, ethnicity and other attributes (e.g., geographic location, clinic type) to assure PA is being equitably applied.

Data that describes the frequency, distribution and rationale for PA decisions can be aggregated and combined with claims-based population data from payers to understand utilization patterns more generally across defined geographic regions (e.g., state or county), or by health system, hospital and/or provider. It can also be analyzed by patient characteristics, such as race. Analyzing data in this way can identify areas of underutilization, as well as overutilization, and point toward possible health inequities.

In fact, published research describes racial inequities in procedure rates for an array of surgical procedures. For example, Black patients are less likely to undergo total joint replacement surgery and spinal fusion than white

patients.[13] This means that even if a particular procedure is overutilized across a population, assuring appropriate use of the procedure requires understanding utilization in subpopulations defined by race or other characteristics of concern.

Improving Quality Through Collaboration

In all cases, the opportunity exists to engage a practice community with data and convene a collaborative effort aimed at assuring local provider buy-in to UM guidelines and improving quality of care. This can be done by connecting to and leveraging existing forums or partnerships, such as regional health improvement collaboratives or advisory groups to state agencies that purchase large amounts of health care. The ensuing dialogue may lead to any number of improvement activities, including efforts to improve guideline clarity, joint efforts to educate providers about best practice, and efforts to address underuse and disparities in access to care. As envisioned, the collaboration would be a multipayer effort, likely best implemented at a statewide level to assure comprehensiveness and efficiency in the application of agreed-to guidelines.

Convening a provider community to transparently develop or endorse evidence-based guidelines, including the use of data to prioritize guideline development, assure rigorous and reliable guideline implementation, and evaluate outcomes, is a challenging endeavor for the field of UM, but it can be and, in fact, has been done as evidenced by the work of the Industrial Insurance Medical Advisory Committee (IIMAC) established by the Washington State Department of Labor and Industries (Washington L&I).[14]

IIMAC, which is composed of 14 practicing physicians nominated by their specialty society or institution, convenes and oversees subcommittees that develop medical treatment guidelines (MTGs) on specific clinical topics. The subcommittees are composed of clinicians with expertise in the topic and they receive technical assistance from an epidemiologist. The work of the subcommittees is grounded in trust, constructive engagement and a commitment to high-quality work. Importantly, IIMAC's MTGs are fully transparent and available to the public. The MTGs are available at https://lni.wa.gov/patient-care/treating-patients/treatment-guidelines-and-resources/#treatment-guidelines.

The utilization review (UR) vendor (in this case, Comagine Health) participates as an invited guest at IIMAC meetings and provides input that can help shape guidelines so that they can be efficiently and effectively implemented as part of the PA process. The UR vendor also can be a source of feedback and data regarding guideline implementation and performance, supporting a continuous cycle of quality improvement. For example, based on its review experience and discussion with requesting physicians, the Comagine Health team can identify clinical circumstances — specific details and nuance — that are not well addressed by an existing guideline. Such gaps are brought back to IIMAC for further discussion and if necessary, the guideline is appropriately modified.

The work of Washington L&I and its IIMAC to develop and implement a UR guideline to assure the appropriate use of lumbar fusion in injured workers illustrates how the deployment of an evidence-based guideline, developed collaboratively with the medical community and implemented through a structured UR program, can improve outcomes and reduce costs.[15]

Clinical trial data demonstrates that spinal fusion for back pain not associated with significant spinal malalignment or cancer is no more effective than conservative treatment with physical therapy and core strengthening in relieving pain and restoring function.[16] Yet spinal fusion is often used for questionable

indications.[17] The rate of spinal fusion in the U.S. continues to increase, and available evidence suggests that as many as 50% of spinal fusions performed in the U.S. may be unnecessary.[16,17]

While there are evidence-based indications for spinal fusion, it is a potentially morbid procedure that is sometimes associated with severe complications, including infection and death. When patients inappropriately undergo a spinal fusion, it unnecessarily exposes them to considerable risk.

Reducing Health Care Costs

A 2014 study demonstrates how claims data can be used to evaluate the costs and outcomes of PA decisions. The study compared utilization and outcomes of spinal fusion in injured workers in Washington state and California. Washington L&I, working collaboratively with the medical community, issued an evidence-based spinal fusion clinical guideline that was implemented using a rigorous and reliable PA. California, on the other hand, maintained more liberal surgical criteria that required coverage for spinal fusion if supported by a second opinion. The study concluded that a "broader lumbar fusion policy was associated with greater use of lumbar fusion, use of more invasive operations, more re-operations, higher rates of complications, and greater inpatient costs."[18]

The use of claims and UM data can also be combined and applied in analytic approaches that enable more rigorous and accurate evaluation of return on investment (ROI). The UM industry currently applies simplified ROI models that are based mostly on cost avoidance. A core assumption of these models is that if a requested service is not approved by the PA process, then the avoided cost from not performing the service constitutes the main measure that drives the ROI calculation. However, such approaches fail to consider the cost of alternative treatments. If a physician requests authorization for lumbar fusion and it is denied based on evidence-based criteria, then the patient will be managed through alternative clinical strategies, such as physical therapy. Appropriate calculation of ROI should also, therefore, consider the costs of such alternative treatments.

Comagine Health worked with researchers at the University of Washington to evaluate the ROI of Washington L&I's lumbar fusion guideline implemented through a transparent and structured PA process. The analysis accounted for:

- The cost of fusions that were avoided because they did not meet evidence-based criteria
- The costs of alternative treatments among those who did not undergo fusion
- The cost of the UR program itself

In this case, the resulting ROI was 60:1. A full description of the study, including methods and results, can be found at https://comagine.org/resource/2341.

Conclusion

Overutilization of medical services continues to plague the U.S. health care system. Efforts to address overuse have frustrated the medical community and as currently conducted, have limited potential to improve quality of care and promote health equity. Going forward, UM strategies that embrace collaboration, data and transparency can harness the expertise and intrinsic motivation of physicians to help people and hold the potential to achieve the Quadruple Aim, including improved provider work life.[19]

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