Partnering in Utilization Review: A New Way for Health Plans to Compete

Today, commercial health plans must cope with new kinds of challenges. Consolidation – and not just among payers – is creating formidable challengers that seek to duplicate health plans’ scale and capabilities. An increasing number of hospital-owned health plans and employers establishing direct hospital system relationships pose a legitimate risk of disintermediation, or the exclusion of health plans from the care delivery process entirely.1 The very role of payers is under threat.

At the same time, CEOs of health systems name value-based care (VBC) as the most important trend facing their industry over the next ten years and are analyzing how soon they should shift their business model and with whom they should partner.2 Health plans have an opportunity to prepare for VBC by establishing hospital trust and creating true partnerships with their hospital systems. This is a tall task: a recent hospital survey of health systems indicates that hospital trust of health plans remains generally low.3 Plus, these goals must still be balanced against the need to operate efficiently.

Effectively addressing these challenges depends on reducing payer/provider friction, particularly from medical necessity denials. Reducing this friction can dramatically improve payer/provider relations, build strong partnerships, and reduce administrative costs.

3 Williams, Kim, "Tracking Payer Performance: The 2015 PayerView Report"
Shifting Dynamics Between Health Plans and Hospitals

Traditionally, health plans were an essential intermediary between consumers and providers. Health plans had significant leverage, since hospitals had to follow health plan policies to receive payment and consumers needed to comply to avoid hefty medical bills. That reality is changing as greater emphasis on affordability and quality of care increases hospitals’ influence on revenue outcomes. The rising cost of pharmaceuticals, labor, and expenditures require hospitals to make hard choices and look for innovative solutions to prepare for value-based care. Some large employers are establishing agreements directly with providers in an effort to reduce costs both for themselves and to improve the appeal of their overall employee benefit packages.

Health plans face a very real threat of disintermediation, and not only from the employer side. Hospital systems are increasingly forming their own health plans to reduce costs and gain operational efficiencies by sharing common infrastructure and core customer platforms. While many of these provider-managed health plans have fewer than half a million members, they also tend to have more delivery system affiliations and establish joint ventures, which allow them to price premiums competitively low.

More than ever, health plans are increasingly pressured to demonstrate the value they provide by cultivating rich hospital partnerships. That objective can be difficult to achieve, though. The ReviveHealth 2015 PayerView Report revealed that health system trust of commercial health plans remains generally low, particularly as it relates to reliability, honesty, and fairness, areas that are essential for maintaining positive provider relationships.

Hospitals are particularly sensitive to friction involved in inpatient/outpatient admission determinations because these decisions directly affect revenue. Hospitals carefully watch the hassle, delay, and likelihood of being paid on-time according to contract terms; these factors are a critical influence on their perceptions of the quality of a payer relationship.

Even in ideal situations, health plans will deny at least some claims, and each denial contains the possibility of frustration and hostility. While this friction may be caused by incomplete information or simple misunderstandings, the effects can still damage long-term relationships. Hospitals assess the overall profitability of adding or continuing health plan affiliations, and significant friction from constantly battling denials can lower projections of the value of that affiliation and increase anticipated administrative costs, both of which can lead to a decision to end their affiliation.

But, perhaps most damaging, extremely poor payer/provider relationships can erupt into the public space. A hospital’s decision to stop accepting a health plan’s insurance affects beneficiaries and attracts media attention, the results of which — lawsuits, bad publicity, 

---

6 Morse, Susan. “For-profit health systems get first-quarter boost, but will it last?” Healthcare Finance News.
8 Kathuria, 3/31/15.
and public arguments – can be damaging. In one instance, claims disagreements (among other issues) caused Highmark health plan and UPMC Health System to end their association with a messy, multi-year public battle that encouraged employers and consumers to partner with a different health plan to avoid an uncertain future.9

Laying the Groundwork for Value-Based Care

While health plans can reduce this friction to improve provider relations and competitiveness in the present, they should also keep an eye on the future: value-based care. Though health system CEOs are still uncertain about which partnerships, strategies, and business models are likely to produce results, they view VBC as the most important trend facing hospitals over the next decade.10 Indeed, VBC has already arrived; a survey of financial executives from HFMA member hospitals revealed that over 50% have already seen a positive ROI from VBC.11

Developing the trust and deep connections VBC will require doesn’t depend on a single, paradigm-shifting change, but rather begins with a series of incremental steps. The AHA found that 89% of hospitals surveyed expected to engage in upside or simple shared savings risk arrangements with health plans.12 These limited relationships – as opposed to full-fledged cost-sharing relationships – are easier to accomplish and involve less adaptation to implement. Health plans that foster trust with their providers and teach them to manage risk internally will enjoy stronger relationships than their less forward-thinking competitors when VBC becomes the dominant care delivery model.

Managing Talent and Costs

While avoiding disintermediation and reducing friction are important goals, health plans must still consider the cost of managing denials. The Affordable Care Act established medical loss ratio (MLR) standards requiring 80% of individual and small-group insurance premiums – and 85% for large group premiums – to be spent on medical costs for exchange-based plans.13 Likewise, CMS included a national Medicaid MLR requirement of 85% in its 2016 final Medicaid rule.14 MLR requirements are more likely to spread than to disappear. Finding ways to reduce costs is now both a good business practice and a legal requirement.

Health plans expend significant resources to effectively manage claims, particularly in the form of medical directors whose valuable skills are dedicated to this singular responsibility.15 Reducing the time they need to dedicate to claims would allow health plans to redeploy medical directors to other roles within the business at a time when finding and recruiting clinical talent is difficult. Rather than recruiting externally, recruiting internally saves time, leverages familiarity with business operations, and shares best practices among departments.

10 Deloitte Center for Health Solutions, 2015.
13 CMS, “CMS-9998-IC3: Medical Loss Ratio Requirements under the Patient Protection and Affordable Care Act; Correcting Amendment”, 2012.
14 CMS, “Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability”, CMS-2390-F §438.4(b) (8), 2016.
15 Frank Diamond, “Medical Directors Explain Hows and Whys of Burnout,” Managed Care Magazine, Sept 2012.
Rethinking Denials: Outsourcing the Contention

Providers care deeply about their patient status determinations since they have a significant effect on their balance sheets. Reducing provider frustration in this area can dramatically improve provider relations. The solution is a simple but profound change: delegating the responsibility for utilization review to hospitals.

In this model, the health plan agrees to accept the patient status determinations the hospital provides, and the hospital, in turn, agrees to rely upon an expert third-party medical necessity reviewer to validate inpatient/outpatient determinations before submitting claims to the health plan. While hospitals benefit from reduced financial uncertainty and lower denial management administrative costs, health plans are freed from the obligations of enforcing the provider contract by issuing a string of frustrating denials. In place of a claims management process that generates rejections and frustration is a process that produces accepted claims, reliable and accurate payment, and positive interactions.

Recognizing that claims cause hospitals pain and establishing an innovative approach to alleviating it can fundamentally change the tone in payer/provider relations. A health plan's willingness to delegate responsibility for utilization review demonstrates a sincere desire to help hospitals reduce uncertainty in an area that highly affects their revenue. In extreme cases, this proof of good faith can repair a damaged relationship and avoid public relations nightmares that accompany splits between health plans and health systems. But, perhaps most critically, this fundamental shift in payer/provider relations is an attainable first step towards VBC that avoids sacrificing the needs of the present.

Designing a Successful Solution

The degree to which delegating utilization review can build strong provider partnerships depends on the accuracy of the patient status determinations. Utilizing an expert third-party to review inpatient/outpatient status is absolutely critical; the partner you choose should possess a few key features:

- **The third party should be an expert in medical necessity compliance.** Because the third party reviewing hospital patient status determinations will review all patient cases, this partner should have significant experience in a broad range of commercial medical necessity reviews. In addition to employing physicians to conduct the reviews, the third party should have medical experts and researchers to remain current on medical trends and cutting-edge science.

- **Determinations should rely on evidence-based medicine and the terms of the provider contract.** Provider contracts offer a factual, mutually accepted basis for the third party to make decisions and provide continuity between traditional claims management and delegated utilization review. For cases that fail first-level screening criteria, evidence-based medicine can augment the contract terms with a clinical basis to reach definitive conclusions without producing acrimony.
• **The third party's recommendations must be accepted by both health plans and providers.** A key benefit of this model is to alleviate the need for health plans to preside as judge over hospital claims. To deliver this value, third-party recommendations must be implemented by providers and accepted as valid by payers.

• **Encompass all medical necessity claims.** The most complex inpatient/outpatient determinations pose the greatest risk of hostility and involve the highest administrative cost. However, even simpler cases possess the potential for heated disagreements, particularly when involving many services. Your delegated UR process should review all cases to eliminate denials and resulting confrontations.

• **Perform a regular review to verify that all parties are following the process correctly.** Fee-for-service and VBC models both emphasize accountable decision-making and efficient processes. The health plan and provider should periodically review the delegated utilization process to ensure that it is being followed diligently. By standing side-by-side with providers, health plans reinforce the value they place on the payer/provider partnership and reduce the friction that causes hostility.

**Stepping Into the Future**

The claims submission and denial process is a source of significant frustration for providers. Even when managing claims optimally, each denial carries the risk of misunderstandings and hostility between payers and providers. This friction can have serious consequences to network stability and satisfaction, both of which will make VBC partnerships that much harder to achieve. The prospect of giving up some control over the claims process can be daunting, but doing so is a meaningful first step towards value-based care.

Delegated utilization review can reduce the friction associated with medical necessity denials and improve payer/provider relationships, especially with high-value or at-risk hospitals. By choosing the right third party to validate patient status determinations, health plans can improve the quality of its provider partnerships while simultaneously reducing their claims management costs and keeping themselves relevant amid shifting care delivery models.

Contact us today to learn how Optum can help you strengthen your hospital partnerships.

Email: info@ehrdocs.com
Phone: 877.347.3627