Managed Care 101: Utilization Management

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Content Overview

Background to importance of coordinated care
- Building the Will…Coordinated Care is the future: Think MACRA….
- Outcome Data supports Utilization Management

What is Utilization Management?
- Essentials of Utilization Management

- Population Health
  - Advanced Care Management

- Importance of Comprehensive Primary Care and Primary Care Medical Home Models?

- Payor Contracts and UM

- Silos of Concern and Importance: Pharmacy and Behavioral Health

MACRA: Demise of FFS and Volume Based Reimbursement for Medicare Beneficiaries

MIPS and APM models all promote quality and cost

- MIPS – criteria applied to 2017 services
  - 0% based on cost of care
  - 60% based on quality of care
  - 15% based on clinical care improvement activities
  - 25% based on advancing care information (formerly ‘meaningful use’)

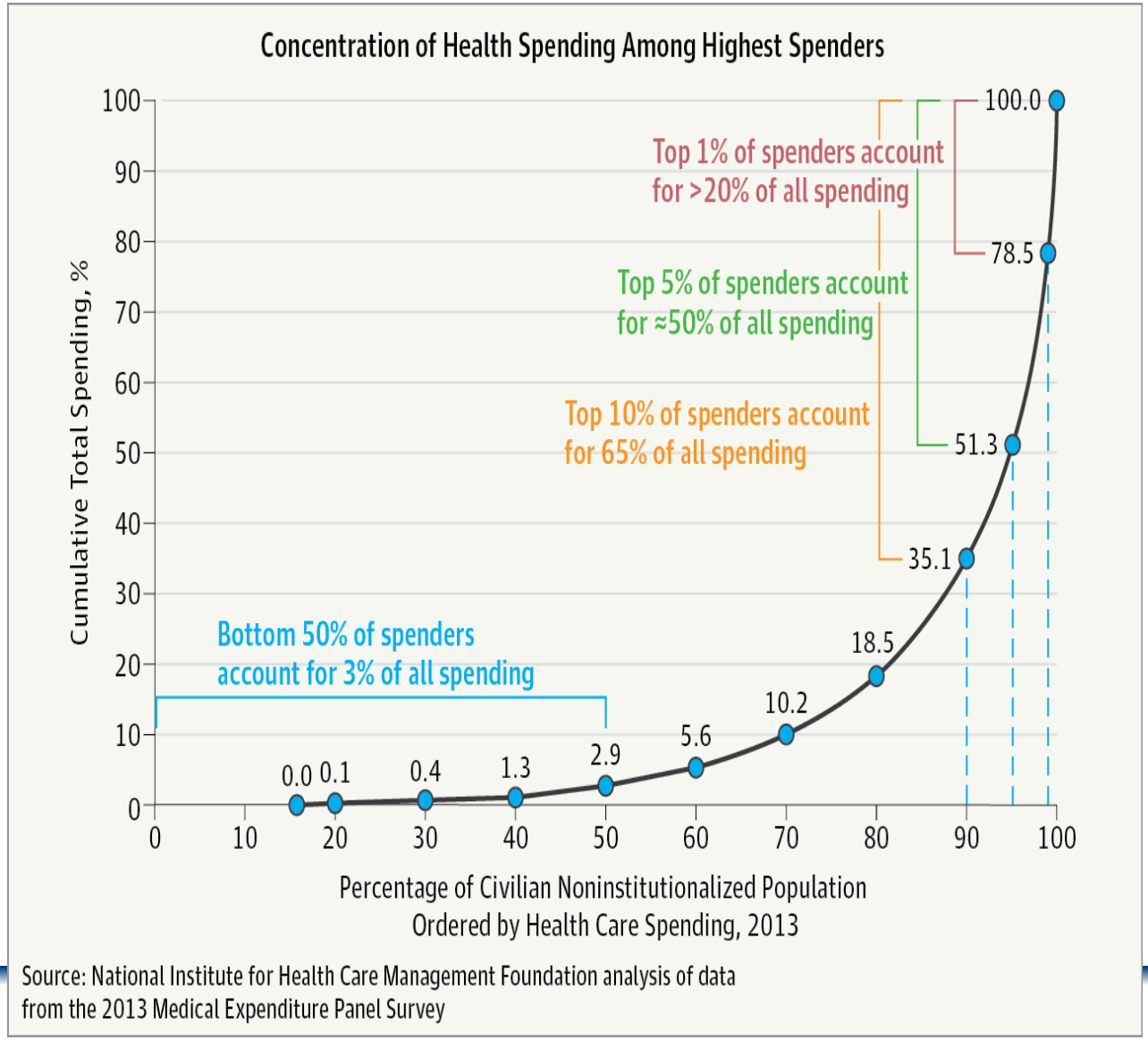
  Impact: +/-4% adjustment to 2019 FFS, with winners and losers

- Alternative Payment Models
  - Must be participant in designated APM model including accountability for quality and cost

  Impact: 5% increase to 2019 FFS reimbursement – all winners!

Commercial and Other Payors Historically Follow Medicare

Cost of Care Remains a Problem



Two-thirds of 2013 California population is included in the Atlas.

California Total Population: 37.2 million

Atlas Total Population: 24.4 million

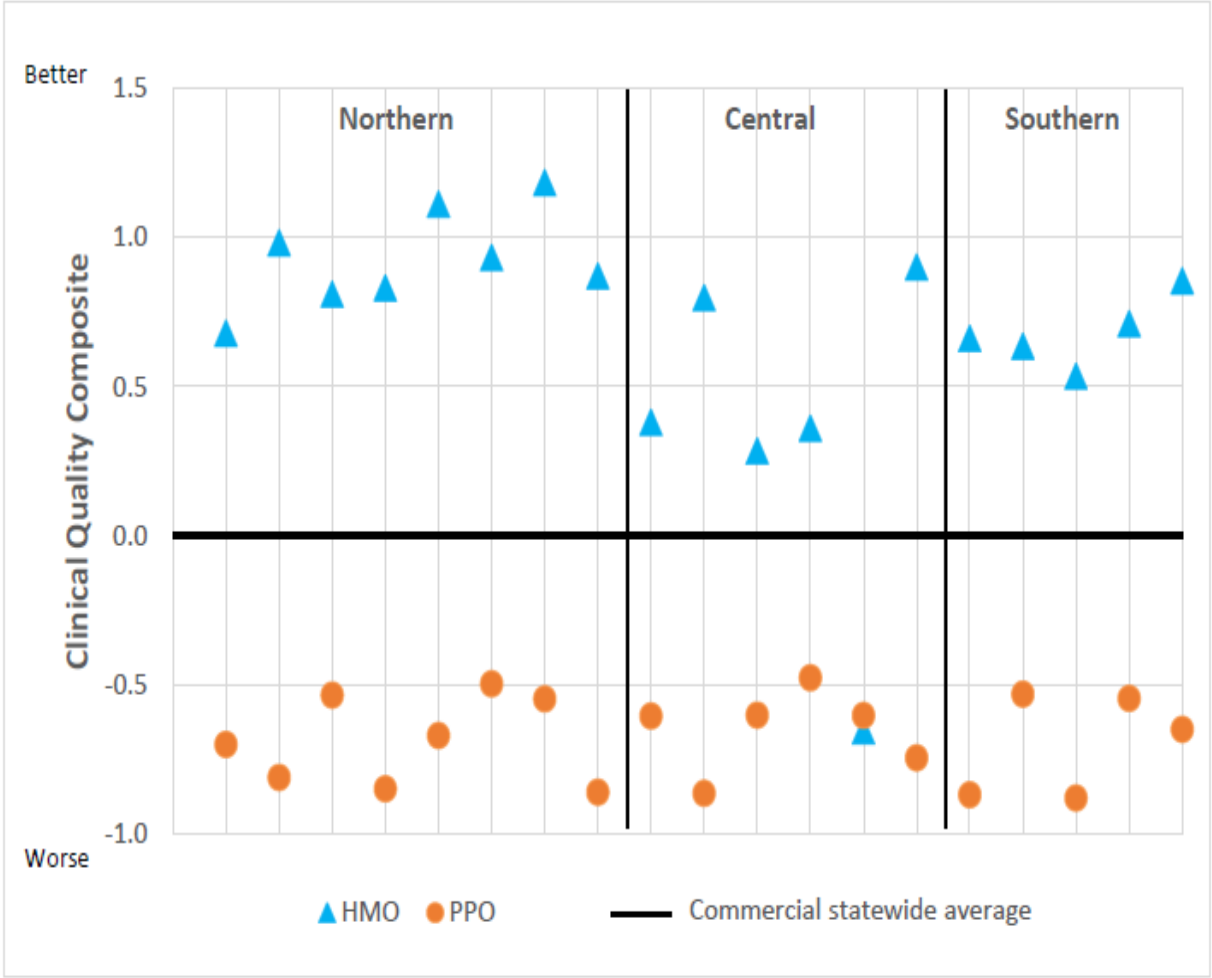
Payer	Product	Enrollment by Product	Enrollment by Payer	Total CA Enrollment
Commercial	HMO	10.1 M	14.5 M	24.4 million Californians
	PPO	4.3 M		
Medicare	Advantage	1.6 M	1.6 M	
	FFS	No member-level data		
Medi-Cal	Managed Care	5.7 M	8.3 M	
	FFS	2.6 M		

Source: California Regional Health Care Cost & Quality Atlas.

A Study to see regional variation, and to compare the performance of integrated care vs. fragmented care

All across CA, ***HMO Outperforms PPO*** in 5 out of 6 clinical quality measures

California Regional Clinical Quality Composite for HMOs and PPOs, 2013

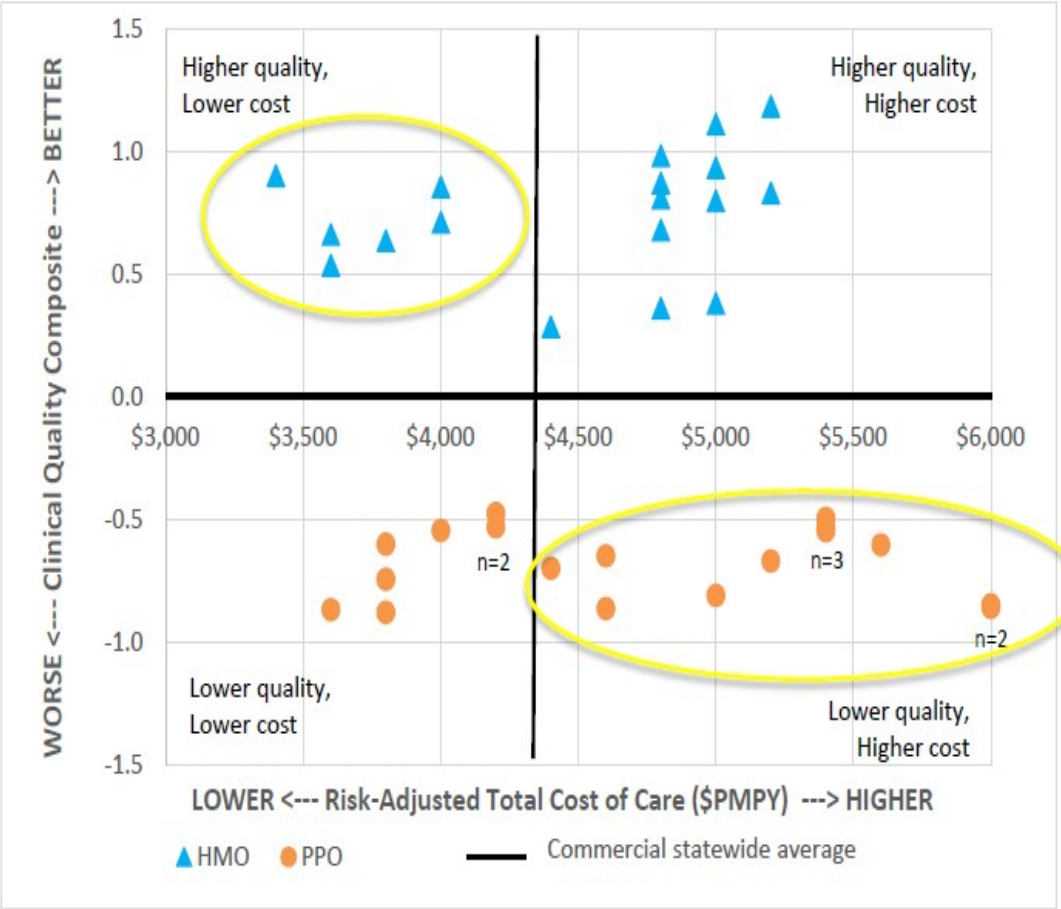


Source: California Regional Health Care Cost & Quality Atlas, commercial HMO and PPO 2013 data.

HMOs:
Higher Quality
Lower Cost

PPOs:
Lower Quality
Higher Cost

Linking California Commercial HMO and PPO Quality and Cost Performance, 2013



Source: California Regional Health Care Cost & Quality Atlas, commercial HMO and PPO 2013 data.
Notes: Region 13, Eastern Counties, is excluded because of insufficient data. When data points overlap on the chart, the number of regions represented is labeled as "n=" on the chart. All cost values are risk adjusted and rounded to the nearest $200.

Bottom Line: Health Care Reform is Here

- Many **physicians and physician groups are not aware of MACRA** and how it will impact their Medicare reimbursement, first for Medicare and likely other payors to follow.
- Physicians and other providers need to align with others, including institutions and select payors, and **collaborate in very different ways**. Integrated medical groups on a common EMR have head start in data sharing; IPA structures can provide infrastructure for those not employed by an integrated health system or insurer.
- **Timely and accurate clinical and cost data is essential** to improving quality lowering costs. Building and sustaining this data infrastructure is complex and very expensive. Interoperability of electronic medical data is goal but far from current reality. Some payors reluctant to share detailed cost data.

Physician provider agreements with payors demand data and may or may not delegate UM functions to the medical group or IPA. If capacity to accept delegation is not yet present, or key payor refuses to delegate, agreements need to hold payor accountable for timely sharing of UM data with clinical providers.

IHA Atlas Measures

Clinical Quality

1. Breast Cancer Screening
2. Colorectal Cancer Screening
3. Blood Sugar Screening for People with Diabetes
4. Poorly Controlled Blood Sugar for People with Diabetes
5. Kidney Disease Monitoring for People with Diabetes
6. Medication Management for People with Asthma
7. Clinical Quality Composite

Hospital Utilization

1. Emergency Department Visits per thousand member years (PTMY)
2. All-Cause Readmissions
3. Inpatient Bed Days PTMY
4. Hospital Utilization Composite

Total Cost of Care

1. Risk-Adjusted Cost (average per enrollee per year)
2. Observed (unadjusted) Cost
3. Total Cost Index

Utilization Management: Definition

URAC

Utilization management (UM) is the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan, sometimes called “utilization review.”

IOM’s Committee on Utilization Management by Third Parties (1989)

A set of techniques used by or on behalf of purchasers of health care benefits to manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision.

More current and explicit descriptions of Utilization Management (UM)

Wikipedia Definition:

"…the evaluation of the **appropriateness and medical need** of health care services and procedures and facilities **according to evidence-based criteria or guidelines**, and **under the provisions of an applicable health benefits plan**. Typically, UM addresses new clinical activities or inpatient admissions based on the analysis of a case, but may relate to ongoing provision of care, especially in an inpatient setting."

URAC standards are intended to ensure that the UM process "… is **clinically sound** and **respects patients' and providers' rights** while **giving payers reasonable guidelines** to follow. URAC's standards address the use of **evidence-based guidelines**, outline **specific reviewer requirements for each level of review**, and **require a policy preventing financial incentives to doctors and other providers based on consumers' use of health services…"**

NCQA Utilization Management Standards and Guidelines

Utilization Management Component	Standards and Guidelines
Internal Quality Improvement Process	Clinical Information
Agreement and Collaboration with Clients- e.g., Delegation	Denial Notices
Privacy and Confidentiality	Policies for Appeals
UM Program Structures	Appropriate Handling of Appeals
Clinical Criteria for UM Decisions	Satisfaction with the UM Process
Communication Services (access to staff)	Emergency Services
Appropriate Professionals	Triage and Referral for Behavioral Healthcare
Timeliness of UM Decisions	Delegation of UM Activities

Other Standards for UM Procedures

- CMS Managed Care Manual
- State Insurance Regulatory Bodies
- Individual Health Plans and Payor Requirements
- Specialty Medical Society Guidelines

Impact for Medical Groups Involved in UM:

- Standards may vary among payors and between plans and the UM process must be flexible to handle differing requirements.
- Conflicts can arise particularly between CMS and State Regulatory bodies with regard to MA plans, with CMS regulating plans with the exception of licensure and financial solvency matters.
- Specialty societies may also disagree on preferred preventative screenings and their frequency, and on treatment recommendations.
- Different timeliness standards may apply between payor contracts, often referred to as TATs.
- Different documentation and communication tools may be required among payors.
- Interpretations of whether standards are being implemented correctly can vary among auditors for plans and CMS at delegation audits, particularly focused on necessary provider and patient communications in the event of a denial.

Potential Issues with Criteria

- Payors may use different criteria and may require their data set be applied for their population.
- If provider group uses different criteria than payor, sharing data for time critical responses to appeals and grievances can be problematic. Plans rarely delegate appeals and grievances.
- Criteria are updated at different frequencies and local adaptation may be appropriate for clinically evolving therapies.

Example: joint replacement may be 'approvable' only after PT trial, even when bone-on-bone X-rays may demonstrate lack of efficacy for PT. Local criteria need to be reviewed and confirmed by competent medical committee

- Criteria may be ambiguous or subject to significant clinical interpretation

Example: determination as to whether criteria for inpatient vs observation admission have been met related to severity of illness and intensity of service, or when criteria for 'safe discharge' have been met

Sources for UM Criteria

Alone or In-Combination

- Develop In-house (may be challenged on content, must be continually refreshed, and need to be integrated into data base in event decision is appealed by a patient, provider, or payor)
- Acquire from vendor (sometimes payor or medical group may not have sufficient expertise for specialized services, often pharmacy and behavioral health)
- Acquired and adapted for local conditions

Commonly used frameworks:

- McKesson InterQual criteria
- Milliman Care Guidelines (MCG)

Proactive Mechanics of UM

- Administrative procedures

- Procedures as determined by benefit plan and payor
  - Discharge planning (from both acute and long term care facilities)
  - Concurrent review planning
  - Pre-certification
  - Clinical case reviews
- Processes as determined by plan, regulation, and risk entity itself
  - Concurrent clinical reviews (in concert with facility personnel) for medical necessity and level of care. [Note: tension re: 'inpatient' vs. 'observation' status]
  - Peer reviews – attention to 'like professionals'
  - Internal process support
  - External communications

Timing of UM Reviews

- Prospective – *to validate medical necessity per criteria and to redirect to more cost effective setting*
  - Routine referrals and prior authorizations
  - Urgent referrals and prior authorizations

- Concurrent – *during and as part of clinical workflow to support point of care decisions*

- Retrospective – *to validate whether appropriate level of care (procedure, location, timing) after it has occurred*
  - Emergency procedures and events
  - Reconsideration requests
  - Appeals and grievance responses – *determinations* rarely delegated by plans

- Administrative – *can be 'urgent'*
  - Internal audit as required by contract
  - Quality assurance and targeted reviews of processes and results
  - External audits – pre-delegation, delegation, special including CMS program audits

Administrative Requirements

- Updated approved program description with associated detailed policies and procedures
- Systems to receive, process, and report out data from UM reviews
  - Escalation process when clinical reviewer and clinician disagree
  - Dispute procedures for patients, caregivers, advocates to challenge a point of care decision'
- Managed care insurance for entity performing reviews
- Appropriate licensure of staff in state where care being delivered and reviews undertaken if review process determined to be 'practice of medicine or nursing' per state law/regulation and for case management activities

Special Considerations for Processes

- Plans typically vary on what medical events require pre-authorization, for both routine referrals and procedures
- Participating network providers vary by plan – redirection of referrals may be desired, necessary for plan reimbursement, and may or may not be allowed
- Inter-rater reliability (IRR) verification of application of clinical standards necessary
- Accurate claims payment requires data from UM system
- Access to historical data – both claims and UM - may be critical tool to new determination

Typical Personnel in UM/Medical Management Department

- Medical Committee Structure
- Program Manager
- Medical Director and Like-Physician/Provider Reviewers
- Often specially trained licensed nurses
- Other health professionals- medical social workers, psychologists/counselors, medical social workers, community health workers, pharmacists, health educators
- Referral Coordinators and other administrative support (including liaison to IT)

Medical Department Salary/Benefit Costs Significant

Common UM Metrics for Program Evaluation

- Per Thousand Members Per Year (PTMPY) Medical/Behavioral Services
  - Inpatient Admissions
  - Inpatient Days
  - SNF Admissions
  - SNF Inpatient Days
  - Home Health Visits
  - ER visits
  - OP visits

- Pharmacy Utilization
  - Generic prescription rate
  - Adherence rates as measured by timely refills

- Other Metrics Per Member Per Month (PMPM) or Per Year (PMPY)
  - PCP visits
  - Specialty Referrals
  - High cost imaging studies (MRI, PET scans)
  - Costs per episode of care

Pharmacy UM Issues

- Often delegated by plans to Pharmacy Benefit Managers (PBMs)
- PBMs vary in quality and frequently contribute to low plan STAR ratings
- Formularies vary significantly as do drug distribution channels, with best patient pricing often limited to single chains or mail order
- No mechanism to integrate with other sources of drug therapy (access through VA, private pay, Canada)
- Tiered reimbursements and prior authorizations for specialty and high risk drugs can adversely impact adherence and timely access
- Costs for pharmaceuticals growing annually – for generics and new therapies
- Huge challenges in drug reconciliation especially at transitions in care from outpatient to institutional and back
- Common problems in communications to groups and clinical providers about drug utilization
- Only large groups and integrated systems typically have internal expertise in complex pharmacy management
- Financial risk sharing complicated by data flow delays and complex financing including rebates to PBMs that may or may not be shared with payors
- Appropriate pharmaceutical management can and does improve quality and may reduce other health care costs

Essentials for Success in UM

- Committed PCPs – best assured by PCPs who have adopted Primary Care Medical Home Model, which can be supported by medical group and IPA infrastructures
  - Team based care
  - All team members working to highest level of education and licensure
  - Robust communication systems with patients before, during, and after in-person office visits
  - Data systems including EMR to identify gaps in care, preventive needs, and clinical pathways
  - Evaluation data transparency of outcomes to support process improvement
- Committed Network of Providers – institutions and consulting specialists
- Payor partners who share accurate and timely data from separate UM activities (especially pharmacy and behavioral health) and from claims

Should Your Medical Practice/Group or IPA Seek UM Delegation?

- Payors vary in willingness for delegation of all types
- Medical Groups/IPAs vary in initial and ongoing capacity for delegation
- With administrative capacity and willing payors – PSW experience that delegation beneficial
  - Better control network to include only cooperative and high quality providers
  - Supports positive relationship with network clinical providers and offices
  - First alert to patients/members in acute or declining health status to offer assistance and ‘care coordination’ as value added service to patients and providers
  - Assures better understanding of risk population for plan negotiations for benchmarking in value based reimbursement and to prepare for and assume risk for both quality and cost

Population Health and Population Health Management

Population Health: the health outcomes of groups of individuals including distribution of such outcomes….aims to improve health of entire population. A priority considered important in achieving this aim is to reduce health inequities or disparities among different population groups due to, among other factors, the social determinants of health (SDOH)

Population Health Management: the technical field of endeavor which utilizes variety of individual organizational and cultural interventions to help improve morbidity patterns (i.e., illness and injury burden) and the health care use behavior of defined populations

Source: Wikipedia

Emphasis of Population Health and Population Health Management

- Risk Stratification
- Chronic conditions and diseases
- Single point of contact and coordination
- Predictive modeling across multiple clinical conditions with an operational strategy of
  - Intensive care management (by healthcare system) for individuals at highest level of risk
  - Personal health management for those at lower risk.

http://blog.centerforinnovation.mayo.edu/2015/12/23/population-health-that-means-us/ *by Barbara O'Keefe*

Caution: Need to be on the lookout for duplication of efforts and fatigue and confusion of patient / caregivers.

Patient Risk Tool Overview

- **4-step Stratification Process**
  - Identify members in high risk population
  - Identify all risk events for members in high risk population
  - Adjust weight of each risk event
  - Add each member's adjusted risk event scores to determine the member's RiskScore

Identification of High Risk Population

- A member is identified as High Risk if they meet criteria for at least 1 of 4 Risk Categories
  - **High Risk Diagnoses based on HCC**
    - 8 HCC categories identified as high risk—patient must meet at least 3
    - High risk HCCs are:
      - **CHF** (HCC 85), **COPD** (111), **Multiple Sclerosis** (77), **Diabetes** (18,19), **Liver Disease** (27,28), **Psychiatric/Substance Abuse** (55,58), **CKD** (136,137), **Malnutrition** (21), and **Parkinson's** (78)
  - **ER Visits that do NOT result in IP/OBS admission**
    - At least 3 within past 12 months
  - **Inpatient Hospitalizations**
    - At least 3 within past 12 months
  - **IP Readmission within 30 days of previous IP Discharge**
    - At least 1 within past 12 months

Identify Risk Events

- Any ER visits (non-admitting) within past 12 months
- Any IP Hospitalizations within past 12 months
- Any IP Readmissions within past 12 months
- Any High Risk HCC categories diagnosed, past 36 months

Compare to Benchmarks

- Milliman
- CMS
- National and Regional

Compare to performance

- Year-over-year
- Clinic level
- Provider level

Apply Weighing Adjustments

- Adjust weight of risk events to weigh more recent events more heavily
  - Event occurred 0-90 days ago: 1 point
  - Event occurred 91-180 days ago: 0.75 points
  - Event occurred 181-270 days ago: 0.50 points
  - Event occurred more than 270 ago: 0.25 points

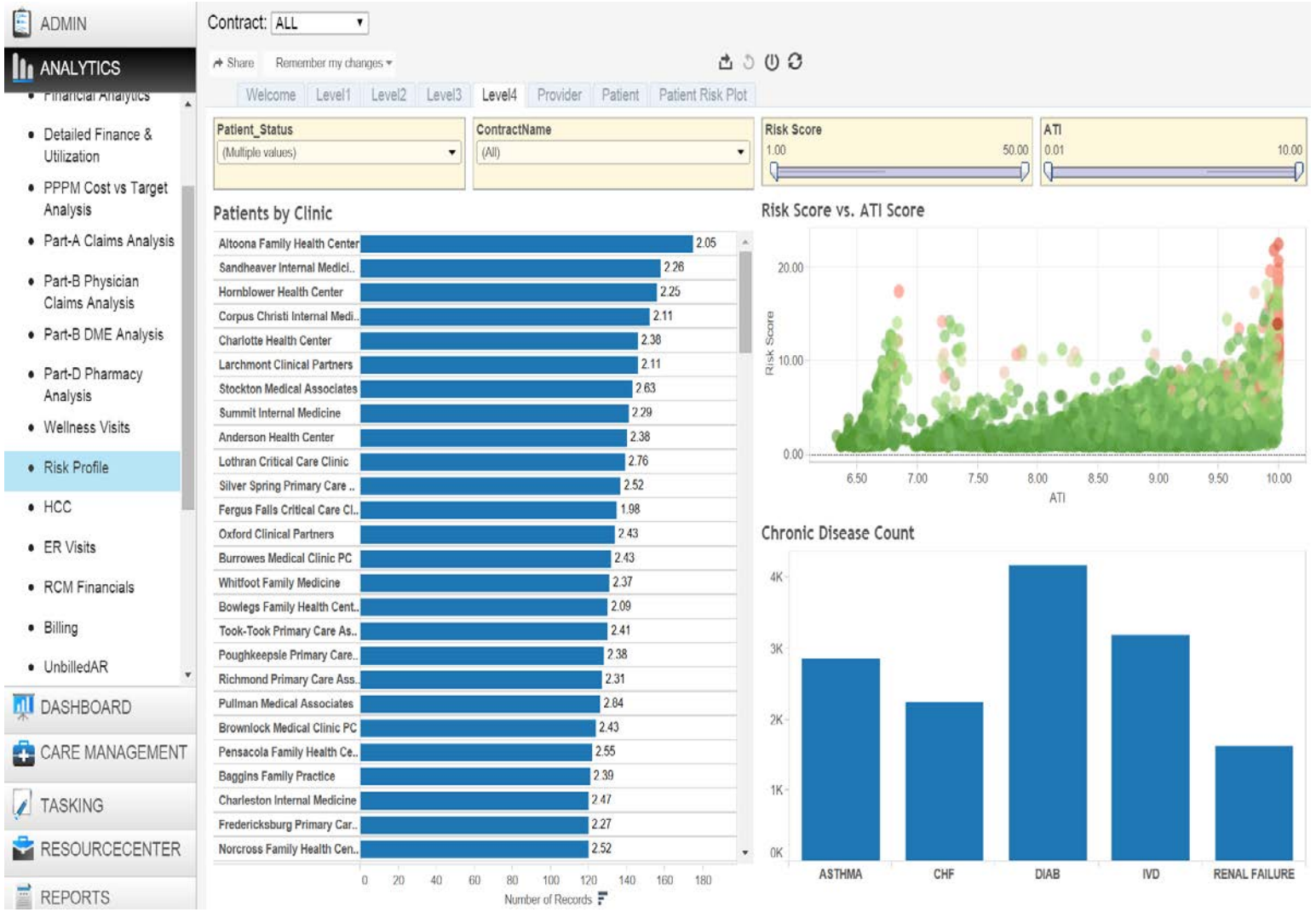
- Increase weight of IP Hospitalizations and Readmissions by 2x
  - Example: An IP hospitalization 100 days ago would be worth 1.5 points; an ER visit 100 days ago would only be worth 0.75 points

- Add 1 point to risk score if member is under 65 years old
- Once all weighing adjustments applied, add totals together to determine patient's RiskScore.

Lightbeam – Risk Stratification Engine

- Helps place focus on the right members at the right time
- Leverages real time clinical data and claims data
- Predictive modeling capabilities
- Identify members you can truly affect

Risk Profile Chart



Lightbeam Health Solutions

Welcome Spencer Adams |

ADMIN

ANALYTICS

- Part-D Pharmacy Analysis
- Wellness Visits
- Office Visits
- Risk Analysis
- HCC Analytics
- Admin Report: S2T Mappings
- Admin Report: EDW MetaData
- Admin Report: MeasureSetup
- ER Visits
- Admin Chart: Measure QA
- Population Analysis

DASHBOARD

CARE MANAGEMENT

TASKING

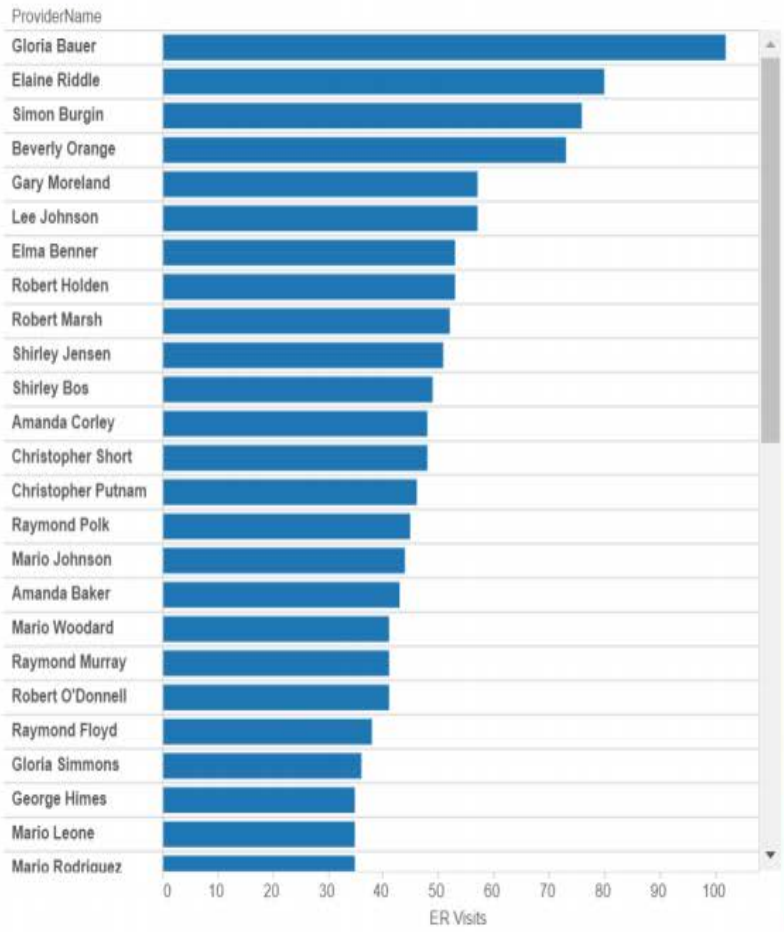
RESOURCE CENTER

GPRO

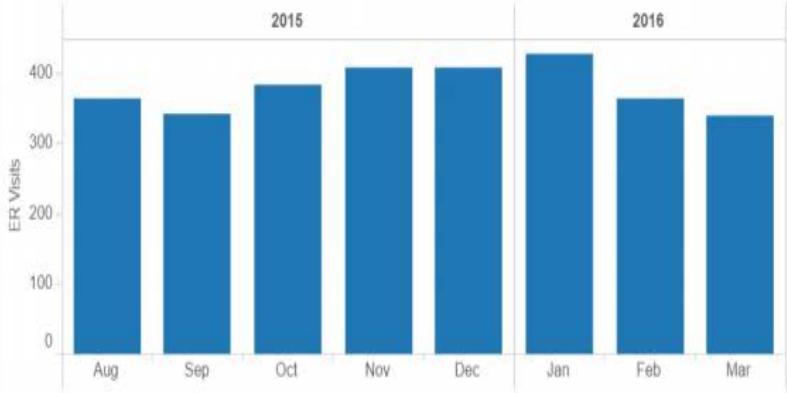
Provider | Filtered By: ALL

Contract Name	Patient Status	ProviderName	Source	Diag.Code & Desc.	ER Visits	Diag Grouping	Date of Service
(All)	(All)		(All)	(All)	By Months	High Level	Last 15 months

ER by Provider

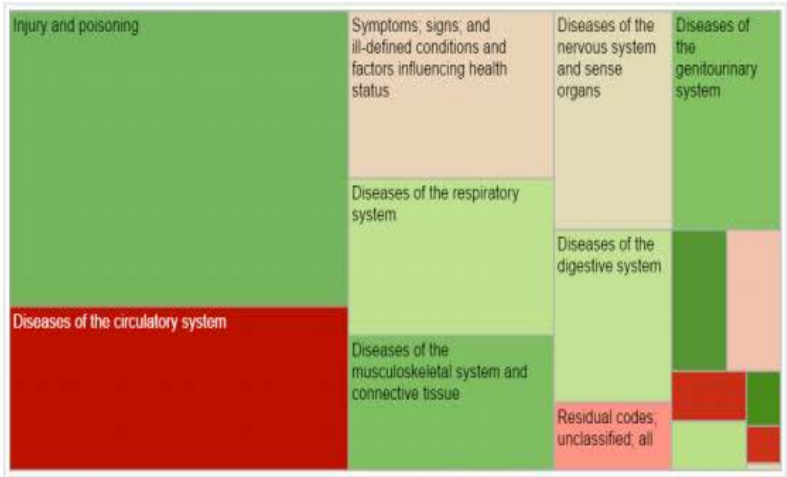


ER Visits By Months



Diagnosis Description

Size = Count, Color = Avg Cost



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CAPG Resources

Standards of Excellence – Voluntary Survey offering 'Blueprint' for success in risk based coordinated care in (6) Domains

- Care Management
- Health Information Technology
- Accountability and Transparency
- Patient Centered Care
- Physician Organization Support for Advanced Primary Care
- Fiscal and Administrative Infrastructure

Risk Readiness Tool – Categories of Infrastructure and Processes to Optimize Quality Cost Effective Services

- Patient Safety Checklist
- Effective Clinical Care Checklist
- Patient-Centered Care and Provider Communication Checklist
- Care Coordination Checklist
- Population Health Checklist

Networking with Other CAPG Member Groups and CAPG Consultants

Education and Meetings – National and Regional Meetings, Webcasts, Symposia, and Annual Colloquium

For further information, contact:

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