APTA Private Practice. A Section of the American Physical Therapy Association
1421 Prince Street
Suite 300
Alexandria, VA 22314
(800) 517-1167
www.ppsapta.org
APTA. American Physical Therapy Association

A Brief History of Utilization Management (UM)

Utilization management has been employed in some form for decades. Retrospective UM first surfaced in the 1950s in an effort to reduce unnecessary hospital services. In this era, health plans began to require second surgical opinions, but this did not become widespread until the 1970s. As UM programs matured in the 1980s, a growing perception took hold that health care cost increases were due to unnecessary medical care that could in fact be harmful to the patient.

In 1965, the federal government established Medicare and Medicaid to improve access to health care services for the elderly and for low-income families. After these programs rolled out, it became apparent that measures would be required to address inappropriate care delivery or overutilization. This resulted in the development of provider-based utilization management strategies, called PSROs (professional standards review organizations) in the 1970s and PROs (physician review organizations) in the 1980s. The increased focus of government and private purchasers on containing costs had a direct impact on the rise of programs, which influenced patient care decision making. Tools became available in the late 1980s that facilitated individual case management, and clinical practice guideline development was encouraged.

From 1980 on, the rapid rise in information technology and computer software development directly contributed to the availability of health care data on costs and utilization. This data allowed health care purchasers to track various metrics over time and identify aberrant patterns later used to inform claims payment decision making. While the data identified the volume of services (services per episode, number of episodes, costs) there was no quality component. Using this data to design risk-sharing payment methodologies, which included capitation (set payment amount per patient enrolled in a health care plan), resulted in decreased utilization. However, it was unclear if medically necessary care was inadvertently discouraged; capitation in particular encouraged underutilization of necessary care.

At the same time, and as health care costs rose over the decades, payer interest in case management grew after the 1960s when health care costs shifted from individuals and employers to third parties. In the early years, insurers, including self-insured employers, managed escalating costs through varied means of adjusting the risk pool. These included experience rating (establishing rates based on health care expenditure history), medical underwriting (excluding individuals with certain conditions), or waiting periods (delaying coverage for pre-existing conditions for a specified period of time). Insurers took steps to redesign benefit plans and exclude coverage for certain services considered "investigational" or "ineffective."

Starting in the 1990s, patients were increasingly asked to accept financial responsibility for their health care through cost sharing that included deductibles, copayments, and coinsurance. Cost sharing, a form of cost shifting, was implemented to try and help consumers become more conscientious health care purchasers and to discourage unnecessary services. At the same time, insurers became more aggressive in their contracting with providers in an effort to control payments. Providers were incentivized through financial arrangements including capitation and bonuses for providing less costly care. Physician gatekeepers were also introduced.

Implementation of the Affordable Care Act
Rising health care costs continued unabated into the 2000s amid increasing pressure from the government and employers to find alternative solutions. In 2010, the Patient Protection and Affordable Care Act, also known as Obamacare or the Affordable Care Act (ACA), was signed into law. This landmark legislation forever changed the United States health care landscape. Provisions of the ACA mandated insurers cover designated essential health benefits, including rehabilitation and habilitation services. Barriers to health care were eliminated as insurers were barred from imposing lifetime limits and refusing coverage or increasing rates based on pre-existing conditions.

The central pillars of the ACA are summarized by the triple aim: improve population health, improve patient experience, and reduce cost. Health care reform is predicated on the need to change the way care is not only paid for, but also delivered. The shift from fee-for-service to value-based contracting is an essential component of this new paradigm.

The ACA included provisions that changed the way private health insurance is regulated, with the goal of providing better value to the consumer with increased transparency. The Medical Loss Ratio (MLR) provision limits insurer profit and requires a specific portion of insurer premium dollars to be spent on medical care rather than administrative costs. However, the MLR provision also facilitated a dramatic rise in third-party UM, particularly in the outpatient rehabilitation space.

With the ACA's attempt at additional consumer access and protections, payers had limited ability to curb expenditures. Insurers began to seek new ways to control costs, reduce utilization, and address cost and quality outliers. Historically, cost insurers had performed retrospective utilization review. It was common practice for payers to request documentation, based on selected data analysis and criteria, to review after care episodes concluded. Payers sometimes used this information to justify denials or modification of payment. However, the MLR required the payer to perform concurrent and prospective review, in addition to other quality initiatives. As most insurers did not have the clinical infrastructure to perform these functions, they began to seek collaborative relationships with third-party administrators (TPAs).

The degree and nature of the functions delegated by the payer to the TPA is currently highly variable. Some payers choose to delegate just the UM function, while others shift responsibility for eligibility, customer service, UM, and claims payment. Generally, but not always, the last levels of the appeal process are adjudicated by the payer.

As with other health care entities, such as hospital systems and provider clinics, consolidation has been occurring in the rehabilitation-related UM segment. Recent mergers and acquisitions resulted in the growth of these vendors in sheer size and scope of service offerings. This has rendered these vendors attractive partners to payers who can then delegate UM for multiple lines of business.