8 payment integrity trends to watch in 2017
Health plan focus on cost reduction drives fresh look at payment integrity

As cost reduction continues to take center stage in healthcare, payment integrity is in the spotlight. Increasingly, health plan executives are recognizing the power of payment integrity functions to add significant value to a health plan’s bottom line by improving the plan’s ability to recover or avoid improper claims payments and improve accuracy of premium revenue. As a result, they are taking a closer look.

Payment integrity (also known as payment accuracy) ensures that claims are paid correctly – by the responsible party, for eligible members, according to contractual terms, not in error, and free of wasteful or abusive practices. It may include functions such as coordination of benefits, claims analytics, data mining, and subrogation, among others.

This increased attention is triggering changes in the way health plans view their overall approach to payment integrity and how they engage with vendors. Discovery Health Partners, a provider of payment and revenue integrity solutions, works with more than 60 health plan clients, including plans from all areas of the country and of all sizes and funding sources (commercial and government). Based on our work with these clients and discussions with nearly three times as many prospects, we have documented eight trends worth watching in the next year.

In general, we see a heightened level of interest in reducing administrative expense without increasing member and provider abrasion. This seems to be the driving force behind much of the activity we’ve seen in recent months, particularly in the area of prepayment cost avoidance as well more rigorous management of payment integrity functions and results. Read on to learn more.

Trend #1: Increased momentum for prepayment cost avoidance

Among health plans – particularly larger health plans – we see increased momentum in the shift from postpayment recovery to prepayment cost avoidance. There is a perceived greater value in prepay, which avoids 100% of the cost of a claim vs. recovering only a portion of the claim cost.

“This is probably the biggest trend in the industry today,” said David Grice, Vice President Strategic Development, Discovery Health Partners. “Why? There is administrative cost involved in reworking and recovering a claim. You have vendor fees and administrative costs of reprocessing a claim. It only makes sense to try to avoid these extra costs and challenges.”

While prepayment cost avoidance is not a new concept by any means, it requires a level of maturity within a health plan’s payment integrity operations that some plans are just now reaching. A key obstacle is that...
prepay cost avoidance requires strong member eligibility management skills. This includes data integration skills to look across functional silos as well as analytics capabilities to support quick decision making.

Plans that have committed to stronger postpayment recovery operations in recent years often have adopted technology and business processes that generate stronger results and capture data that they can use in a business case to support the shift to prepayment cost avoidance. They have developed the capability, either internally or through vendors, to integrate member data from disparate sources and use advanced analytics and data mining to identify potential eligibility issues among their members. With this advancing maturity, these plans have the appetite to explore prepayment cost avoidance tactics more aggressively.

Another consideration in the move to prepay cost avoidance is the member and provider abrasion that could result when claims are pended or otherwise questioned. This requires health plans and their vendors to consider strategies to minimize this abrasion, acquiring the information they need while communicating with constituencies on their terms. This may include a combination of traditional communication channels as well as member and provider portals, mobility, and automation to productively exchange information.

**Uncertain value proposition is key challenge**

Regardless of the type of payment integrity function, many plans have held back from prepayment cost avoidance due to the lack of a specific, concrete value proposition. No clear financial model has been accepted across the health insurance market to support prepay cost avoidance vs. the clear financial model associated with postpay recovery. As a result, shifting to a cost avoidance point of view can be challenging and without a clear path to success.

“The shift to prepayment cost avoidance is difficult for most organizations,” said Paul Vosters, President, Discovery Health Partners. “It’s a whole new model and some systems don’t even accommodate prepay capabilities. Meanwhile, there is no industry standard method of quantifying cost avoidance, so it can be difficult to generate the business case.”

We believe we are seeing the market leaders move toward prepay cost avoidance and their success will pave the way for others to join. In our work helping commercial health plans identify and validate other health insurance for their membership, we see that within commercial plans, 5% of members have other insurance indicators, on average at any given time. Additionally, we see early evidence that with stronger cost avoidance capabilities, health plans can save up to five times as much as they recover in postpayment operations, when accounting for both avoided claim expense, as well as administrative costs. The opportunity could be huge and health plans are more actively testing the possibilities.

For more information, read our blog post, The eligibility impact: how and why eligibility data issues affect payment integrity.

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Trend #2:
Despite uptick in prepayment cost avoidance tactics, postpayment recovery continues to be necessary

While we believe that prepay cost avoidance is an important part of the payment integrity strategy, several factors require that postpayment recovery must be part of that strategy as well. Timeliness of information and the dynamic nature of eligibility and primacy information are two elements that often influence a plan’s ability to make a payment decision on the front end. Information often isn’t available fast enough to decide if a claim should be held or pended, so prompt pay rules dictate the plan must pay the claim. Meanwhile, because member eligibility status and primacy are constantly changing, payment decisions often will be based on outdated information. And for some offerings, prepay cost avoidance is only focused on part of the whole recovery. With subrogation, for example, health plans can avoid costs only on the first party liability and not the third party.

“The move to prepay cost avoidance is largely a cultural thing,” said Grice. “It’s about a plan’s readiness to be able to adopt prepay, and a lot of times it’s about regulations and state and federal laws as it relates to some of this.”

In our view, prepay cost avoidance and postpayment recovery must become an integrated solution, so you can follow the transaction through the whole cycle. The goal should be to find the right balance for your organization.

Trend #3:
Payment integrity gains visibility at higher levels within the health plan

Cost containment is a high priority for executives

Payment integrity is gaining more visibility at higher levels inside health plan organizations, including more involvement at the C-level. In the wake of healthcare reform, health plans must balance higher risk pools and increasing medical costs while maintaining relatively steady premium prices. Limited in their ability to increase premium rates, and beholden to Medical Loss Ratio regulations, executives must look more closely at costs in order to manage health plan margins and avoid monetary penalties.

The accuracy of claims and premium payments offers a fertile ground for such examination. According to the United States Government Accountability Office, improper payments amount to more than $70 billion for Medicare and Medicaid – errors predominantly attributed to administrative and process errors, member eligibility issues, and insufficient documentation. There is a significant opportunity to improve financial outcomes by more effectively managing payment accuracy.
Executive oversight can help identify and correct inefficiencies

Discovery has been advocating a higher level of payment integrity oversight for a couple of years and considers this a good trend. Payment integrity traditionally has been a fragmented function within health plans, which often perpetuates errors and increases costs associated with payment integrity.

We see functions such as coordination of benefits, subrogation, and claims analytics (among others) managed across multiple areas of a health plan – from operations and claims to legal and finance. In fact, it is not uncommon to see multiple departments owning various pieces of a process for a single payment integrity function. For example, within the coordination of benefits process, the enrollment group may be responsible for member eligibility information, while a claims organization investigates payer primacy, and a finance organization manages and adjudicates claim recoveries.

Yet there is no alignment across these organizations to ensure that when a claim is recovered, the information makes it to the claims system or that when a member’s eligibility information is updated in the claims and eligibility systems for one line of business, that it is also updated in the claims and eligibility systems in other lines of business – i.e., Medicare and Commercial.

For more information, download our infographic, “Three reasons to evaluate claims payment integrity at an enterprise level.”

Consolidated view of payment integrity functions identifies $40 million increase

A regional health benefits company spends $6 billion a year paying claims on behalf of two million members. When the plan looked across all disparate payment integrity functions with Discovery, we identified opportunities to double recoveries from $40 million to $80 million in just 18 months.

Additionally, we discovered that three of eight recovery teams were responsible for 75% of recoveries, while a cost comparison showed that the plan’s internal team was less expensive and more productive than all its vendors. Only a consolidated view of all payment integrity functions could have yielded these results.

Trend #4:
Uncertainty about payment integrity performance by internal and vendor teams

As payment integrity becomes more visible within higher ranks of health plans, more scrutiny is being given to the results generated across recovery areas. Whether a plan executes payment integrity using internal teams or vendors, or most likely a combination of both, there is a cost involved. And as costs are more deeply scrutinized throughout all parts of a health plan, it’s only natural that executives want to understand the return on this investment.

We increasingly hear frustration among health plan executives about the difficulty involved in understanding payment integrity results. No generally accepted industry benchmarks exist to tell payers how they are performing related to their peers across payment integrity functions. Without this insight, executives are hard-pressed to know whether their payment integrity results are actually good or not. For example, is a 1% claims recovery rate from subrogation good? Should it be 3% or 5% or more? The lack of benchmarks masks opportunities to improve cost savings, increase revenue, and enhance operations in specific areas.
A big part of the problem is the fragmented nature of payment integrity solutions and a general lack of transparency across solutions, vendors, and business lines (i.e. Medicare and Commercial). Across the industry, reporting has not been a focus for payment integrity. Other than standard reporting, you often don’t have access to useful analytics around vendor and internal processes. As vendors are still developing these capabilities, the IT departments within health plans are in such high demand that payment integrity groups don’t get their attention to develop more sophisticated reporting and analytics.

As a result, it’s difficult to measure performance by recovery area and vendor on a timely basis. This situation often leads to issues including multiple versions of the truth, difficulty in forecasting future recoveries accurately, and decisions based on intuition versus facts. Health plans are recognizing this challenge and looking at ways to get the insight they currently lack. That may mean looking for vendors to put more technology in place, developing better internal reporting capabilities, or consolidating payment integrity operations. In any case, we expect to see health plans place increasing pressure on their vendors to be more transparent about their processes and to show clear results.

For more information, read our checklist, “Five things every health plan should know about its payment integrity programs.”

Trend #5:
Market consolidation leaves fewer vendor options for health plans

The payment integrity, healthcare analytics, and claims processing markets have seen billions of dollars in investments, mergers, and acquisitions among vendors and private equity firms in the last three years. While mergers and acquisitions allow firms to expand their offerings or acquire new technologies, the result is fewer vendor choices for health plans in the payment integrity space. In the last year, we have heard frustration among clients about reduced options in some areas of payment integrity.

“There is a downside to market consolidation,” said Grice. “You’ll see less competition. As a result, a health plan will have less ability to negotiate pricing, and RFP processes will be more difficult because they won’t have as much comparative data in terms of functionality, innovation, and pricing.”

This could impact health plans’ ability to put in place tiered vendor strategies, in which they use multiple vendors for a single payment integrity area. Additionally, there is a concern that consolidation will limit innovation in payment integrity as smaller, more innovative vendors continue to be acquired. Ultimately, health plans should be alert to integration stressors for companies that have been through a recent merger or acquisition and may be distracted with technology, process, and culture integration.
Trend #6:
Health plans continue to prioritize business process outsourcing above software solutions

Though we have seen a slight increase in health plans looking for payment integrity software solutions, the majority of plans we talk to continue to be interested in outsourcing their payment integrity business processes. This reflects the drive to focus on core business vs. administrative tasks and is consistent with Gartner’s findings in its March 2016 Market Guide for Payment Integrity Solutions for U.S. Healthcare Payers. “Vendors report that 61% of payers are using outsourced payment integrity solutions, while 39% are primarily relying on internal staff and software to address payment integrity issues.” That being said, we find that health plans value the technology that vendors use to deliver their solutions, particularly transparency in case management tools and dashboards.

Trend #7:
Interest in outsourcing the entire payment integrity function

It remains to be seen whether the notion of outsourcing the entire payment integrity function is a trend that will take hold; however, in the last year, we have heard this idea articulated by a couple of large health plans.

Specifically, they are looking to outsource the management of all recovery services, including internal plan operations and vendor operations, to a single vendor. This includes coordination of benefits, auditing, claims adjustments, and much more. The requests also have included requirements to negotiate and manage vendor contracts; provide consolidated results across all vendors and payment integrity functions in the form of KPIs and dashboards; and provide reporting for other internal teams, such as finance and underwriting.

This trend reflects the challenges and costs involved in managing payment integrity and a desire to focus on core functions instead of administrative functions. Specifically, some challenges include:

- Data exchange with multiple vendors
- Consolidation of multiple report formats
- Inconsistent methods of measurement and reporting
- Uncertainty about how to interpret results – lack of benchmarks
- Vendor management – a large plan might have dozens, or even hundreds, of payment integrity vendors
- Lack of sufficient resources to give payment integrity functions appropriate attention

Consolidated payment integrity operations yield $2.7m within 9 months

With a goal to consolidate all payment integrity operations with a single vendor, this plan decided to start with Discovery’s MSP Validation solution for its 17,000 Medicare members. We restored $1.9 million for the plan within just 30 days and another $800,000 within 6 months. The client appreciated our team’s subject matter expertise and leadership to get the job done with little intervention required on the client’s part.

Happy with the results, the client very soon added our MSP Part D Validation solution for Medicare members, as well as Coordination of Benefits, Subrogation, and Claims Recovery solutions for their full membership of more than 200,000 lives.
Based on the increase in executive oversight of payment integrity, we expect to see more plans explore this option, asking themselves the critical question: Is payment integrity a core competency? For some plans, the answer may be to outsource — if they can find the right support. This significant shift will require a vendor that can meet the demand. Few vendors are able to deliver the full spectrum of payment integrity functions and most specialize in certain areas. This explains in part why health plans tend to work with multiple vendors in the first place. A lead outsourcer must have the data management, project management, and consulting skill sets required to manage and consolidate multiple data feeds from multiple vendors and provide oversight of perhaps a dozen different payment integrity areas.

Trend #8:  
Growing acceptance of cloud-based solutions ... but with increasingly complex security requirements

When Discovery first started out in the payment integrity market in 2008, we invested heavily to build a secure cloud and earn clients’ trust that our cloud-based software was accessible, reliable, secure, and HIPAA-compliant. They were suspect of any solutions that lived in “the cloud.” In the years since, health plans have gradually become more accepting of cloud-based software. They realize that cloud technology is necessary to access innovative technologies and capabilities quickly and cost effectively.

This is all to be expected, considering the need for privacy and protection of healthcare data amid the prevalence of cyber-attacks in recent years. We do not see this trend fading any time soon.

Though they now accept that cloud deployments can be secure, health plans want their vendors to prove it and demonstrate that they are covered for risk. In the last year, we have seen a dramatic increase in the depth and complexity of information security requirements among health plans. Security assessments are now a standard part of the contracting process for most health plans and are more comprehensive than they were in the past. However, the lack of a generally accepted healthcare-specific security standard has made security assessment and risk analysis more complicated and more costly than it should be for both health plans and vendors. We see HITRUST (Health Information Trust Alliance) certification emerging as a potential solution to simplify and lower the cost of information security risk management.

For more on cloud-based solutions, download our cheat sheet, “Why IT should care about payment integrity in the cloud.”

Conclusion

Amid fluctuating healthcare regulation and shifting business strategies, one thing will remain constant for health plans: the need to manage costs in order to maximize margins. As health plan executives take a growing interest in payment integrity’s contribution to their bottom lines, they should keep these things in mind:
• **Rebalance:** Look at the balance between prepayment and postpayment across their payment integrity functions. Postpayment is not going away, but there is room for a prepay function that will help avoid costs.

• **Measure:** Establish key performance indicators for payment integrity and share them internally and externally with vendors so you can measure results, create accountability, and set realistic goals for future improvement.

• **Analyze:** Examine the organization’s appetite for investment vs. strengths of vendors and let that drive the strategy for which functions to outsource and which ones to keep in-house.

• **Partner:** Engage with vendors that act as partners and can fill gaps in your organization. They should understand your business drivers and challenges, provide superior technology to drive better results, and be highly transparent about their efforts and results.


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*About Discovery Health Partners*

*Discovery Health Partners offers payment and revenue integrity solutions that help health payers improve revenue, avoid costs, and enhance the member experience. We offer a unique combination of deep healthcare expertise and analytics-powered technology solutions to help our clients improve operational efficiency, achieve financial integrity, and generate measurable results.*