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Payment Integrity Best Practices for Regional Health Plans and TPAs

Keeping costs low for consumers is a central goal for healthcare stakeholders. Healthcare premiums are typically tied to how much a health plan spends, highlighting the opportunity for payers to prioritize improving their financial operations.

Ensuring that healthcare claims are paid accurately the first time around can help avoid overpayments and prevent high levels of administrative work. Health plans can improve claims management by leveraging payment integrity, which is designed to pay claims right the first time by focusing on addressing waste and abuse.

In a recent *HealthPayerIntelligence* webcast, Shelley Dean, director of payment integrity at Regence, shared key measures and considerations that can help health plans achieve payment integrity success.

Key measures for payment integrity effectiveness

Health plans should track several measures to determine the success of their payment integrity solution.

First, they should assess if their payment integrity solution reviews all of their claims.

Next, it is important to note how much savings are identified pre-payment. This can help minimize the abrasion for providers as they do not have to adjust their accounts receivable.

“Over time, you really want to see the vast majority of your savings pre-payment,” Dean said.

Measuring the accuracy of payment integrity is also essential. Health plans must ensure they conduct audits on staff or solutions to determine how accurate their processes are. Per employee per month savings are another measure of success.

“What are you generating for your groups and your members, and how are you matching up to your competitors so you know what bar to meet?” Dean offered.

Educating providers on appropriate billing practices can facilitate payment integrity.

“The most ideal scenario here is a comprehensive view of all education opportunities for providers,” Dean explained. “The more that we can do in this space, the better, the more you’re reducing your workload and building relationships with providers.”

Payers should prioritize communicating with providers on at least a quarterly basis, Dean noted.

Health plans should also focus on cost avoidance and the pre-payment solutions included in their process. Determining where each solution should be in the adjudication cycle can help ensure overall payment integrity success. Minimizing recovery is also a key component of adjudicating claims.

Deciding between human review and automation

Health plans must assess human review and automation as they integrate payment integrity solutions.

“There’s not always a clear decision. It can absolutely depend,” Dean pointed out. “Human versus automated: We believe there’s a sweet spot. It’s not 100% of one or the other. You need to have a balance to assess the different pieces of work that you’re dealing with to determine where it belongs. Not one solution can do it all.”

Some claims may require additional information for health plans to make a determination, such as medical records or itemized bills. Reviewing and editing all claims manually is not feasible for payers, opening the door for automation. However, while the primary focus should be automation, it may not always be the best route.

Health plans can use data mining to figure out the most efficient way to address an issue, improve the accuracy of claims, and prevent future errors. In terms of innovation opportunities, artificial intelligence solutions could potentially help minimize time spent

on unnecessary or low-value work and identify complex scenarios.

Roadmap for implementing payment integrity

Regence has created a process that allows its payment integrity initiative to be effective and create transparency. The first step of this governance process is intake.

“This is where you identify all of the places that you get your work from and where you may want to get them in the future that you’re not getting today,” Dean shared.

Next is evaluation, where health plans should spend the bulk of their time. During this step, plans should do an in-depth assessment of their initiatives to determine if there’s a policy to support the audit and the impact it will have on members and providers.

“Business case is the next step, which is where you need to collaborate with your finance departments to ensure the initiative you are pursuing is worth pursuing,” Dean added. “Then there should be another checkpoint to make sure that your organization has the desire to continue.”

Implementation is the last step of the process. Health plans must also support the outside teams needed to support payment integrity initiatives. For example, teams managing technical integrations and groups in charge of provider relations should each receive their own roadmap and tools to support their role.

“Identify the roles and responsibilities for the folks that are involved. This will allow anyone on your team to pick up a project and run it through, knowing all of the checkpoints and where they need to take action.”

“We believe having a highly integrated solution, with all key players at the table, will make your implementations much more successful,” Dean concluded.

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