Proactive Payment Integrity Is a Strategic Investment

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Expert presenters

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Increased pricing pressures and rapid market changes resulting from health care reform — combined with health care costs rising two times faster than inflation in 2012 — are prompting health plans to start thinking about payment integrity as a strategic imperative, according to Chris Dorn, vice president, Payment Accuracy, Optum.

"Health care reform is not going away — it's here to stay, and the growth in the cost of care is skyrocketing," Dorn said March 12 during an Optum Perspectives webinar, "The Prepayment Imperative: A Proactive Approach to Payment Integrity."

"Because of these and other factors — such as health care insurance exchanges leading to pricing power declines — health plans that don't pay attention to payment integrity issues are going to be facing some potentially difficult times," he explained. "There is an imperative to look at payment integrity and make it a priority in your organizations now."

Defining scope of program integrity

For the industry as a whole, this imperative is worth roughly $362 billion in medical cost savings related to improved payment integrity and decreased overpayments, Dorn said, adding that administrative cost savings alone are $47 billion if plans use predictive modeling to pre-score claims for coordination of benefits (COB), upcoding, subrogation, fraud and medical management prior to payment.

Most organizations define payment integrity to include fraud, waste, abuse, COB/third-party liability, subrogation, error/clinical editing and administrative overpayment, said Matt Choffin, vice president, Commercial Payment Integrity, Optum. "Between 3 percent and 7 percent of health care claims are inaccurately paid, in a continuum that ranges from mistakes to intentional fraud," he said. Further, because payment integrity issues are "difficult to parse," identifying and resolving them "can lead to overlap, inefficiency and abrasion," he noted.

Although some plans use "intent" to define the scope of payment integrity, a better approach to determining which claims should be pursued starts by identifying those entities who are gaming the system by inappropriately inflating patients, units or unit cost, according to both speakers. Dorn explained that when Optum's clients use intent to drive their approach, they are not as successful as when they look at "revenue maximization" behavior and use data analytics to detect and validate this behavior.

Payment integrity demands enterprise-wide approach

Ideally, plans should implement an enterprise-wide strategy for payment integrity. "When looking at organizations' philosophy and goals for payment integrity programs, we find that as the level of commitment increases, there is a correlation to a greater level of savings," Dorn said. Most plans tend to start with a compliance-based/post-payment approach, which requires the least commitment, but as they move from that to a recovery-focused approach, then to a "path to avoidance" approach, and finally to an avoidance-focused approach, they will move up both the commitment chain and the value chain to address pre-payment issues (see Figure 1).

Figure 1

Common Payment Integrity program designs

Coordinating the program integrity effort across the enterprise and developing strategic enterprise capabilities — such as root cause analysis — also reduce operating expenses, mitigate future risk and retain member and provider loyalty. "Using a disjointed approach can create tension and provider abrasion," Dorn noted.

However, he acknowledged that execution of a coordinated, comprehensive program has its challenges, especially in the current environment of increased provider/member focus on fraud: the complexity and expense of anti-fraud programs, the highly specialized staff and analytics skills and technology required to run a strong program, the administrative burden (including vendor management and initiative coordination) and the pressure to deliver return on investment.

Program integrity best practices save plans time and money

To streamline the execution process and help meet these challenges head on, the speakers recommended the following best practices:

1 Make payment integrity a strategic imperative for the entire organization. "In other words," Dorn said, "break down silos." A compartmentalized approach negatively affects profitability, provider relations, member satisfaction and the long-term outlook for a health plan. Plans should appoint an executive sponsor for payment integrity within the organization to help "socialize" the concept, and define corporate philosophical components and program components, including prevention, detection, investigation and education. Plans also should develop key performance indicators to measure effectiveness, including specifications and frequency of evaluations. A well-coordinated program integrity effort "will reduce unnecessary provider abrasion," Dorn said. "You have a finite group of providers to work with, so you want to ensure a long-term relationship."

Figure 2

Why Is Payment Integrity a Strategic Imperative

2 Consolidate vendors to increase efficiency and reduce provider abrasion and reduce multiple vendors going after same providers. Many core activities for payment integrity are handled by outside vendors, but managing multiple vendors can ratchet up command and control issues as well as costs. "Whether the function is technology or administrative, managing a vendor carries associated costs, and many plans do not have a consolidated view of what they are really spending and what opportunities exist to reduce the number of vendors," Choffin said. "Selecting vendors that can do more than one thing and do them all well really can increase efficiency and reduce costs."

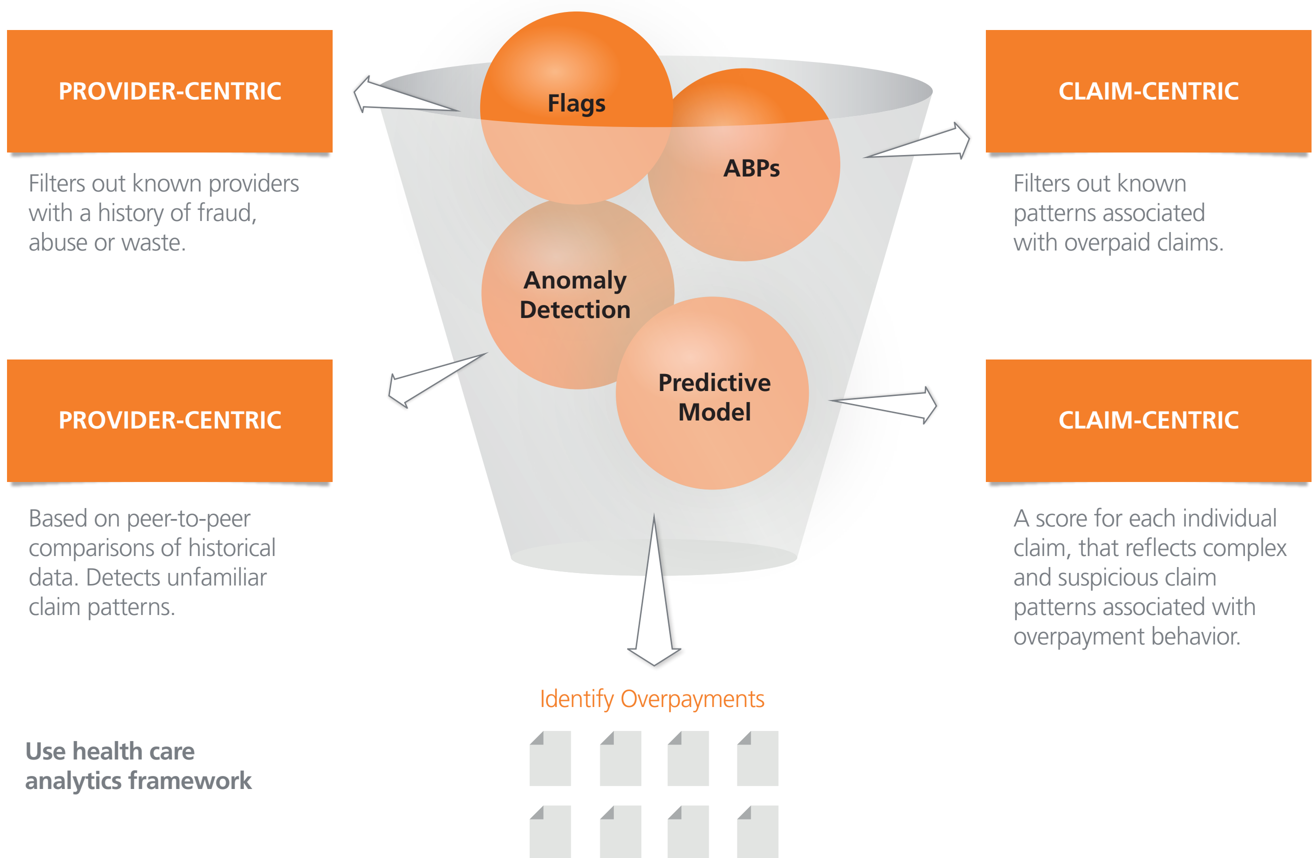
3 Use an enterprise payment integrity platform to eliminate silos and consolidate efforts. There are three primary elements that should be a part of a plan's payment integrity platform: advice engine; library; and intelligent analytics, according to Choffin. The advice engine looks at supervised and unsupervised edits in the prepayment claims management arena. "This tool can identify specific sources in the marketplace that indicate whether a claim is properly paid or follows certain guidelines," he said. The library, which includes shared intelligence (both empirical and sourced knowledge bases), is "a combination of all knowledge within the health plan, including fraudulent providers, abusive billing practices, etc." Intelligent analytics use statistical models that look for trends in billing and anomalies within billing and payment "to identify such issues as certain specialists billing for procedures that are not consistent with their specialty," Choffin explained. "Intelligent analytics can drive out claims issues that other categories cannot find," he said.

4 Focus on intelligent, integrated analytics as a way to get the most out of multiple-platform analytics. Delving deeper into the analytics, Choffin told attendees that plans should be using both provider-centric and claim-centric approaches to increase the level of claim problem detection (see Figure 3). "As you combine the two methods and the complexity of the model increases, a higher number of overpayments or inaccurate claims are identified," he said. Dorn added that using claim-centric models in addition to provider-centric models, improves the plans' ability to pick out of the claims stream only those claims that are highly likely to be problematic and have the highest potential for savings. "Stopping just one-tenth of 1 percent out of your daily claims stream can drive savings up by 5 percent to 10 percent," Dorn said.

5 Use a service provider to access high-end analytic tools. Dorn stated that there is a high bar for investing in high-end analytic tools and services, because it is expensive, complicated and requires specialized staff to run. Partnering with a vendor on a service basis does not require software purchase, installation or maintenance and reduces the investment in time and capital. And, Dorn said, doing so allows plans "to potentially work with a vendor that has expertise in the marketplace, can reduce those false positives and get your team working on the issues that will give you the best return on investment."

Figure 3

Intelligent, Integrated Analytics — Enables highly accurate detection



6 Incorporate data analytics, clinical reviews and investigative results to provide a comprehensive picture. "You need to understand where you are paying so you know where you need to invest resources," Dorn told attendees. He referred back to the discussion of the payment integrity "library" (see #3, above) and noted that the empirical knowledgebase should include all known suspect providers, schemes, aberrant behavior patterns and algorithms, as well as other payer inputs. The sourced knowledgebase should include such resources as national correct coding, medically unlikely edits and sanctioned/unlicensed providers.

7 Execute a payment integrity sweep post-adjudication/pre-check run. Dorn pointed out that this practice is the "last line of defense and a final opportunity to identify payment issues before the payment leaves the health plan. Stopping the payment from going out the door in the first place is seven to 10 times more effective than 'pay and chase.'" Choffin added that when plans deny or correct a claim up front, "they get 100 percent of the expected savings."

8 Work with partners who will focus on root cause identification. "The idea here is to promote moving detection up from recovery to prevention by increasing accuracy, creating process improvements, reducing administrative/operating costs, optimizing medical contracts and policies, identifying claims payment leakage and mitigating overpayments," Dorn said. Plans should be aware, Choffin advised, that "finding a vendor/partner will be more difficult than finding a vendor."

At the end of the session, Dorn also commented that having a clear communications plan and working with providers to avoid abrasion and internal network administration issues is important.

"Proactive program integrity is a strategic opportunity to position your plan for better financial strength in the future," he said. "If your organization hasn't started yet or only has a limited program in place, it's time to evaluate and determine how and where to expand capabilities and make a strategic investment."

How Optum can help

Optum offers end-to-end payment integrity solutions to maximize claims accuracy and medical savings. We can help your organization:

- Drive pre-payment accuracy and auto-adjudication
- Identify, recover and prevent overpaid claims
- Improve provider relationships with first time claim payment accuracy and edit transparency

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