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Modernizing utilization management: A case for system-level change

For many health systems, utilization management (UM) has long been a functional necessity, but rarely a strategic priority. Originally designed to ensure clinical appropriateness and support payer requirements, UM often grew up within hospital walls, shaped by local workflows and embedded within broader care management structures. As a result, traditional UM functions today are frequently fragmented, inconsistent and outpaced by competing financial, operational and regulatory demands.

Today's healthcare environment calls for elevated utilization management performance. Capacity constraints, complex payer expectations and heightened scrutiny on patient status determinations have elevated UM's importance within the context of organizational strategy. What was once seen as a component of care management is now its own critical piece of systemwide performance. This means that health systems face a pivotal moment. The question is no longer whether to modernize UM, but how.

Limitations of traditional UM models

Legacy UM functions typically evolved at the hospital level, often with autonomy or at least variability in how, and by whom, utilization reviews were conducted. This allowed flexibility, but it also led to fragmentation. Processes varied across facilities within the same system. Decision criteria were inconsistently applied. In some systems, UM was housed under nursing; in others, it reported to finance or revenue cycle. Centralized governance was lacking, and with it, accountability.

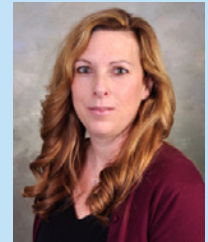
Another challenge has been role dilution. In many hospitals, case managers or care coordinators were tasked with handling UM reviews in addition to discharge



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planning and patient progression. These competing responsibilities often forced staff to triage their time—focusing on immediate discharge barriers while deferring UM reviews. That delay undermined timely care decisions and exposed systems to payer denials, which jeopardized reimbursement.

Even in systems that attempted to centralize UM, true standardization was rare. Policy differences persisted across hospitals. Staff training was inconsistent. And technological support was often lacking, with manual processes prevailing over integrated digital workflows. The result: a patchwork of practices with no unified approach.

The case for centralization

In contrast, a truly centralized UM function offers a strategic, scalable alternative. A centralized approach separates UM from other care management functions by establishing dedicated teams focused exclusively on utilization review. Staff are trained in clinical criteria and payer-specific requirements. Workflows are standardized across the enterprise. Technology enables real-time status reviews, communication with payers and audit trails.

Centralized UM brings several advantages. First, it **reduces variation**. With shared protocols and unified oversight to ensure medical necessity documentation is captured, health systems can count on consistent decisions, regardless of site, shift or reviewer. This helps reduce denials, improve documentation accuracy and support compliance with payer rules.

Second, centralization **supports financial accountability**. By aligning UM under the revenue cycle or in partnership with finance, organizations reinforce the connection between clinical decisions and reimbursement integrity. Escalation pathways for complex cases, pre-claim appeals and physician advisor reviews become embedded processes, not *ad hoc* reactions. This establishes a proactive, not reactionary, approach to securing authorization or payment.

Third, centralized UM **strengthens payer engagement**. Health plans increasingly demand timely, well-documented reviews supported by standardized clinical evidence. A cohesive UM structure gives systems the data, scale and clout to negotiate and advocate effectively.

Governance, leadership and culture

Successfully building a centralized UM function requires more than reassigning staff. It demands system-level governance and strong, visionary leadership. UM must

Successful elements of a centralized utilization management function

1. Strong support from C-suite leadership
2. Strong partnerships with onsite clinicians and care management
3. Comprehensive staff training
4. Clear definitions of roles
5. Technological support

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be anchored in executive priorities and supported across revenue cycle, operations, clinical leadership and information technology. In high-performing systems, sponsorship often comes through the chief financial officer (CFO) or revenue cycle, while nursing and hospital operations ensure day-to-day integration.

But structure alone is not enough. Culture matters. A shift to centralized UM must be framed not as a loss of local control but as a strategic evolution. Clear communication, aligned incentives and transparency about roles and expectations are essential to build buy-in and sustain momentum.

The role of physician engagement

Equally critical is physician partnership. UM functions thrive with the active involvement of physician advisors (typically reporting to the chief medical officer) who guide clinical decision-making, support appeals and bridge conversations with frontline providers. This clinical voice is vital in maintaining credibility and trust.

Yet true engagement extends beyond leadership roles. Successful UM programs cultivate collaboration between reviewers and admitting and attending physicians. This fosters shared ownership of status decisions and streamlines workflows to minimize administrative burden on clinicians. The clinician retains responsibility for the status decision, but UM provides a critical support and assist role. Under this model, UM is not merely a financial function. It's a clinical partnership.

Case study: Geisinger's UM transformation

In 2020, Geisinger Health System was confronting a capacity crisis. Across the Danville, PA-based system's 9 hospitals, inpatient units were regularly at or above full occupancy, stalling patient throughput and creating operational strain. Upon closer analysis, Geisinger identified a critical bottleneck: its UM function, then embedded within case management and discharge planning, was delaying status determinations and contributing to financial risk.

Nurses tasked with UM reviews were also responsible for discharge planning and patient progression. Pulled toward urgent clinical needs, they often didn't initiate UM reviews until days into a patient's stay—far too late to meet payer notification requirements or support timely reimbursement.

To address this, Geisinger partnered with Claro Healthcare (now part of Kaufman Hall, a Vizient company) to centralize and restructure its UM function. The new model created a dedicated UM team, separate from discharge planning, with clear role definitions and focused accountability.

Several elements enabled the shift. Leadership buy-in was foundational—particularly from the CFO, revenue

cycle and clinical operations. Staff were trained to apply evidence-based clinical criteria, despite the variability in payer standards. Technology enhancements linked admission orders to automated work queues within the electronic health record, enabling timely review. Physician engagement was also key; the UM team committed to minimizing unnecessary communication and maintaining clinical alignment.

The results were swift and significant. Observation rates dropped from over 26 percent to between 7 and 10 percent depending on the campus, and the system realized \$54 million in revenue improvements in the first year. The division of labor also proved vital during the Covid-19 pandemic, helping discharge planners stay focused amid unprecedented demand.

Geisinger continues to refine the model. In 2023, it launched a strengthened appeals and denials management initiative, escalating payer disputes to physician advisors and initiating pre-claim appeals. Early signs point to stronger compliance and financial performance, reinforcing the value of centralized UM as both a strategic and operational asset.

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