Using a new network-centric utilization management model, healthcare organizations are realizing up to $20 million in total net financial savings and up to 80 percent reduction in the number of codes requiring review.

Healthcare organizations that want to increase value from utilization management—and improve provider relationships—are disrupting the status quo. They are adopting a risk-based, data-driven approach to replace the traditional disease-centric utilization management model with a network-centric one.

The new model focuses on practice patterns to drive efficiencies in receipt and review of requests and enables utilization management clinicians to work at peak productivity. It can save medical and administrative costs, reduce provider burden, and improve consumer satisfaction.
Stuck in the past

Utilization management has long been a strategy for healthcare organizations to contain costs, maintain quality and reduce unnecessary and inefficient care. With up to one-third of medical care today unwarranted according to some studies, efforts to control utilization of services are understandable. The question is not whether to do utilization management—it is how to do it better.

Yet surprisingly little has changed about today’s disease-centric utilization management program that took shape in the 1980s. It is a one-size-fits-all, gatekeeper approach focused on disease states and high-cost, high-volume services identified by perception and customer requirements, not by data insight.

Current utilization management programs are highly manual, expensive and inefficient. Many healthcare organizations have multiple authorization lists to accommodate different lines of business and customers, adding to administrative, software and training costs. Most (64 percent) physicians find it difficult to know what services require prior authorization.2

Physician practices typically devote more than 20 hours a week of physician, nursing and clerical time combined to prior authorization processing, and spend on average over $68,000 annually per physician on all interactions with payers.2

Accenture analysis of national and regional payer organizations across commercial, Medicare and Medicaid lines of business shows that utilization management does provide value. Even in a disease centric model, payers are realizing a positive return on investment (ROI) but there is room for improvement. By transitioning to a network-centric model, organizations can streamline their operations to significantly increase their ROI.

Start with the network

Healthcare organizations can benefit from evolving to a network-centric utilization management model that is risk-based and data-driven. It supports decisions about what is specific and known, not what is general and assumed.

With this model, healthcare organizations can identify unique network practice patterns and membership characteristics to inform decisions about prior authorization requests. This eliminates waste, lowers medical and administrative costs, reduces provider and consumer abrasion, and supports a whole new level of informed decision making.

Healthcare organizations using this model have achieved significant benefits, realizing up to $20 million in administrative and medical cost savings combined. They have also reduced the number of codes requiring review by 60 to 80 percent annually, driving a 17 to 40 percent reduction in administrative costs (see Figure 1.).

FIGURE 1: BENEFITS OF NETWORK-CENTRIC UTILIZATION MANAGEMENT

Up to $20 million in administrative and medical cost savings combined

60-80% annual reduction in the number of codes requiring review

17-40% reduction in administrative costs resulting from fewer codes

Source: Accenture analysis

Network-centric utilization management is built on several fundamentals

**MANAGEMENT BY EXCEPTION**
Healthcare organizations conduct utilization management activities only for those services, admissions and continued stays where there is ROI for conducting the review. Utilization management clinicians practice at peak productivity while healthcare organizations and providers work more efficiently and cost effectively.

This is a big departure from the challenge that healthcare organizations have today determining the associated financial value of utilization management clinical review. It also reduces the number of unnecessary requests that providers submit to err on the side of caution.

**CONTINUOUS MONITORING**
Healthcare organizations conduct ongoing analysis of the utilization management program, turning on and off rules in response to changing costs, quality, practice patterns and member characteristics. This creates a flexible approach that can stand up to shifting market demand unlike today’s processes that are not monitored regularly for costs, efficacy or accuracy.

**AUTOMATION**
Healthcare organizations apply a detailed analysis of their utilization requirements and processes that exposes areas ripe for automation. This reduces costs further by limiting which requests go to clinicians for review while delivering faster decisions to providers. Automation is a change from the status quo—Accenture analysis shows that 60 to 80 percent of utilization management requests require manual intervention today.

**COMMUNICATION**
Healthcare organizations publish targeted utilization management requirements to increase transparency and reduce provider and consumer confusion.

**Losses in exchange markets**
The need for this network-centric utilization management model is further driven by what is happening right now in the exchange markets. In fact, shifting from the “old” to the “new” utilization management model may be a matter of survival for many health organizations.

Health insurance delivery is rapidly shifting to the exchange model. By 2017, nearly one in five Americans will purchase benefits from a health insurance exchange, public or private.

Payers are reporting significant losses in exchange markets, with several planning to pull out completely. More healthcare organizations will likely face the same fate—disappearance from a growing market—if they do not evolve utilization management to align with a consumer market that has very different health characteristics.

**When everyone wins**
The shift to a network-centric utilization management model is a win-win-win. Healthcare organizations increase ROI, achieve cost savings and streamline resource use in a dynamic market where effectively managing utilization of services and costs is a matter of survival. Providers reduce administrative burden and costs and have a better understanding of health organizations' utilization management requirements. And today’s healthcare consumers continue to receive the healthcare services they expect, with the greater transparency and patient-centered focus they demand.

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