Aite Novarica

OCTOBER 2022

PAYMENT INTEGRITY AND COST CONTAINMENT IN HEALTHCARE

PAYMENT HARMONIZATION BENCHMARK

PREPARED FOR:

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SUMMARY AND KEY FINDINGS

This study is based on a Q1 2022 survey of 214 healthcare payer executives. The survey was designed to establish the current state of engagement with members, identify gaps for payers to consider enhancing the member experience, and explore the interdependence among payers, providers, and members.

Findings from the study are presented in a series of five reports. This report is the second in the series, highlighting survey findings from payment accuracy executives and offering an outline for the next wave of payment integrity between payers and providers. The key findings from this report follow:

- **The shift to pre-pay and beyond lies on the horizon.** Automating claims adjudication continues to shift toward pre-pay processes, aiming to prevent overpayments altogether.
- **Provider abrasion remains a sticking point.** A gap between payers and providers requires reporting and transparency tools if it is to be mended.
- **Medicare and Medicaid claims require automation.** Eight percent of respondents list their claims processing as fully manual (queue management). These issues may be related to Medicare or Medicaid claims entered into claims systems manually, as automation around ingesting those claims tends to be lower than commercial claims.
- **Technology adoption is well underway, but plenty of manual processes remain.** While industrywide technology adoption remains strong, gaps remain in areas such as complex diagnostic-related group (DRG) review, which can be considered a "final destination" for automation due to its complexity. DRG is the last bastion in automation because of the unique nature of these claims. Less than half of payers use complex DRG review.
- **The path to automated adjudication is long.** Rates of combined manual/automated adjudication reviews hover near 50%, while rates of fully automated reviews average 27%, and rates of manual reviews average 20%.
- **Communication leaves room for improvement.** Sixty-six percent of payers maintain regular communication with providers, and slightly over half seek feedback from providers. A consistent and intentional communication cadence with providers can go a long way to reduce denials and appeals.

INTRODUCTION

For health plans that grapple with cost containment and preserving their provider networks, increasing focus on provider satisfaction—both prior to claim submissions and after—can be a valuable differentiator. Increasing focus entails relationship building, aligned incentives, and agreement on a common set of operating metrics. While the personal touch that builds relationships cannot be automated, technology can nevertheless streamline some repetitive processes. Claim submissions that have appropriate medical documents prepared in a manner that reduces denials and appeals improves the experience and fosters good relationships.

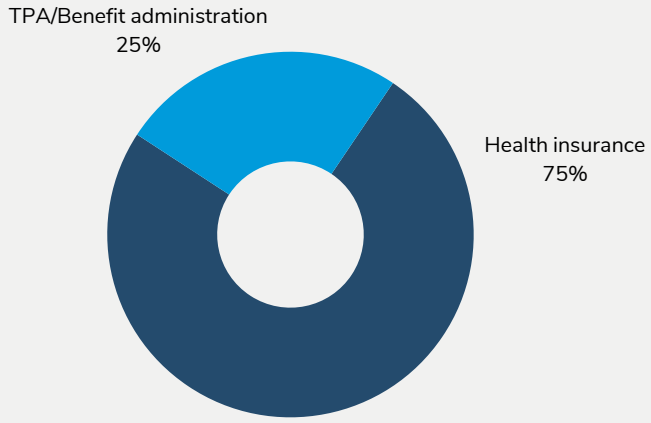
This Aite-Novarica Group report assesses how payment integrity and cost containment professionals across U.S. healthcare payers are applying data, analytics, and automation in their processes to address the biggest gaps and opportunities. More specifically, this report highlights the tools, functionality, and services that payers can leverage as part of strategic cost containment efforts. This report is relevant for payment integrity and cost containment executives at health plans and third-party-administrators (TPAs), benefit administration companies, and patient accounting or practice management software vendors.

METHODOLOGY

This study was based on a quantitative survey conducted in Q1 2022. In total, 214 healthcare payer executives participated, 75% of whom work at health plans, with the balance working at TPAs (Figure 1).

FIGURE 1: DISTRIBUTION OF SURVEY RESPONDENTS BY HEALTH PLANS AND TPAS

Q. Which of the following industry types best describes the company at which you work?
(Base: 214 respondents from health insurance and TPAs/benefit administration)



Source: Aite-Novarica Group study on healthcare payment optimization, Q1 2022

The survey screened participants to identify and select candidates with responsibilities that tied directly to four functions that had a role in payments modernization: payments, cost containment or payment integrity, provider network management and development, and member engagement. Participants who qualified for the survey hold responsibilities in finance, operations, member engagement, payables, network development and management, accounting, and fraud, among others. Many are knowledgeable about multiple functions.

The findings presented in this report are drawn from Aite-Novarica Group's knowledge of member engagement tools, vendor briefings, and responses of 71 payment accuracy executives in healthcare payers across the U.S. This report is also supplemented with additional context and analysis from Aite-Novarica Group research. The quantitative data presented have a 10-point margin of error at the 90% level of confidence.

CURRENT STATE OF PAYMENT INTEGRITY: THE BENCHMARK

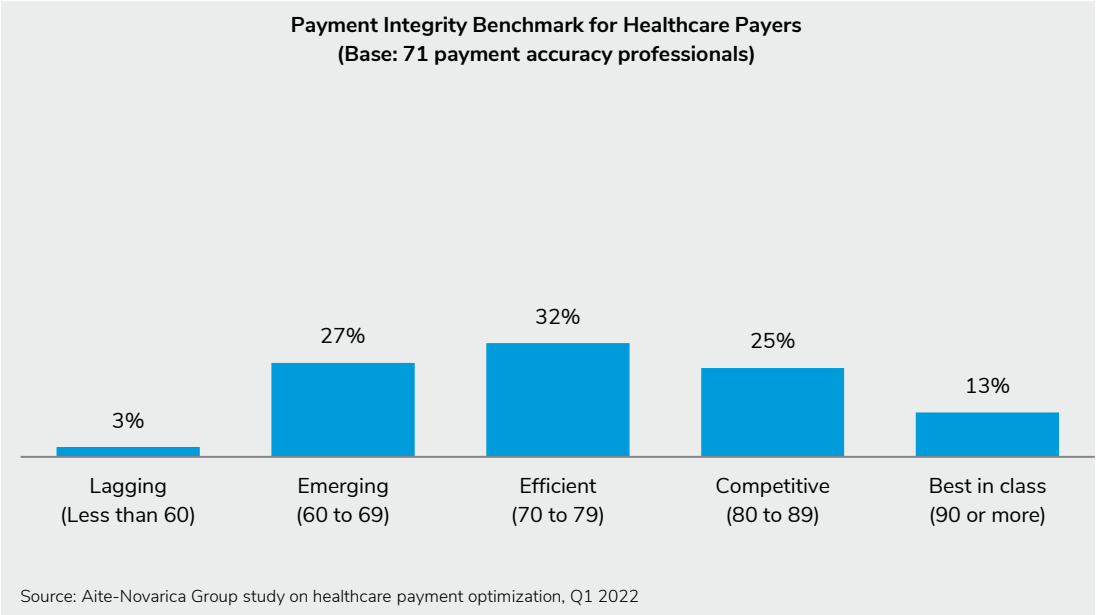
Healthcare payers are continually seeking to optimize their operations and financial results. They can do both through cost containment measures designed to ensure that reimbursements to providers are paid for the right members, at the right levels, for the right codes, and to the correct providers. While most payers have moderate to strong levels of automation in their payment integrity processes, just how comprehensive the automation is, along with how they approach their processes, vary considerably.

The study outlined in the Methodology section yielded a weighted scorecard that considers measures in place for pre-pay and post-pay automation, reduction of denials, appeals, and provider abrasion, as well as the extent that analytics are used for claims adjudication. Payers that had taken more steps aligned with their priorities for harmonious cost containment results earned more points. In a similar fashion, payers that had fewer actions in place to support process harmony earned fewer points. When aggregated and weighted, all scores ultimately formed an industry index. Responses are ranked in stages labeled as laggard, emerging, efficient, competitive, or best in class.

The index had interesting results:

- The payment integrity benchmark is a point of reference to assess how well payers are enabling harmony in the cost containment process. Ultimately, actions that healthcare payment integrity executives took to advance harmony in their cost containment programs determined their scores and, in turn, how well they fared compared to the benchmark.
- Only 13% of respondents showed leadership in implementing measures that promote harmony, placing them in the best-in-class group. Thirty percent of payment integrity executives placed as laggards or emerging players by indicating they had only partially carried out actions to enable a harmonious process (Figure 2).

FIGURE 2: PAYMENT INTEGRITY BENCHMARK FOR HEALTHCARE PAYERS



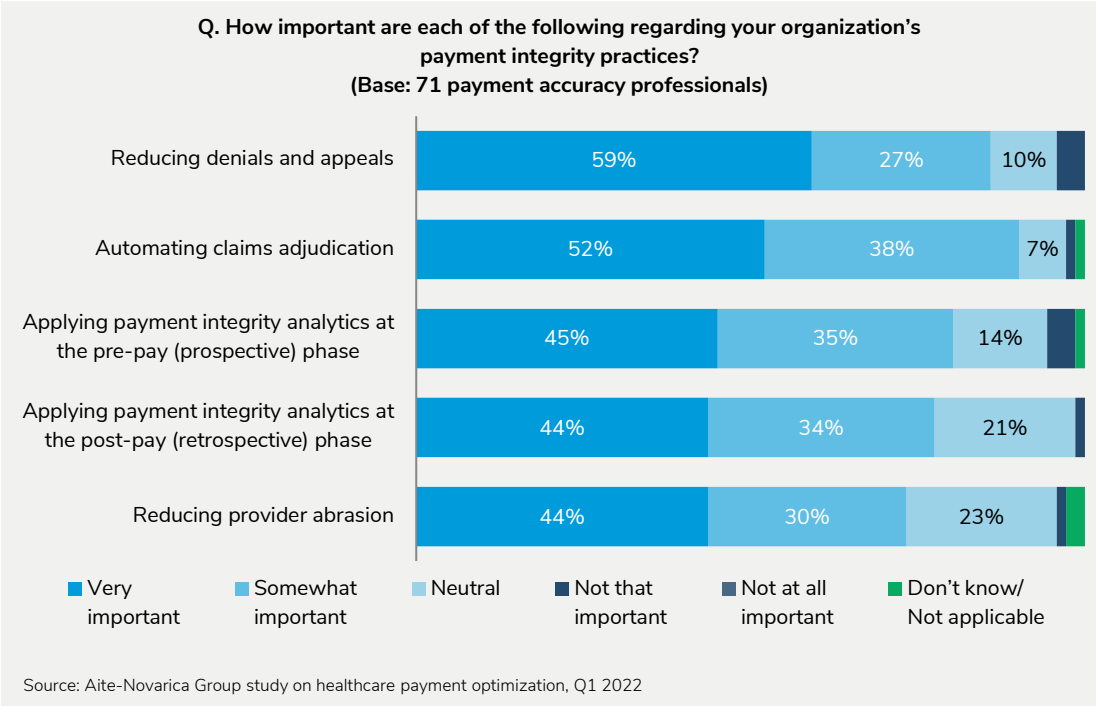
Source: Aite-Novarica Group study on healthcare payment optimization, Q1 2022

The balance of this report explores payment accuracy executives' responses to questions that ultimately formed the benchmark.

PAYMENT INTEGRITY PRACTICES

At the heart of payment integrity lies claims adjudication. So, it is no surprise that automating claims adjudication has the highest overall level of importance for payers. Reducing denials, appeals, and provider abrasion remain a major sticking point as well. Payment integrity solutions that enable harmony extend beyond ensuring that claims get paid at the correct rates while flagging others for review; they balance minimizing provider abrasion with preventing improper payments. Best-in-class payers rely heavily on their vendor partners to serve as a communication conduit with providers to address and limit denials and requests for medical records. The balancing act entails serving as a feedback loop, explaining the reasons behind claim denials to providers and influencing provider behaviors to conform to claim adjudication requirements and reduce inappropriate billing practices for future submissions (Figure 3).

FIGURE 3: IMPORTANCE OF PAYMENT INTEGRITY PRACTICES



Source: Aite-Novarica Group study on healthcare payment optimization, Q1 2022

Aite-Novarica Group's Take

Payers and providers have vastly different perspectives on just how much provider abrasion exists. Payers posit that providers receive ongoing streams of claims to review, which later get audited, but that they do not keep up with quality and timely responses. Some payers find that providers are less responsive than ever, even as they are facing more denials. Providers lament how strict and unwilling payers are to issue reimbursements and that payers question their medical and professional judgment. Vendor partners can bring a level of objectivity to this issue with reporting and transparency tools. For example, a report that can spotlight how frequently a provider has been audited in each period is a valuable tool in predicting and preventing provider abrasion.

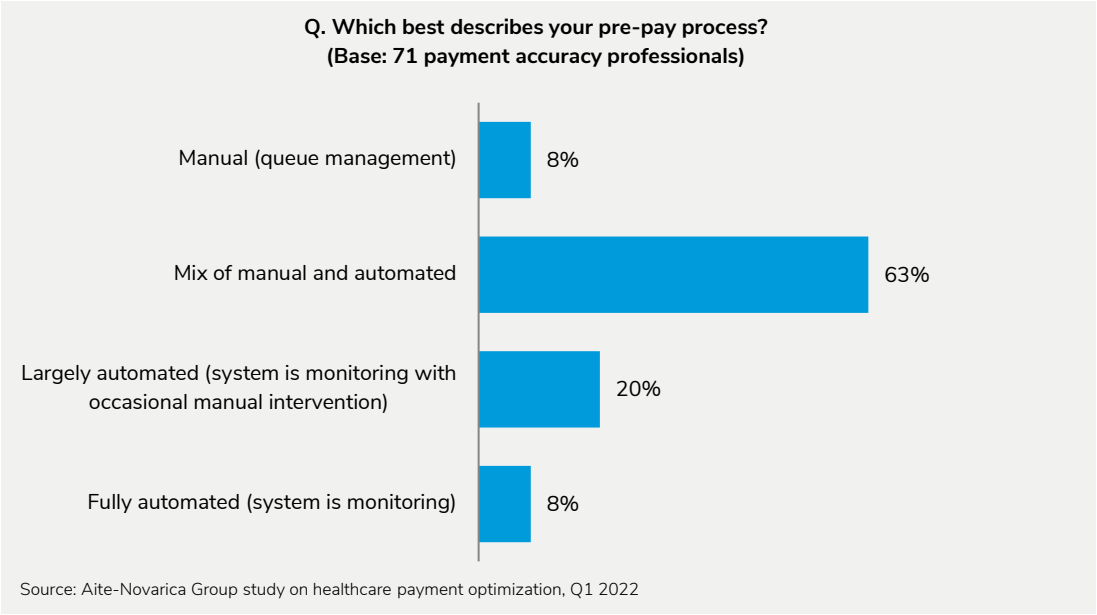
PRE-PAY PROCESS INTEGRITY

The proverb "an ounce of prevention is worth a pound of cure" can apply to cost containment efforts and payment integrity teams—so does the Six Sigma First Time Right principle. The goal with both these adages is to minimize and do away with errors that require rework. In healthcare, the shift-left approach encapsulates the same idea. Shifting left—moving the review of claim payments from after a claim is paid, or post-pay, to before a claim is paid, or pre-pay—is the standard that health plans and vendor partners alike continue to strive toward today.

Payers use a blend of manual and automated pre-pay processes during claims adjudication. That blend is effectively low-hanging fruit, ripe with the opportunity to eliminate rework. The goal is to move away from the traditional pay-and-chase model and toward more proactive solutions that focus on engaging with targeted providers sooner and stopping improper payments before they happen. As such, pre-submission claims and pre-pay capabilities will continue to be a valuable capability to supplement and eventually decrease the need for post-pay heavy lifting.

Payers that are quicker to adopt claim adjudication automation have robust vendor partnerships in place and rely largely or fully on automated pre-pay processes to filter incoming claims. On the other end of the spectrum, 8% of payment accuracy professionals list their claims processing as fully manual (queue management). These issues may be related to Medicare or Medicaid claims coming in and being entered into claims systems manually, as automation levels around ingesting those claims tends to be lower than commercial claims (Figure 4).

FIGURE 4: PRE-PAY AUTOMATION PROCESS



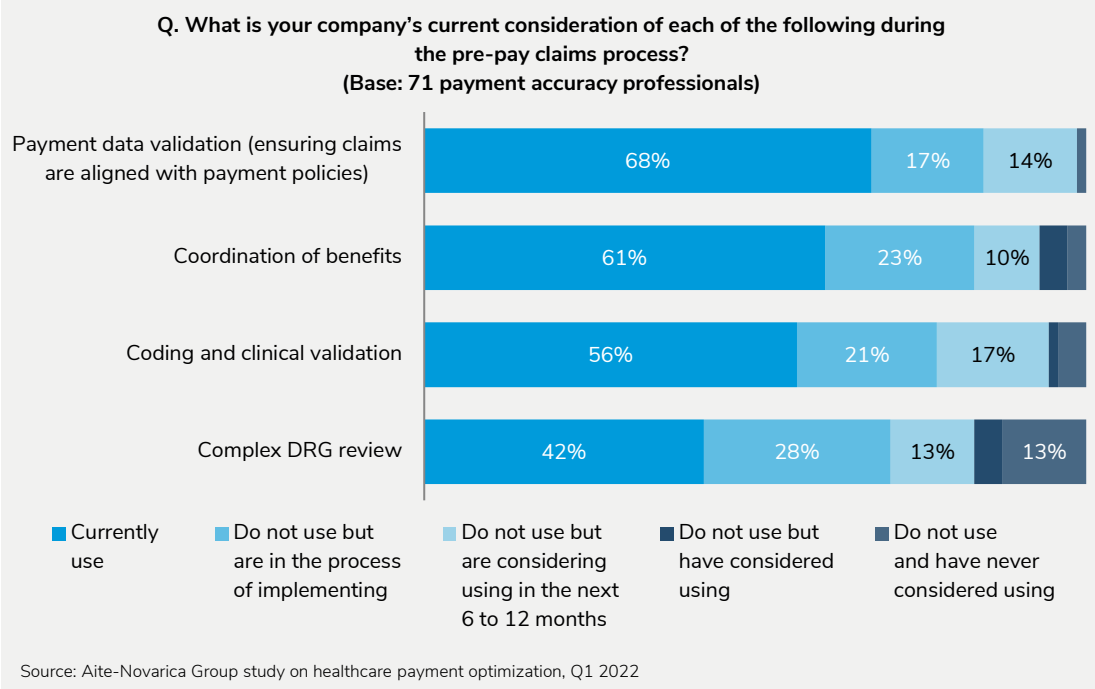
Source: Aite-Novarica Group study on healthcare payment optimization, Q1 2022

While this mix of automated and manual may not seem to pose critical problems today, population growth, chronic conditions and an aging population are signs that point to an increasing claim volume. Such claim volume will require automation if payers plan on reimbursing providers in a timely manner. Payers that have growing Medicare and Medicaid plans will benefit from familiarizing themselves with tools that can help alleviate that processing workload whether through internal system buildouts, or more likely through seeking support from technology partners specializing in this space.

Getting it right the first time requires that all claim and payment data be available at the outset of the adjudication process. Member data and health plan data must match up with plan policies. Sixty-eight percent of payers currently utilize claims validation tools to ensure claims and policies are aligned. Coordination of benefits (COB) is another valuable step early in the claims adjudication process to ensure that the right health plan is billed for a service, in the right order. In other words, in case an individual has access to two plans, one through Medicare or Medicaid and another through a commercial health plan, COB data, often available through technology partners, would provide a payer with a robust set of members that have Medicare or Medicaid coverage. Considering that individuals may be enrolling in those plans at different points in the year, payer IT departments should integrate access to third-party data sources to plug

any gaps in implementing COB-related checks and help limit the payer's reimbursement responsibility. DRG is the last bastion in automation because of the unique nature of these claims. In fact, less than half of payers use complex DRG review because of multi-layered automation complexities and difficulties in applying machine learning/artificial intelligence. Fortunately, 41% are currently implementing DRG reviews or are considering implementation in six to 12 months (Figure 5).

FIGURE 5: PRE-PAY CLAIM STRATEGIES



Source: Aite-Novarica Group study on healthcare payment optimization, Q1 2022

Aite-Novarica Group's Take

In an ideal world, all claims would be reviewed for accuracy at the time of submission, and none would require post-pay reviews, audits, or claw-back efforts of past paid claims. While industrywide technology adoption to that end remains strong, gaps remain in complex DRG review, which can be considered a final destination for automation due to its complexity. Payers expect vendor partners, including those that specialize in DRG audits, to help them understand DRG reimbursement methods and intervene at the pre-pay phase, rather than post-pay phase, to validate that a DRG has been coded correctly.

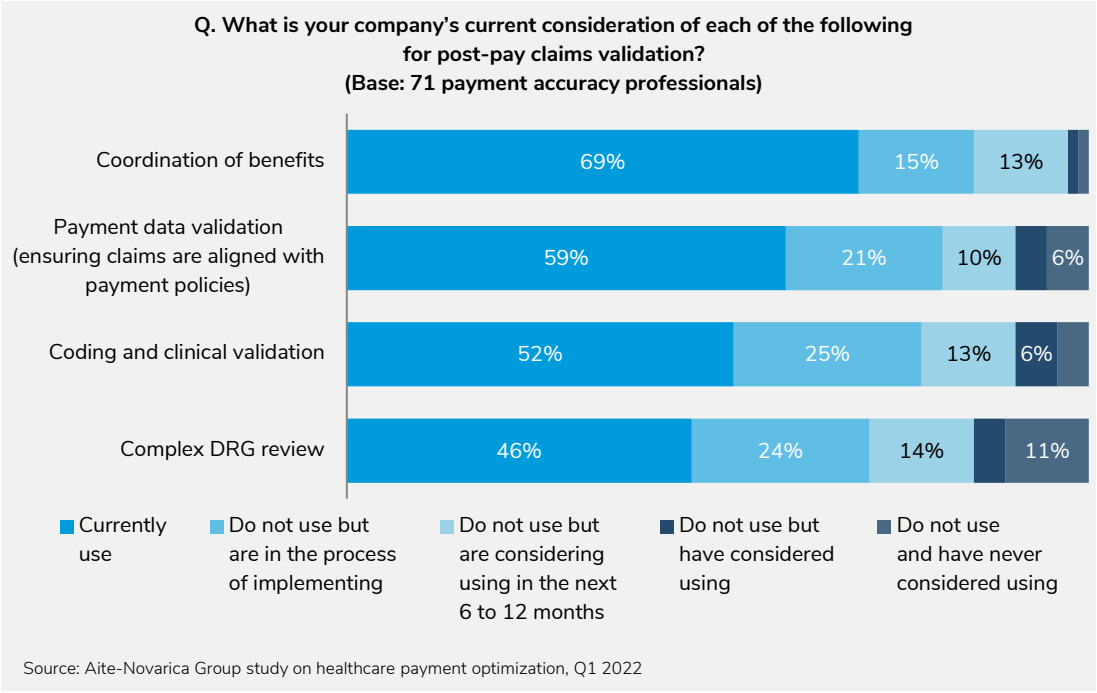
POST-PAY PROCESS INTEGRITY

Post-pay reviews entail assessing claims paid for accuracy and identifying cases of overpayment or fraudulent claims. Data mining is at the heart of post-pay reviews. It pinpoints those claims with erroneous payments and overpayments using a mix of analytics and medical expert validations. A robust post-pay review delivers information on payment terms and explanations of errors to healthcare payer clients so they can determine whether and which claims to seek to recover.

Payers are well entrenched in the world of post-pay claim reviews. COB and claims validation—ensuring that claims are paid in alignment with plan payment policies, coding, clinical validation, and complex DRG reviews—are some of the main post-pay claim review strategies. Sixty-nine percent of payment integrity professionals rely on COB for post-pay claim review, signaling that this strategy is well established and is on its way to becoming table stakes. COB analyzes health plan policies, eligibility files, and third-party data to determine which entity has the payment responsibility. The goal is often to identify members that may be enrolled in Medicare or Medicaid. Once identified, the healthcare payer can recommend that the providers refile their claims with Medicare or another federal plan.

Healthcare payers looking to go beyond the basics are expanding their focus to other post-pay claims validation tools, policy alignment or coding, clinical validation, and complex DRG review. Medical coding, which entails converting medical services to standardized medical reimbursement codes, is one to pay attention to both for payers and providers as it helps streamline claim payments. Medical codes that came into existence throughout the COVID-19 pandemic, an assortment of telehealth practices, emphasis on mental health services, advances in genomics and genetic tests, and evolving diagnostic tools have this field is brimming with dynamism (Figure 6).

FIGURE 6: POST-PAY CLAIM STRATEGIES



Source: Aite-Novarica Group study on healthcare payment optimization, Q1 2022

Aite-Novarica Group's Take

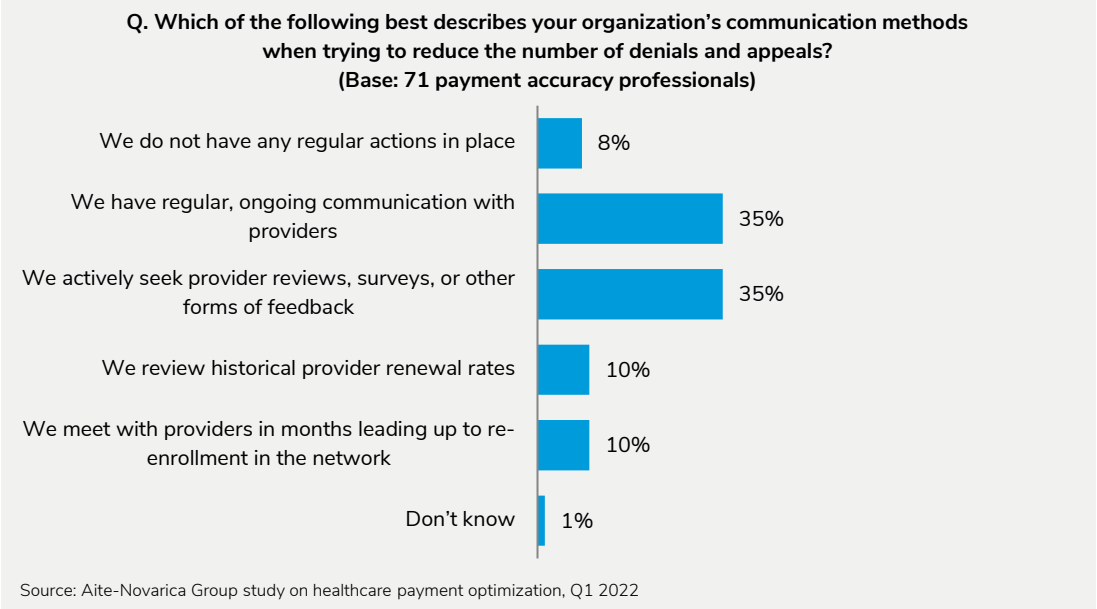
Payers have traditionally reviewed and audited claims after they have been paid (post-pay). Emerging tools and analytics are available to payers and their claim processing teams to further those reviews to make them more comprehensive and cutting-edge. Claims validation, coding, clinical validation, and complex DRG reviews are some of those tools to consider.

Going a step further, payers that view cost containment as a strategic priority can apply lessons learned from post-pay reviews to drive more savings in the pre-pay phase. These measures will not only serve to reduce abrasion but also alleviate strain on functions such as claims adjustment and special investigation units (SIUs).

DENIALS AND APPEALS

Communication with providers is essential to efforts in reducing appeals and denials of claims. Only 35% of respondents have regular contact with providers, while another 35% actively seek provider reviews, surveys, and other forms of feedback. Note that 8% of respondents do not have regular communications in place with providers (Figure 7).

FIGURE 7: COMMUNICATION RATES REGARDING DENIALS AND APPEALS



Source: Aite-Novarica Group study on healthcare payment optimization, Q1 2022

Aite-Novarica Group's Take

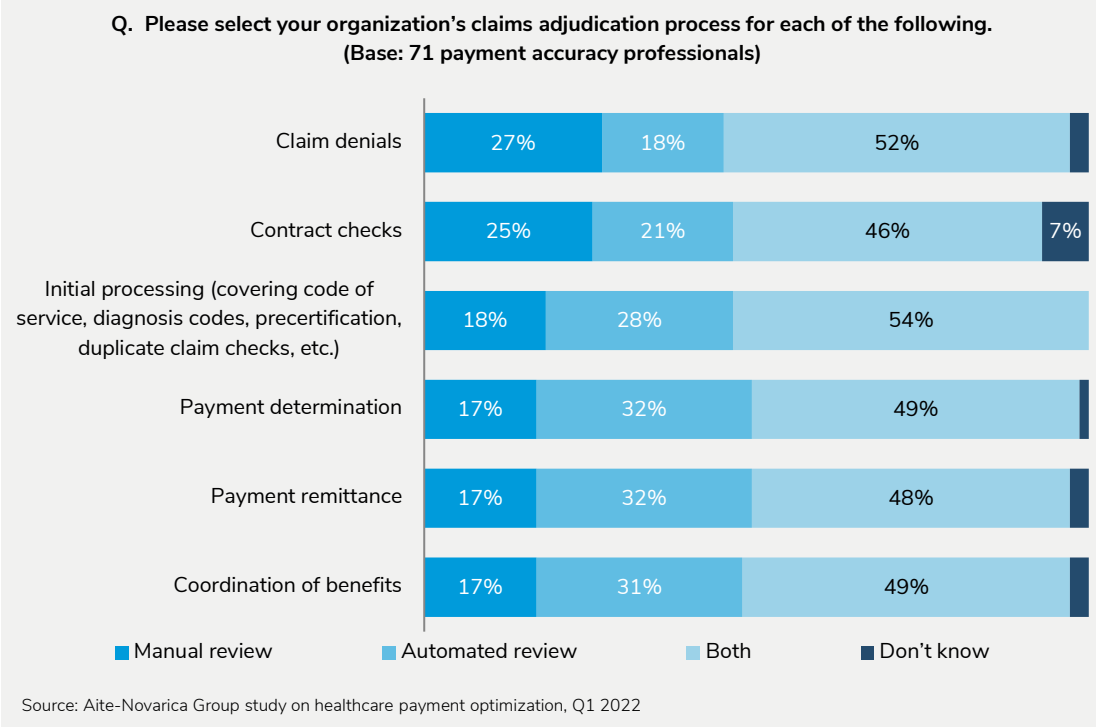
Minimum requirements for payment integrity solutions include a delicate balancing act of minimizing provider abrasion and preventing improper payments while paying claims correctly and in a timely manner. Payers rely heavily on their vendor partners to serve as a communication conduit with providers to address and limit denials and requests for medical records. The balancing act entails serving as a feedback loop, explaining the reasons behind claim denials to providers and influencing provider behaviors to conform to claim adjudication requirements and reduce inappropriate billing practices for future submissions.

As policies, laws, and regulations evolve, so does the need to update business rules to reflect those changes. Audit and case management tools on the back end of the claim adjudication process must also reflect these updates.

CLAIMS ADJUDICATION

Rates of combined manual/automated adjudication reviews hover near 50%, while rates of fully automated reviews average 27%, and rates of manual reviews average 20%. Initial processing (code of service, precertification, etc.) has the highest overall uptake among respondents (Figure 8).

FIGURE 8: AUTOMATION IN CLAIMS ADJUDICATION



Source: Aite-Novarica Group study on healthcare payment optimization, Q1 2022

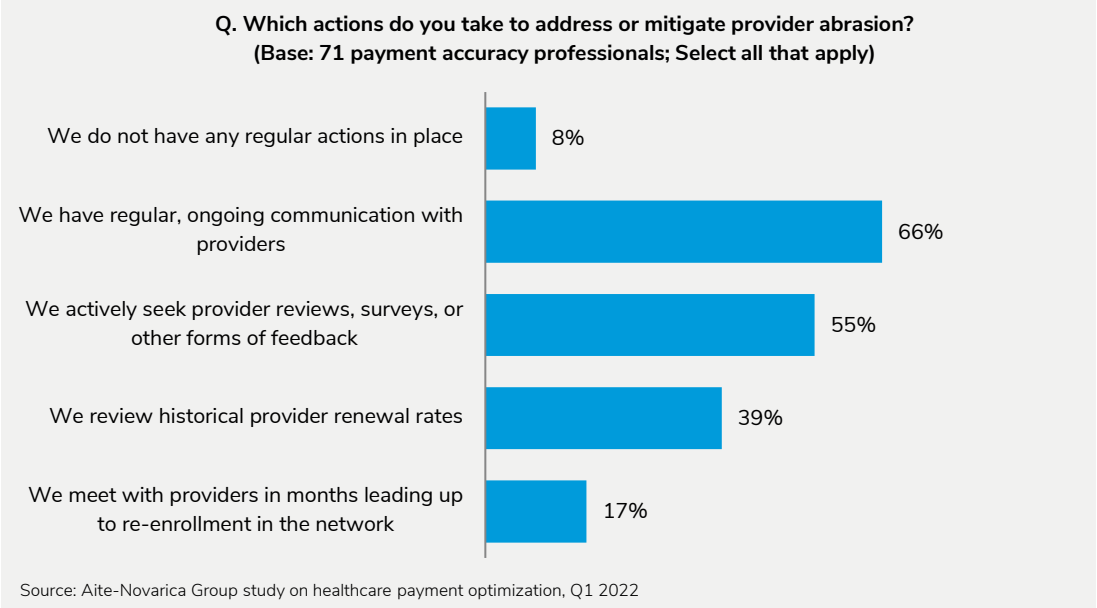
Aite-Novarica Group's Take

Claims adjudication is both at the core of payment integrity and accuracy. Automated tools have been around to streamline that effort, and vendor partners with strong analytics and AI capabilities are taking adjudication to a whole other level. Optical character recognition (OCR) vendors are worthwhile technology partners for helping with contract checks, claim denials, and initial processing, while payment vendors can assist with payment determinations and remittances. It is possible to automate the entire adjudication process via partner integrations with aligned solutions.

PROVIDER ABRASION

The ruler is in the eye of the beholder when it comes to measuring provider abrasion. Payers and providers have vastly different perspectives on just how much provider abrasion, in other words, an element of mistrust, exists. Payers lament slow response times from providers while providers express disappointment when questioned about their medical and professional judgments on medical care delivered. Communication and alignment are key to set and strive for realistic expectations on both sides. Sixty-six percent of payers maintain regular communication with providers, and slightly over half seek feedback from providers on making the claim review process less cumbersome. Both are promising numbers regarding progress made to date. Payers that focus interactions only when their re-enrollment periods roll around or that do not have any intentions or actions in place should expect the friction to continue unabated (Figure 9).

FIGURE 9: COMMUNICATION RATES REGARDING PROVIDER ABRASION



Source: Aite-Novarica Group study on healthcare payment optimization, Q1 2022

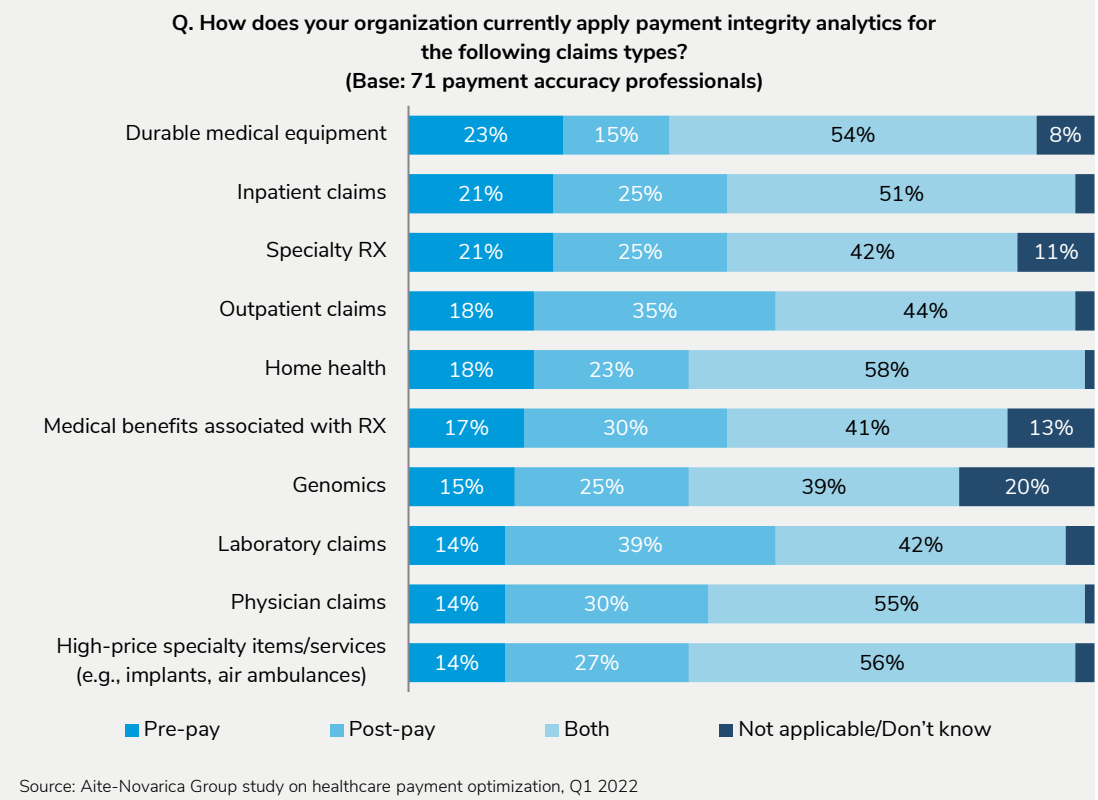
Aite-Novarica Group's Take

Vendor partners have a unique opportunity to introduce a level of objectivity to denial management and requests for medical records, serving as a communication conduit with providers through reporting and transparency tools. A report that spotlights how frequently a provider has been audited can make for a valuable example in measuring abrasion and pinpointing the sources.

PAYMENT INTEGRITY ANALYTICS

While analytics find a wide swathe of applications in payment integrity, organizations are keen to apply analytics chiefly first and foremost to claims in which dollar amounts are highest and fraud, waste, and abuse risks are elevated. Pre-pay filters come into play in cases in which the claim goes through preauthorization, such as for durable medical equipment and some inpatient claims. Pre-pay filters decline for home health services, medical benefits associated with medications (RX), and emerging services such as genomics. The use of payment integrity analytics overall is also lower for niche claims like genomics (39%) and for medical benefits associated with RX and specialty RX (Figure 10).

FIGURE 10: PAYMENT INTEGRITY ANALYTICS BY CLAIM TYPE



Source: Aite-Novarica Group study on healthcare payment optimization, Q1 2022

Aite-Novarica Group's Take

AI and predictive analytics continue to permeate the pre-pay and post-pay phases of claims adjudication. As payers become more familiar and comfortable with leveraging data and analytics to understand the inner workings of claims editing and adjudication tools, they will seek next-generation capabilities that rely more on preventing and saving, ultimately resulting in predicting claims and avoiding overpayment.

CONCLUSION

Payment accuracy executives at healthcare payers:

- Claims adjudication is a heady process involving multiple steps and providing many opportunities for automation to improve efficiencies. Payers should consider using OCR technologies and leveraging digital payments partners to ease the strain.
- Maintaining a consistent and intentional communication cadence with providers can go a long way to reduce denials and appeals and limit provider abrasion. A vendor with a good relationship with providers is valuable to retain.
- Working with vendor partners can add flexibility to the payer organization to support understaffed areas and functions, such as claims adjustments and SIUs.
- Payers with a backlog of claims to review and high denial rates indicate that a First Time Right mindset is not a regular practice within the organization. In such cases, payers would benefit from furthering efforts, moving the review of claim payments from after a claim is paid to before a claim is paid, in the pre-pay phase.
- Population growth, chronic conditions, and an aging population are signs pointing to increasing claim volume. Payers that have growing Medicare and Medicaid plans will benefit from familiarizing themselves with automation tools to alleviate that increase in workload.

Technology partners:

- Play the role of objective partner to provider abrasion by introducing reporting and transparency tools into the claims adjudication process.
- Invest in enhancing the use of third-party data, customizing features of reporting and visualization tools, and shifting to the cloud. Prioritize recruiting professionals from the medical profession, federal fraud investigators, and data scientists.
- Invest in next-generation capabilities, moving from preventing and saving to predicting and avoiding overpayment. The next chapter will go beyond transitioning to pre-pay and extend to First Time Right claim processing—in other words, predicting and preventing overpayments altogether.

ABOUT AITE-NOVARICA GROUP

Aite-Novarica Group is an advisory firm providing mission-critical insights on technology, regulations, strategy, and operations to hundreds of banks, insurers, payments providers, and investment firms—as well as the technology and service providers that support them. Comprising former senior technology, strategy, and operations executives as well as experienced researchers and consultants, our experts provide actionable advice to our client base, leveraging deep insights developed via our extensive network of clients and other industry contacts.

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