

# WHAT'S KEEPING YOUR CEO UP AT NIGHT?

by Brian Smith

Let's pretend you are the CEO of a fully insured health plan with 300,000 members and \$1 billion in revenue. You have seemingly pushed on every area within the company, and some tough decisions need to be made to be able to meet the board's expectations for the next year. You are leading a discussion with senior management on cost containment strategies. You have tasked each person with coming up with ideas that will help the company

meet its fiscal obligation to the plan, the board, and, most importantly, to your members. You have heard from every associate of your senior management team, and the final two members to speak are your COO and CFO. Your COO presents a plan to reduce SG&A by 5 percent in the next year. Your CFO presents a plan to aggressively focus on preventing professional and outpatient claim overpayment and fraud by 2.5 percent.



What proposal has the biggest impact on bottom line plan profitability, all else being equal?

LET'S LOOK AT THE MATH:	
<b>Plan Revenues</b>	<b>\$1,000,000,000</b>
SG&A	\$ 120,000,000
Physician costs	\$ 330,000,000
Out Patient costs	\$ 150,000,000
Inpatient Hosp	\$ 200,000,000
Pharmacy	\$ 140,000,000
Other Services	\$ 50,000,000
<b>EBITDA</b>	<b>\$ 30,000,000</b>

Here are the facts. A 5 percent decrease in SG&A produces \$6 million in bottom-line effect — a significant impact if the COO will truly be able to execute on these savings. A 2.5 percent reduction in inappropriate claim payments because of abusive or potentially fraudulent provider behavior within outpatient and physician claims results in \$12 million to the bottom line. As the CEO, you know that reducing the SG&A by 5 percent means less people doing more work. This will be difficult, but not impossible. Impacting the Physician and Outpatient claims payments by 2.5 percent will mean working differently to yield more results. So, as CEO, what do you decide to do? The answer is “both”.

What area should you focus on first? The immediacy of preventing claim overpayments and fraud should begin quickly. Your best bet to solving this problem is taking advantage of your available resources of talented people and the latest technology.

Ironically, technology has become both a blessing and a curse to claims processing productivity and accuracy. Many health plans believe that using technology to become more efficient is a good thing — and it is. The introduction of the Internet and other technology into health plans does provide solutions, but also it creates opportunities for a negative cause-and-effect to your bottom line. Electronic Data Interchange (EDI) and Internet claims processing increases efficiency. Yet, the more automated you make the process, the greater the potential for losses due to fraud and overpayment. As the cycle for paying professional and CPT coded outpatient claims reduces from days and hours to minutes and seconds, the potential for large sums of claims dollars to change hands quickly grows, as does the exposure for claims overpayment and fraud. This also limits human data-review by experienced clinical and claims coding experts. We hear many health plan professionals bragging about their auto-adjudication rates in the marketplace. While becoming more efficient is a goal of every operation person, confirming that the efficiency is making a positive financial impact should be the true

aspiration. Fundamentally, a health plan should not get better at paying “inappropriate claims” faster.

Even though most claims payors are operating on aging legacy systems, the good news is that new technology will add “business intelligence” without the cost or risk of having to replace the legacy environment. It is merely an enhancement to the tried-and-true platforms. Application Service Providers (ASPs) and SAAS web-enabled software (Software as a Service) are allowing health plans to use advanced analytics, similar to what the banking industry has used for decades, to apply rules-based logic in order to prevent overpayments and detect aberrant provider billing trends.

The key is to use technology to do the large-scale, high-volume claim overpayment and fraud review on a post-adjudication basis. Highly skilled personnel can then focus quickly and efficiently on patterns and trends. By using prior member and provider level claim history on the 5 to 7 percent of claims and 1 to 3 percent of providers from the system output, they can eliminate false positives that are on the low end of the fraud continuum.

The real dollar savings from fully re-priced and adjudicated/to be paid claims come from this integrated process of preventing duplicate, up-coded, unbundled, and inappropriate modifier 25 and 59 claims combined with profiling providers administering services inconsistent with accepted clinical practices.

This technological approach — when combined with a client’s claims and clinical investigative units — will deliver highly actionable and detailed cases for follow up and recovery to the health plan’s Special Investigative Unit (SIU) and claim level adjustment, allowing for and explaining the modification to the claim payment.

The benefits of integrating fraud detection and investigative tools with post adjudication/prepayment claims/overpayment prevention services include:

- Acting as a deterrent when the health plan publicizes its use of advanced technology to fight insurance fraud and abusive coding
- Ensuring uniform fraud and claim-overpayment prevention throughout the enterprise
- Eliminating the unnecessary referral on non-fraudulent claims to the SIU
- Allowing investigators to focus their efforts on providers and claims that require additional investigation
- Measurable claims overpayment and fraud-recovery savings, which improve financial performance
- Creating competitive advantage relative to other organizations that use less accurate processes of fraud detection and overpayment prevention

As CEO of your organization, have you ever considered or measured what percentage of your medical loss

# DOING NOTHING IS NO LONGER AN OPTION.

ratio is associated with fraud and claims overpayment? What is the cost of doing nothing? If you do nothing, providers are overcharging or inappropriately charging your members. This is not only an expense to your health plan, but to your members, as well. It is a “double whammy.” Doing nothing is no longer an option. Yet, if an executive cannot see an identified cost problem, they assume there is no problem.

Are you doing everything possible to protect your bottom line and customer assets from fraud and claims overpayments?

If not, now is a great time to begin a review of your current payment practices to determine if there are dollars being paid that should not be paid. With a new year just around the corner and new budgets to be approved, reviewing the strengths and weaknesses of every person and process in your overpayment and fraud recovery departments will present opportunities for improvement. Identify these opportunities to improve by working with a vendor that can bring in subject matter experts to perform a fraud and abuse risk analysis based on your claims history to pinpoint areas of claims savings and benchmark against industry averages. This rigorous diagnostic process is critical for learning the unique circumstances present in your business model, as well as the all-important operational and cultural changes that need to occur within your organization. Once this diagnosis phase is complete, a customized implementation can be designed to attack the “low-hanging fruit,” educate providers, and reinvigorate the SIU and claims overpayment prevention staff with better data and more user-friendly tools. Your vendor should

be your business partner in the management of implementation risks, the optimization of the value achieved, and the provision of value measurement and enhanced sustainability. Remember, fighting fraud and abusive billing practices is a continually evolving process — not a single event. Once fully implemented, it’s a win for everyone, including non-fraudulent providers, members, employers, and government. ■

