Article 3:
Payment Integrity Evolution

How are things changing and what does that mean now and for the future

Lay of the land

With healthcare spending on the rise again post the COVID-19 pandemic, health plans and payers are relying more on payment integrity efforts to contain costs and maintain quality of care, while continuing to build strong provider relationships. A surprising portion of overall health care costs are driven by claims that are paid incorrectly. The U.S. General Accounting Office has estimated that healthcare fraud, waste, and abuse alone may account for as much as 10% of all healthcare expenditures. (source: Centers for Medicare and Medicaid Services: National Health Expenditure (NHE) Fact Sheet, September 2023: cms.gov)

Over the past decade, the healthcare industry has seen payment integrity evolve from an under-resourced operational niche to a strategic asset that is central to the overall management of medical expense. A paradigm shift is underway, wherein many payers are recognizing that the status quo will not suffice in a volatile, disruptive market where, among other things, technology is advancing rapidly. Many are at the initial stages of fully understanding and implementing elements of a comprehensive future vision for payment integrity efforts, which in addition to dedicated analytic staff, comprise a team committed to ideation and innovation. Vital measures to track and drive performance of Payment Integrity (PI) initiatives, including the use of industry benchmarks and annual goal setting are gaining traction.

Let us look at some of the things in the overall environment that have changed, prompting this transformation. Notable among these are the rise of generative AI and payment model innovation, including the transition of about 75 percent of total care delivery reimbursement to value-based care payments.

Ongoing Complexity

Healthcare billing and reimbursement has become increasingly complex. There are well over one hundred thousand diagnostic and procedure codes that are constantly being added and updated, which creates the perfect storm for errors. Also, contracts between payers and providers can include unique reimbursement rates for different circumstances, creating the potential for human error in interpreting and loading contracts into reimbursement systems.

Policy changes, particularly for government sponsored payers (Medicare, Medicaid, as well as other state-level clinical associations) release ongoing guidance related to both reimbursement and other medical policies, again creating potential for error during transition periods as payers and providers work toward incorporating updated guidelines. In a

similar vein, product changes (new or revised product benefits designs such as updated pharmaceutical formularies) create the need to modify payment systems.

Movement to New Forms of Contracting and Reimbursement

The COVID-19 pandemic accelerated a shift in care to alternative settings, such as home and virtual care. The subsequent emergence of new care delivery models and increase in the use of virtual care have made it necessary for payers, health systems and policy makers to design new billing and reimbursement guidelines, which have created new sources of potential errors.

Movement to value-based care (VBC) and payment models is also a driver of change. Broadly defined, the shift to VBC entails tying reimbursement to health outcomes or value for patients – ranging from pay-for-performance models to fully capitated reimbursement. This creates complexity that can result in new categories of payment errors. It also encompasses other steps in the payment process that need to be accommodated.

The rapid growth of alternative settings for care (telehealth as a prime example) have been a positive force relative to access to care and various forms of wellness and disease management, but they have also led to new payment models that need to be accommodated within a payment integrity solution. There is a lot of variability in services and coverage for these new avenues for care delivery, and this creates challenges for making sure payments are accurate and in accordance with established coverage limits and related policies and procedures. For example, because services may no longer take place physically in an office, it can make it more difficult to verify the validity of services provided.

Steps in VBC Payment Process

Patient attribution to a risk-bearing provider

Attribution is typically tied to a patient-primary care provider designation. However, in cases where there is no known association, claim based algorithms are created to "assign" patients. As a result, risk-bearing providers do not always have transparency into the patients for which they are financially accountable until well into a performance period.

Financial and Quality of Care Performance Tracking

There are typically various metrics created to measure and track financial and quality of care performance. It is not uncommon for these metrics (a result of complex contract negotiations) to be unique to each contract, and the data required to compute measures include elements where there have not previously been standards created nor audit processes to evaluate their validity. Furthermore, all the sources of payment complexity and error associated with fee-for-service billing persist in VBC payment processing and as they also form the basis for calculation of metrics.

Contract Configuration and Audit

Contracts are seldom standardized and vary by contract and payment model. For example, the exact diagnostic and procedure codes included in a capitated payment model can differ across providers. Interpreting and accurately loading contracts into payment systems can be challenging, and development of more systematic audit processes (across different contract types) cannot generally be accomplished.

Reconciliation and Settlement

This typically involved financial analysis where both parties (payers and providers) must have visibility to an agreement on the various elements mentioned above.

Transparency Challenges

We live in a time where trust and credibility are being questioned more than ever. It is important to recognize these challenges as they pertain to payment integrity, the variables that may hinder transparency and techniques to overcome those challenges. Areas that will benefit from further consideration in this regard include the following:

- ✓ The lack of standardization and interoperability in health care data makes it difficult to track payment information consistently, identify trends and patterns, and detect errors and waste in a way that lends itself to full disclosure.
- ✓ The complex and ever-changing regulatory environment can make it hard for payers and providers alike to keep up with payment requirements, which can lead to confusion and misunderstandings in the payment integrity

process – even the potential for perception of a "bait and switch" as billing practices lag new guidelines and regulations.

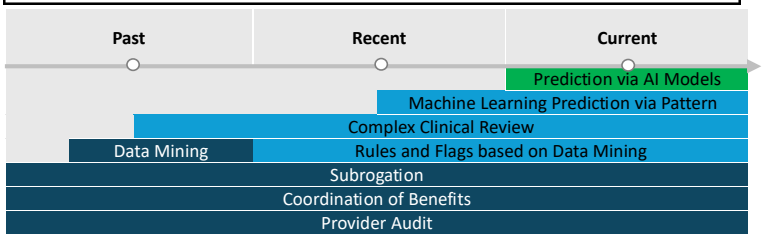
Transparency benefits from the following practices that can be woven into an established PI practice:

- ✓ Clear and concise communication about changing payment policies, procedures, and related expectations for all stakeholders (internal and external) to help ensure everyone understands the changing process and their roles in assuring accurate billing and payments.
- ✓ Sharing data and information about payment trends, patterns, and anomalies with providers so that there can be a more collaborative effort to help identify errors and promote a culture of shared accountability and transparency.
- ✓ Improving data collection and reporting systems and in doing so, be better able to provide a more complete picture of payment accuracy and emerging areas for improvement.
- ✓ Regular audits and assessments stacked up against emerging regulations, changing clinical protocols and patterns of care delivery, and industry standards.
- ✓ Finding new ways to engage providers and patients in the payment process can only help to build trust and accountability – promoting an atmosphere of no surprises ("gotchas").

Data Analytics and Predictive Modeling

A leading area for investment and development is data analytics and predictive modeling focused on identifying improper claims before payment is made. In addition to more sophisticated claims editing software, having a more centralized organizational focus (structure) in the form of an integrated platform that can search beyond coding edits yields incredibly significant benefits.

The application of analytics, predictive modeling and artificial intelligence has supported the extension of payment integrity from largely retrospective to prospective and even preemptive efforts (Gartner, 2024 AI Predictions)



Data analysis tools within the realm of artificial intelligence (which includes machine learning) can bring together disparate pieces of information across the organization. This can help establish a more self-sustaining infrastructure, and maximize efficiencies via a more proactive, data-driven approach. It helps, regardless of what organizational structure is in place, for data to be centralized and shared to produce a wholistic view across the various facets of payment integrity.

Being able to leverage analytics proactively opens the door to the prospect of incorporating clinical expertise into payment integrity efforts. Leveraging the knowledge and expertise of clinical resources has the potential to not only help ensure fair reimbursement for providers but also contribute to better patient outcomes by recognizing emerging care delivery trends and promoting evidence-based care. By leveraging technology, clinical expertise and open communication, payers can optimize their payment integrity efforts while strengthening their relationships with providers and bettering mutual goals to improve care delivery.

Cautions in Leveraging Artificial Intelligence

Analytics and generative AI have great potential to augment existing capabilities across the PI value chain. The advent of artificial intelligence (AI) creates new challenges and opportunities for payment integrity efforts. Payment integrity capabilities depend on the expedient review and synthesis of a variety of data sources. For example, during the review or audit of complex claims, AI can review and synthesize a complex combination of structured and unstructured data (e.g., encounter data, medical record details, reimbursement policies) supporting the human reviewer in making decisions and improving the accuracy and efficiency of the review process.

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Another example is around fraud and abuse where AI can be put to the task of proactively flagging suspect pattern billing and related outliers. The foundation for tackling fraud and abuse encompasses establishing and reinforcing rules. While predictive modeling creates an opportunity for the discovery of additional rules based on patterns and trends, there remains the need for ongoing validation (predictive modeling allows addition of rules but needs a "human eye" to establish validity and transparency in the application of new rules).

A potential perceived shortcoming of relying too heavily on AI generated analytics is failing to recognize that it requires a "human element" – output needs to be reviewed to determine validity. Further, rules and flags placed within the data are generally efficient but may not go far enough to proactively detect emerging errors and mistakes in provider billing practices.

Some providers argue that decisions generated by AI are opaque and lack clear explanations, making it difficult for them to understand and challenge claim denials. They also raise concerns about the fairness and accuracy of the AI algorithms, suggesting the system might be biased against certain types of providers or services. A way around this (in addition to the steps listed above to address transparency) might be to streamline dispute resolution processes to ensure quick and fair resolutions.

Defining and Measuring Success

What is the best way to determine where to go from here for an organization looking to make further investments in PI? How should such efforts be evaluated and justified relative to competing pressure for resources?

It is not just that savings can be fed into competitive pricing for services and coverage plans. PI efficiency frees up funds to reinvest in more sophisticated technology and "smart" processes with analytics that go beyond payment integrity – getting more comfortable with the integrity of claim data to predict patient and provider behavior and establish protocols and benefit plans that are individualized to specific circumstances.

Barometers of success are different for every organization, in part dependent on their current PI structure and governance. Regardless, key performance metrics should quantify the effectiveness (achievement) of efforts to improve payment accuracy and point to areas for improvement via preventive measures. Success measures should also be able to help determine trends as well as risks and opportunities for improvement. Examples include:

Evaluate effectiveness:

- ✓ Tag volume and rates (number/percentage of claim/claim lines identified against total number of claims run through identification method
- ✓ Error volume and rates (number/percentage of claims/claim lines with claim denied or adjusted)
- ✓ False positive volume and rates (how many and what percent of claims were tagged for review but released without findings)
- ✓ Auto-adjudication rates and drivers
- ✓ Medical cost savings overall and per claim tagged for all detection methods
- ✓ Overpayment recovery rates, dollars, and timelines
- ✓ High dollar identification and review process, and results

Future trends:

- ✓ Diagnostic trending to ascertain if certain types of codes are more often tagged and corrected
- ✓ Provider trending to identify if certain providers are billing incorrectly more frequently
- ✓ Overpayment recover rates, dollars, and timelines – current and overtime
- ✓ Reimbursement policy trending/review to ensure policies align with appropriate payment benchmarks.

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In summary, as healthcare spending continues to rise and payment methodologies evolve, maintaining payment integrity as a key area of focus should remain central for any organization looking to thrive in a rapidly changing competitive landscape. Taking steps to transform payment integrity into a strategic asset can go a long way toward addressing rising medical costs, identifying and resolving administrative inefficiencies and improving relationships with providers – all toward the goal of delivering affordable care without sacrificing quality.

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