White paper

Payment integrity: a central strategy

Getting claims "right" as soon as they enter the claims processing cycle is vital to a health plan's ability to manage medical expense trend and increase administrative efficiency.

Payment integrity (PI) is the process health plans use to be sure a medical claim is managed and paid correctly. Payment integrity is a multifaceted practice that detects and corrects claims based on a variety of factors including but not limited to: health plan processing errors, other payer liability, correct industry coding guidelines, or questionable provider billing patterns where fraud, waste, abuse and error caused inaccurate payment. Successful payment integrity pays the right provider, the right payment, at the right time.

A fragmented approach is inefficient

Growing claims volume, increasing complexity, and fragmented payment integrity efforts spread among multiple department silos continue to challenge health plans. With claim payment accuracy problems increasing at about the same rate as medical inflation, it means 5% to 8% of all claims are paid inaccurately.* When analyzing claims data and relevant reports, leading health plans view payment integrity as one problem, not three or more separate problems, and are pushing to centralize all payment integrity oversight into a single executive leader. A fragmented approach causes:

- Competing and conflicting goals and incentives
- Duplicative vendor solutions and scopes
- Limited visibility of total program performance
- Frustration, disruption and administrative friction for providers
- Gaps in internal processes resulting in missed opportunities to correct payments
- Lack of communication that allows for solving the claim payment error where it originates

Health plan executives must implement an enterprise approach to payment integrity to transcend the performance of departmentally managed solutions.

Successful payment integrity

The importance of a central payment integrity office

The benefits of building a central comprehensive payment integrity office have proven themselves time and again. In fact, leading health plans may see an 8% to 10% or greater reduction in medical expenses and lower administrative costs.* As the market has become more aware of the impact that payment integrity has on cost containment, the importance of implementing a central, robust program continues to increase. Having a central office with a dedicated executive leader that manages the entire payment integrity cycle is a key strategy for financial health. Leading health plans are realizing that by taking a closer look at payment integrity they can:

- Reduce their medical spend
- Lower administrative expenses via reduced rework and multiple claim touches
- Improve their medical loss ratio
- Improve the consumer and provider experiences

There are benefits to all aspects of the healthcare system

Having a high-performing centralized payment integrity program not only benefits the health plan but also their providers, consumers and employer groups:

Employer/client impact

The health insurance market can be a crowded field with health plans often trying to find ways to differentiate themselves. Health plans strive to increase the demonstrable value they bring to their fully insured and self-funded employer base through their PI savings and ability to drive lower medical and administrative costs.

Provider impact

Ensuring providers are paid uniformly by limiting payment discrepancies for claims and capturing as many errors as possible before a claim is paid or even submitted, to prevent recoups or take backs on claims that have been paid many months ago.

Consumer impact

Ensuring a health plan is doing everything it can to pay a claim accurately the first time and pre-payment to limit any impact to a member's deductible, copayment or premium.

Impact to self-funded clients and their members

When payment integrity practices are applied to fully insured health care benefit plans, there is a positive impact on cost reduction and administrative efficiency. Why is it common for health plans to limit payment integrity practices to fully insured clients only and not extend to self-funded clients?

There's no one answer but rather a combination of answers ranging from employer assumptions, to vendor market complexity, to a lack of a health plan understanding their own payment integrity practices, and/or to clarity around savings opportunities.

As the health plan and employer group markets become more aware of the positive impact payment integrity has on cost containment and efficiency, the importance of health plans implementing these practices for their self-funded clients continues to increase.

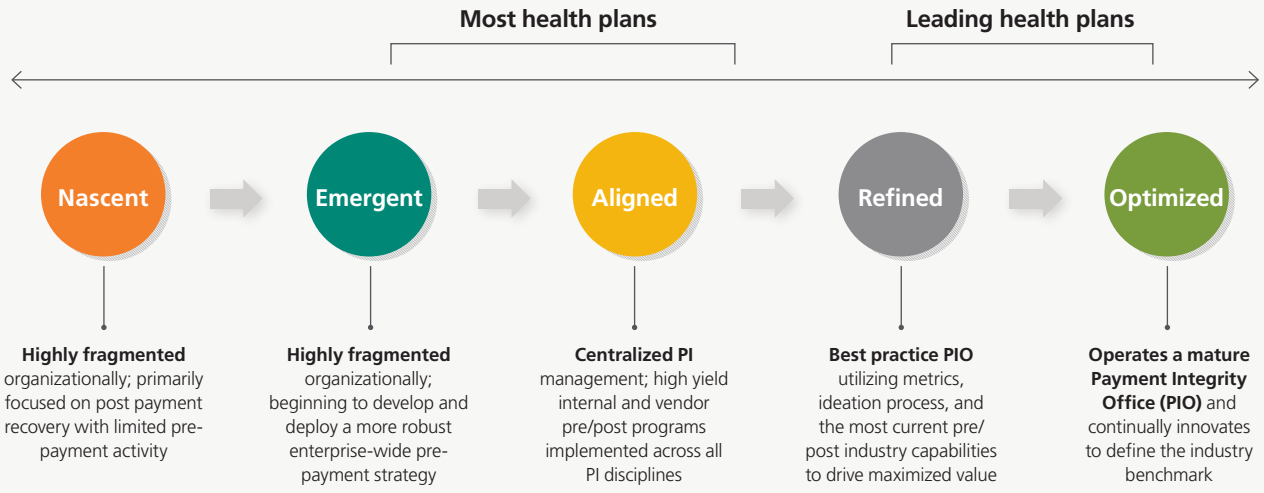
Current PI trends

The graphic above highlights key focus areas of a payment integrity office executive:

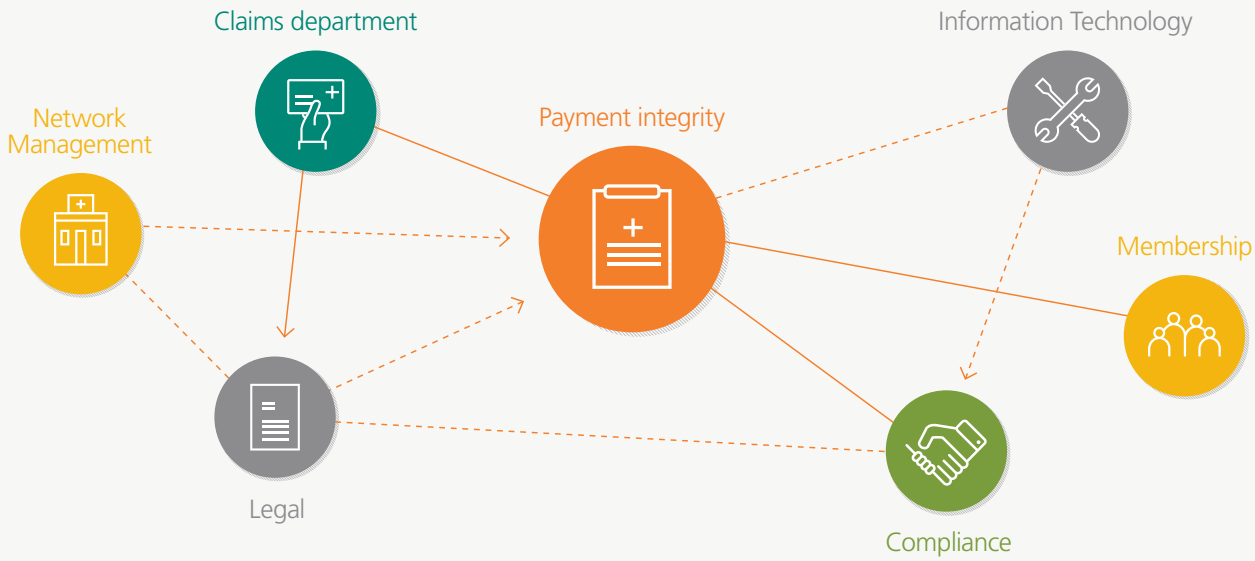
1) End-to-end approach — Ensure one executive is responsible for the entire medical cost containment program within a health plan. From provider education and avoidance before a claim is billed, through pre-payment editing and audit programs, and the host of post-payment review and audit programs a health plan might operate.
2) Analytics/content rich — Insist that the program looks at all medical and pharmacy claims, to ensure programs are not missing medical expense trend areas. Emerging spend areas around genomics, labs and specialty RX are becoming more and more important in addition to the more traditional spend types such as facility and professional claims.
3) Experience of all constituents — Ensure the Payment Integrity Program is aligned to the right goals, not only of the health plan but also of the member/consumer and the provider. Make billing practices and processes available to providers and ensure payments are consistent across claims. For members, move as much of the payment integrity activity to pre-payment or pre-claim, to lessen impact on the member's experience.
4) Pre-payment — Gone are the days of health plans wanting to find the majority of their billing and payment errors through post-payment programs. Although post-payment programs are still important, health plans are focusing increasingly on how to catch and fix incorrect claims before payment is made. This helps lessen provider abrasion and limits member impact on deductibles or copayments that might have been paid incorrectly.

Where is your organization in its PI journey?

Your organization may already be taking steps toward managing payment integrity centrally, but if you have a fragmented approach, you're missing a big opportunity. The following diagram shows the evolution that health plans might experience when centralizing their payment integrity efforts:



If you are in either the nascent or emergent stages, you may have a structure in place that looks similar to the below example with no central office dedicated to payment integrity. The multiple departments that are participating are in silos:

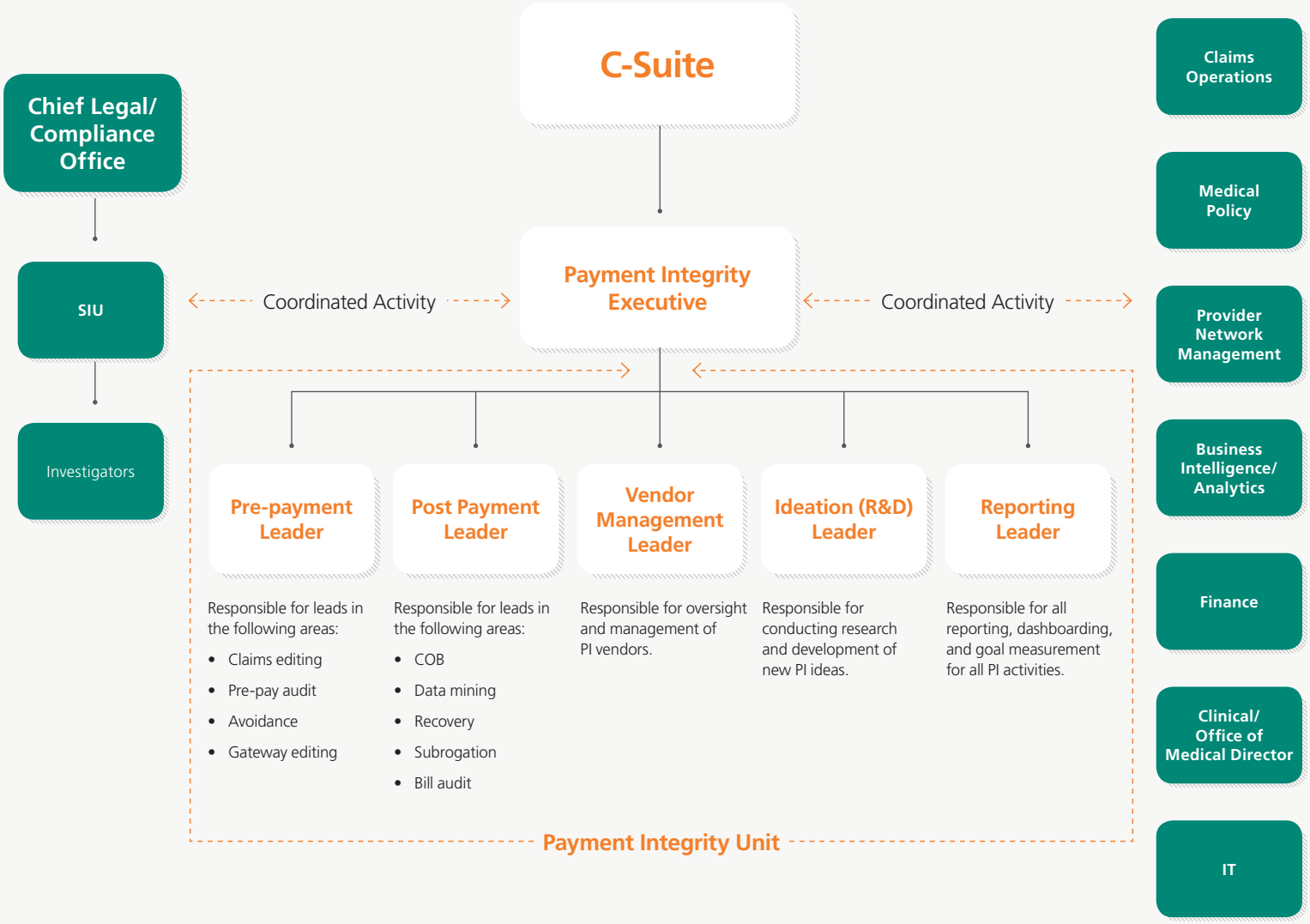


Build a strong foundation

To begin your journey toward a centralized payment integrity strategy, it is important to start with these foundational requirements:

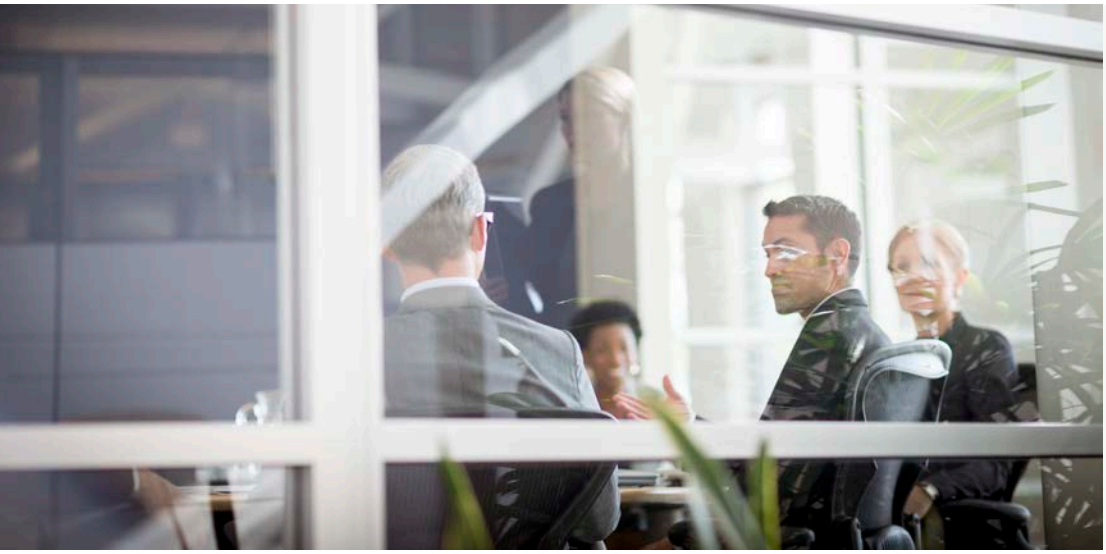
- Deep understanding of your health plan's current payment integrity processes and value
- Capability to build or manage a comprehensive approach
- Active engagement and sponsorship of the program by C-suite leadership
- Expertise in pre-payment and analytics within the payment integrity team
- Robust dashboard reporting and analysis within the payment integrity team

To be sure you have a leading payment integrity program, you must include all departments involved in all aspects of paying claims along the way. The following diagram shows a sample best practice organization structure. Notice the coordinated departments that are essential to make this model work:



Performance is key to success

Once you identify and engage all participants of your central payment integrity office, it is crucial to form a steering committee to develop key performance indicators (KPIs). The KPIs must align with payment integrity initiatives to be able to attain the performance objectives. The committee must also identify and resolve competing and conflicting incentives across the organization.



It is crucial to form a steering committee to develop key performance indicators.

Take inventory of vendors and their services

Chances are if you are using a fragmented payment integrity approach, you may have multiple vendors supporting those efforts with a narrow focus on one specific activity. Once you identify all of your vendors, review their contracts, pricing and service level agreements to form an assessment of their performance. At this point, the steering committee needs to review the vendor assessment and decide which vendors to move forward with as high performing partners and which vendors to remove. This exercise is necessary to help facilitate development of the payment integrity portfolio strategy, eliminate vendors performing the same services, and identify which bring the most value to the business capabilities with favorable contract terms.

Vendors will play a role

Once you identify the vendors you'll work with, consider them stakeholders to your central payment integrity office efforts and a vital part of your steering committee. Be sure they are core participants for the Steering committee. You will want them participating in other committee meetings focused on innovation, continuous improvement, and sourcing new capabilities.

Leading health plans are consolidating key vendor partnerships measured by common KPIs. Using fewer vendors with larger scope allows vendors and health plans to work broadly across pre-payment and post-payment functions, and limits provider abrasion, simplifies internal processes complexity, and lowers overall total cost of ownership (TCO).

5 key takeaways to fit all

All central payment integrity offices will have differences and similarities. Here are five key takeaways that will apply regardless of what central office strategy looks like:

1. **Dedicate a central leader for all payment integrity functions in your organization.** Make payment integrity a strategic asset of your organization and ensure it's viewed to be as important as quality, network, finance and other key areas.
2. **Include all lines of business in your payment integrity program.** Including self-funded plans, fully insured clients and government products can drive significant medical expense savings opportunities and administrative efficiencies.
3. **Engage executives and other stakeholders from across the organization.** This includes IT, finance, compliance, claims, network management, medical management, customer service, vendor management, legal and any specialty or delegated entities.
4. **Formulate KPIs with payment integrity stakeholders to prioritize and assign metrics.** It's vitally important to the success of any payment integrity efforts to monitor performance and report progress.
5. **Identify vendor stakeholders in your central office and take inventory of payment integrity capabilities and suppliers.** Look to move away from many vendors with smaller focuses and shift toward fewer vendors with a larger scope across pre-payment and post-payment services with mutually aligned KPIs offering a lower total cost of ownership.

*Optum client observed experience.

Learn more about setting up a central payment integrity office in your organization. Contact Optum to learn more today.

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