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Total Value:

How to build a better payment integrity program

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Total Value: How to build a better payment integrity program

Successfully managing payment integrity programs is getting more challenging. Rising medical loss ratios (MLR), administrative pressure to keep costs low, and plan-wide pressure to build and maintain a satisfied, engaged network combine for a complex balancing act. Add the fact that many payment integrity vendors offer limited support options for their solutions, and health plans might be feeling overwhelmed.

But for plans that truly want to go above and beyond to satisfy members, keep costs low, and onboard reliable partners, their payment integrity programs will only reach their potential for total value when they look at the big picture. Plans need to implement programs and solutions that balance price with net medical cost savings, taking time to consider the value of service models that offer more benefits and that take on more administrative burden. This not only helps plans get long-term value but can even improve relations and engagement with members. Better payment integrity can help contribute to lower costs and better help for members, ensure more accurate health records, and bolster trust by showing a plan's commitment to accuracy, transparency, and accountability.

In this eBook, we will outline the ways that health plans can get the best cost benefits from their payment integrity programs in three areas: dimensions of value beyond medical cost savings, meaningful innovation, and true consultative partnership.

Moving toward payment integrity total value

There are a number of ways that plans can take payment integrity efforts to the next level and increase the total value they achieve.

Integrate prepay and postpay approaches

For health plans looking to optimize their payment integrity programs, one of the most important ways to go beyond medical cost savings for long-term value is by integrating prepay and postpay efforts, in short, laying the groundwork for a complete continuum. The most effective payment integrity programs are those that marry prepay and postpay efforts, moving as much as possible into prepay while still understanding the importance of a strong postpay approach. The result is that findings that can't be identified prepay will be identified quickly postpay. Integrating the two approaches demands tight technological connectivity, but by bringing them together, health plans can lower administrative burden and provider abrasion and ultimately accelerate findings.

Implement second-pass editing

A second pass at claim editing can avoid improper claims that get missed by primary editing due to more clinically complex claim scenarios—sometimes by as much as 4% of annual claim spend, according to Cotiviti data. Still, many plans overlook the savings

that can be recovered with second-pass editing, perhaps because it can be difficult to manage in-house. Keeping payment policies and their supporting editing rules constantly updated is paramount to health plans avoiding penalties from noncompliance, ensuring claim payment accuracy, and reducing medical costs.

But policy configuration and maintenance to support compliance efforts takes a significant investment in a clinical service model that can be difficult to replicate in-house. In fact, among Cotiviti's own clients, 90% or more of client policies need to be updated each year to reflect the latest industry changes. These policies can include edits that are anywhere from brand new to those that have been in the works for 10 years or more, making it an area that requires constant vigilance. For plans choosing to take this task on themselves, it's necessary to consider the time and energy it requires.

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Streamline DRG and clinical reviews

Plans should also consider how they can strengthen efforts in streamlining diagnosis-related group (DRG) and clinical reviews. With the right vendor, getting a high-quality retrieval process

sets a plan up for success. For additional value, seasoned medical directors; client service teams; and clinical, coding, and repricing experts can ensure that health plans receive highly sustainable audit results and feel supported throughout the process.

Bolster coordination of benefits (COB) and data mining programs

COB can be notoriously difficult to nail down, with fragmented member data that is typically filled in by chasing providers for information. But while member data is a key area for effective COB, it's not sufficient to identify opportunities and to determine primacy and properly coordinate benefits for members with multiple coverage. Consider these additional sources of value:

- **Supplement data sources.** Multiple data sources are necessary to confirm accuracy. However, plans and their vendors should consider where, when, and how to augment data and leverage supplemental data sources. Plans should also consider the sources of supplemental data and the expense of licensing and data cleansing. Data from third-party coverage databases alone, for example, is often incomplete and can contain errors. For one of Cotiviti's national health plan clients, 40% of the commercial other health insurance findings we identified were not present on the widely used Council for Affordable Quality Healthcare (CAQH) data file. Health plans must have systems in place to back up primary data and to research, validate, and identify errors in payment that result from incorrect data sources and incorrect application of policies.

- **Go beyond data.** Following the member journey with COB should also be top of mind. Health plans must navigate many complexities when applying order of benefit determination rules. These rules rely on a member landscape that's always changing, as members experience employment status changes, family relationship transitions, health changes, births, and more. Working with experts that understand the places where coverage and life intersect is vital to a smart, well-designed COB process.
- **Harness proper analytical power.** Being able to not only look up results but benefit from the guidance of clinical experts is invaluable for accurate data. Tapping into vendor partners who staff registered nurses, medical directors, and other medical professionals can provide layers of value over data-only solutions and less experienced vendors. These experienced teams assist with claims and policy inquiries, as well as appeals and disputes. They also have the expertise needed to identify the more complex findings. Recently, Cotiviti's data mining experts found more than \$300 million in annual savings via postpay data mining behind two clients' first-pass vendors.

Cotiviti is a proven partner for health plans looking to get total value out of their payment integrity efforts. Looking to learn more about getting the total value out of your payment integrity program? Listen to our [latest podcast](#) as we break down the total value approach to payment integrity.

Innovation for payment integrity success

Within payment integrity, there is a lot of buzz around innovation and new technology, especially the possibilities for moving to prepay and for applying appropriate tools such as artificial intelligence (AI) and machine learning. But plans need to look beyond hype and look toward meaningful innovation. Plans should ask: What innovations are bringing us true, sustainable value? How can we combine the speed of technology, which deals in probability, with clinical knowledge, which is invaluable for decision-making? In this section, we'll explain how plans can achieve value with the right mix of innovation and service.

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Use machine learning to achieve better ROI

Powerful algorithms can help by automatically flagging outliers in data. Machine learning algorithms can be used to help select the claims with the highest probability of yielding a finding, such

as the practice Cotiviti uses in its DRG review solution. Leveraging AI through these advanced analytical models this way allows plans to avoid the administrative waste and provider abrasion of unnecessary chart retrieval. For Cotiviti clients, the result is an industry-leading average change rate—the proportion of claims audited that result in an overpayment finding—of 38%.

Another innovation in clinical reviews that can minimize chart requests while increasing findings lies in finding ways to perform deeper and more precise auditing without a chart. For example, Cotiviti's cross-claim clinical review approach applies machine learning to historical data to build a member's history—their complete claim record across all providers—and then uses data analytics to find overpayments that are sustainable through the appeal process without the administrative burden and provider bother of a chart request.

Integrate prepay and postpay efforts

In the process of integrating prepay and postpay efforts, health plans should seek out vendors that are using innovation to improve prepay capabilities, retaining flexibility for the plan (one size does not fit all), and understanding the key role postpay continues to play. Some important new prepay innovations include:

- **Add prepay claim pattern review.** Traditional prepay review is done claim-by-claim, but fails to find and stop claims that are improper as part of a larger pattern of aberrant provider billing. The addition of prepay provider claim pattern reviews to a claim editing platform can help impede more suspect claims while helping to flag providers that warrant immediate investigation sooner. Machine learning analytics should use claim editing

results and other provider peer comparisons to increase true positive findings. For example, Cotiviti recently helped a Medicare Advantage plan [prevent more than \\$1 million in inappropriate payments](#) in less than a year by analyzing claim patterns, improving the plan's payment integrity and protecting members' benefits.

- **Create a comprehensive DRG review solution.** Shifting reviews to prepay when possible helps plans realize value sooner and avoid the provider abrasion inherent with pay and chase. For example, using the analytic models described above to isolate the charts with the greatest opportunity, Cotiviti can shift about 20% of a client's retrospective DRG inventory into the prepay space for DRG reviews, and then still complement that with retrospective DRG review.
- **Seek out true prepay COB.** A number of vendors offer a member data-only solution and call it prepay COB because plans can apply this data to understand which insurance should be primary for a dual-eligible member for all future claims, to give one example. However, a true prepay COB solution adds incremental value, reduces abrasion, and improves cost avoidance. A short pause-and-review service can leverage analytics to identify and pause claims for expert review after adjudication but before payment. By introducing prepay COB, a health plan could increase its overall COB program value by 10-20%.

Discover innovations in postpay data mining

Implementing a successful comprehensive payment integrity program means acknowledging the important role postpay

solutions play. In fact, Cotiviti has found that 74% of the overpaid claims identified with data mining were excluded from the prepayment data set provided by our clients.

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In terms of breadth, plans should be asking whether innovations are happening across all aspects of review to include billing errors, pharmacy billing, CMS, AMA, state and plan policies, contract compliance, and multiple payments. In terms of depth, they should consider how innovation can help identify errors beyond the typical analytical indicators. For example, at Cotiviti, by investigating contract trends specific to medical pharmacy claims, we identified a finding that saved one client \$20 million in less than three months.

Another example includes policy updates. Analytical indicators often flag a claim for billing differently than the policy update. But to reap the full value, plans should ask not only whether the claim is billing according to the policy, but whether the policy itself is being updated completely and correctly. For one such Cotiviti client, our auditors identified \$1.6 million in savings by detecting that a policy they updated wasn't completely performed.

Finding the right payment integrity partnership

A successful payment integrity program does more than identify findings—it creates sustainable and defensible findings that can ultimately be converted into savings. In choosing a trusted partner, health plans should consider going beyond basic software offerings to find a supportive team and a service model that helps them take payment integrity efforts to the next level.

Ensure the right clinical resources for analytic and policy support

Dedicated teams and medical experts add to the basics that plans can't get from software alone and can proactively guide plans through policy decisions to close gaps in their payment integrity programs.

Full-service payment integrity vendors tailor policies to individual plans and lines of business for the best results. Plans can also tap the expertise of educated and experienced partners using benchmark analytics to help guide them on their policy decisions. For example:

- Cotiviti has found that 56% of a plan's prepay improper claim avoidance tends to be generated by the plan's customized rules (vs. "off the shelf" standard rules); this rises to 67% in commercial lines of business.

- In the prepay fraud, waste, and abuse (FWA) space, one pattern of inappropriate behavior does not apply to all—only 1% or so of provider submissions to a vendor should be selected for prepay review, helping to focus on the truly aberrant billing providers.

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Consider value intangibles in supporting your payment integrity team

An important dimension of value in prepay payment integrity that is often overlooked is the expert service component often needed to support claim decisions. Claim editing software may include transparency tools for self-service lookup, but a clinical expert is frequently needed to support the provider relations team and claim analysts. In-house clinicians need to take up the slack unless the vendor provides registered nurses and medical directors to work personally with claim operations to address claim-level and policy inquiries as well as appeals or disputes.

Whether in-house or provided by a vendor, medical directors and other claims experts should provide monthly updates and ad hoc reporting to support business decisions and meet customization requests quickly. Management should maintain appropriate staffing (including qualifications, tenure, and volume of staff) at all times.

Other capabilities that health plans absorb when using a software-only or point solutions are:

- Added costs for software licenses, hardware, security, and personnel
- Claim repricing
- Inventory management
- Provider outreach to collect additional data, confirm units or authorizations, and more
- Accommodation and support of unique processes like white paper and validation reviews
- COB employment verification
- Contract reviews
- Navigating inventory systems, third-party tools, and portals
- Managing multiple vendors
- Enabling network reviews
- Support inventory and exchange reporting

Cost and relative savings is certainly a top area of value when considering adding solutions to a payment integrity program. But thoughtful payment integrity professionals should pause a bit to avoid drawing too simplistic of an ROI conclusion. True value of payment integrity requires changing your payment integrity mindset, examining what truly makes innovation meaningful, and how to turn support into a consultative partnership. Taking all of these steps into account not only benefits the health plan but the relationship with members and provider partners, improving engagement by fostering trust and getting claims as accurate as possible as quickly as possible.

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[Start the conversation with Cotiviti](#)

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As executive vice president of payment integrity operations, Matthew is responsible for the success of Cotiviti’s prospective payment solutions and content development team. Since joining Cotiviti in 2004, he has held roles with responsibility for implementation teams, software development, clinical claim validation, and retrospective claims accuracy. Prior to Cotiviti, Matthew was a senior manager of healthcare at Accenture, where he consulted and defined solutions for Blue Plans and other large national payers with their business challenges as they sought to improve care and reduce administrative costs.