DOWNLOAD PDF CONTROLLING UTILIZATION OF HEALTHCARE SERVICES

Chapter 1 : Controlling avoidable utilization: How to use clinical evidence and data to improve care

Assessment and analytic tools that have helped the move toward utilization management include (1) explicit criteria for assessing the appropriateness of medical services, (2) statistical methods for setting utilization norms, and (3) methods for assessing the health status of different patients and population groups.

To accomplish this, some organizations are targeting "wasteful spending" in their clinical service lines, or spending not associated with improved quality or patient outcomes. Unnecessary testing, over-testing, duplicative services and other low-value care represent a substantial opportunity for healthcare providers to reduce costs and improve patient health across their enterprise. Combining and analyzing clinical, financial and operational data can help organizations pinpoint opportunities to reduce or eliminate low-value care. However, implementing a robust analytics program can be cost-prohibitive and impractical for organizations facing capital constraints or interoperability issues, limiting the amount of data they can access. This content is sponsored by HealthTrust. To overcome these barriers, hospitals are seeing value in partnering with group purchasing organizations to leverage their extensive data and reduce avoidable utilization of healthcare services, products and advanced technologies. The cost of avoidable utilization Unnecessary medical services fuels a large portion of wasteful healthcare spending. In , the Institute of Medicine released a report stating 30 percent of total healthcare spending in the U. When a physician orders excessive testing or treatments that offer little proven benefit, the cost of care increases while patient health remains unchanged, or in worst case scenarios, is actually harmed. Studies have found low-value care is prevalent in the U. A study of Medicare claims data revealed between 25 percent and 42 percent of Medicare patients received at least one of 26 test or treatments that scientific and professional organizations have consistently determined to have no benefit to patient health. With such drastic effects on both finances and patient care, reducing unneeded healthcare services is a top priority for many healthcare leaders. CEOs ranked the issue their fifth-highest concern out of 26 topics in Hospital CEOs are not the only ones concerned about the overuse of medical services. The American College of Physicians cites high rates of unneeded care, as well as the use of unnecessary technology, as major drivers of healthcare spending. Hospitals can use cost, outcomes and reimbursement data to support outside clinical evidence and drive insights that help inform clinical decision making, reduce unnecessary patient care and enhance clinical value. Clinical analysis allows clinicians to better understand the benefits and outcomes of various procedures and services for specific patient populations. Once these outcomes are understood, clinicians can tailor treatment plans to ensure the best care possible, delivered in the most efficient manner. Defining the data challenge To create a clear picture of value, hospital systems must be able to quickly and efficiently combine the data they collect and manage on a daily basis â€" clinical, financial and operational â€" and use it to understand processes and drive insight. Once health systems identify inefficient or ineffective patient care methods, they can implement appropriate use criteria or initiate a usage monitoring process to ensure the patients who will benefit most from the product or treatment are the ones receiving it. To determine the cost effectiveness of their clinical care, hospitals must have analytics technology, data scientists and governance processes in place to extract meaning from the data, according to Michael Schlosser, MD, CMO of HealthTrust, a Nashville, Tenn. Specifically, they need access to information on product cost, technology costs, use rates and clinical outcomes of specific products and services. Since GPOs have access to a much larger amount of data than an individual hospital does, these organizations are a helpful resource for information to drive change. GPOs also have the tools and expertise necessary to extract meaning from the clinical evidence and data by evaluating its potential value, biases or flaws. While this type of data analysis is still very much a manual process, leading GPOs seek to automate and centralize the process to vet evidence, look at new technology and share the information with member hospitals on a regular basis. On the other hand, healthcare organizations that try to gain information about cost effectiveness from other sources, such as product vendors and government agencies, face three key challenges, according to Dr. The

technology and products introduced in healthcare settings are largely driven by vendors who encourage surgeons to constantly push the envelope by using the latest and greatest devices, says Dr. Since the Food and Drug Administration does not require companies to complete cost-effectiveness studies prior to product approval, vendors place little focus on this information. Scientific data is not real-world data The FDA offers several different pathways for products to earn approval, and each requires different levels of science, says Lynn Tarkington, RN, assistant vice president of physician and clinical services at HealthTrust. However, when the product is used in a real-world setting, none of the variables are controlled, and clinicians use the technology to treat various patients with different conditions. Data can be overwhelming Healthcare organizations must sift through mountains of data â€" from both clinical studies and their own cost, reimbursement, supply chain and patient outcomes data. The data can present itself in many different fashions and forms, and there is not always a clear link from one data set to another, says Mr. Harnessing the power of data GPOs can help healthcare organizations study, understand and provide high-value care by helping them measure utilization and cost data against clinical outcomes. Finding the right talent. Some healthcare organizations are building on their traditional relationship with GPOs by partnering with them to study clinical and financial data together to determine care value. Physicians can provide clinical feedback on contracted products and also help develop new ways to combine data sets, study the products and understand patient outcomes. Looking for outliers and trends. GPOs also offer large scale registries â€" big selections of real-world data â€" which serve as another valuable tool for informing better utilization. Conclusion "Data is an asset to a healthcare organization, and you have to treat it like such," says Dr. Data analysis is crucial for hospitals to know not just the individual price of a service or item, but to understand how much it costs and how effective it is for patients. Ultimately, the hospitals that see data as an asset, rather than an overwhelming burden, will be most successful in reducing costs and achieving clinically effective and efficient care. View our policies by clicking here.

Chapter 2 : FastStats - Access to Health Care

Major drivers of health care costs include: inappropriate utilization especially of advanced medical technology, lack of patient involvement in decision-making, payment system distortions that encourage over-use, high prices for health care services, a health care.

Depending upon the circumstances, this outside party may be involved in discussions about where care will occur, how treatment will be provided, and even whether some treatments are appropriate at all. First, how do we ensure that people get needed medical care without spending so much that we compromise other important social objectives? Second, how do we discourage unnecessary and inappropriate medical services without jeopardizing necessary high-quality care? Experience indicates that these questions have no fixed answers. Rather, we find a series of working hypotheses and partial solutions that are continually revised, discarded, and even reinvented as changes occur in medical technology, social values, economic conditions, and other circumstances. Page 2 Share Cite Suggested Citation: Controlling Costs and Changing Patient Care?: The Role of Utilization Management. The National Academies Press. One recent survey reported average cost increases from to of 14 percent for employers with insured health benefit plans and 25 percent for employers with self-insured plans. In the private insurance sector, many commercial insurers, Blue Cross and Blue Shield plans, and HMOs have seen substantial losses, and some commercial insurers are withdrawing from the group health insurance market. To the dismay over rising health care costs has been added a growing perception that a significant amount of medical care is unnecessary and sometimes harmful. The studies that have contributed to this perception have also produced some optimism that external review of physician practice decisions could detect unnecessary care, influence physician behavior, and reduce costs without jeopardizing access to needed services. Such review has also appeared to offer an alternative to retrospective denials of claims for benefits and across-the-board cutbacks in health plan coverage. In this preliminary report, the Committee on Utilization Management by Third Parties examines several questions. The focus is on the private sector, in which two-thirds of the nonelderly population are covered directly or as dependents under employer-sponsored health plans. An estimated one-half to three-quarters of the individuals in these plans are subject to utilization management. Current Status of Utilization Management Early in its discussions the committee realized that the term utilization management has no single, well-accepted definition. As with the labels cost containment and managed care, different people may mean different things by the term. In this report, the committee considers utilization management as a set of techniques used by or on behalf of purchasers of health benefits Page 3 Share Cite Suggested Citation: The dominant utilization management strategy is prior review of proposed medical or surgical services, which includes several related techniques such as preadmission review, continued-stay review, and second surgical opinions. Prior review provides advance evaluation of whether medical services planned for a specific patient conform to provisions of health plans that limit coverage to medically necessary care. Typically, all elective hospital admissions are subject to such review before the patient enters the hospital, all emergency admissions must be reviewed within a short period following admission, and the need for continued hospital care is assessed periodically. High-cost case management is a more focused strategy that concentrates on the relatively few people in any group who have generated or are likely to generate very high expenditures. Empirical evidence on the effects of utilization management is fairly limited and suffers from a number of methodological weaknesses. Despite these limitations, the committee believes that available evidence, taken together, indicates that utilization management has had some impact on health care use and costs. Employee groups with higher initial levels of hospital use tend to show more change than groups with lower initial hospital utilization. Savings on inpatient care have been partially offset by increased spending for outpatient care and program administration. Some of this offset is an expected and acceptable result of utilization management and other factors , and some is an unwanted consequence of moving care to outpatient settings, where fewer controls on use and price now

operate. Employers who saw a short-term moderation in benefit expenditures are seeing a return to previous trends. Systematic evidence about the impact of utilization management methods on the quality of care and on patient and provider costs is virtually nonexistent. During the course of this study, the committee did not locate documented anecdotes or other information to suggest that prior review programs in the private sector are jeopardizing patient safety. However, the processes of prior review and associated changes in courses of treatment may cause anxiety and inconvenience to some patients. And utilization management does add to the administrative burdens on practitioners and institutional providers and contributes to resentment about reduced professional autonomy and satisfaction. More positively, the committee has some confidence that high-cost case management is easing some financial and emotional burdens on catastrophically ill patients and those who care for them. Several features of utilization management are important to keep in mind. First, utilization management as it currently operates in the private sector is highly variable, which makes generalizations difficult. Second, until recently utilization management has focused on the site, duration, and timing of medical care. The unnecessary use of the hospital, rather than the actual need for a particular service, has been the main target. The primary strategy has been discussion and negotiation about appropriate care. Refusals to certify benefits appear uncommon, perhaps 1 to 2 percent of cases. Third, utilization management in the private sector operates under few explicit legal restrictions. There is, however, considerable awareness among review organizations and major purchasers of the legal risks inherent in efforts to influence patient care decisions and operationalize the terms of health benefit plans. The lack of good research on the effectiveness and impact of utilization management is a frequent theme in this report, which likewise notes that research on the effectiveness of many medical procedures is also limited. As utilization management expands its review of the actual need for specific procedures, the clinical foundation for such assessments becomes more important. Good research is a critical base for good utilization management. Moreover, the research on feedback and education strategies to influence physician decisions suggests that utilization management criteria will be Page 5 Share Cite Suggested Citation: How Utilization Management Is Evolving The continuing evolution of utilization management is most evident in its scope and its operational efficiency. The reasons for these developments are several. First, the initial savings from shifting the site and timing of care have largely been realized, and the survival of review organizations may depend on their continuing ability to affect benefit costs. Third, the administrative and other costs of review programs, including physician dissatisfaction and employee confusion, make simplification and efficiency important objectives. Thus, based on survival instincts and evidence of continuing utilization problems, the emphasis of utilization management is beginning to expand from the site and duration of care to include the actual need for specific types of inpatient and outpatient services. Again, the availability of sound clinical criteria for assessing medical necessity is one constraint on this movement. Legal concerns are another factor. At this time, the committee does not see utilization management moving toward intentional rationing of clinically necessary medical services. A decision not to approve payment for an unnecessary service is not rationing per se. However, the committee recognizes that there may be instances when review nurses or physicians may apply implicit cost-effectiveness judgments. In high-cost case management, such judgments may be explicit, but the intention is to determine whether services normally excluded from a benefit plan should be covered to permit less costly but still appropriate care for a particular patient. With respect to administrative costs, frequently mentioned priorities include greater computerization, expanded use of treatment protocols in high-cost case management, and greater targeting of reviews to high-payoff categories of problems and services. In some cases, gains in operational efficiency should reduce administrative burdens on patients, physicians, and institutional providers of care. Issues For the Future The committee has identified some shortcomings in utilization management or gaps in the knowledge of it that raise concerns about patient protection, particularly given the growing focus on the appropriateness of Page 6 Share Cite Suggested Citation: If the positive potential of utilization management for improving the cost-effective use of health resources is to be encouraged, then the committee believes that several issues need attention. There needs to be more confidence about what works and what

does not and under what circumstances. Physicians, purchasers, and patients should know the basis for judgments about the site, timing, and need for care. A more complete picture of costs and benefits is needed. This is an essential protection for patients. Review organizations should have standard operating procedures for responding to the quality problems they uncover. Recommendations For the Near Term The committee believes that utilization management has sufficient promise that a number of short-term and long-term efforts should be made to promote its positive potential and guard against its shortcomings. Responsibilities of Employers and Purchasers As financers of both utilization management and health services, employers are in the best position to exert influence on the conduct of utilization management. Although such an effort may be beyond the resources of small employers, larger purchasers should investigate the operating procedures and capabilities of the organization or organizations from which they purchase review services. This review should include organizations such as HMOs that provide prior review and high-cost case management as part of a broader package of services. Human resources staff should be trained to respond to employee questions, assist with problems, and handle grievances. Employers should also examine other aspects of their health benefit plans for impediments to the appropriate use of medical services or the rational payment for these services. Moreover, workers must be clearly informed of their responsibilities and rights. Also, although employers have the right and responsibility to take vigorous actions to manage the costs of employee health benefits, they should respect both the confidentiality of medical information about employees and the primary obligation that physicians have to serve their patients. Responsibilities of Utilization Management Organizations Any supplier of services has responsibilities to purchasers that are intrinsic to the concept of a buyer-seller relationship. It is in the business interest of review organizations to anticipate and respond to purchaser demands for information about the organization, its services, and its results. Further, it is in the legal interest of these organizations to manage their activities rationally, to act in good faith, and to maintain careful records. Although good business and legal judgment should dictate prudent behavior, those who provide utilization management services also have a moral obligation not to harm the patients whose medical care they review and influence. Harm includes discouraging appropriate care and mishandling confidential information. When organizations perform prior review and high-cost case management for individually purchased insurance plans with no employer sponsorship , they have a particular responsibility to provide good educational materials and appeals processes for beneficiaries who have no employer or other sponsor to act as their agent and aid. They should also develop guidelines for what to do when they discover quality of care problems. The committee is aware that further steps, in particular, making clinical criteria available, raise difficulties given the competitive environment of Page 8 Share Cite Suggested Citation: Though these are reasonable concerns, on balance, they are outweighed by the need to move toward open criteria and standards. Responsibilities of Practitioners and Institutions The committee found the responsibilities of physicians and other health care providers in utilization management the most troublesome to analyze and define, a situation typical of many current ethical and policy issues in health care today. Manipulation and evasion can have serious risks. Moreover, perceptions by purchasers that physicians are gaming the system undermine professional credibility and stimulate the sorts of auditing, second-guessing, and external oversight to which practitioners object. Page 9 Share Cite Suggested Citation:

Chapter 3 : Origins of Utilization Management - Controlling Costs and Changing Patient Care? - NCBI Boo

With some extra efforts monitoring of the utilization of healthcare services by the poor at the facilities can be done reliably. If monitored, the findings can guide the programme and facility managers to act in a timely fashion to improve the effectiveness of the programme in reaching the poor.

Before the s, few Americans had anything resembling modern health benefit plans Anderson, , ; Somers and Somers, Concerns about medical costs were defined largely in personal rather than governmental or corporate terms. For example, the Committee on the Costs of Medical Care CCMC reported in the early s that less than 15 percent of American families bore the burden of more than half of all annual family expenditures for illness Anderson, For individuals, medical care expenses were highly unpredictable, ranging at that time "from five dollars to one thousand dollars or more" for a single illness Rorem, , p. When patients and families first parties could not pay these costs, health care providers second parties absorbed them with varying amounts of assistance from other organizations third parties such as local governments, religious groups, and private charities. A classic text on insurance McIntyre, describes traditional conditions for insuring a hazard or risk. The insured event 1 must be susceptible to unambiguous description, 2 must not be something the insured person wants or can control, and 3 must be a relatively uncommon occurrence for individuals but have a predictable incidence for a group. Medical care presents problems in all three areas. Nevertheless, in the early s, a number of individuals, influenced by the analyses of the CCMC, began a virtual social movement to organize and promote new kinds of "third-party" financing for health careâ€”although they did not use the term explicitly Anderson, , ; Rorem, ; Somers and Somers, They believed that medical expensesâ€—at least, hospitalization expensesâ€—for a group of people could be projected with some accuracy so that a group could do what the individual could not: Real growth in health insurance began during the crisis of the Depression. The federal government rejected health insurance as a priority in developing Social Security legislation, but in the private sector communitywide hospital benefit plans began to be organized for employed groups. These plans collected monthly per-employee payments premiums that were independent of individual episodes of ill health. Early premiums ran about 50 to 75 cents per month per member. Once private health insurance had a chance to prove itself, it quickly became regarded as a necessity and enrollments grew rapidly Figure By the end of World War II, more than 30 million people had private hospital insurance, and employment-based insurance was becoming the norm in major companies. Insurance coverage continued to expand during the next quarter century, reaching a peak of over million people in Health Insurance Association of America, , Figure Private health insurance enrollment. Percentage of civilian population with hospital expense, surgical expense, "regular medical," and "major medical" coverage, Data are based on end-of-year population and enrollment figures. Recently, after 50 years of growth, the reach of private health insurance has begun to decline. AS shown in Table , the percentage of the nonelderly population covered by employment-based plans dropped from In the same period, the number of individuals with neither public nor private insurance expanded to an estimated 37 million in Chollet, ; Congressional Research Service, Those people represent A recent revised estimate puts the number of uninsured at Some individuals move in and out of coverage as they take seasonal or other periodic employment, but many of the uninsured are full-time workers and their dependents. In , 15 percent of workers reported no health insurance from any source Monheit and Schur, Although a variety of economic and social conditions lie behind the decline in insurance coverage, high costs for health care certainly contribute to it. In fact, the continuing escalation of health care costs is once again prompting questions about the insurability of medical care and the viability of private health benefit plans Abramowitz, ; Freudenheim, ; National Health Policy Forum, Early Cost-Management Efforts By Third Parties The transfer of many health care costs from individuals to third parties has been accompanied both by a shift and a recasting of the cost problem. Insurance has added new complexities to the problem, along with new resources for managing it. Table , which shows changes in the general consumer price index and selected

medical care items from to , reveals a sharp postwar increase in hospital rates compared to physician fees. These include management of the risk pool, design of the benefit plan, controls on payments to health care providers, constraints on the supply of health care resources, and review of the appropriateness of utilization. Management of the Risk Pool The founders of health insurance plans in the s and s had to abide by a fundamental principle of all insurance: The composition of the risk pool is critical to the cost and survival of a plan. If the people who buy health insurance are disproportionately those who expect high expenses for health care, then insurance will be, at best, a form of group budgeting for the ill minus the critical feature of risk-sharing with healthy individuals. The choice of the employment group as the foundation for private health insurance was a key element in managing the risk pool. The employee group was attractive because it existed for reasons other than the purchase of insurance. Many of the early nonprofit health insurance plans were also committed to "community rating. However, "experience rating" soon emerged as a way for insurers to compete by segmenting risk. Insurers could attract business by offering lower premiums to groups with lower health cost experience or lower projected costs. This left smaller employers, groups with older and less healthy workers, and self-insuring individuals to pay higher premiums. To make it feasible to sell insurance directly to individuals, most insurers have devised various controls. These include medical underwriting that is, excluding those with conditions such as cancer or charging them higher rates and waiting periods for coverage of preexisting medical problems. Such controls are designed to limit or compensate for the disproportionate selection of an insurance product by less healthy individuals. Recently, with many employers offering several health plans to their employees, the management of risk within and across these plans has become a major issue. The long-term impact of this new fragmentation of the risk pool on benefit costs and on the stability of health plans is the subject of spirited controversy Scheffler and Rossiter, Efforts to create sound risk pools for small groups, the self-employed, the fragmented employer group, and others remain an elusive goal for those trying to extend health benefits to the nonpoor uninsured. Design of the Benefit Plan Like management of the risk pool, the centrality of benefit design was also quickly appreciated as a vehicle to control health plan costs. One way to limit expenses is to require patients to bear some of the cost of care themselves through deductibles, copayments a flat payment per service , coinsurance a percentage of a charge , and dollar maximums on benefits for all services or specific categories of service. Cost-sharing has two objectivesâ€”first, the simple transfer of some liability for costs to the patient and, second, the discouraging of patient demand for care. Plan administrators also concluded that premiums could be held in check by excluding coverage for experimental and ineffective treatments, for treatments whose use was highly discretionary or difficult to monitor, for extended or custodial care for chronic conditions, and for relatively low-cost services that could be scheduled and budgeted. Early benefit plans often limited coverage to selected hospital services. These coverage limitations applied uniformly to the covered group and did not require patient-by-patient judgments of medical appropriateness. Later, as insurers and employers became more comfortable with sponsoring health plans, coverage began to include nonhospital services. Controls On Payments To Providers During the financially uncertain years of the s, contracting and risk-sharing with providers were important economic elements of prepaid group practice arrangements and some health insurance plans. Later Blue Cross plans also had provisions for some sharing of risk by their contracting hospitals or physicians, and negotiated limits on fees were elements in many plans Donabedian, ; Hellinger, Strong contractual relationships that included some risk-sharing or limits on payments to providers, however, were hard to establish and maintain Werlin, The expansionary postwar decades stimulated hospital restiveness with the contractual relationship that guaranteed service to Blue Cross enrollees at a negotiated price Anderson, Physicians continued to fight prepaid group practice plans and other forms of contracting and risk-sharing. Health planning had received much of its initial nationwide impetus as a tool for guiding the expansion in community hospital resources under the Hill-Burton program established after World War II. Beginning in the late s, however, the growing supply of hospital resources came to be viewed as a source of rising health care costs Roemet and Shain, , and health planning was seen as a way to limit excessive capital

investment Somers and Somers, By the s, a full-blown federal, state, and local health planning program was attempting to regulate resource development IOM, ; Yordy, Many insurance officials and employers were active supporters of these efforts Ennes, ; Herod, Department of Health, Education, and Welfare, , some insurers warned that unless hospitals cooperated with public or voluntary health planning, "we will not pay full reimbursement or continue our contract with a hospital" Walter McNerney, quoted in Somers, , p. In the s, faith waned that health planning could be effectively implemented as a cost-control tool Schwartz, W. Utilization Review Historically, payers have concentrated their cost-containment energies on the unit price of medical services and have directed less attention to the volume of those services provided by institutions and practitioners. Although some hospitals used committees to monitor utilization in an effort to cope with the short supply of hospital beds during World War II, the first explicit use of retrospective utilization review to control fee-for-service payments for unnecessary and inappropriate hospital services seems to have begun in the s Payne, , p. Abuses in the use of hospital services and facilities coming to the attention of this hospital utilization committee could be disciplined to the point of near deletion" cited in London, , p. Apparently, high optimism about the impact of utilization review was born with the idea itself. The s also appear to have seen the first attempt to establish provisions in health benefit plans to encourage or require second surgical opinions Rutgow and Sieverts, The United Mine Workers Union tried to institute second opinion requirements but failed because of resistance from organized medicine. The San Joaquin County Foundation for Medical Care FMC , founded in , not only served as a model for many IPAs but also helped inspire several medical societies to organize peer review of health care utilization and quality. FMCs pioneered many utilization review tools, including model treatment profiles to assess physician performance, protocols for reviewing ambulatory care, and computerized screening of claims. By , there were 61 FMCs in 27 states Egdahl, Utilization review also spread in other settings Werlin, In the early s, more than 60 Blue Cross plans reported programs to review hospital claims for the appropriateness of admissions, and more than 50 looked at the length of stay. In an observation echoed many times over the next 25 years, one speaker at a conference on cost-containment programs observed that insurer staffs had varying opinions on the effectiveness of utilization review, lamenting that "specific data are lacking" Fitzpatrick, , p. To summarize, as third-party payment for medical care services expanded from the s into the s, payersâ€”primarily insurers and health maintenance organizations HMOs â€”tried various tools to control these costs. These tools may have had some impact, but they often were neither rigorously applied nor rigorously evaluated. Government and Employer Involvement Two major developments differentiate third-party involvement in containing health care costs during the periods before and after The first is the entry of the federal government as a powerful force for both cost escalation and cost control. Second, and somewhat later, private employers began serious efforts to control their expenditures for employee health benefits. The latter program also gave states an increased stake in containing health care costs. Both programs responded to inadequacies in private group insurance as a means for covering high-risk or low-income individuals. State and federal spending for personal health care services rose from 22 percent of total spending on these services in to 40 percent by Table When Congress established the Medicare and Medicaid programs in to increase access to health services, it also recognized the need for constraints against overuse of services. The initial strategy was to expand and strengthen provider-based utilization review. Hospitals and extended-care facilities were required, as a condition of participation in Medicare, to have operational utilization review committees to assure the medical necessity and quality of care "without involving government in day-to-day hospital operations" Mills, This was consistent with the preamble to the Medicare legislation, with its famous prohibition against federal "supervision or control over the practice of medicine or the manner in which medical services are provided" P. The costs of the Medicare program soon climbed at rates far above what was predicted when the program began. As one result, policymakers came to view the strategy of delegating utilization review as ineffective, "more form than substance" U. In addition, the medical profession and some consumer groups were complaining about the claims reviews and payment denials instituted by the private contractors that processed Medicare claims. Department of Health, Education,

and Welfare had required these activitiesâ€”which some contractors already used in their private businessâ€”when they saw that expenditures were quickly exceeding projections Blum, et al. In the Social Security Amendments of P. Building on many of the concepts developed by the Foundations for Medical Care and the Experimental Medical Care Review Organizations federal demonstration projects beginning in , PSROs were to be physician-controlled community organizations that would develop and apply professional standards to the review of institutional health services Blum et al. The law required PSROs to perform concurrent review, but preadmission and retrospective review were optional. In their decade or so of existence, the PSROs designed and refined many of the data collection and analysis techniques used by successor organizations to serve both public and private purchasers. Congress also got interested in the mids in second surgical opinion programs as a means of reducing unnecessary surgery.

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Chapter 4 : Utilization management - Wikipedia

The best utilization management definition encompasses all forms of healthcare services, including all procedures, as well as the determining the optimal use of facilities. The management process is used to ensure patients have appropriate care and are provided all required services to maintain their health without overusing resources.

Copyright notice Abstract Utilization management UM is now an integral part of most public and private health plans. Hospital review, until recently the primary focus of UM, is associated with a reduction in bed days and rate of hospital cost increases. These reductions appear to have had limited impact on aggregate health care costs because of increases in unmanaged services. In the future, with electronic connectivity between payers and providers and the use of clinical guidelines and computer-based decision-support systems, the need for prospective case-level reviews will be reduced. With these changes, UM programs are likely to become more acceptable to providers and patients. Introduction The great majority of Americans are now enrolled in privately or publicly funded health plans that use utilization management UM programs as a primary cost-containment strategy. This includes 90 percent of privately insured employees and all Medicare and Medicaid participants Sullivan and Rice, Considering that few employees were enrolled in these programs until the middle s, the growth of UM has been phenomenal. Now that UM programs are established, it is an appropriate time to assess their impact and to reflect on their future role in the health care delivery system. There is an extensive descriptive literature on UM mainly for inpatient care , and a small but growing body of scientifically rigorous analytic work evaluating its impact on utilization, costs, and quality. This literature is briefly summarized here. The primary concern of this article is the future of UM. The two critical questions of concern are: Will externally run public and private UM programs continue? If so, what changes are expected in UM operations over the next 5 to 10 years? This article focuses on the UM program sponsored publicly for Medicare, or peer review organizations PROs , and those operated by UM companies that do not have a contractual relationship with physicians and hospitals. UM programs used in health maintenance organizations HMOs , preferred provider organizations PPOs , and other network-based managed care plans are excluded because their effects are confounded by the other intrinsic cost-containment features. Utilization management programs UM as used in this article is: The rationale for UM rests on three underlying assumptions: In a predominantly fee-for-service payment system there is considerable unnecessary and inefficient care provided to patients. Unnecessary care can be controlled, saving substantial amounts of money and improving the quality of care. The cost of operating UM systems is small compared with the savings. Extensive literature suggests that perhaps 10 to 30 percent of diagnostic tests, procedures, and hospital admissions are unnecessary Chassin et al. Whether or not UM can control unnecessary care and do it efficiently is addressed in this article. Two general aspects of effectiveness are considered: Medical care utilization and costs at the program and system levels and the quality of care. A brief description of the major UM programs and the history of UM can be found in the Technical note. Individual program utilization and costs Inpatient medical and surgical review The impact of PROs on hospital utilization is unknown, but it may be limited because only 2 to 3 percent of admissions are denied Vibbert b. On the other hand, the diagnosis-related-group DRG payment system gives hospitals the incentive to admit Medicare patients more frequently. Nonetheless, Medicare admissions have declined during the past 7 years. Some investigators have posited that this decline can be attributed, in part, to the PRO program Christensen, ; Sloan, Morrisey, and Valvona, Two studies have examined the effectiveness of private sector, phone-based hospital admissions and length-of-stay certification programs using multivariate statistics and before-and-after control group design. One study reported reductions in medical, surgical, and psychiatric bed days per 1, employees of 8 percent and in total health care costs of 6 to 8 percent Feldstein, Wickizer, and Wheeler, ; Wickizer, Wheeler, and Feldstein, ; Wickizer, ; Wickizer, Another study of medical and surgical admissions showed a reduction in bed days of 34 per 1, employees per quarter, or 13 percent. Inpatient expenses were lowered by 8 percent, and

total health care costs by 4. Compared with telephone-based hospital review, reductions of another 6 percent in bed days per 1, employees and 9 percent in net costs are reported when the need for hospital admissions and continued stay is reviewed onsite in the hospital by nurses Smith and Gotowka, Psychiatric and substance abuse Because Medicare has limited mental health coverage, PROs have little involvement in managing psychiatric and substance abuse utilization. For private sector, telephone-based UM programs, the one published multivariate study found reductions in length of stay of 20 percent, in admission rates of 13 percent, and in net inpatient costs of Medical and surgical procedures Until recently, PROs prospectively reviewed up to 10 surgical procedures using explicit criteria. There is little information available on the impact of these reviews, but because they have been discontinued, it is apparent that they were not considered to be effective. Many studies in the private sector have assessed the effects of second surgery opinion systems, and the results are mixed Leape, The weight of the evidence suggests that these programs are only marginally effective in controlling costs. The use of clinical protocols to prospectively assess the need for selected tests and surgical procedures is just getting started. Denial rates appear to be substantial for some services, e. The denial rate across all inpatient and outpatient services averaged 11 percent. No data are available on net program savings. Case management The one study of case management programs reported negligible short-term net savings Henderson, Souder, and Bergman, Because of the paucity of studies and the complexities of evaluating case management programs, any conclusions would be premature. System level trends At the delivery system level, hospital precertification systems are considered to be an important factor in the dramatic reduction This reduction in bed utilization is associated with a substantial reduction in the rate of hospital cost increases Schwartz and Mendelson, However, these hospital UM programs appear to have had only a modest impact on total health care cost increases Schwartz and Mendelson, ; Chulis, Apparently, providers responded to lower bed occupancy rates by increasing utilization of outpatient tests and procedures and inpatient and outpatient fees. Quality The effect of UM on the quality of care has generated a great deal of speculation but little serious study. The specific effects of PROs on quality were not examined separately. Most other work in this area concerns provider, patient, and employer satisfaction with UM systems. An examination of their combined impact on quality provides some insights on the effect of UM programs. Focusing on five conditions acute myocardial infarction, pneumonia, congestive heart failure, cerebrovascular accidents, and hip fracture , a comparison of mortality and morbidity rates before and after the introduction of the PPS and respectively showed that PPS was associated with: Little is known about the impact of private sector UM programs on quality. Another dimension of quality is provider, patient, and employer satisfaction with UM. There is considerable provider dissatisfaction with UM programs. These problems are exacerbated by the additional operating expenses associated with UM Holthaus, ; Mayo Clinic, On the other hand, it is clear that most physicians and hospitals have acquiesced to UM and do comply with UM processes. The key provider concern now appears to be the need to standardize and improve UM systems and operations Institute of Medicine Committee on Utilization Management by Third Parties, Patients and employers Information on patient satisfaction with UM programs is very limited. However, a recent survey by A. Foster Higgins suggests that employers have some skepticism about the effect of UM: Will payer operated UM continue? If so, what changes are likely to occur in UM programs over the next 5 to 10 years? There are two reasons to believe that publicly and privately operated UM programs will continue. UM can make a significant contribution both to managing health care costs and to assessing the value of health services in improving health. Managing costs Although the number of scientifically rigorous studies is limited, the available literature indicates that hospital admissions and length-of-stay precertification programs, both medical and surgical, and psychiatric and substance abuse, have led to significant reductions in bed days per 1, employees. The data from individual studies are supported by additional evidence from national trends in hospital admissions and length of stay. Clearly, UM systems are associated with major changes in practice behavior. As to their effect on costs at the individual plan level, a few well-controlled studies of hospital review programs report net total health care savings of 4. Likewise at the system level, UM programs are associated with a significant reduction in the rate

of increase in hospital costs during the s Schwartz and Mendelson, In terms of total health care costs, hospital utilization review has had less impact. This may be in part a timing effect, because it is only in the last few years that the majority of employers have had hospital precertification. Another and more important explanation may be the substantial increases in utilization for non-reviewed services, mainly outpatient. To deal with this problem, utilization review is now being extended to the outpatient setting, and in time should lead to significant reductions in utilization rates. With all the major medical care services under management, it is far more likely that decreased utilization rates will be reflected in significant reductions in the growth of health care costs. This does not mean that UM will be the primary method for bringing health care cost increases down to socially acceptable levels. Rather, it is an important component of a larger managed care strategy that includes contracting with or employing a select group of providers and having appropriate financial incentives to encourage them to practice high quality efficient medicine. Increases in consumer cost sharing may also be a necessary component of an overall national cost-containment policy. Within this context, UM can play a significant role in improving the efficiency of the delivery system. Assessing value Another reason that UM is likely to continue relates to the rising demand for accountability and value. With large and growing expenditures for health care, payers want to know how their money is spent and what it produces in terms of health care quality process and outcomes. This is in part the result of growing public awareness of how little is known about the effects of medical procedures and tests on health outcomes, and the significant and unexplained variation in practice patterns among geographic regions and individual physicians. There appears to be greater appreciation that the linkage between utilization of service and health outcomes is very complex, and that more services do not necessarily mean better health. The point is that the need for UM goes beyond the issue of controlling costs. UM is a primary approach that public and private payers can use to determine if patients are receiving appropriate care and if the money spent on health care is providing value. With this information, payers are in a better position to make informed decisions about health plan and delivery system changes that will lead to greater value. In summary, there are good reasons to believe that UM will continue. Indeed, UM systems of the general type used in the United States may eventually be adopted by other countries that have controlled health care costs through global budgeting but have little information on the value of the services purchased Anderson, Sheps, and Cardiff, ; Hurst, Utilization management changes What is likely to change in the next 5 to 10 years are the form and content of UM. Most of these changes will be driven by new UM technologies and organizational relationships. Effective UM is dependent on having access to detailed clinical information on the care proposed or delivered to patients, clinical guidelines that define appropriate care, and positive long-term relationships with providers. UM programs are severely constrained by the lack of adequate data to support informed and timely decisions on the appropriateness of care delivered to individual patients and to cohorts of patients in a practice or region. Moreover, current approaches to collecting data over the telephone are complex, physician-time intensive, and expensive. This is certain to change in the next few years as providers and payers become linked electronically.

Chapter 5 : Health Care in the United States: An Evolving System

() refers to the cost management of health care services utilization by controlling who the consumer sees and how much the service cost. managed care (True/False) Point of Service Plans a type of HMO/PPO hybrid.

For example, in and , two of the largest health care systems in southeastern Michigan i. These closures result in additional strains on remaining hospitals, creating even greater stresses for an already fragile system. While hospital closings and mergers create many issues and concerns, both the declining number of beds and the declining number of admissions is related to a significant decline in the number of in-patient surgeries. By , the respective percentages of in-patient and out-patient surgeries were 42 percent and 58 percent. While the cost savings to insurers is real, although difficult to calculate, the impact on formal and informal after-care services and in home health care is equally difficult to estimate. Now many more patients return home on the same day of their surgeries. For individuals with familial and social supports this reality may not be as challenging as for patients who live alone and have little if any family or social network on which to depend. It is calculated by the Institute for the Future that 40 percent of sickness is related to life style and health behavior choices. Clearly education and early case finding are paramount. Prevention has proven effective for individuals or families who have made life style and health behavior changes. However, for many patients, changing to a managed care program, or switching between managed care programs, changes and limits the choices of providers to those on preferred panels. In many plans, if a patient wants to see a provider with whom he or she is familiar, but who is not included as a provider in their "new" plan, an option may exist for obtaining "out of network" services, but it almost always comes with a significantly higher out-of pocket co-pay. Some employers are covering fewer persons. Some are passing the increases on to employees and requiring higher levels of employee contribution. And some employers are just doing away with health care benefits all together. While reductions in the "value" of an existing plan adversely impact employees, the ability to contain insurance costs helps for more people to at least remain covered in some fashionâ€”even if their coverage is only for very serious illnesses. The number of people in the population without health care has increased. Currently it is estimated that 42 million people, or 16 percent of the population, is without any form of health care insurance. The Institute for the Future projected that the number of uninsured will reach 48 billion by While this statistic usually rises during times of recession and decreases in times of expansion, the number of uninsured has increased even during the expansion of the late s and early s. The Institute for the Future also reported that the number of non-elderly persons covered by employment related health insurance dropped from In Michigan, for example, the Access to Health Care Coalition reported that between and the percent of residents without health insurance decreased from However, given the relationship between the economy and the availability of health insurance, this decrease appears temporary. An increase is expected in the number of uninsured, especially in light of the economic downturn of While not all eligible children have been enrolled in these programs, a considerable number are not eligible based on family income exceeding a percentage of the Federal Poverty Level FPL. Mirroring national trends, Michigan is struggling with rising unemployment, a budget deficit, and growing demands for health services and insurance coverage. Often the underinsured and uninsured use the emergency room, the most expensive form of health care service, for any illness. Weiss and Lonnquist reported that uninsured emergency room care visits totaled 93 million in In approximately half of the cases, urgent care was not needed, nor did the individuals seeking care have a regular physician or other option for gaining access to health care services. Their observations are summarized below: The first group represents 38 percent of the population. It consists of empowered consumers with considerable discretionary income, who are well educated and use technology, including the Internet,, to get information about their health. Usually they are able to make choices in their plans and coverages. They are able to educate themselves about health behaviors as well as health care issues and concerns. They are likely to engage in shared decision making with physicians and other allied health professionals. Their primary

concern is benefit security and the issue of value as plans become more restrictive. People included in this group include those with unstable job security, both employers and employees, and also early retirees who are waiting for Medicare to begin. Though they have limited access to information, they are likely to focus on learning more about plans and coverages. They are also likely to become more empowered due to some of the voluntary associations to which they belong who focus on problems in the health care system. The third group represents 28 percent of the population whose main concern is access to health care. It includes people under 65 who are uninsured as well as children who have no coverage or are covered by Medicaid. Access to care for this tier is severely limited because the safety net has frayed. People in this tier depend on the limited resources and strained generosity of safety net funding streams and providers. While some are covered by Medicaid, this plan offers only limited choices and benefits depend on funding which often competes with prisons and schools. Generally poor and lacking education, most people in this tier have serious trouble overcoming the information gap between patients and providers. They may be largely ineffective in changing legislation or the structure of health care. If the problem of access is to be solved, it will need to be driven from the top two tiers. Trust however is another issue. Survey results indicated that only 30 percent of patients in managed care plans trusted that their plan would do the right thing for their care, while 55 percent in traditional plans trusted their plans. Also, fewer than 30 percent of patients trusted their HMOs to control costs without adversely affecting quality of care Dranove, Managed care has a long way to go in persuading the public that managed care is actually care management, although they frequently advertise high quality at a reasonable cost. What Can Be Done? All of this information may be overwhelming, although it represents only a brief overview of the issues and concerns related to our evolving health care system. Nevertheless, there are several practical steps that we can take both individually and collectively: What Does the Future Hold? While trends can be traced and often predicted, there are a significant number of "wild cards" in the future that make the evolution of the American health care system uncertain and volatile. Some of these, according to the Institute for the Future , include Demographic trends and increasing numbers of elderly people in the population; Reimbursement rates for home health care services; new cost containment and cost-shifting strategies; Increasing technology; Economic recessions or expansions; legal and mandatory restrictions on managed care plans; Malpractice insurance, settlements, and jury awards; universal health insurance legislation; and Switching from a private and public insurance model to a national health insurance system. One solution is to learn from other health care delivery models. Perhaps we could benefit both by learning more about other systems especially from countries with high levels of access , and also by beginning to advocate for needed changes in the American health care system. Indeed, the greatest changes may come about as consumers make their concerns known to providers and to state and federal policy makers. It would also make strategic and tactical sense for providers to partner with consumers and policy makers to bring about needed changes. Given our current reality, the focus of change will need to address both access and affordability. References Access to Health Care Coalition Improving access to health care in Michigan. Blue Cross Blue Shield of Michigan. Retrieved March 1, from http: A comprehensive summary of U. A clinical approach 2nd ed. The evolution of American health care. Employer-Sponsored Health Benefits Institute for the Future Health and health care The forecast, the challenge. National Survey of Health Insurance. National health spending trends in Health Affairs, 17, The sociology of health, healing, and illness 3rd ed. Upper Saddle River, NJ: For more information please contact mpub-help umich.

Chapter 6 : Utilization management as a cost-containment strategy

There appears to be greater appreciation that the linkage between utilization of service and health outcomes is very complex, and that more services do not necessarily mean better health. The point is that the need for UM goes beyond the issue of controlling costs.

The focus may be on the site of care, the timing or duration of care, or the need for a specific procedure or other service. The first point of assessment, often called preadmission review, may occur before an elective hospital admission. This is what Greta Harrison and her physician experienced in one of the vignettes that opened this chapter. In this case, the review did not challenge the need for the procedure itself or the need for hospital care, but it did challenge the proposed admission 2 days before surgery. The terms preservice review and preprocedure review are sometimes used to indicate that the focus of review is the need for a procedure, regardless of whether it is to be performed on an inpatient or an outpatient basis. For emergency or urgent admissions to the hospital when prior review is not reasonable or feasible, admission review may be required within 24 to 72 hours after hospitalization to check the appropriateness of the admission as early as possible. The vignette describing Mr. Travers involved this technique as well as continued-stay review or concurrent review, which assesses the length of stay for both urgent and nonurgent admissions. Reviewers may press for timely discharge planning by hospital staff and, in some instances, assist in identifying and arranging appropriate alternatives to inpatient care. Increasingly, preadmission review or preservice review is used to screen patients so that referrals for second opinions are focused on patients for whom the clinical indications for a service are dubious. To encourage patients covered by a health plan to cooperate in the 2 Medical necessity is another term that is used differently by different people in different contexts. Some use it generally to cover assessments of the site and duration of care as well as the clinical need for a particular procedure, whereas others use it only in the latter sense. Those who use the term more restrictively tend to apply the term appropriateness to the former assessments. For a discussion of legal interpretations of medical necessity, see the paper by William A. Helvestine in Appendix A of this report. Page 19 Share Cite Suggested Citation: Controlling Costs and Changing Patient Care?: The Role of Utilization Management. The National Academies Press. Chapter 3 provides more details about the mechanisms of prior review. Although terms like prior review, predetermination, precertification, and prior authorization of benefits are often used interchangeably, the approval of benefits in advance of service provision may be contingent rather than final. For example, if a retrospective claims review suggests that the information on which the predetermination was based was seriously flawed, payment of a claim may be denied upon further investigation. Or if a utilization management firm does not have access to the details of the benefit plan for a group, it might authorize services not covered by the contract. A review of claims prior to payment might then result in denial of benefits. Retrospective denials of claims following prior certification appear to be rare, as are refusals to preauthorize services. For the United States as a whole in , 1 percent of the population accounted for 29 percent of total health care spending Berk et al. It differs in its targets, those very expensive cases for which specialized attention may encourage appropriate but less costly alternative forms of treatment. In contrast to prior review programs, high-cost case management programs are usually voluntary, with no penalties for patient failure to become involved in the process or comply with its recommendations. Finally, exceptions to limitations in benefit contracts may be authorized in advance if this will permit appropriate but less expensive care. For instance, additional home nursing benefits may be arranged so that an individual can avoid further Page 20 Share Cite Suggested Citation: Retrospective Utilization Review Utilization management techniques, particularly prior review methods, attempt to overcome the disadvantages and unhappiness associated with retrospective review and denial of claims after services have already been provided. Retrospective utilization review methods have a longer history of general application than do prospective methods Blum et al. Its strengths and weaknesses have been scrutinized in a number of studies before this one and are not explicitly

considered in this report. However, constraints on retrospective review have been a key stimulus for the development of prior review methods. Many of the concerns raised by the committee about the clinical soundness of review criteria, the fairness of procedures, and other matters described apply to both prospective and retrospective reviews. Other Cost-Containment Methods The techniques of prior review and high-cost case management are but a subset of the cost-containment methods that can influence decisions about patient care. Other methods, some of which are discussed in Chapter 2 and Appendix B, include the following: The different strategies for influencing decisions about patient care, however, vary in their emphasis or reliance on different models of control such as professional self-regulation, informed consumerism, or prudent purchasing , their techniques of influence such as education, financial incentives, peer pressure, or external oversight , and the parties involved that is, patients, primary care practitioners, or specialists. As will be described in Chapter 2, different strategies for cost containment have been tried, abandoned, and revived as third-party financing of health care has expanded. This history reflects both the difficulties of the task and an appreciation that there is no single solution to problems of health care costs, quality, or access. Many strategies have a place, each of which has different strengths and weaknesses and each of which needs monitoring and adjustment as circumstances change and people adapt to various attempts to shape their behavior. Two Notes of Caution Obstacles To Evaluation This report laments the limited evidence on utilization management and calls repeatedly for more and better assessments. Nonetheless, the committee is well aware that sound evaluation of utilization management programs faces several obstacles. Some are intrinsic to the research problem, some reflect common organizational behaviors, and some involve particular pressures faced by market-driven organizations. Rigorous evaluation also tends to be quite expensive. In Appendix B of this report, the commissioned paper by Joan B. Trauner notes that evidence about the impact of physician financial incentives on patient care decisions and quality of care is also quite limited. Intrinsic Conceptual and Methodological Problems A number of problems in evaluating utilization management and other cost-containment programs are predictable difficulties faced, to one degree Page 22 Share Cite Suggested Citation: One such problem is that there are no uniformly accepted and applied rules for measuring health care utilization or adjusting data for differences in the characteristics of groups being compared. Other methodological difficulties involve 1 data quality and availability; 2 definitions and measurements of program characteristics, group characteristics, outcomes, and other variables; 3 projections of what would have happened without the interventions; and 4 generalizations to other programs and settings. Common Behavioral Biases Against Evaluation Under this heading come obstacles to systematic evaluation that are typical of organizations whether they be public or private, for-profit or not-for-profit, big or small Eddy and Billings, ; Hatry et al. In addition, faced with limited resources, managers are frequently reluctant to allocate funds for evaluation instead of wages and benefits, shareholder dividends, or other activities. The committee has no information about what utilization management firms spend on evaluation for internal use or for clients or how much different employers invest in systematically assessing the impact of prior review or other cost-containment strategies. The Health Care Financing Administration does have performance standards for PROs, but they tend to emphasize process rather than outcome and tend to involve measures of impact that are more appropriate for ongoing monitoring rather than systematic evaluation of the review techniques. Page 23 Share Cite Suggested Citation: Certainly, competition can be a powerful stimulus for internal evaluation of how well a product is working and what makes it work better. Also, clients of utilization management organizations have a strong interest in obtaining reports on results and in shifting their business to other firms if they cannot get such reports. Balanced against these forces are several threats posed by evaluation. Further, evaluations of utilization management programs may provide competitors with statistical norms or even provider-specific information that would not be readily available to them otherwise. Likewise, if firms that invest in relatively sophisticated research and development reveal their work, they may give a free ride for competitors to copy or build on the resulting review criteria, analytic methodologies, or other products. In a new and rapidly evolving industry, this can seem a significant issue for more experienced organizations. Forces Behind Rising Health Care Costs The Committee on

Utilization Management by Third Parties also recognizes that the forces behind rising health care costs are exceptionally strong and difficult to constrain through moderate means. Many believe that, for the foreseeable future, health care costs will continue to increase faster than costs in the rest of the economy. For example, women who underwent mastectomy for breast cancer and had no evidence that the cancer had spread were until recently not expected to benefit from chemotherapy, but some new analyses suggest such treatment does increase survival rates. Recent guidelines for the use of mammography screening could greatly expand the amount of such screening but some professional sources question whether the guidelines are clinically warranted McIlrath, Page 24 Share Cite Suggested Citation: Advances in screening techniques may catch individuals much earlier in the course of disease and reduce the numbers who will receive later expensive treatments. The question is, will the costs of screening and early treatment offset the savings? Will real survival rates increase? Researchers involved with cancer point to methods under development to screen for very early traces of dozens of different kinds of cancer, not all of which are more successfully treated if they are detected earlier. Department of Health and Human Services, Whether this will bring a surplus of physicians is a matter for debate Ginsburg, ; Schwartz et al. What are the short-term costs and for whom of increasing access? What long-term costs and benefits can be expected? Society may not be willing to make such changes, particularly in the short run Curran, It may continue the search, described in the next chapter, for more moderate strategies to control health care expenditures. Utilization management is one such strategy. It is an unfortunate reality, however, that most cost-containment strategies eventually disappoint their supporters and evaluators to some degree. Even when these strategies seem to reduce costs initially, trend projections do not appear to show an appreciably lower increase in total costs over the longer term Prospective Payment Assessment Commission, Unwarranted or excessive negativism can, in turn, be counterproductive and lead to premature abandonment of modest but still helpful strategies. Cognizant of these hazards, the Committee on Utilization Management by Third Parties has tried to approach its initial evaluation of utilization management with reasonable expectations. To this end, the committee has reviewed the development of third-party financing of health care in the United States and the ways in which various strategies to manage costs have evolved. The next chapter summarizes this review. Aspen Systems Corporation, Health Administration Press, Page 26 Share Cite Suggested Citation: