EVERNORTH
HEALTH SERVICES

How to stay ahead of a rapidly evolving utilization management landscape

Contents

Introduction

Utilization management (UM) is a process used to ensure that patients receive health care services that are appropriate, necessary and cost-effective. UM can be a critical tool within pharmacy and medical coverage in ensuring patients get the right care at the right costs.

We'll unpack the indispensable nature of UM, and outline what is being done to evolve the workflows and requirements with a patient's whole plan of care in mind. Although UM remains essential, many payers and providers still face administrative challenges associated with UM, and patients can at times find themselves confused by certain benefit requirements and processes. **However, there are a number of industry and technological advancements underway to support the right-sizing and evolution of UM policies and processes, creating hope for more clarity and seamless experiences in the future.**

In the following pages, we'll take a closer look at:

- The complexities involved in UM
- UM's shifting state and federal landscape and the latest UM-related trends
- How Evernorth is adapting to these changes, and how our unique capabilities protect patients and identify savings opportunities—now and in the future

Utilization management complexity

Among others, some of the primary utilization management functions include:

Prior authorization (PA), which prevents unnecessary or inappropriate services by requiring providers to follow clinical recommendations from leading medical societies, clinical experts and federal health authorities to demonstrate the medical necessity of a requested service.

Step therapy that promotes cost-effective treatment by encouraging the use of front-line medications before second-line medications.

Drug quantity limits to prevent fraud, waste and abuse by restricting the amount of a medication that a patient can receive over a specified period based on clinical guidelines.

Gap in care closure to ensure that patients receive preventative and screening services that optimize health maintenance and reduce the risk of severe disease and higher health care costs later.

These UM functions are applied to both traditional and specialty treatments and services. However, specialty care can be complex, and with more facets of patient management involved, plan sponsors and payers need greater awareness of the nuances to effectively navigate them.

Specialty medications can be oral, infused, injected or inhaled, and may be administered in different locations. Some may be administered at a physician's office or a hospital and thus billed on the medical benefit, while others may be received through home delivery or home infusion services and may be billed under the pharmacy benefit. The prescription and claims process for a medically-billed versus pharmacy-billed medication are different, though UM tools like PA are applied to treatments billed on both benefits.

Patients—whether on specialty or traditional medication—may also need other medical services, such as laboratory work, CT scans or MRIs. These services and procedures also leverage PA and broader UM functions to ensure clinical appropriateness and safety.

For both medications and services rendered, PA as a part of UM is intended to ensure clinical appropriateness and prevent members from taking medications or undergoing procedures that are unlikely to provide any health benefit based on current medical evidence. It's ultimately only one of many tools to help keep patients safe, ensure the right care and eradicate wasteful spend.

The evolving state and federal landscape for utilization management and prior authorization

We are living in an era of incredible medical advancement with breakthroughs nearly every day. For example, the National Comprehensive Cancer Network (NCCN) issued over 200 updates across their cancer guidelines in 2023. But those innovations can only make a difference if patients and providers can access them. We know that may not always happen today, with one study showing nearly **four in ten** patients don't get care that meets the latest medical evidence.[1] Another study indicated low-value care costs the U.S. health care system **$340 billion**,[2] and nearly **90%** of doctors have reported negative impacts from low-value care.[3]

Prior authorization, as a part of UM, is an important safety tool that helps to guide medically necessary care by ensuring that the latest evidence-based clinical information is used in making decisions about patient care. PA has been under intense media and regulatory scrutiny in recent years, with some of the more common complaints involving administrative burden, delays in care and provider dissatisfaction. Legislators and regulators at both the federal and state levels are increasingly turning their attention to UM and PA practices which they believe can act as barriers to care.

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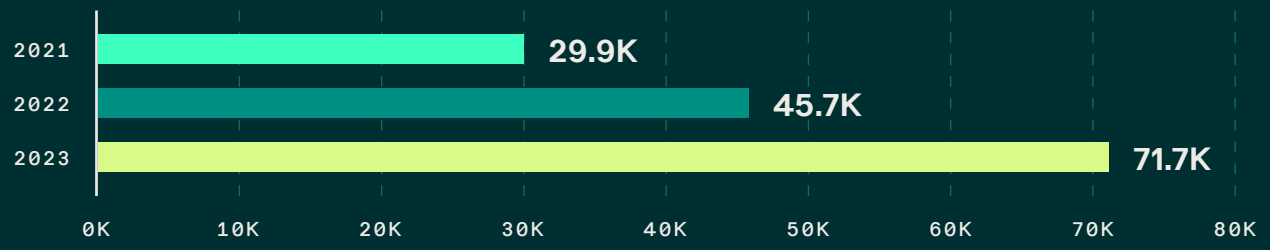
To put in perspective the increased attention on the PA landscape, take a look at the number of media mentions of PA-related regulations and legislation over the past three years alone:[4]



As legislation is often influenced by public opinion, this increased media attention makes state and federal advocacy efforts on behalf of clients especially critical. It also highlights the importance of combating false narratives to ensure that people are provided with accurate information about the importance of UM and PA.

The Centers for Medicare & Medicaid Services (CMS) recently finalized two major rules—Advancing Interoperability and Improving Prior Authorizations Processes for Medicare Advantage and Other Plans and Policy and Technical Changes for the Medicare Advantage Part C and Part D Programs for 2024—meant to improve the electronic exchange of health information, reform PA processes and reduce disruptions for beneficiaries. **Both regulations are focused on PA for medical services rendered.**

CMS has indicated that more rules further addressing **PA improvements for medications and additional medical services, including shortened turnaround times, are likely**.

Federal and state lawmakers have also begun to take aim at UM practices impacting medications with varying degrees of success. Although some bills introduced in Congress have bipartisan support, movement on the two most prominent federal bills targeting PA processes for medication—the Improving Seniors' Timely Access to Care Act and the Safe Step Act—had initially stalled out given the high cost and short window for legislative activity. However, a newly reworked version of the Improving Seniors' Timely Access to Care Act focused primarily on implementing electronic prior authorization (ePA) programs for Medicare Advantage plans seems likelier to pass with a much smaller price tag.

Nevertheless, CMS remains focused on the need to improve health information exchange to achieve appropriate and necessary access to health records for patients, health care providers and payers.

At the state level, numerous legislative proposals have been introduced seeking to restrict the use of UM solutions for both medications and services. The types of state legislation generally fall into these overarching categories:

+ Partially or entirely eliminating certain UM solutions
+ Gold carding
+ Requiring same-state licensure
+ Requiring same-specialty review
+ Mandating the use of single criteria
+ Reducing the administrative burden (e.g., mandating turnaround times)

Gold carding allows health care providers to bypass the PA process for certain services if they meet criteria such as consistently high approval rates.

One recent law is Vermont HB766, which prohibits commercial health plans from requiring PA for any admission, item, service, treatment or procedure ordered by a primary care physician (PCP). With the definition of PCP broadly written, almost any clinician—including physician assistants and nurses—can order treatment without pre-authorization.

States that seek to require the use of gold carding within UM have proven they do not significantly address provider complaints. Whether they apply to services, medications or both, these laws increase inappropriate care and costs, result in greater confusion and increase administrative burden for providers and eliminate several important benefits of utilization review. In the 2024 state legislative sessions, there have been **19** proposed gold carding bills and three states—Colorado, Wyoming and Illinois (Medicaid only)—have passed such laws.

Requiring same-state licensure, is another example of a provision that impedes the efficiency and effectiveness of UM processes without providing any additional value to patients. The practice of medicine, whether general or specialty, doesn't vary significantly from state to state across the country. To require that clinicians conducting utilization review be licensed in the state where the patient resides adds costs and delays without improving the quality of care.

When it comes to legislation designed to reduce the administrative burden of UM, we urge legislators to be mindful of an unintended consequence of shorter turnaround times, as that can reduce time for peer-to-peer provider discussions and result in more denials if the necessary clinical information can't be gathered from the ordering provider in the mandated time frame. Decisions that can be made quickly tend to be approvals, and delays in decision-making are most commonly related to attempts to obtain either more clinical information or facilitate a discussion with the ordering provider.

Federal and state legislative efforts have not fully addressed the root causes of the administrative burden that is driving provider complaints. The answer to creating a better system will rely on insurers, payers and others to transform UM into a more effective, collaborative and transparent system through data, technology and innovative approaches.

Utilization management and prior authorization trends

As a result of increased regulatory pressure across the country, some health insurers have begun to reduce PA requirements. Others have begun replacing traditional PA with new processes or incorporating new technologies into their systems, such as:

Utilizing artificial intelligence (AI) to automate the PA approval process while still ensuring adverse decisions are individually reviewed by qualified physicians or other medical specialists

Emphasizing electronic prior authorization (ePA) to reduce turnaround time

Implementing gold card programs that allow providers who meet certain eligibility requirements to bypass PA for many procedures, echoing the sentiment of federal legislation

Requiring advanced notification to qualify for such gold card programs

Some of these developments should be welcomed, as enhancing the PA process and reducing pain points with breakthrough technology will benefit everyone in the long run. **Other developments which would bypass PA processes entirely may not be as appropriate or helpful in maintaining patient safety or minimizing waste.**

It's estimated that anywhere from **$100 billion to $700 billion** each year is wasted on low-value care such as unnecessary scans, procedures and prescriptions.

It's also important to keep in mind that eliminating PA and other UM functions would likely have unintended consequences, including potentially **increasing commercial premiums by approximately $600 to $1,500 per member annually**.[5]

Ultimately, insurers, payers and providers will need to evolve the way we think about and navigate PA and other UM policies, with the intention to right-size these policies and streamline processes to deliver high quality, evidence-based care at the right cost.

How Evernorth is adapting to help payers keep up with new regulations and legislation

Evernorth is actively engaged in public policy debates and proposals at the state and federal levels, advocating for medical management policies that align with our organization's mission, vision and values. **Our primary objective is to ensure the patients we serve receive the most up-to-date, evidence-based care within an overall more affordable, equitable health care system.** Our advocacy teams are supporting proposals that will expand payer choice and flexibility while increasing quality, innovation and access to treatment for patients.

The team's priorities are directly informed by the issues and challenges of our plan sponsors. In fact, our federal and state government affairs teams have dedicated resources to prioritize high impact issues and engage lawmakers using advocacy strategies in partnership with impacted employers and allies in the community.

These teams help define and design the advocacy platforms of our industry associations and are frequently viewed as expert partners to legislative and regulatory policymakers. Our clinical expertise and analytic capabilities help policymakers and partners understand the implications and magnitude of proposed legislation, which informs the development of meaningful, sustainable policy solutions on a wide range of health care issues, including UM and PA.

"Our State Government Affairs team works with payers every day to be their guide across the growing amount of regulatory and legislative activity. This includes working with clients to help them understand the issues that could impact them in state capitols and helping develop custom solutions to legislative problems."

MATTHEW NESS
DIRECTOR, STATE GOVERNMENT AFFAIRS EVERNORTH

Case example

A state fee-for-service Medicaid program was found to have significant waste and misuse related to medical imaging, resulting in poor quality of care for patients.

High-risk groups such as pregnant women and young children, for whom radiation exposure can be particularly harmful, were especially vulnerable because of the existing benefit design. Prior to implementing a PA program advocated for by our State Government Affairs team, this plan had:

+ A pregnant patient who received 22 CT scans at tremendous risk to the unborn child
+ A two-year-old patient who received 19 scans in a period of just one month, including five scans in a single visit

These two patients exemplify the potential for clinical risks and misuse of health care dollars.

The future of utilization management

Supporting plan sponsors in making informed decisions about their benefit and helping them navigate the landscape is certainly one critical piece of the puzzle. But focusing on optimizing policies and evolving UM processes into the future are going to help make the biggest strides in delivering the right care at the right cost.

When we right-size UM tools across diagnostic and treatment services, UM can serve as a partner in the health care ecosystem rather than, as some perceive today, a traffic cop.

"When we leverage UM tools more holistically—centered around the patient's individual care and timed to match when clinical care decisions are being made for the patient—we are able to move away from siloed areas of expertise and discrete transactions. This approach clarifies the purpose of UM functions like prior authorization, and there is broader acceptance of the necessity of this kind of support and oversight. Adding new collaborative tools to effectively manage utilization in partnership with providers and payers allows us to return prior authorization's focus to the services that are truly too clinically risky or too costly to permit a single instance of inappropriate use."

DR. ERIC GRATIAS
CHIEF MEDICAL OFFICER, EVICORE BY EVERNORTH

Some of the frustration with UM among patients, providers and payers comes from the various administrative challenges they face, including:

+ Inconsistencies between policies across medical and pharmacy benefits
+ Limited payer visibility into true specialty drug spend across medical and pharmacy benefits
+ Fragmented, outdated, often highly manual internal processes
+ Time-consuming paperwork and question sets that may lead to gaps in care
+ Limitations in clinical strategy, alignment and execution
+ Confusion surrounding certain benefit requirements and processes for patients

Transforming UM means thinking about the whole plan of care—not just the medications, or the medical services required, but looking at the patient as a whole person and ensuring the care plan is best for them as an individual. Evernorth is invested in and focused on partnering with providers and payers in improving the outcomes and experience of the patient.

"Despite the back-end nuances involved in UM, from a patient perspective it should be a more uniform and seamless experience across medical and pharmacy services. That is, the provider writes an order or prescription, and it's our job collectively to streamline what happens after that, all in better service to the patient."

DR. JEREMY ROWER
SENIOR MEDICAL DIRECTOR, EXPRESS SCRIPTS BY EVERNORTH

Sneak peak | Here are a few highlights as to what's being done across Evernorth to transform UM for our stakeholders in a meaningful way.

The future of UM for patients and providers

Ideally, UM works to ensure that the right health care service is being issued to the right patient at the right time, with the least amount of patient and provider burden. This can be difficult to achieve, particularly on PAs for complex services like specialty medications—where, on average, there are **seven times** the amount of questions for a specialty drug PA compared to a traditional drug PA and **75%** of traditionally faxed or phoned PAs can take longer than one day to approve.[6]

In the pharmacy UM space, we're working hard and collaborating to optimize workflows and leverage technology within our traditional and specialty pharmacies in order to further simplify the experience by:

Moving away from fax and phone PAs which take longer to process and can delay therapy, while embracing digital PA pathways

Being proactive and increasing the amount of lead time for physicians to avoid gaps in care

Alleviating unnecessary strain on providers by leveraging integrated data to answer questions ourselves and reduce the question sets we send to them to complete

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In one year alone, Evernorth's Smart Coverage Review (SCR) program eliminated **4.6 million** questions a provider would have otherwise needed to answer across **3.4 million** PA cases. With SCR, on average, there was a **20%** reduction in questions per PA case that required a physician response and in approximately **10%** of PA cases, no questions had to be asked of the provider at all and were instead appropriately auto-decisioned.

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"We have seen some great success in creating a more proactive outreach process and promoting ePA usage. When PAs are completed through digital tools and are done proactively we see a two-day improvement in turnaround time and fewer issues related to PAs that might cause delays in getting the prescription to the patient. And that's just the start of the work we're doing at the pharmacy to optimize workflows and alleviate prescriber and patient burden."

JIM BLONDIN
SENIOR DIRECTOR, DIGITAL SOLUTIONS, ACCREDO BY EVERNORTH

In the medical UM arena, Evernorth's EviCore has been a market leader in establishing and making significant investments to ePA solutions which simplify the sharing of health care information among providers, patients and clients—all in compliance with new regulations. The advanced predictive algorithms as a part of intelliPath® accelerate medically necessary approvals, even **providing immediate approvals for 40-60% of eligible requests**.

"Studies have shown that these well-designed, properly monitored algorithms have become better predictors of appropriate requests for some services than even some of our historical attestation-based clinical surveys. In addition to speeding up appropriate approvals, using predictive AI in place of the survey for select services also allows our team of experienced clinicians to focus their efforts on requests where medical necessity is truly in question, leading to faster and more accurate outcomes during the entire utilization management process."

DR. ERIC GRATIAS
CHIEF MEDICAL OFFICER, EVICORE BY EVERNORTH

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Creating and optimizing these tech-enabled processes means a simplified, more transparent UM experience for providers and patients alike—making sure that patients are able to get the care that they need when they need it.

The future of UM for payers

As an example of how we've been working diligently to address some of the key challenges facing payers when it comes to navigating UM for their members, Evernorth created The Institute of Clinical Oversight and Guidance (ICOG) in 2023. ICOG acts as a central hub for all UM policy creation across medical and pharmacy benefits, for traditional and specialty medications and for wider medical treatment. Nearly 100 clinicians within the ICOG organization manage thousands of policies that are updated and reviewed annually.

"We are able to leverage deep clinical expertise from around the organization to ensure we're developing the most clinically sound policies in the most efficient and expeditious way. This clinical alignment is imperative to the integrity of our clients' and our UM programs and enables us to utilize prior authorization data in new ways—decreasing work for physicians and hastening appropriate care for patients."

DR. JEREMY ROWER
SENIOR MEDICAL DIRECTOR, EXPRESS SCRIPTS BY EVERNORTH

Another way we're moving UM forward for our clients is through a uniform end-user experience, which will act as the foundation of a more transparent and connected management experience for payers with:

- Integrated reporting for visibility across benefits to see total specialty spend
- A single UM platform with a dedicated operational team for consistent clinical policy application and results
- Technology-enabled cross-benefit strategies for optimal clinical and financial outcomes
- An improved provider and member experience with streamlined processes and enhanced cross-benefit capabilities

"Greater visibility and connectivity between benefits will pave the way for truly integrated benefit management. That will mean predictive analytics to forecast the impact of new drugs coming to market along with consultative ideation that wields the decades of combined experience between Evernorth and health plans to develop cross-benefit strategies, real-time benefit guidance, outcomes-based monitoring and an enhanced digital experience for providers and members."

MARK BINI
SENIOR VICE PRESIDENT, CARE SOLUTIONS, EVERNORTH

Putting it together

As rapidly advancing technology, shifting public perceptions and dynamic legislation continue to impact UM as we know it, it's clear that staying informed and securing forward-thinking partners will be crucial for payers in transforming patient and provider experiences.

Now more than ever, payers need a right-sized UM strategy. Integrating data-driven insights and technology with unmatched clinical expertise allows for UM capabilities that are not only cost-effective but truly patient-centric.

Contact your Evernorth sales or account representative or drop us a note at businessdevelopment@evernorth.com for more information on something you read.

Case studies: How Evernorth increases savings and ensures patient safety through utilization management

Many of the policies and controls we already have in place today are providing plan sponsors the flexibility they need, while staying compliant with new regulations, removing wasted spend and keeping patients safe. **In this section, we've included the experiences of our clients and patients across the spectrum of Evernorth's end-to-end UM services today.**

Here's a guide to help you understand the role each entity in our organization plays:

Evernorth Health Services			
EviCore by Evernorth	**Evernorth Medical Drug Management**	**Express Scripts PBM**	**Accredo and Express Scripts pharmacies**
UM for medical services rendered (interventional procedures, cancer treatments, DME, post-acute care and diagnostic studies such as labs, imaging or sleep testing)	UM for medications billed on the medical benefit, which are often, but not always, specialty medications	UM for medications billed on the pharmacy benefit, which can be both traditional and specialty medications	Following UM policies set by other payers and entities; enhancing processes to streamline pain points within the policies set

EviCore by Evernorth

EviCore's utilization management solutions are designed to **inform and expedite the most appropriate and effective testing and treatment options** for each patient's needs and condition(s), based on the latest evidence-based guidelines. That means preventing inappropriate utilization, unnecessary radiation exposure and low-value procedures, which can jeopardize patient health and safety and increase costs. With a team of over 500 board-certified physicians and over 1,200 clinicians covering more than 60 specialties, EviCore offers solutions for key clinical areas across specialty and traditional therapy classes.

A musculoskeletal patient's experience

Alice*, a 50-year-old woman, was experiencing leg pain from a pinched nerve in her back. Here's how EviCore's evidence-based guidelines helped her avoid a potentially dangerous health event:

+ Alice's primary care physician submits a PA request for an MRI and refers her to a pain specialist for an epidural steroid injection.
+ EviCore approves the request for the MRI, as it meets evidence-based guidelines for advanced imaging of the spine. The epidural injection requires further review once the MRI results become available.
+ The EviCore medical director reviews Alice's MRI results and notices a possible malignancy in her spine. Epidural steroid injections in patients with spinal malignancies can have catastrophic consequences, including paralysis and loss of bowel and bladder control.
+ The EviCore medical director initiates a proactive peer-to-peer (P2P) discussion with the pain specialist to discuss Alice's MRI results suggestive of a spinal malignancy.
+ Following the P2P discussion, the pain specialist refers Alice to an oncologist because of the possible malignancy in her spine.

Read more about Alice's journey here.

*Not patient's real name.

Evernorth Medical Drug Management

Evernorth Medical Drug Management (MDM) provides comprehensive safety and trend management solutions for specialty medications within the medical benefit. We offer the latest tools to maximize savings, reduce gaps in care for patients, enable cost-effective clinical decision making and minimize administrative demands for physicians. With a wealth of experience in MDM, our program offers innovative functionality, including coverage alerts across benefits, Medicare B versus D management and advanced analytics. This offering includes a savings guarantee, with an average client savings of eight dollars per member per month (PMPM). Plans trust Evernorth with their medical utilization management, claims and more in order to achieve more savings, better control, efficiency and compliance.

Hear from our health plan clients on how they've benefited from our Medical Drug Management program:

Operational efficiencies

"We value the prior authorization criteria provided by Evernorth's Medical Drug Management medical policy committee. This **frees up our internal P&T Committee** to focus on pharmacy benefit drugs. We also like the **ability to customize** prior authorization criteria if needed."

VP OF PHARMACY, HEALTH PLAN

Cost savings

"The UM criteria in place with Evernorth has helped prevent utilization of a thyroid eye disease drug greater than eight administrations... **At $60,000 a pop, this adds up fast and avoids inappropriate, costly care**."

VP OF PHARMACY, HEALTH PLAN

Patient care

"In a regional health plan, covering approximately 120,000 lives, we implemented Medical Drug Management. A physician sought to initiate a patient on a drug for postmenopausal osteoporosis. Utilizing electronic prior authorization, the physician conducted **a real-time check and received immediate approval** while the patient was still in the office. Consequently, the patient could schedule a follow-up appointment for administration before leaving. The patient later expressed gratitude to their health plan for such an efficient process, which **significantly reduced the time taken to obtain their medication**."

VP OF PHARMACY, REGIONAL HEALTH PLAN

Pharmacy Advanced Utilization Management

As previously described, utilization management programs on the **pharmacy benefit**, like Advanced Utilization Management (AUM), work to drive members to the most clinically appropriate, cost-effective **medication**. Cost of treatment is one of the most important factors in driving adherence: in 2022, over **20% of older adults and 18% of all U.S. adults reported cost-related nonadherence**.[7]

Today, more than 5,200 payers choose us to manage their traditional and specialty pharmacy utilization—resulting in $6 billion in ingredient cost savings for 2023.[8]

Cost savings

A commercial national client saves nearly $20 million ($2.29 PMPM) in a single plan year from AUM prior authorizations on specialty inflammatory condition medications.[9]

Patient care and savings

A patient suffering from moderate plaque psoriasis sought treatment from their dermatologist. The physician initially prescribed a costly biologic due to the success recent patients have experienced with similar cases. The physician's office pursued a coverage review, where ESI advised that the patient try a traditional systemic treatment before trying the more advanced biologic treatment. The physician then prescribed the patient a pill which provided results within four weeks. Additionally, the out-of-pocket cost for the patient was **$881 less per prescription**, and their **plan saved over $102,000 annually**. The patient, who was already struggling with physical aspects of this condition, also improved their overall mental health—depression and anxiety can affect up to 55% of psoriasis patients.[10] In this scenario, both the patient and their plan sponsor saw cost savings, while the patient improved their mental and physical health.

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Contact your Evernorth sales or account representative or drop us a note at businessdevelopment@evernorth.com for more information on something you read.

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