

A new model for payment integrity: strategic and centralized

Payers need to move beyond post-payment recovery efforts to drive down costs and deliver affordable coverage. Emerging, disruptive technology and a stronger role for payment integrity are leading them to adopt a comprehensive approach that ensures they have a strategic plan in place to identify and generate opportunities to increase medical expense savings.



A NEW PARADIGM FOR PAYMENT INTEGRITY IS EMERGING

All payers use payment integrity measures in one form or another to achieve savings. But their efforts are usually centered around post-payment identification and scattered across multiple departments. Odds are, savings being realized today are just a portion of the opportunity.

A new paradigm is emerging.

Payers are starting to elevate PI into a core strategic function governed by a unified vision and directed by top executives, knocking down silos and aligning efforts across the organization to make sure the right claim is paid at the right time for the right amount.

The cornerstone of this centralized model is the establishment of a Payment Integrity Office (PIO) with a single leader who typically reports to the CEO or another C-suite executive. The PIO assumes responsibility for all internal and vendor PI efforts already underway and, moreover, sets PI strategy and ensures that the right investments are being made in the right areas. It is up to the PIO to drive a vital cultural shift away from objectives built around annual recoveries and reorient efforts toward genuine avoidance by putting the necessary assets in place throughout the claim lifecycle.

The PIO's key tools and tasks include dashboard reporting, scorecarding, vendor management and, most importantly, acquiring and developing the right analytics and ideation resources internally and externally to discover and take advantage of payment integrity opportunities.

A leading area for investment and development by payers implementing a centralized PI model is data analysis and predictive modeling to focus on problem areas and identify improper claims before payments go out the door. In addition to sophisticated claims editing software, payers are rolling out integrated platforms that look beyond coding edits and target waste, error, and abuse, often by using medical record reviews. These integrated systems often sit post-adjudication, pre-payment and introduce an additional level of claim accuracy. This move to pre-payment also helps limit abrasion to the provider community.

For payers already taking a new approach to PI, the benefits have been substantial. Payers that have adopted the centralized PIO model are seeing a quick return on investment by improving efficiency and ensuring any gaps are filled. In the typical, decentralized model – with its focus on the traditional post-payment approach – payers typically lose 20 to 30 cents for every dollar recovered. This pay-and-chase methodology creates frictions with providers as they have already been paid and are now being contacted by a payer asking for a refund. The PIO, working closely with providers to clarify claims procedures, can strengthen relationships, and focusing on cost avoidance before payment reduces attrition. Meanwhile, coordinating and rationalizing PI efforts across departments and vendors generates valuable administrative efficiencies and frees health plans to focus on serving members.

With so much money at stake - 3% to 7% of claims are paid inaccurately due to failures ranging from commonplace mistakes to fraud - forward-thinking health care plans recognize they must centralize PI and dedicate resources to an ongoing search for new sources of savings as technology continues to advance and regulation evolves.¹

A recent study of payer professionals, including CEOs and other top executives, by SourceMedia Research gives a clear view of the need for a comprehensive payment integrity strategy.

PAYMENT INTEGRITY AS A STRATEGIC ASSET

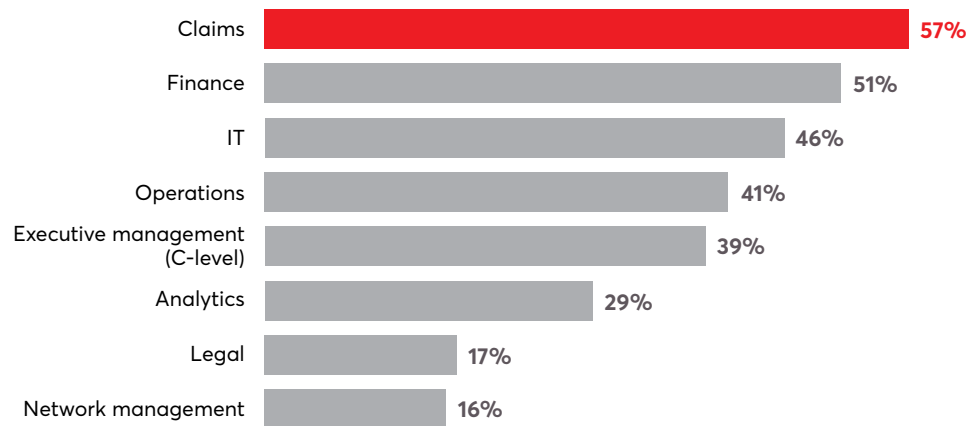
Payers seeking to improve payment integrity must first review their fragmented organizational structure. An extensive survey of payer professionals shows that PI functions are typically spread across several departments — claims, finance, information technology, operations and others (see Fig. 1). Further, claims reports tend to be developed by separate internal groups and various third-party vendors — just 35% of the survey's respondents say reports are created by one centralized department.

WHAT IS PAYMENT INTEGRITY?

Health care payment integrity is the process of ensuring payments made from one organization to another are managed correctly and that appropriate payment accuracy checks exist to minimize the likelihood of errors. Successful PI reflects an organization's ability to accurately pay the right person the right amount of money, through the right program, at the right time.

Figure 1: Departments with PI responsibility

% of respondents



Q: Which of the following departments have responsibility for payment integrity functions in your organization?
Please select all that apply. n=155 (Base=All respondents)

Source: Optum Healthcare Payment Integrity Custom Research Study, SourceMedia Research/Health Data Management, October 2017

A centralized Payment Integrity office (PIO) will:

- Break down silos
- Align PI activities
- Generate administrative savings

Establishing a centralized office to oversee PI is the foundation for breaking down silos, aligning activities and generating administrative savings. Typically, separate departments and individual vendors focus on niches in the payment stream, and their efforts can overlap or even clash.

"Many payers have vendors and departments all across the organization doing different things and not communicating because they don't roll up to the same executive. Additionally, they are not incentivized to fix root causes or drive avoidance because their scope is limited and their incentive model is built on the errors re-occurring," says Rob Mayer, vice president of product strategy for Optum's PI business.

This fragmented PI structure means that errors aren't caught until after payment, if at all. The data needed to address such problems early in the claim cycle sits in silos, and the departments that could use it to fix problems at their root are left in the dark. The resulting improper payments—if they're identified—generate additional work to recover. The recovery effort also exacerbates provider abrasion. Providers may now be required to return payments they have already received. And worse, plan members can get caught up in the process, presented with and sometimes fighting bills for services they believed were properly delivered and covered.

In contrast, a centralized office can perform data analysis to determine where problems are occurring and coordinate fixes across the organization. For example, a payer might start by identifying where post-payment recoveries are producing the best results — perhaps in cardiology or oncology — and design ways to stop errors early by strengthening pre-payment and pre-adjudication cost avoidance measures in those areas.

A centralized office exercising a unified strategy and governance through PI dashboards and unified reports is also far more effective than multiple departments that have independent goals and measures of success — and may not share data.

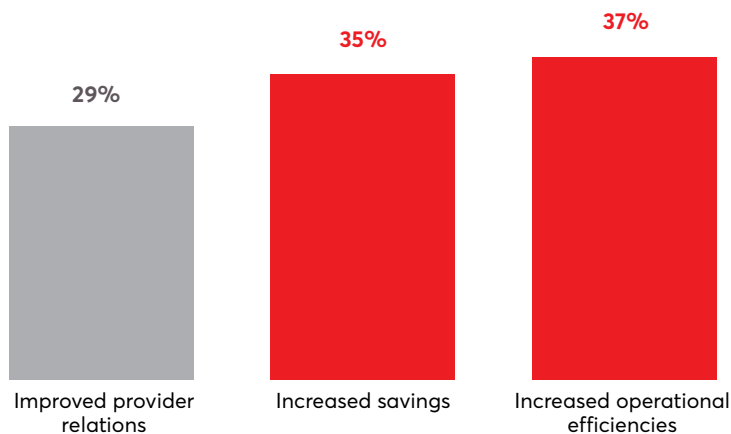
Most importantly, a centralized office with a leader who reports to the C-suite transforms PI into a strategic function, creating a modern technology platform for continuous improvement. This is key, because for comprehensive PI to succeed, health care plans must engage in an ongoing search for ways to harness developments in predictive modeling, machine learning, contextual computing and other technology to tap into new sources of savings.

WHAT PAYERS WANT FROM PI

The second factor payers must understand is that PI is more than just claims payment reduction. Indeed, survey respondents put roughly equal emphasis on three related PI objectives: increased operational efficiencies, increased savings and improved provider relations (see Fig. 2).

Figure 2: Primary measure of PI progress/success

Mean percentages (out of 100)



Q: What is your company's primary measure of payment integrity progress or success? Please allocate 100 points among each so that allocations represent the relative importance of each measure.n=155 (All respondents)

Source: Optum Healthcare Payment Integrity Custom Research Study, SourceMedia Research/Health Data Management, October 2017

Maintaining focus on the big picture can be accomplished by establishing a PIO to coordinate a comprehensive strategy, which is critical for achieving all three.

A PIO that aligns PI activities across internal departments and vendors not only can improve medical expense savings, it also has the potential to produce administrative savings by finding inefficiencies across vendors, departments, and staff. Emphasizing pre-payment cost reduction narrows losses that are inevitable when trying to recover payments that have already gone out the door, and greatly reduces pay-and-chase — one of the most abrasive parts of payment integrity to relations with health care providers. The PIO also contains an innovation and ideation shop where payers can conduct an ongoing search for new savings opportunities.

In fact, comprehensive PI embodies the components payer professionals say are the most important — in the areas they find the most challenging (see Fig. 3). For example, more than two-thirds of survey respondents say that the ability to measure results and perform claims analytics are very important for an enterprise-wide payment integrity strategy, but roughly three-quarters describe these activities as challenging. With centralized oversight, the right vendor partner, unified dashboards, and reporting, a PIO provides a solution.

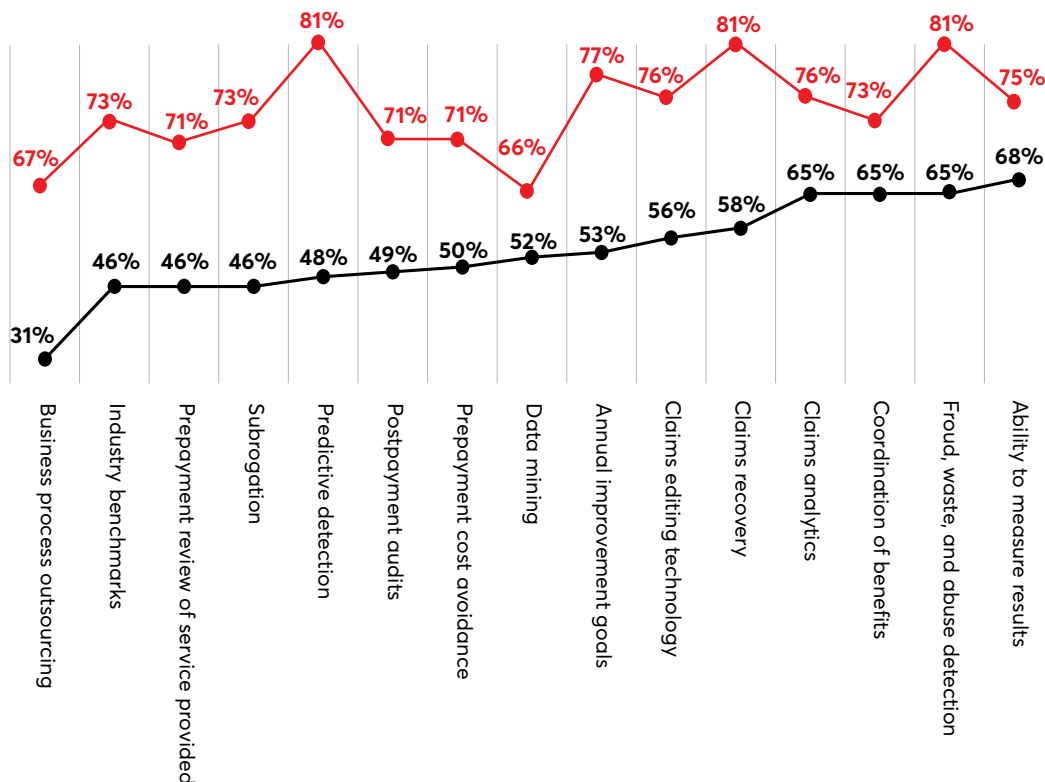
What payers want:

- Increased savings
- Increased operational efficiencies
- Improved Provider relations

Figure 3: Key PI drivers

% of respondents indicating "Very important" and "Somewhat challenging" or "Very challenging"

- Very important
- Challenging



The most challenging PI activities are the ones that will yield the highest savings.

Q: How important to your company is each of the following components in an enterprise-wide payment integrity strategy? Q: Now, how challenging are each of the following components in your company's payment integrity operations? For each feature, please select one choice for each. Base=All respondents (excludes "Don't know")

Source: Optum Healthcare Payment Integrity Custom Research Study, SourceMedia Research/Health Data Management, October 2017

Indeed, without a PIO, payers cannot form an accurate understanding of the scope of potential savings they're missing. With PI fragmented across departments and vendors, performance measures are also partial, and a complete picture does not reach senior executives. Without a PIO, payers are also working without comprehensive industry benchmarks to compare themselves against, and a platform for ideation about what can be achieved.

SAVINGS FROM MEDICAL EXPENSE REDUCTION CAN FUND INNOVATION AND IDEATION

Payers have likely already gone through several rounds of streamlining efforts on the administrative side, leaving operations as lean as they can reasonably get without eroding services to members. While payers are understandably cautious about approaching medical expenses as a source of savings because they are committed to providing the best care to their members, reducing inappropriate claim payments and overpayments represent a smart way to achieve savings.

Respondents give very mixed assessments of how much of inappropriate claim payments and overpayments their current measures capture. This indicates that in the current decentralized PI model and without a PIO in place, most payers do not understand how they're performing, much less

their opportunity to capture more. With a wide range of estimates on total health care claims paid inaccurately across the industry due to failures ranging from commonplace mistakes to fraud, the money at stake is enormous.

A fully implemented comprehensive PI strategy can capture the majority of improper payments, resulting in a 1% to 3% increase in medical expense savings.²

Across the industry, deploying comprehensive PI could yield \$362 billion in medical cost savings, according to industry research.³ In addition, predictive modeling to pre-score claims for coordination of benefits, upcoding, subrogation, fraud, waste, or abuse prior to payment could produce \$47 billion in administrative savings.⁴

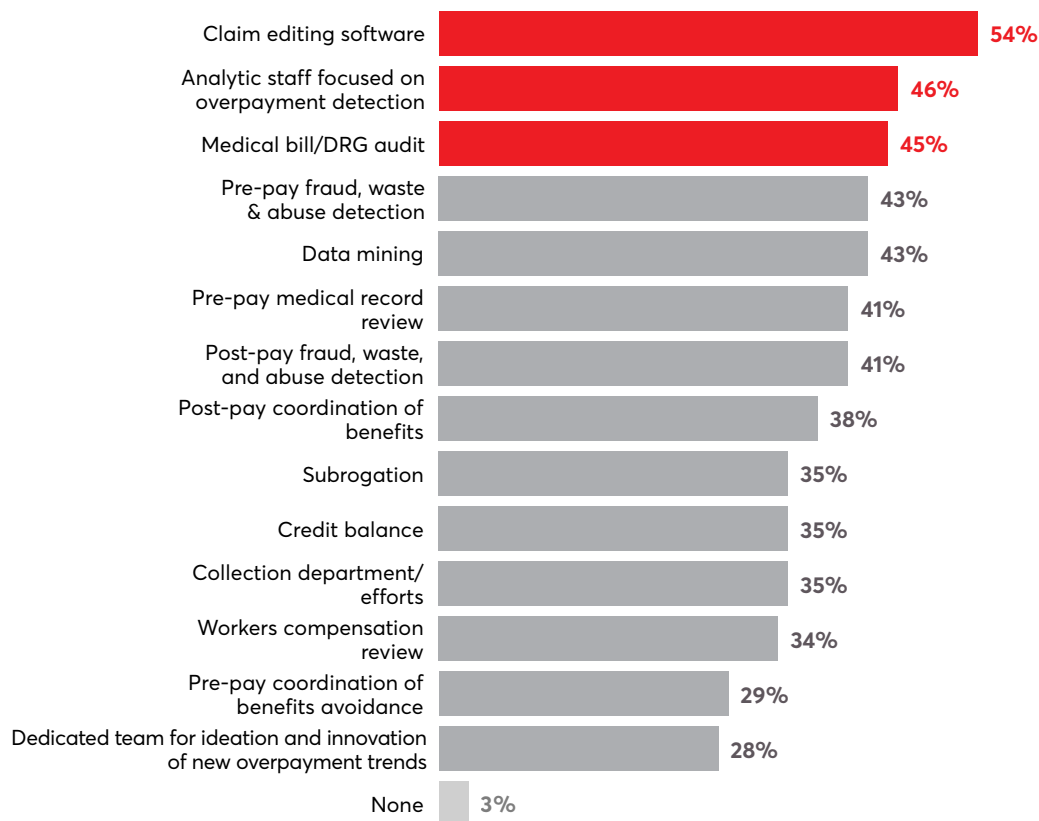
A PARADIGM SHIFT IS UNDERWAY

Many payers recognize that the status quo will not suffice in a volatile, disruptive market where technology is advancing rapidly. Many are just at the beginning stages of understanding and implementing key elements of a comprehensive PI strategy. For example, almost half of respondents say they have analytic staff looking for overpayment (see Fig. 4). A smaller vanguard also is instituting more advanced elements, such as a dedicated team for ideation and innovation. Vital measures to track and drive performance, including the use of industry benchmarks and annual goal setting, also are gaining traction.

Deploying comprehensive PI could yield \$362B in medical cost savings annually.

Figure 4: PI process components

% of respondents



Q: Which of the following components are included in your company's current payment integrity process?
Please select all that apply.n=155 (Base=All respondents)

Source: Optum Healthcare Payment Integrity Custom Research Study, SourceMedia Research/Health Data Management, October 2017

It is not just that savings can be fed into competitive prices for coverage. PI efficiency frees up funds to reinvest in ever more sophisticated technology and smarter processes. Advanced analytics even go beyond payment integrity: Claims data can be used to predict a person's health and behavior and to design an individualized plan tailored to a member's health needs.

For most health plans, the path forward involves identifying external partners with the industry experience and technological scale to show the way. A good partner should excel at both "detection and prevention" and "discovery and investigation," and have the flexibility to move at the plan's pace, leaving the client firmly in control. A plan might want to start with a handful of initiatives to establish some early wins and reinforce buy-in across the organization — but it needs a partner with the capacity to scale up to hundreds of initiatives to fully achieve the potential of comprehensive PI.

The right partner should have experience delivering holistic PI products and services to payer clients today. The partner should have end-to-end solutions that cover the entire claim lifecycle from the minute a claim enters an electronic data interchange gateway to well after it's paid and stored in a payer's data warehouse.

Many external vendors today offer point solutions that only focus on a narrow scope or leave out critical parts of a PI function. Their ability to really drive avoidance is limited because their PI products and services are limited. The right partner will also develop an incentive model that ensures they are doing the right thing for the payer by working to avoid overpayments in the first place.

CONCLUSION

It's time for payers to assess payment integrity practices and develop a strategy to modernize and thrive in a rapidly evolving technological and competitive landscape.

Comprehensive, centralized payment integrity is the way forward. For too many payers, PI activities remain fragmented across vendors and internal silos, and existing systems capture small fractions of inappropriate claim payments and overpayments. The traditional focus on post-payment recovery has become outdated, as advances in data analytics, predictive modeling, claims editing software and electronic data interchange platforms have enabled application of powerful cost avoidance measures before claims are adjudicated and paid.

Finding a partner with the consulting expertise, analytic capabilities, industry experience and technological resources to help centralize PI and transform it into a strategic function can address rising medical costs, identify and close administrative inefficiencies and improve relations with health care providers.

Optum has been a leading player in PI innovation, helping state Medicare and Medicaid programs and commercial plans adopt comprehensive strategies for 15 years. Clients routinely experience a 1% to 3% increase in medical expense savings. Since payers have already gone to great lengths to trim administrative overhead, additional cost reductions of that scale are hard to come by, but essential to remaining competitive and delivering affordable coverage without squeezing the quality of health care.

HOW TO SURVIVE – AND THRIVE – IN A RAPIDLY CHANGING PAYER UNIVERSE

- Executives must begin to work together and start connecting and modernizing internal PI systems.
- Data must be centralized, analyzed and shared to produce a 360-degree view that yields greater benefits and beats the competition.
- Plans should hire internal experts or choose external partners that have the right skill set, knowledge and experience to keep moving into the future.

¹ Optum observed client experience

² Optum observed client experience

³ UnitedHealth Group. Health care cost containment. UnitedHealth Center for Health Reform & Modernization Working Paper 2; 2009.

⁴ Dorn C, Choffin M. Proactive payment integrity is a strategic investment. Optum white paper, 2013.

METHODOLOGY

In October 2017, SourceMedia Research conducted an online survey among 155 health care payer professionals involved in payment integrity strategy, drawn from the opt-in subscriber base of *Health Data Management*.

ABOUT OPTUM

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