VIRTUALHEALTH ITILITI HEALTH

The Case for Technical Alignment

How Combining CM, UM & FHIR® Solve Critical Prior Authorization, Interoperability, and VBC Challenges

Value-Based Care Models Need UM & CM Alignment

When a utilization management (UM) program is aligned with the value-based care (VBC) goals the care management (CM) program is built around, this can help an organization achieve critical objectives: improving patient outcomes and population health, improving experiences and satisfaction, and reducing health care costs.

Aligning UM and CM under an organization's VBC objectives can also support better relationships with providers by facilitating greater collaboration via a seamless healthcare data exchange, EHR and EMR integrations, automated prior authorizations, and the ability to review patient data, care plans, goals, and recent care activities in real-time.

In this white paper, we'll examine how aligning UM and CM can unify teams and streamline value-based care and how current-day technology features can enable connected, double-sided automations that bring CM and UM closer together to optimize care delivery and health outcomes.

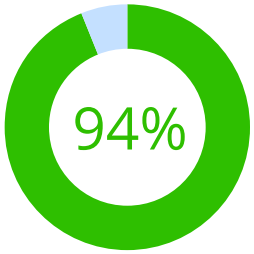
The Need for Alignment: Critical Challenges in UM Are Connected to CM & Vice-Versa

Why is the connection between care management (CM) and utilization management (UM) critical for value-based care payers?

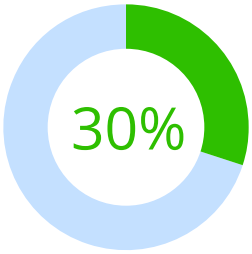
Primarily, both CM and UM are impacted by the same challenges. When issues arise in UM, they also often manifest in CM, creating a cycle of inefficiency.

By closely integrating CM and UM, payers can identify and address these shared challenges more effectively, leading to improved patient outcomes, streamlined collaborative care, and a more efficient use of resources. This integration is essential for achieving value-based care goals, which focus on providing high-quality care while controlling costs.

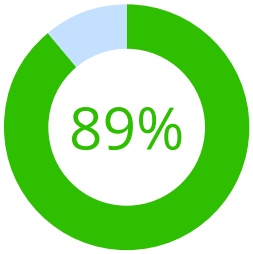
The Medical Group Management Association's (MGMA) Annual Regulatory Burden Survey highlights how escalating regulatory demands, particularly those around prior authorization, are creating significant obstacles that are contributing to provider burnout, and impeding health outcomes and clinical goals.



94% of physicians reported care delays while waiting for payers to authorize necessary care



30% of submitted prior authorizations are for procedures that don't require a PA approval



89% of physicians say prior authorization has a negative impact on patients' clinical outcomes.

Moreover, many said payers need to do a better job communicating prior authorization requirements, which leads to thousands of phone calls and unnecessary submissions.

A lack of EHR interoperability was also listed as "very or extremely burdensome", and as seen with the recent CMS-0057-F prior authorization and interoperability ruling, FHIR®, prior authorization, and care delivery/quality are intimately connected.

Below are the most critical challenges in CM and UM programs, and you'll notice they're all connected by the thread of delivering cost-effective, high-quality care. And in the case of UM, prior authorization issues are front and center.

CRITICAL CHALLENGES IN UM & CM

Increasingly complex regulatory and accreditation requirements

Escalating regulatory deadlines, transparency, and federal- and state-legislated requirements

Rising volume pressure related to delivering high-quality care while controlling costs

A nationwide shortage of healthcare professionals, especially nurses and behavioral and mental health specialists

Burnout among staff on the payer and provider side due to high workload and large, complex care population needs

A lack of shared visibility and insights due to insufficient, or a lack of, interoperability

Issues with prior authorizations: errors, inefficiencies, duplications, and delays, that are creating care delays or negatively impacting clinical outcomes

See the Correlation?

The challenges that exist within CM and UM programs are fundamentally similar.

Addressing and overcoming these challenges often comes down to the alignment between CM and UM and focusing on two core issues related to resource optimization and patient-centric care: **interoperability and prior authorization.**

By ensuring that both CM and UM are working cohesively, payers can streamline processes, eliminate redundancies, and enhance the overall patient experience. This alignment not only helps in controlling costs but also ensures that patients receive timely and appropriate care, ultimately driving better health outcomes and higher satisfaction rates.

Addressing the Challenges

Why are **healthcare interoperability** and **prior authorization** the critical issues for payers to address? Addressing both will solve or improve many of the issues noted on the previous page.

- **Implementing the newly mandated FHIR® prior authorization API** will help payers meet CMS requirements, facilitate faster decisions and appeals, and remove care delay issues
- **Using a payer-to-payer FHIR® API** to exchange data between settings will help eliminate administrative burdens for healthcare providers and staff, enable accurate and shared patient views, and reduce spending associated with inaccurate or unnecessary care decisions and services
- **Implementing the proper APIs and a FHIR® transformation solution** can help facilitate greater EHR interoperability and support a democratization of data and transparency across the continuum of care that fosters comprehensive collaboration and more accurate care decisions and delivery
- **Automating UM processes** can help alleviate staff burnout as inefficiencies are removed and unnecessary administrative work is eliminated, and help reduce costs as automations power greater efficiencies and cost reductions
- **Achieving end-to-end digital prior authorization** can help payers meet new digitization needs, proactively determine if PA is even necessary, and help eliminate inaccuracies and delays that prevent members from getting the care they need (and from wasting funds on unnecessary or inaccurate care)
- **Improving prior authorizations and data accessibility** will create more communicative and beneficial provider relationships and experiences, which will help drive both quality improvements and better health outcomes

CM and UM have a bi-directional relationship that can either impede or improve the goal of every VBC organization:

To deliver the right care, at the right time, in the right place, and at the right price.

From enhanced care delivery and accuracy, end-to-end-visibility, and accuracy, to improved health outcomes and more connected, cost-effective care. All these things can be impacted by how aligned the CM and UM programs are for an organization. And that is where technical alignment comes in.

The Alignment Opportunity

In the 2024 Gartner Healthcare Payer Research Panel Survey, 42% of surveyed healthcare payers indicated they were considering a new care management system to deploy within the next 6 to 24 months. Another survey by Becker's Healthcare noted that technical alignment was a critical concern along with a lack of interoperability and prior authorization challenges.

The above challenges, solutions, and potential benefits coupled with these recent survey findings speak to a desperate need for a single enterprise platform that allows for visibility and insights across the continuum and maximizes efficiencies with interconnected workflows.

This is why VirtualHealth and Itiliti Health partnered to offer an integrated solution that supports a more automated and accurate UM and CM experience. Moreover, because HELIOS® is the only platform to offer an integrated FHIR® data interoperability solution (HELIOS**hub**), payers can simultaneously address prior authorization, FHIR®, and interoperability concerns.

ROI FOR HELIOS & ITILITI HEALTH CUSTOMERS

- **Millions of dollars saved** in administrative costs annually
- **30% reduced** prior authorization submissions
- **Near elimination** of prior authorization disputes
- **Up to 93% increase** in care team efficiency
- **Up to 92% higher** care team productivity
- **80% faster** bi-directional data delivery
- **Faster closure** of critical care gaps

Designed as a single solution for payers seeking to solve requirements around prior authorization and FHIR® interoperability, and elevate CM objectives, HELIOS with Itiliti enables organizations to:

- Meet the new and evolving prior authorization and interoperability requirements
- Improve utilization and care management programs
- Maximize operational workflow efficiencies
- Drive significant cost savings
- Automate and streamline prior authorizations, appeals, grievances, reviews and more
- Clearly communicate payer rules to providers
- Leverage FHIR® interoperability and intelligent automation (AI-powered automations)
- Reduce administrative and clinical burdens associated with prior authorization
- Ensure compliance with federal and state regulations (including CMS-0057-F)
- Seamless integration with external and internal systems
- Utilize clinically-integrated workflows to optimize process efficiencies and eliminate barriers to care delivery
- Improve provider relationships and experiences

Making the Case for a Single Solution

There are seven categories of value that payers can potentially unlock through the technical alignment of UM and CM in a single solution and the use of configurable workflows, intelligent rules engines, powerful integrations with other systems, and automated prior authorization capabilities.

1. A Unified Ecosystem to Accelerate Care & Operational Value

Excellent care (and profits) come from streamlining and connecting activities undertaken by UM and CM staff. A unified system allows organizations to make the most efficient use of resources and fosters a connected care approach that helps keep members on track throughout their healthcare journey.

Moreover, this technical ecosystem provides opportunities for reporting efficiencies and deeper data to drive workflow improvements, regulatory reporting, and compliance. This is especially critical in value-based care. Insights from UM can drive sound decision-making in CM (and vice versa).

For example, knowing a member's clinical background, ongoing care, ED utilization, and pharmacy history can provide a wider knowledge base for care managers and help identify where preventive interventions or greater coordinated efforts are needed. When those are employed, the healthcare costs associated with this member are usually reduced as the need for complex services that drive high utilization are eliminated over time.

---

2. Greater Organizational Adoption & Reduced Operational Costs

Key drivers behind payers' desire for technical alignment, a consolidated tech stack can provide both these benefits for short- and long-term value. This is also another reason VirtualHealth ensured its care management, utilization management, and FHIR® data interoperability solutions are part of the larger HELIOS platform. It's also why VirtualHealth and Itiliti Health worked to integrate Itiliti's prior authorization technologies within HELIOS.

When an organization has a single source of truth for CM and UM, it's far easier for teams to learn, adopt, and utilize the workbench of tools that enable foundational automation and cost-effective value-based care success.

---

3. Improved Interoperability to Drive Critical Automations

By combining the HELIOShub solution with Itiliti's suite of prior authorization products, payers can now improve their interoperability via FHIR® transformations and critical APIs to empower faster prior authorization, decisioning, appeals, and grievances.

Ready to learn more about leveraging the power of technical alignment?

Scan the QR code or click this link to set up a time with our team and see how HELIOS with Itiliti Health can help you overcome key CM and UM challenges to better achieve your value-based care objectives.

4. Remove Barriers to Care Delivery, Provider Communication & Collaboration

Payer relationships with providers are often hurt by slow, inconsistent, and inaccurate prior authorization processes.

In the MGMA survey, providers noted that "payers do a poor job of communicating prior authorization requirements" resulting in thousands of phone calls and unnecessary submissions. Moreover, 33% of physicians said prior authorization has led to a serious adverse advent; 30% of submitted prior authorizations are for procedures that don't require a PA approval; and 80% of physicians said prior authorization delays/issues can lead to treatment abandonment.

Leveraging a solution that addresses prior authorizations within the scope of supporting value-based care, can resolve these issues for providers, identify when prior authorization is actually needed (and expedite it when it is), and in turn, lead to better health outcomes for health plan members and reduce staff burnout. Instead of wasting your valuable and highly-trained and expert resources (nurses, care managers, etc.) on unnecessary authorizations or administrative work, you can take humans out of the PA request workflow and let them focus 100% on members' health.

5. Simplify Regulatory & Compliance Adherence

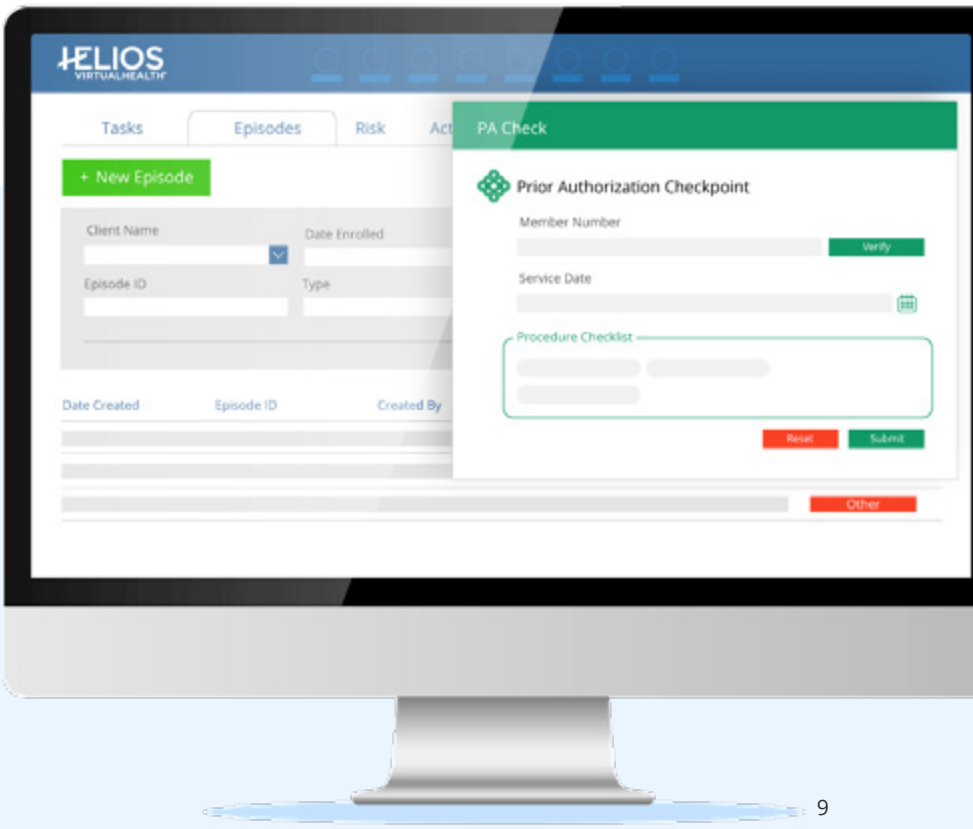
Interoperability is critical for frictionless, touchless prior authorizations and collaborative, coordinated care. This is why payers who opt for a single solution to support CM, UM, and interoperability will have an easier time meeting evolving requirements. This includes federal and state regulations (e.g., CMS-0057-F) and internal medical policies, and accreditation requirements such as those from NCQA or URAC.

---

6. Enterprise-Wide Visibility Removes Silos & Blind Spots Preventing Operational & Efficiency Gains

A single solution can also help with enterprise-wide data democratization that eliminates barriers to seeing critical insights teams need to improve processes, management, policies, and decision-making. When a payer can use a single solution and drive organizational visibility, this can lead to:

1. Improved management of operations (UM and CM)
2. Improved efficiency at each position in UM and CM
3. Improved policy-making and internal decisions
4. Allow the ascension of data hierarchy to power the entire organization (e.g., Data to Information to Insight to Wisdom)



The Time is Now

With the new requirements for prior authorization and FHIR® standards coming over the next two years, many payers may be thinking about how to accomplish this or even considering waiting until next year.

Huthaifa Khan, Director of Solutions Architecture at VirtualHealth, and Michael Lunzer, CEO and Founder of Itiliti Health, leaders in the FHIR® and prior authorization space, **both agree payers need to start solving for prior authorization and FHIR® now and that if their CM system isn't enough, it's time to update.**

Huthaifa Khan

Director of Solutions Architecture, VirtualHealth

"I think it's super important to start thinking ahead as an organization, and there's a lot behind the FHIR® APIs that I think drive this particular recommendation that I have. First and foremost, FHIR® is the standard that CMS has chosen for the final rulings, and it's been their choice for years, I think it's also really important to notice that CMS-0057-F, does require the prior auth rule to be incorporated with the Patient Access API.

So it's super important to understand that it's not just the prior authorization process, as far as FHIR® that we're talking about here, but it's really also bringing a little bit of that compatibility into earlier FHIR®-based rules that CMS has introduced. And that really speaks to organizations needing to get started on this earlier, because it's not just a single process that they're dealing with here.

It's a wider ecosystem of interoperability that CMS is pushing around FHIR® and value-based care, and getting around to that and starting to push your internal enterprise architecture towards that, sooner rather than later, will reap benefits, not just from a business perspective in terms of the return on investment when you're incorporating or integrating with new systems that you're bringing on into your enterprise, but also in making it easier to meet the compliance requirements sooner, and having that time to address any changes or concerns that CMS might raise between now and the next couple of years."

Michael Lunzer
CEO and Founder, Itiliti Health

"Essentially what we've heard from CMS is they anticipate that it will take 30 months to become compliant. And you know, if you look at those requirement dates, it's January 1, 2027, so I'm trying to get people to stop thinking about it as 2027 and start thinking about it as the end of 2026. Because that really shifts things a whole year in perception. And then another key element is that there are a lot of things to do in this requirement. And many of them can be started now and are not big major lifts. But they're important to do now to set the foundation for the future. So then when you look at what needs to be done and back up the estimate 30 months from the requirements date, payers are looking at July of this year. The timeline in play here means payers really have to get started on their prior authorization and FHIR initiatives now to set a strong foot forward."

Watch the Webinar to learn more.

What Comes Next?

An aligned ecosystem holds a wealth of opportunities and benefits for payers, providers, and health plan members alike. As payers seek to solve prior authorization and interoperability requirements over the next year or two, the technical alignment of CM, UM, and FHIR® provides a cost-effective solution to addressing critical value-based care challenges and to setting the foundation for long-term success, growth, and improvements.

Ready to get started aligning your CM & UM functions more closely? Contact us today.

VirtualHealth is a mission-driven company seeking to make healthcare more proactive through technology. VirtualHealth simplifies value-based care management for healthcare's largest, most innovative payers with our cloud-based platform, HELIOS®.

HELIOS is the country's leading enterprise technology for care management, disease management, utilization management, and population health management. We are proud to provide a solution that's available to fit organizations of different sizes and population needs, and helps to eliminate data silos, streamline processes, reduce IT resource usage, and support whole-person, value-based care across generations.

For more information, visit www.virtualhealth.com.