A New Payer Model For Medical Management Execution

To combat rising costs and inefficient use of resources, payers can streamline utilization management and optimize care management through medical management delivered as a service.
Executive Summary

Medical management promised to control costs and drive improved quality of care. Utilization management was designed to ensure members and patients received the most appropriate medical services for their conditions. Care management was supposed to serve individual members, helping them manage chronic conditions and achieve better health, thereby reducing expensive acute care episodes. Yet as typically practiced today, medical management has been an expensive disappointment. Some of the reasons it has not lived up to its promise include:

- **Inefficient resource use.** Medical management requires highly trained clinicians to perform menial tasks and is a large administrative expense.

- **Ineffective structure.** Medical management operations are expensive and labor intensive, yet they rarely contribute meaningful data to key clinical or financial performance quality metrics.

- **Lack of virtualization.** Most payer medical management organizations draw heavily on local resources for highly structured utilization decisions and care management administrative tasks. These aspects of medical management can be delivered virtually at lower cost.

- **Poor ability to support innovation.** Lack of meaningful data derived from medical management makes it difficult to evaluate current strategies and practices for improvement.

While medical management is a necessary component of payer operations, we argue that its traditional model consumes scarce resources that payers need to adapt to changes sweeping the healthcare industry. To free resources to address consumerism, evidence-based medicine and ongoing cost pressures, it is time for the industry to adopt a new perspective and best practices model for medical management. This model relies on a skilled, specialized partner to deliver medical management as a service (MMaaS).
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The Vast Potential of Medical Management as a Service

With MMaaS, payers turn to an experienced managed services provider to deliver their utilization, care, disease and population management operations in whole or in part. The new “as a service” model has three layers: infrastructure, labor and best practices and processes.

- **Infrastructure:** Payers completely eliminate medical management capital expenditures because this layer is hosted entirely by the services provider.
- **Labor:** Costs are reduced, since payers tap highly qualified clinicians, including physicians, nurses, social workers and support staff, who can be located virtually anywhere to manage the majority of medical management decisions.
- **Best practices and processes:** Combining industry best practices with their own policies generates greater efficiencies.

Payers gain increased management agility and financial flexibility because of the on-demand, consumption-based pricing model of services delivered through MMaaS. By our calculations, MMaaS will cut total utilization management costs by nearly 50% and care management costs by up to 30%. Our research indicates that medical management costs range between $1.50 to $2.30 per member per month for plans with one million covered lives. These costs encompass all related infrastructure, applications and clinical support. The MMaaS model can cut costs to approximately $1.00 per member per month.

The model will also enable payers to redeploy valuable human and financial resources and apply them to true core competencies that generate value and competitive advantage. These more strategic activities include enhanced member and provider relations, customer-centric service and product design and marketing.

This white paper examines the opportunities that MMaaS will create for payers to fully realize the potential of medical management and increase their abilities to respond effectively to ongoing healthcare industry transformation.

**1 Focus on value-generating customer-centric activities through redirected clinical and financial resources.**

**Cognizant’s POV:** The vast majority of utilization decisions and even care management administrative tasks do not require the attention or skills of local nurses and clinicians. MMaaS will enable health plans to leverage U.S. licensed global clinical resources to manage these administrative aspects of utilization and care management.

Tapping offshore clinical resources could enable health plans to transfer 80% of skilled local clinicians from utilization reviews to more critical and rewarding member-focused areas, such as disease and care management.

Similarly, administrative and clerical tasks in the care management area can be delivered by globally based clinicians, freeing local case managers to focus 100% on patient care. Typical activities that can be transferred to the MMaaS model include post-discharge and prescription compliance phone calls, transport arrangements, and patient and provider correspondence. With these tasks handled by globally based clinicians, local case managers still receive valuable insights from medical peers about a patient’s health status.
By aligning highly trained clinicians with more patient-facing activities, plans will enhance their ability to retain valued clinicians through higher job satisfaction, increase patient and plan member satisfaction and improve quality of care. These factors will be critical in attracting and retaining members in increasingly competitive and saturated markets.

2 Reduce utilization management administration costs, increase productivity and capture better data faster.

Cognizant’s POV: Utilization management is transaction intensive, with a majority of utilization decisions following clearly structured guidelines that do not require special clinician attention. Building on these guidelines, utilization review workflows can easily be standardized and automated. In fact, the American Medical Association has called for the “streamlining, standardization and automation” of preauthorization processes, citing potential cost and time savings for physician practices.

The successful MMaaS platform will incorporate “best practice workflows” culled from the industry’s leading health plans. The health plan has the flexibility to combine the best practices for prior authorizations, concurrent reviews, post-services reviews, etc. with its existing workflows. The plan thus retains its own utilization policies, while improving operating efficiencies and reducing costs. These more streamlined flows can also be the foundation for future automation of utilization decisions.
3 Improve member, patient and provider experiences for greater retention.

Cognizant’s POV: The approximately 34 million new insurance customers expected to enter the industry in the wake of healthcare reform will force virtually all healthcare organizations to acquire new customer service skills. Further, as this new wave of patients accesses healthcare services, providers will call on payers to respond more quickly to requests for eligibility and authorization data. Consumers will also expect prompt response to requests for data on a variety of electronic and mobile devices.

MMaaS can help payers effectively meet these customer service challenges. First, providers will have faster, accurate answers to their preauthorization queries, thus enabling plan members to obtain quicker status updates through the MMaaS platform.

For care management, a solid MMaaS platform also can support delivery of data on a variety of devices. This capability will support local care management services by enabling case managers and clinicians to access patient and member data on current and future generations of mobile devices. Plan members and patients also could receive health coaching tips and reminders on mobile devices, a capability many plan customers will expect.

4 Improve patient care and gain business intelligence by capturing and analyzing meaningful, measurable data through MMaaS.

Cognizant’s POV: Most traditional medical management solutions lack the automation required to capture a variety of key quality measures. Competing technology and service priorities have made it difficult for payers to invest in robust medical management systems that are able to track metrics such as hospital bed days, length of stay, readmission rates and emergency room visits. The analytics capabilities built into an MMaaS platform should easily capture this data – including those generated by concurrent reviews that take place during a plan member’s hospital stay.

In turn, this data can help payers meet or exceed their medical loss ratio measures by providing more accurate measures of the cost of care and pinpointing areas for improvement. For example, the MMaaS analytics may flag hospitals at which inpatient admission rates following member emergency room visits are nearly 100%. The data analysis can further show that a high percentage of these are unnecessary admissions, so the health plan and provider can work to reduce them.

Enhanced MMaaS data analysis can also help plans create benchmarks for the costs of clinical initiatives, providing detailed “before and after” snapshots for better evaluation of efforts. The analytics capabilities of the MMaaS model will help payers better understand and manage quality of care with more meaningful and well-monitored metrics.

5 Achieve a comprehensive view of individual members and patient populations derived from all MM programs by eliminating data silos.

Cognizant’s POV: The integration of utilization and care management on a single MMaaS platform enables better coordination of services across a multidisciplinary care team, from primary care physician to hospital to care manager. This should reduce waste and duplicated efforts, help case managers coordinate services more efficiently, and provide members with greater access to more appropriate and effective services earlier in the care continuum.
Eliminate capital expense, gain predictable operating costs and redeploy IT resources to high-value customer-centric areas.

Cognizant POV: MMaaS platforms built and maintained by experienced service providers will eliminate the need for health plans to invest in data centers, IT and communications infrastructure, as well as forgo future maintenance and upgrade costs. These all become the service provider’s responsibility.

Service providers are also responsible for building the scalability and flexibility necessary to adapt the MMaaS platform to new regulations, enhanced technology and emerging best practices. With the technology burden firmly on the service provider, a payer’s IT resources can be reallocated from medical management to value-generating activities, including health exchange participation, customer-centric mobile applications, wellness and care management support tools, etc.

Payers may address medical management inefficiencies on a continuum.

Cognizant’s POV: The MMaaS model assumes a health plan will always hold full ownership of its business strategy and clinical decision-making policies, while the payer may adopt MMaaS capabilities in increments. MMaaS at first could build on the payer’s technology and processes, while tapping the global clinical knowledge base. This model reduces costs, improves productivity and gives the payer more human and financial resource flexibility.

The payer may gradually move toward complete MMaaS implementation for the greatest savings and business flexibility. At this end of the MMaaS continuum, the payer adopts a service provider’s platform and processes, using the provider as a trusted partner to deliver utilization and care management services in alignment with the payer’s business and clinical strategies.

New at-risk organizations, such as accountable care organizations (ACO), can immediately adopt the service provider’s full MMaaS capabilities. That is, their utilization operations and care management support can be virtually delivered from their inception. In this way, the ACO eliminates the capital investment of building a medical management infrastructure, as well as related maintenance and upgrade costs.

Evaluating the Need for MMaaS:
Key Indicators

Health plans must realistically evaluate their existing capabilities to reinvent medical management to generate real value through innovation. Critical capabilities to assess include:

- How effective are we at identifying members who would benefit most from care management and early preventive measures? The ability to identify members for whom early interventions will have a maximum impact on disease and health management is increasingly critical to cost control. The MMaaS platform provides an integrated clinical view of individual health for analysis compared with mining claims data to find predictive patterns.
• How efficiently can we track a member across our various programs to understand how the services the member receives are related and complementary? Medical management operations today rarely integrate utilization, care management programs, wellness initiatives, etc., and they don't provide a single view of services that a member is receiving. The integration and management of these services from a single MMaaS platform enables plans to more effectively apply clinical treatment guidelines, as well as analyze the financial and clinical effects of a suite of services on individual members and patient populations.

• How committed are members to our health management and wellness programs? Most of these types of programs are voluntary, so plans need to influence and reward member participation. These goals are easier to achieve with an MMaaS platform supporting innovative approaches, ranging from remote patient monitoring to pushing personalized health tips to members’ mobile devices. The platform can also track how members respond so health plans can evaluate and adjust incentive programs on a more customer-centric basis.

• How do we measure the clinical and financial success of our medical management programs? Cost pressures make it imperative that health plans evaluate the effectiveness and return of intervention and care management programs, and manage investment dollars accordingly. Yet most in-house legacy medical management systems cannot capture today’s range of financial and clinical metrics. These metrics and analytics enable payers to understand what services actually cost to deliver and provide views of member health, so plans can measure program efficacy against accurate clinical and financial benchmarks.

• What is our internal human and technological capacity to absorb the care coordination and health management needs of our existing members, plus those to whom we will be marketing? Platforms that support a wide range of data access and delivery options for clinicians and members are critical to successful medical management. Clinical expertise for care management is another vital, expensive component. The MMaaS delivery model supplies the technology and expertise required for successful, value-generating medical management, yet minimizes the costs of implementing it.

Creating Value from MMaaS

MMaaS will help payers unleash currently captive value and successfully compete in the new healthcare market by streamlining operations, improving care and becoming a critical factor in delivering mobile, virtual and consumer-centered healthcare. The new medical management model will quickly deliver reduced costs and greater flexibility in how payers deploy clinical and financial resources. These benefits, delivered without capital expenditures and coupled with predictable, manageable operating costs, ensure that MMaaS will soon become standard practice among leading payers.
Footnotes


About the Authors

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