

## SUMMARY OF THE VALUE & INNOVATION FORUM

### Innovations and Alternatives to Traditional Utilization Management

December 14, 2020

Opportunities to personalize care in clinically appropriate ways suggests that new approaches to utilization management (UM) are necessary to limit inappropriate variation in care while allowing appropriate variation. On December 14, 2020, the Value & Innovation Forum convened a panel of experts to discuss innovative, real-world alternatives to traditional UM with an emphasis on those that align with the shift from volume-based to value-based healthcare.

**Opportunities for Collaboration and Multi-stakeholder Design.** [Kate Berry](#), Senior VP of Clinical Innovation for America's Health Insurance Plans (AHIP), said health plans are willing to collaborate with other stakeholders to improve UM programs and explore alternative approaches. She shared findings from a recent AHIP landscape assessment that identified three areas for improvement:

- automation (electronic submission of prior authorization requests),
- provider/plan collaborations on performance-based contracts, and
- following evidence-based guidelines.

Berry also explained the goals of current UM practices, saying they are designed based on evidence, such as peer-reviewed publications, clinical data, and government guidelines to protect patient safety, and reviewed once or twice a year to incorporate new data and adjust based on performance.

[Jay Scott](#), Director of Managed Care at Minnesota Oncology, stated that collaborations between employer groups, payers, providers, patients, and government are key to new approaches to UM that can increase quality care, eliminate low-value care or “waste in the system,” and improve the patient experience. Minnesota Oncology has created such a program with its largest payer based on adherence to national guidelines. Scott said their oncologists follow National Comprehensive Cancer Network (NCCN) guidelines and look at value opportunities within these guidelines, working collaboratively with payers and the community to provide the highest quality care at the “right cost” while minimizing administrative burden and maximizing personalized patient care.

[Robin Zon](#), MD, FACP, FASCO, Chair, American Society of Clinical Oncology (ASCO) Pathways Task Force, and President, Michiana Hematology-Oncology, noted that ASCO published [UM Principles](#) outlining several provider concerns with UM as a barrier to quality care. Zon echoed Scott and Berry's comments on [the need for broad stakeholder representation in UM designs](#), including health plans and employers. She cautioned against limiting treatment options based only on results from clinical trials since those sources consider only 3-4% of the population. Real-world evidence and “personalized care” need to be integrated into UM innovations as well.

Moderator [Alan Balch](#), PhD, CEO of the National Patient Advocate Foundation offered the patient perspective. He emphasized that if the goal to give “the right care to the right patient at the right time” is integrated into novel approaches to UM, then certain unique attributes

of patients would naturally be a more robust factor in treatment selection when appropriate. Opportunities exist to involve patients not only in the collection of real-world evidence that would help inform appropriate customization of care but in discussions about cost transparency and care planning and coordination, as well.

**Specific Examples of UM Improvements.** Panelists presented examples of current improvements to traditional UM that make the process more efficient and thus reduce some of the administrative burdens to various health system actors. Berry commented on the importance of technology to improve UM process efficiency, citing an AHIP-initiated project to collaborate with multiple technology providers, health plans, and clinicians to implement electronic prior authorizations, adding transparency and bi-directional information exchange between health plans and clinicians. Launched as a pilot initiative in early 2020, the [Fast Prior Authorization Technology Highway \(Fast PATH\)](#) uses proven automated technologies to speed prior authorization requests, responses, and information exchange. This scalable solution is payer neutral and easily integrated into provider workflow. Results from the pilot, including an analysis of improvements to the patient-provider experience, are expected in early 2021.

Dr. Zon added three other existing strategies designed to reduce UM burden – ‘gold carding,’ high quality ‘pathways,’ and Oncology Medical Homes. She called out the need to incorporate patient-reported outcomes and patients’ perceived experience into these efforts.

Some payers grant physicians who consistently follow treatment guidelines, or prior authorization requirements, a “gold card” which exempts clinicians from full prior authorization reviews.<sup>1</sup> Scott noted that Minnesota Oncology partners with community payers on ‘gold carding’ based on adherence to NCCN guidelines and value pathways. Minnesota Oncology shares a “quality report” with payers that provides data regarding on- and off-pathway prescribing decisions at the practice level. To maintain ‘gold card’ status, which enables exemptions from certain prior authorization requirements, physicians must achieve a certain rate of adherence to pathway protocols. Minnesota Oncology also uses technology to improve quality and decrease low-value care or waste. [‘Navigating Cancer’](#) (allows real-time communication between patients and providers, avoiding unnecessary in-person visits. Importantly, Scott noted that with value-based care, everyone needs “some skin the game,” in the form of risk/incentive payer agreements to encourage high-quality care and decrease waste.

Balch shared a variation on ‘gold carding’ used at Seattle Cancer Care Alliance, where a payer agreement allows for the elimination of prior authorizations for most imaging orders placed by providers who complete training on the NCCN Imaging Appropriate Use Criteria.

**Alternative Care Delivery Pathways and New Payment Models.** The panel’s final topic focused on what all the panelists agreed was one of the greatest opportunities for replacing the presence of or minimizing the need for utilization management as we currently know it: value-based payment models with shared risk.

Dr. Zon said alternative payment models (APMs) must be based on care delivery pathways to ensure value-based care. She cited the Oncology Care Model (OCM), which focused on the entire cost of a patient’s care continuum, so patient outcomes are optimized cost-effectively. Compared to traditional volume-based care, APMs represent a comprehensive,

multi-stakeholder view of care. Zon feels this approach will be successful and will be an “evolutionary process” to determine what works and what does not.

Scott echoed Zon, stating that we must move away from fee-for-service models with misaligned incentives to APMs because government, payers, and patients won’t be able to handle the current trend of health care costs. Healthcare consumer ‘choice,’ added Scott, should be a key component to redesigning reimbursement and care models. More ‘choice’ brings the risk of additional and unnecessary costs, but also provides the opportunity to save money while involving patients more in the decision-making process and highlights the importance of communication and data sharing amongst providers.

Berry agreed, stating that APMs involving risk/reward-sharing allow alignment of incentives that also benefit patients to optimize outcomes. She added that collaborative arrangements provide the opportunity to consider delegating some UM functions typically managed by health plans to providers. She shared that AHIP has initiated a data-driven, collaborative project in collaboration with an expert team from Johns Hopkins. The project uses claims data analysis for specific procedures with specialist agreed upon appropriateness parameters that identify physicians who are outliers and provide information to them to help them improve their performance; and therefore, improve patient care.

Balch brought in the patient perspective again noting that, as collaborators, patients have always had “skin in the game,” taking the burden of out-of-pocket costs and placing their bodies and lives on the line. It will be important to appropriately build patient experiences and person-centered outcomes into the risk-sharing of care delivery models that could represent ‘gold card’ type pathways for payers.

Dr. Zon cautioned against disadvantaging or disincentivizing doctors who care for the sickest patients as we move to APMs. Rewarding high-performance providers could leave a patient population that doctors do not want to care for because they cost more.

Scott said efforts are needed to incentivize patients to make the “right healthcare decisions and “figure out how to get Pharma involved and place more skin in the game.”

**One Last Question.** Balch asked panelists for their best guess on how long it might take for payment and care delivery models to radically change the current UM paradigm. Scott is not optimistic about radical changes in the short-term. However, he did note there are many incremental improvements around the country where costs have been lowered and quality of care is improving. Zon thinks it will take 5-10 years to see changes at the national level but expects more initiatives and innovations on the local level will be coming in 2-5 years. Berry agrees with both Scott and Zon, confirming pockets of success locally between plans and providers; but noted it will be a long journey to scale nationally.

Balch thanked panelists for taking a positive approach to a difficult topic, noting opportunities for change lie within the incremental improvements in UM and local innovations. So, concluded Balch, “there’s hope!”

## About the Value & Innovation Forum

The Value & Innovation Forum is a collaboration of the National Forum for Heart Disease & Stroke Prevention and Patient Advocate Foundation, both 501(c)(3) nonprofit organizations. Briefing topics are selected by the Value & Innovation Forum Steering Committee which includes representatives of the Alliance of Community Health Plans, Association of Black Cardiologists, Caregiver Action Network, and National Osteoporosis Foundation, in addition to the National Forum and Patient Advocate Foundation.

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