OPTUM™

Maximize savings with an enterprise payment integrity strategy

Administrative cost savings reach $47 billion if plans pre-score claims for coordination of benefits, fraud, subrogation and other categories.

To combat the enormous cost of resolving incorrect payments long after claims were received — a labor-intensive process that costs the health system billions — health plans should develop an enterprise payment integrity strategy and commit to it fully. As the level of commitment increases, so do the savings.

Health plans currently transforming their business models to accommodate new markets and new lines of business also may be experiencing a strain on their payment integrity programs. This strain results from fluctuations in membership, business complexities and regulatory mandates across all areas of claims processing. Without a vigorous payment integrity strategy, these pressures can create competing or misaligned objectives across the claims process continuum and lead to more manual interventions that increase both provider abrasion and costs.

Implementing a well-coordinated enterprise payment integrity program that will both identify pre- and post-payment claims processing problems and yield actionable intelligence for systemic improvements will improve accuracy, lower costs and improve provider satisfaction.

Payment integrity is a strategic enterprise capability and necessary to compete and thrive in today's consumer-focused market.

Payment integrity, by the numbers

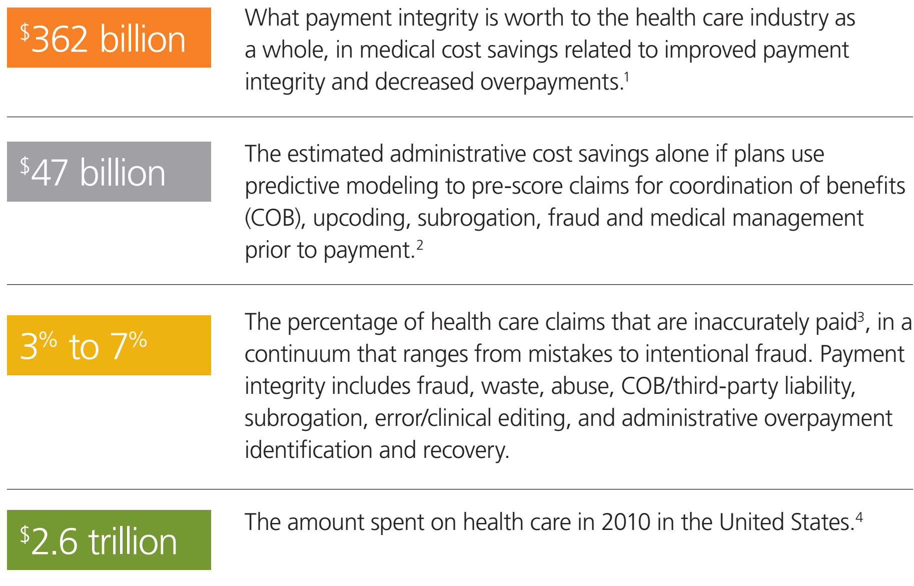

Figure 1

Greater commitment leads to greater savings

Health care reform has dramatically changed the market. Although the public and private exchanges provide an opportunity to expand lines of business, the associated membership flux can result in additional claims payment issues — requiring an increased focus by payers on a proactive, prepayment approach.

Currently, most health plans ease into such a prepayment plan, with each level increasing in commitment, value and savings:

- **Compliance-based, post-payment:** This approach requires the least commitment. It readily handles tips and referrals, and coordinates with anti-fraud groups and government agencies. It has limited investment in fraud detection capabilities and recovery resources.
- **Recovery-focused:** This approach invests in the resources and tools to deliver post-payment recoveries with defined recovery targets and reporting. Some plans might outsource some or all of their special investigation unit (SIU) function.
- **Path-to-avoidance:** This approach invests in strong post-pay detection, as well as prepayment technology to deliver cost-avoidance savings.
- **Avoidance-focused:** This approach invests in targeted processes to identify the root cause of financial leakage across the fraud, waste and abuse spectrum — and errors caused by a variety of issues (contracts, provider networks, membership, etc.)

Typical payment integrity approach

- Focuses on retrospective pay and chase
- Lacks unified enterprise-level reporting
- Creates competing objectives across claim processing departments
- Causes provider and member friction around payments
- Increases administrative and medical costs, potentially impacting medical loss ratios (MLRs)

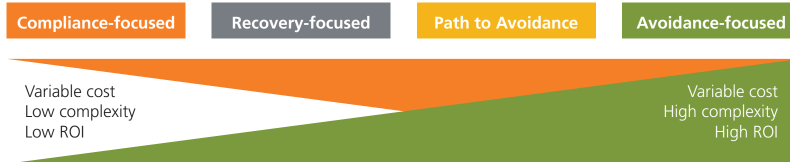

Figure 2

Bring payment integrity into focus

It is critical that health plans make payment integrity a strategic imperative for the entire organization. A siloed approach negatively affects profitability, provider relations, member satisfaction and the long-term outlook for a health plan. Plans should appoint an executive sponsor to help socialize the concept and define corporate philosophical components and program components, including:

- Prevention
- Detection
- Identification
- Education

Plans also should develop key performance indicators (KPIs) to measure effectiveness. A well-coordinated strategy employing best practices will reduce costs and unnecessary provider abrasion.

Payment integrity best practices

To capitalize on the opportunities that an enterprise payment integrity strategy offers, consider applying these seven best practices:

1. **Conduct regular self-assessments to identify gaps in enterprise payment integrity capabilities to establish a "best practice comparison."** With the disparate point solutions supporting the claims processing environment, plans must assess and determine effectiveness and gaps — from claims editing to fraud to credit balance standards to recovery rates. A payment integrity champion who is committed to optimizing the provider payment process should lead this effort. Internal or external experts can manage the self-assessment, which should be based on industry benchmarks.

2. **Commit to a proactive prepayment approach via claim edit and prospective payment solutions, as well as prepayment fraud, waste and abuse and coordination of benefits.** This can create a processing environment focused on efficiency and accuracy.

   i. Claim edit systems can detect billing errors, fraud and abuse using rules and source edits at the code-relationship level. Plans need to provide full disclosure and transparency to providers and members so they can understand benefits and payments — and to minimize the impact of potential inquiries and appeals. The edit system also should be flexible enough to complement the core adjudication system — automating new payment policies driven by the launch of new products and contracts. The system should be able to create new rules as needed without relying on the vendor to provide these mission-critical logical statements.[5] With facility claims making up more than 40 percent of overall health care spending, it's important to have rules for both commercial and Medicare facility claims editing. And of course, an ideal approach enables health plans to align their rules to their specific line of business, including Preferred Provider Organizations (PPOs), Health Maintenance Organizations (HMOs), consumer-driven plans, provider networks, employer groups, and public and private exchanges.

ii. By using Medicare's Prospective Payment System (PPS), health plans share the risk with their provider network, making each group accountable for the portion of risk they can effectively manage. Health plans should apply PPS methodologies to commercial business, Medicare Advantage and Medicaid lines of business. PPS can be used to manage risk, calculate reimbursement for inpatient and outpatient out-of-network claims, and model the impact of reimbursement strategies before implementation. It's important to consider the best way to manage the software and associated pricing libraries to maintain compliance and accurate claims pricing. Equally important, plans must minimize conflicts between the claim edit and prospective payment systems, and a unified claims accuracy platform helps address these issues.

iii. Plans should take a more aggressive prepayment approach to combat fraud, waste and abuse due to the high cost of recovery. A comprehensive system to detect and prevent payment of misrepresented, exaggerated or fraudulent claims must include the right combination of financial analysis, business/relationship analysis, medical insight and analysis, detection of changing behaviors and a feedback loop that learns. Applying knowledge gained from claim surveillance allows detection mechanisms to continually improve, keeping pace with newly evolving fraud schemes.[6]

iv. Implement comprehensive coordination of benefits. Health plans should incorporate enrollment integrity services that remove the member from the middle. This data-driven approach drives identification, validation, recovery and equal access to information. With emphasis on prepayment, it should reduce provider abrasion and improve member experience. Analyses indicate that 2 to 4 percent of commercial members have other insurance coverage. Payers could be paying millions of dollars a year on claims that are the primary responsibility of another commercial payer and spending unnecessarily on secondary members' health and care management programs.

Research has demonstrated more than a 30 percent reduction in primary responsibility and an average of 360 days of overlapping coverage. As a result, payers can reduce their primary liability and reduce the amount of time and resources spent on recovery efforts and member outreach, according to Optum client observations from over the past three years.[7]

3. **Use a service provider to access high-end analytic tools and ancillary prepayment software.** There is a high bar for investing in superior analytic tools, software 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 it reduces the investment in time and capital. Doing so allows plans to work with a vendor that has expertise in the marketplace, can reduce false positives and allow teams to work on issues that provide the best return on investment (ROI).

4. **Focus on intelligent, integrated analytics to get the most out of multiple-platform analytics.** Health plans should use both provider-centric and claim-centric approaches to increase the level of claim problem detection.

   Provider-centric analytics, based on peer-to-peer comparisons of historical data to detect unfamiliar claim patterns, filters out known providers with a history of fraud, abuse or waste.

   Claim-centric analytics filters out known patterns associated with overpaid claims. There is a score for each claim that reflects complex and suspicious claim patterns associated with overpayment behavior.

   Combining these two methods increases the model complexity and yields a higher number of overpayments or inaccurate claims — and improves the ability to pick out of the claims stream only those highly likely to be problematic and have the highest potential for savings. Stopping just one-tenth of 1 percent of inaccurate claims out of the daily claims stream can drive up savings by 5 to 10 percent.[7]

5. **Employ electronic payment systems to meet regulatory requirements and lower costs.** A complete electronic funds transfer/electronic remittance advice (EFT/ERA) solution can significantly increase payment integrity — and reduce administrative costs by decreasing paper and printing costs, postage, manual labor, banking fees, fees for voided or returned checks, and call center volume. These systems are easy to implement and can streamline the payment process by integrating claims payments and remittances with banking functions. Look for vendor partners with an extensive provider network to make it simple to connect and pay them electronically.

6. **Work with partners who will focus on root-cause identification.** The objective is to move payment integrity issues up from detection and recovery to prevention. Organizations can accomplish this by increasing accuracy, creating process improvements, reducing administrative/operating costs, optimizing medical contracts and policies, identifying claims payment leakage, and mitigating overpayments. Some vendor partners might be content with business-as-usual results and not take an aggressive approach to proactive payment integrity.

   Although root cause analysis is not a new concept, the right level of executive support is integral to transition claims problem detection from a post-payment arena to a pre-payment arena.

7. **Consolidate vendors to increase efficiency and reduce multiple vendors going after the same providers to avoid friction.** Many core payment integrity activities are handled by multiple vendors, a scenario that can ratchet up command-and-control issues and costs. Whether it is applied technology or administrative services, managing a vendor carries associated costs, and many plans do not have a consolidated view of what they really spend and what opportunities exist to reduce redundancy. Selecting vendors that can do more than one thing and do them all well can greatly increase efficiency and accountability — and reduce costs. A high-performing partner should be able to provide expertise across the operations. This includes claims editing, prospective payment, fraud/waste/abuse, data mining, subrogation and other third- party liability (TPL) activities, enrollment integrity (coordination of benefits), credit balance and recoveries.

The road to recovery

Optum conducted a root cause analysis for a regional health plan using a random sample of claims. Three-quarters included claims without errors, but 68 percent of the remaining claims included errors that resulted in manual claims processing — driving up administrative costs. The findings helped the plan to more tightly focus its payment integrity efforts.

Take advantage of the enterprise approach

Proactive payment integrity is a strategic opportunity to position health plans for better financial strength in the future and to compete in today's consumer-focused market. Applying these best practices enables a consistent approach that delivers results across claims processing operations.

If your organization has not started yet or only has a limited program in place, it is time to evaluate your situation. Begin with an assessment to better understand your organization's capabilities and determine a strategic, enterprise approach to payment integrity — one that delivers administrative and medical cost savings, streamlines the payment process and enhances provider relationships.

Payment integrity is a strategic imperative

The strategic payment integrity approach:

- Cuts operating and medical expenses
- Mitigates future risk
- Retains member and provider loyalty

Figure 3

Sources:

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