RISK strategies CONSULTING

WHITE PAPER

Comprehensive Healthcare Auditing: Ensuring Transparency and Responsibility

July 2024

Overview

Our white paper, *Disclosure, Transparency, and Fiduciary Responsibility in Healthcare, Risk Strategies Consulting,* described the critical need for transparency and disclosure within the provision of employee benefits. A significant aspect of our company's value proposition is our audit team's ability to provide a broad array of audit capabilities that enable the client to fully understand what they have purchased, how their purchase has benefited them *and* their covered populations, as well as to accurately and fully determine their vendor partners' value propositions within the proper context.

Our team brings deep knowledge and understanding of needed audit practices, protocols, policies, processes, and platform to healthcare industry stakeholders. This enables us to determine a full view of actual versus expected performance levels as well as to provide identification of and potential solutions to root causes of any shortfalls. Our comprehensive approach includes an upfront understanding of the vendor partner's business structure, a review of any public filings by the vendor partner, a search for any legal matters the vendor partner is facing, as well as a request to the vendor partner for any internal and external audit findings they completed on themselves or have otherwise had completed on them. We are examining financial, technological, operational, clinical, and compliance-oriented considerations. This includes review and analysis of data flows, workflows, process flows, and business processes.

The Plan Sponsor has an obligation to itself and the covered population to ensure that administrative, compliance, financial, and strategic requirements and objectives are being met or exceeded. The needed diligence process begins with a thorough Request for Proposal (RFP) which outlines objectives, key performance indicators, performance guarantees, required contractual language, definitions and protections, as well as the various methodologies for measuring each. The diligence process continues through strong vendor partner management which includes thorough documentation, and robust business cadence supported by reporting and analytics. The process then moves to the needed auditing which validates apparent results, while illuminating the underlying causalities for the actual results.

Audit is much more than the identification and calculation of missing information, accuracy, validity, proof points, and thoroughness at the individual transaction level. The audit field has transformed into a necessary, innovative, and indispensable function within today's vast and dynamic landscape of industry stakeholders. In fact, proper auditing brings needed context to clinical and financial factors such as payment regulations and oversight, mergers and acquisitions, high-cost therapies, revenue cycle management opportunities, and value-based reimbursement. Each of these considerations bring operational and financial complexity, with a potential for fragmentation of care, as well as limited documentation, resulting in poor information flow.

Importantly, the auditing profession requires *highly skilled auditors*, who are not only familiar with tried-and-true audit practices, but who can also view the data and information panoramically, using more modern connectivity paths that integrate administrative functions, care delivery, and payment activity ***longitudinally throughout a patient's journey***. As the healthcare industry becomes increasingly complex, the *depth and types* of required auditing are also becoming more intricate. Healthcare systems, from those of health plans to providers, face unique challenges and require more efficient auditing approaches than ever before to ensure ***integrity and diligence***. More progressive healthcare ***financial, operational, compliance, and clinical*** auditing innovation will help bring increased accountability to an industry that continues to struggle with outdated claims systems, systems integration barriers, patient-value transitions, and a flawed "status quo." *In other words, take a step back and discern how well these core systems and technology platforms align and impact stakeholder experience, especially for the member/ patient and provider.*

Risk Strategies Consulting's Distinctive Audit Approach and Resources

In our overview, we outlined a broader than industry standard definition of "audit," along with corresponding needed considerations, capabilities, and expertise than is the present industry standard. Consultants need to play a critical role in examining the performance of a client's vendor partner beyond traditional, contractual performance standards and guarantees, key performance indicators, and other limited viewpoints. A thorough auditor should provide the client with insights into multiple levels of the vendor partner's performance, how and why those performance levels are achieved, as well as recommendations for optimization.

In the health plan space, traditional audits are limited because they typically allot examination of only up to 250 randomly stratified claims. This limitation makes it nearly impossible to understand a vendor partner's financial, operational, and clinical performance. The goal of the audit should be to educate and improve, rather than define "what is wrong." This is particularly important given the various complex ecosystems plan sponsors and health plans have created and work within.

Our auditing capabilities and approach apply to all vendor types utilized by our clients. These include, but are not limited to, eligibility and enrollment, medical, pharmacy, various point solutions, short and long-term disability, and other key vendor partners.

Comprehensive Audit Platform and Framework

- At Risk Strategies Consulting, we have created a ***comprehensive audit platform and framework*** that launches with a consistent cadence, starting with a *discovery* phase that allows us to identify common themes and patterns throughout the data and business processes.
- This exercise continues with a controlled approach and discernment of ***content coupled with context*** to ensure we are, with great depth and breadth, examining hardwired information flow, the levels of automation and configurability within the data management, data warehousing, and transactional processes. We place particular attention and focus on customized workflows, knowing that manual workarounds create a significantly higher opportunity for error. We utilize ***proprietary tools and protocols*** to enable ourselves or third parties to audit our calculations, methodologies, and results. This enables an understanding around the *how and why* of successes and failures. The audit process demonstrates the accuracy of the completed work product, while also ensuring that the processes utilized are repeatable and scalable.

Comprehensive Audit Example

One example of the needed, more comprehensive definition of audit is our methodical approach of assessing health plan financial disclosures. Risk Strategies Consulting has developed a *Comprehensive Network Quantification and Financial Disclosure Questionnaire* tool that can be utilized to conduct a side-by-side comparison of health plan bidders in an RFP to support development of a more panoramic view of total costs and value for a plan sponsor and to aid health plans in identifying and consolidating fragmented cost and savings streams. The ultimate objective of the tool is to clearly, and specifically, state the types, amounts, frequency, transmission methods, and purposes for any disclosed and/ or undisclosed costs and revenue streams that impact cost or value of healthcare for a self-funded plan sponsor. Ensuring transparency, clarity, accuracy, and appropriateness of the content and impact of all direct and non-direct health plan revenue that impacts plan sponsors is highly important in order for them to responsibly understand, manage, and make strategic decisions regarding healthcare benefit administration on behalf of their employees. **Revenue types** are categorized into the following high-level groupings:

Administrative Fees	Clinical Fees	Pass-through Savings
Performance Payments	Pharmacy Benefit Manager (PGM)-specific	Affiliated Organizations

Within each of the above groupings, we elicit per employee or member per month amounts, frequency, transmission method, purpose, any dollars withheld from the plan sponsor, and a comparison to book of business averages. We also require the health plans to elaborate on any fees or savings not explicitly requested via the tool.

Audit Tools and Resources

Conducting a multifaceted approach ensures audits are more refined and better equipped to detect and prevent issues across the employee benefits spectrum. In particular, Risk Strategies Consulting believes that with the increasing complexity of the healthcare ecosystem, emergence of innovative specialty treatments such as cell & gene therapies, and growing numbers and types of value-based care (VBC) arrangements, there is a critical need for comprehensive auditing that encompasses ***clinical, financial, health equity, and experience*** domains.

The audit process entails examining a broad range of *related considerations and intersections*, including but not limited to, the following:

- Information technology and claims platform(s) and determining *automation, types of configuration, and customization* levels
- Software applications
- Review of third-party audits from regulators and via system and operation controls, the latter of which focuses on the systems used to process user data and the safeguarding of this information[1]
- Business and operational processes
- Data, work, and process flows
- Baselines benchmarks and means of measurements of stated performance standards including use of study and publication statistics

Essentially, forward-thinking consultants such as Risk Strategies Consulting advise adopting new and innovative auditing approaches to help healthcare organizations deal with outdated systems and to mitigate a myriad of potential difficulties. This includes not only ensuring the depth and integrity of the data, but also involves evaluation of all *supporting policy and documentation* and consideration of the use of automation and customized practices. This includes evaluating the types and numbers of payment integrity (PI) oriented vendors, their contributions distinctly from others and the organization itself, the cost/ savings/ pricing models, and where they lie on the payment continuum. Moreover, leveraging the following combination of ***technology-fortified and human capital solutions*** may significantly benefit healthcare entities.

- **Advanced data analytics tools:** These tools enable auditors to efficiently ingest and process vast amounts of healthcare data across platforms and can help identify patterns, anomalies, and trends within claims and medical records faster than people. By analyzing the data transactions, auditors can uncover potential errors and help them prioritize which claims to investigate more thoroughly, making the process more focused and cost-effective for a variety of use cases.

- **Generative machine-based learning (ML) models:** These models use predictive analytics and assess and help manage the financial and clinical risks associated with healthcare claims, reimbursement, and related expenses. They enable auditors to make data-driven observations, identify potential areas of concern, and develop financial sustainability as well as compliance strategies.
- **Clinical knowledge and expertise:** Having subject matter experts ensures auditors can more accurately assess the clinical efficacy of healthcare claims and services. This expertise contributes to error identification, clinical standards compliance, care quality assessment, and the promotion of efficient, patient-centered, healthcare practices.

Risk Strategies Consulting also has its own ***data warehouse and employs proprietary tools*** that are designed to cleanse the data and enhance claim workflow, process, dashboards, and data dissemination. Use of these core solutions empowers us to focus on a multitude of in-demand, client-centric, product offerings to our clients and enhance audit comprehensiveness by addressing multiple angles.

Audit Types and Approaches

Fundamentally, Risk Strategies Consulting is following the accuracy and efficiency of how information and revenue flow among healthcare stakeholders directly align to care delivery. When implemented longitudinally across the patient journey, connectivity is gained across stakeholders that supports operating models, which directly or indirectly impacts member experience and care. Therefore, audit cannot be a siloed effort. Instead, audit must be carried out in methods that encompass all aspects of healthcare delivery and that incorporate functions and transmissions of all stakeholders, so that up and downstream impacts are contemplated.

Risk Strategies Consulting's investigation and research, as well as our vast audit experience, affords us valuable insights into the approach of those who currently oversee the payment process cycle. We employ a robust auditing team consisting of ***auditors, nurses, pharmacists, and data scientists***, among others, and base our insights and future-ready solutions on the team's expertise in frontline healthcare issues, using and leveraging technology, disparities, and gaps in systems, while considering the nuances involved in the audit process.

Patient-Centered Approach

The Risk Strategies Consulting framework is embodied, not only with a laser focus on the claim line level detail, but importantly and atypically, also takes an **integrated and longitudinal view throughout the *patient's journey* within their healthcare ecosystem** – and *across the provider and health plan environments*. Viewing the claims methodology in a single, claim by claim method renders important findings but viewing longitudinally reveals a *contextual* perspective of care activity over time. Furthermore, other dimensions crucial to claims adjudication are factored in such as health plan and employer policies, clinical management program inputs, local and federal legislation by plan/ offering type, and provider-specific contract provisions and reimbursement clauses. *These aspects apply regardless of the audit type or subject at hand.* Indeed, to accomplish this more holistic evaluation, the technology and data elements below in **Figure One: Auditing Validation** *coupled with auditing and clinical professionals*, are imperative for dynamic auditing validation that focuses on key issues and solutions.

Figure One: Auditing Validation

Pattern recognition across transactions

These approaches uniquely position us to deliver an ROI-focused higher rate of recovery, operational efficiency, financial value, reduced abrasion, predictable revenue cycle management, and causal interception for efficiencies in recovery. This further helps to address the fragmented, antiquated systems that are currently being used to navigate data management and supports ***complex reimbursement models and specialty drugs***. Having a transformative partnership with clients redefines audit, shifting downstream impact to upstream solutions, creating value beyond a traditional recovery focus, and allowing for an alignment of incentives.

ROI Model Validation

Compellingly, our audit platform is the mirror to another of our innovative developments, the Risk Strategies Consulting Return on Investment (ROI) model, revealing to us on a retrospective basis, if and how the audited vendor or situation has succeeded or failed. This method also ensures that the ROI, as stated, is accurate and complete in its methodologies and calculations. The audit function becomes a needed control mechanism to ensure the quality and depth of recommendations being derived from the ROI model.

Why is this relevant? One example is the explosion over the past decade or so within healthcare of the rapid emergence of a variety of healthcare point solutions, that are in some instances, causing employer and consumer fatigue, if for no other reason than the sheer volume; so many choices, so many access points and applications, so many educational opportunities – and how do these align to what a primary care or specialist may be advising? Point solutions have been particularly leveraged by mid- and large-sized employers, who are trying to tamp down rising medical costs, attract and retain talent with greater access and engagement opportunities, and address health conditions about which we have gained greater awareness and have begun to destigmatize to a certain degree such as behavioral health, autism, menopause, infertility, and insomnia. Focusing on these conditions may also require non-standardized clinical and administrative approaches. Creating a heightened intensity of attention on troublesome health conditions is a positive event and cause for some level of celebration; however, the more cautionary view advises that, without significant integration and care coordination efforts, these solutions can further fragment care, increase unnecessary utilization, and potentially offer differing answers to medical problems that are difficult to decipher.

On the other hand, they offer an alternative access point, usually digital, that may be more convenient for patients, potentially making treatment adherence stronger and more consistent. Also, if aligned to physician care planning, they can augment or reinforce treatment plans, theoretically offering better overall results and condition control, especially if program, clinical, and engagement data is shared with clinicians. This could particularly benefit physicians and patients included in VBC arrangements.

With many of the point solutions relatively new to the market, corresponding to less outcomes data and proof points to date, conducting ROI assessments is highly important for employers and health plans to properly evaluate actual or potential value for their members and their mix (demographics, condition types, engagement levels and methods). Research shows a void exists in the market, whereby promised results of point solution network configurations, clinical solutions, and other tools being sold are not being properly audited for actual results.

So, how does auditing fit in? Risk Strategies Consulting has created a methodology to determine the metrics and results tied to an ROI model, which quantifies and qualifies cost of goods, clinical outcomes, member, and provider experience as well as health equity. Noteworthily, we want to understand, not only how a solution stands alone, but also how the solution integrates and aligns to other health and care activity within a patient's ecosystem, using the aforementioned longitudinal approach.

Quality, Efficacy, and Cost (QEC) Analytics

QEC is Risk Strategies Consulting's ongoing assessment of claim payment accuracy, clinical efficacy, and reasonableness as well as audit process identification within healthcare practices and pricing, all of which help ensure clients are up to date with health and welfare program management. Our proprietary software solution processes claim extract data, and the results are deployed to identify claim payment anomalies, aberrant clinical utilization, questionable provider practices, price volatility, and other pertinent areas that may result in suboptimal financial results or clinical outcomes. The analysis is designed to go beyond standard claim audit practices, which merely focus on accuracy of processing and payment, and is designed to identify and inform clients of financial, clinical, or operational opportunities. Findings associated with QEC analyses are intended to inform a client of potential opportunities that might otherwise go unnoticed. Addressing these opportunities may result in the following outcomes:

- Mitigated healthcare spend waste
- Potential recovery of unwarranted paid claims
- Improved clinical management
- Enhanced operational workflows, data flows, and/or process flows
- Optimized plan design strategies
- Validated operational and clinical efficiencies

Below is a small sampling of Risk Strategies Consulting's over 30 targeted QEC areas.

- Duplicate Payments – Identify payments that are duplicative in nature by dollar, procedure, date of service, and provider.
- End-stage Renal Disease Non-transition to Medicare – Identify members who continue to incur claims after meeting Medicare requirements.
- Dose Rounding of Chemotherapy Drugs – Identify service healthcare common procedure coding system codes for chemotherapy drug administration, and calculate potential savings based on industry standard pricing methodologies. Additionally, quantify claim liabilities attributed to product wastage.
- Multiple Claim Submissions – Review instances where a provider re-submits billing on the same patient for similar services, ensuring no duplicate billing occurs. This also identifies and addresses instances where providers gain additional reimbursement amounts based on billing practices intended to bypass the claim management system
- One-day Length of Stays – Calculate one-day length of stays as a percentage of all inpatient admissions.

Prevalent Types of Healthcare Audits

The following are the most prevalent types of healthcare audits and a description of how Risk Strategies Consulting views the areas of focus for each. These specific audit types are critical to maintaining strong client/ vendor partner management practices and successful relationships.

- **Clinical audit:** Clinical audit is an intricate review of all clinical programs, utilization management, clinical operations protocols, pharmacy, therapeutic, and formulary management policies and procedures. This ensures all delegated clinical functions are being executed by the Pharmacy Benefit Manager (PBM) or health plan to provide access to the most cost-effective therapies that promote positive health outcomes for clients' membership.
- **Contract analysis and audit:** This is a review of health plan or PBM contractual terms to ensure services are being provided to the client in accordance with contract provisions and requirements.

- **Implementation audit:** Pre- and post-implementation audits are vital to ensure shared success, and they set the stage for how new technology, operations, and relationships are forged and embraced. Making sure sufficient and diligent testing is conducted and in sync with expectations, end user experiences, and overarching timelines are highly important to minimize disruption and abrasion across an organization and externally to clients and stakeholders. Phased implementations are sometimes appropriate to manage the magnitude of work effectively.
- **Large claim audit:** This audit ensures that high-cost claims and those qualifying as either aggregate or individual stop loss are reviewed for financial accuracy, and clients receive appropriate coverage on their claims. Intervention on a "catastrophic" claim optimally occurs early in a claimant's treatment. The integration of pre-certification, large case management, concurrent review, and discharge planning must mesh effectively in order to manage the claim, while maintaining leverage to negotiate meaningful savings before a claim is paid. For larger claims, the longitudinal auditing approach is even more compelling, in consideration of the complexity of larger claims and the potential, related contract provisions and clinical oversight frequently deployed upon the occurrence of these more intense medical events. This essentially translates into visualizing the dimensions of comorbidity and clinical risk in conjunction with billing practices and patterns. Indispensable to this practice is devising a methodical approach inclusive of pinpointing elements such as these:
  - National provider identifier (NPI) level pattern recognition
  - Patient history and all diagnoses
  - Use of severity adjusters
  - Modifier inclusion
  - Non-truncated claims
  - Reconciliation of revenue, procedure, and diagnostic related grouping codes
  - Presence of outliers and carve outs
  - Individual and aggregated claims
  - Use of health grouper for setting episode of care
  - Waste and/ or abuse

  Large claims best practices are naturally highly relevant to aggregate and individual stop loss claims auditing as well. Risk Strategies Consulting's Stop Loss Team audits cumulative and catastrophic healthcare claims on behalf of stop loss carriers and their contracted managing general underwriters for eligibility and recommended reimbursement under the stop loss policies issued to self-funded plan sponsors. The outsourced and objective scrutiny of these claim filings provides a unique perspective of the coverage spectrum and greater peace of mind that obligations of all parties are being met. The process follows the journey of the claimant, from eligibility under their plan, through the course of care delivered over a specified coverage period and the applicable requirements of the respective policies. Layered aspects along the journey must be qualified and approved throughout the process, and Risk Strategies Consulting is uniquely qualified to evaluate and justify reimbursement recommendations in an organized and thorough manner. The audits provide detailed findings that uphold recommendations, introducing substantial opportunities for operational improvements and cost savings. The stop loss audits can impact everything from the underlying plan design to claim data integrity, underwriting of risk, eligibility of participants, processing of frontline claims, introduction of cost saving measures, and the financing of plan expenditures. Our team touches on the accountabilities of many parties and strives to improve communications and outcomes that benefit all.

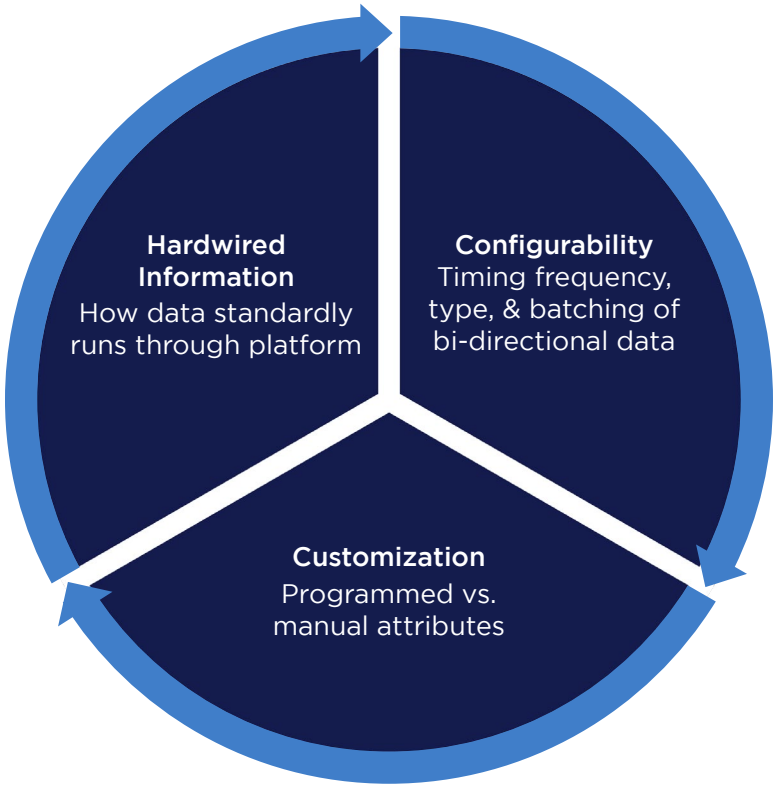
- **Medical audit:** Medical audit is a methodical review of a client's medical plan to ensure accurate and appropriate plan design and administration to validate that the medical plan is fulfilling fiduciary responsibilities including identifying claim overpayments, eliminating systematic errors, enforcing performance guarantees, and detecting opportunities for improved services.

- **Operational audit:** Operational audit is an evaluation or business process analysis of day to day and overarching organizational performance that aims to reap the most efficient, cost-effective, yet high quality, approaches to running company workflows, processes, transitions, and departmental functions. This audit type is particularly applicable as a foundational piece of any pre-implementation or post-implementation audit whenever a Plan Sponsor is either experiencing poor member services or when changing vendor partners. An essential piece of the operational audit is to verify that the various systems and platforms have been programmed to accurately transact the agreed to specifications and requirements. This could include a wide range of examples such as plan design, provider contracts, member and provider service escalation policies, and other critical functions. Scalability, automation, and flexibility are assessed as well as the optimal use of technology and human resources. Some companies augment operational audits with six sigma exercises, aimed at lowering error rates and refining efficacy across teams. A key question is, "Does each system, human and platform, work proficiently on its own -- and do they augment each other and align seamlessly?" Importantly, operational processes also support compliance with governmental and industry standards.
- **Pharmacy audit:** Pharmacy audit is an assessment of self-funded plan sponsor agreements to ensure appropriate charging of claims. Our PBM audit includes computing claims, performance guarantees, supportive operational workflow, and rebates for a comprehensive review of retail, mail, and specialty pharmacy. All allowable rebates are collected and reviewed to identify further opportunities to collaborate with the PBM around optimal patient care and cost savings.
  - Verify claims are processed in accordance with PBM terms, conditions, and plan design.
  - Reconcile financial guarantees and validate that claims are processed in accordance with contract terms.
  - Review plan design and benefit changes.
  - Evaluate and value trend and opportunities across medical, pharmacy, and vendor programs.
  - Offer guidance around industry issues.
  - Offer reporting including quarterly dashboards of pharmacy utilization, high-cost claimants, and specialty and non-specialty trends.
  - Provide clinical review and analysis including formulary assessment and selection and evaluation of clinical programs, drug pipeline, and medical-based pharmacy drugs.
  - Examine pricing and lessor than logic amongst various pricing options, unit costs, and dispensing fees.

  Recent advances in targeted specialty drug therapy, with an annual cost ranging anywhere from $75k to several million dollars per patient is possible, not to mention skyrocketing pharmacy cost spend related to many drugs including the well-known glucagon-like peptide 1 agonists that are used for diabetes and weight loss (e.g., Ozempic, Wegovy, Zepbound).
- **Platform audit:** Platform audit propels deeply into the inner construct of the data warehouse, data ingestion, and transmission points and evaluates the ability of the platform to cleanse data for accuracy and validation purposes. Critical dimensions to assess within any platform are these: hardwired information, configurability, and customizable attributes. Within these dimensions, auditors discern the strengths and limitations that are evident to support root cause examination. Up to date platforms also include machine learning capabilities and contain flexibility for application programming interfaces. All of these features need to be fortified through industry standard and healthcare-specific security protections.

Figure Two: Framework Structure Dimensions

Examines three levels of structure programmed within a system.
Broad and deep analysis of systematic issues and underlying causality.



- **Reconciliation audit:** Reconciliation audit verifies all costs and revenues within the client's financial institutions that are attributed to the health plan or PBM and compares them to contractual obligations such as administrative services only fees, payment integrity savings, out of network monies, clinical program buy-ups, value-based shared savings and risk models, and more.
- **Value-based arrangement audit:** In our whitepaper, *Challenges and Opportunities in Assessing Healthcare Provider Networks*, we discuss the shift in financial agreements within the healthcare ecosystem from fee-for-service (FFS) structure to VBC arrangements. The healthcare market largely believes the FFS model creates incentives for inefficient/ overuse of care and services as well as certain revenue cycle enhancement behaviors by some providers, whereby they up-code to maximize financial returns. The market response to this has been to create a variety of VBC arrangements designed to address value over volume of services. The definition of "value" has evolved over time, and measuring success fairly for all constituents in these programs has been challenging. However, generally, value is measured as a combination of cost, quality, experience, and equity components that are slowly evolving from process-based to outcomes-based, as more providers take part in these arrangements, and the government continues to promote their usage.

As the implementation of VBC models continues to grow, the current state of the market and audit and payment integrity functions must be equipped to accommodate quality, performance, and equity measures. Risk Strategies Consulting recognizes the need for clearly communicated, understood, and validated clinical and quality metrics between the health plan and the provider that demonstrate value to patients. We also believe that financial performance goals need to be aligned with these metrics. Without clear alignment, common understanding, and effective data, reporting, and analytics, abrasions between the health plan and provider will continue to arise throughout the revenue management cycle.

As the utilization and implementation of high-performance provider networks that can serve as the foundational building blocks for VBCs continue to resonate with plan sponsors and health plans, the need to evaluate their efficacy is a natural result. By utilizing the additional data touchpoints provided from a longitudinal view, an analysis focused on a provider, using their National Provider Identifier (NPI), can be conducted with the evolving technology that is available through generative AI and ML. With this analysis, a provider's case mix as well as service mix, and even billing and admitting patterns, can be used to offer insights into care, coding, and billing services, that when benchmarked against either a local or national cohort, can highlight inefficiencies and inconsistencies that could impact financial and clinical outcomes. Risk Strategies Consulting recognizes the impact that analyses such as these could have on the market through the continual shift towards a VBC financial structure and believes that the billing and coding efficacy determined by a future-ready audit solution should be a factoring criterion in the designation of a provider as high performing. In other words, payment model innovation without payment integrity is incongruent.

Because the audit and PI markets were developed based on the FFS versus the VBC model, future-ready solutions need to bridge and accommodate both revenue models. VBC revenue flow and reconciliation features present new challenges that are an important domain of future-ready audit solutions. These models may encompass total cost of care, episodic, and/ or primary care or specialty-oriented VBC arrangements, and they may represent a multitude of revenue and reconciliation streams. Today, VBC settlement may occur outside the claims adjudication system with manual intervention. Oftentimes, FFS claims are retrospectively reviewed, and a surplus or risk share is determined based on per member per month costs as compared to a pre-determined, risk-adjusted population target. Other times, a fee schedule may be dialed up or down depending on performance, and other times, claims are either retrospectively reviewed for bundled arrangements, or with more sophisticated machinery, may be prospectively grouped under a convener episode provider. The latter usually require a vendor-supplied solution outside the typical claims adjudication system. Surplus, risk share, and clinical coordination monies need to be reconciled on a different timeline than the normal claims payment timeline, and therefore, the plan sponsor bank account and claim wire needs to be assessed for these activities as health plans offer different levels of settlement dollar transactions. Solutions that invest in VBC audit and lead the market have a unique opportunity to be greatly rewarded. To reiterate, it is worthwhile for those with the foresight and vision to adjust to the changing audit and PI landscape because they will deservedly reap the benefits and rewards.

- **Value proposition audit:** We define this audit as testing and validating a proclaimed value proposition of a service, product, or solution through data and programmatic analysis. Does the data support the claims being made as value to a client? Is the value qualitative and quantitative? Are continued investments advised to support improvement and innovation to right-size or change the client offering?

PI Inclusion and Implications

The healthcare industry continues to attract more stakeholders, vendors, payment regulations and oversight, mergers and acquisitions, and innovative revenue cycle management opportunities – and with these, come complexity and sometimes unexpected pricing outcomes and incentives that can affect patient care coordination. These make following the policies, edits, program guidelines, and dollars throughout a multifaceted process even more challenging, creating the significant need for PI excellence. This means a great deal more than adding layers of PI vendors during the pre- and post-payment stages to catch a variety of payment mishaps.

Moreover, these PI audit processes are paramount to improving clinical outcomes, lowering member and provider abrasion, and delivering better access to care. In essence, PI is about aligning incentives and closing gaps, leading to better care and financial rewards, making strategic partnerships for successful payment innovation solutions imperative. Consultants can play a critical role in facilitating efficient and diligent PI processes. They can bring specialized expertise and experience to help healthcare providers, health plans, and clients navigate this crucial undertaking.

Traditionally, PI is the function that ensures accurate payment for claims, encompassing actions related to elements such as quantity, coverage, and service. This adept framework surrounds the complex healthcare delivery system and the transaction ecosystem with broad-based implications. PI impacts, and is impacted by, areas such as clinical policies, coding, fraud/ waste/ abuse, and contracting, involving the provider network, care delivery, and how pharmacy (Rx) is architected within the plan design. In its current state, PI is also heavily impacted by compliance requirements from regulatory, fiduciary, and standards vantage points.

With a heightened focus from regulatory and financial perspectives, plan sponsors and health plans must demonstrate accountability and understanding of where every dollar goes; PI is an integral part of that discipline. When executed correctly, PI can positively (indirectly or directly) impact a better member and provider experience, positive clinical outcomes, more equitable access to care, and better stewardship of medical cost dollars that are saved via reduction in fraud/ waste/ abuse. The key to supporting quality care, with the added benefit of increasing financial responsibility, is through the alignment of incentives with payment accuracy and the use and installation of **appropriate controls**.

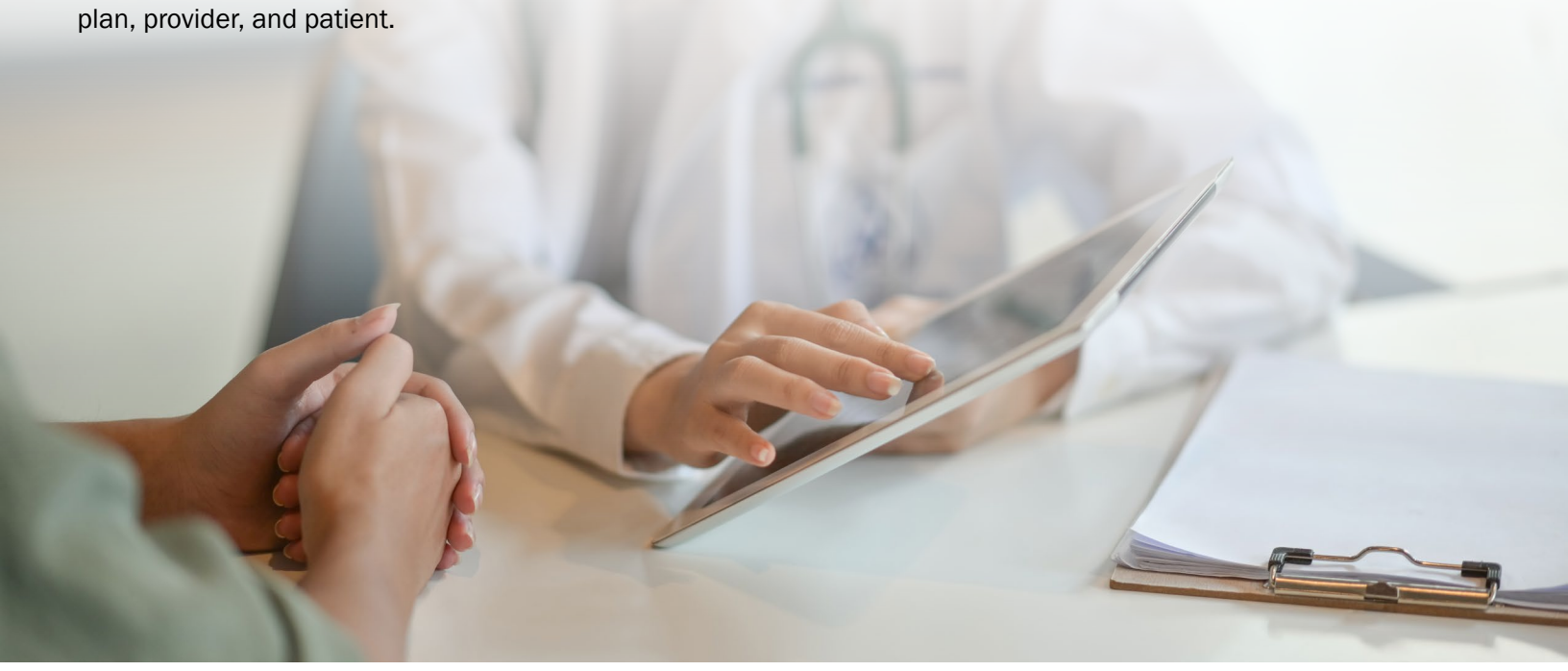
Historically, PI has occurred in pre-payment prevention and post-payment recovery environments. The prefixes "pre" and "post" refer to the review stage of medical claims and bills intended to ensure accuracy in billing coding and methodology, providing needed transparency in the claims payment process. This process also reveals who is financially responsible for the claim and any patterns that may be occurring in billing and coding methodologies.[3] In a pre-payment system, coded claims are reviewed *before* they are paid, and any monies are dispersed to proactively identify and correct any errors or issues. During the "pre-adjudication process" phase, basic coding logic is applied to claims such as whether the correct number of units are utilized and if the codes can be billed together.[4] If everything is accurate, the claim then moves along for review and release. The pre-payment interventions have been seen as an opportunity to reduce provider abrasion and burden in post-recovery efforts; however, these efforts can be limited based on suboptimal data logistics management, lack of a more longitudinal view of claimant, and insufficient technology to assess the complexity of service, procedure, and/ or product.

A post pay methodology has been the common practice in PI; after a claim has been billed and subsequently paid, the claim is reviewed for billing charge and coding accuracy. If errors are discovered, and the health plan's resources validate these findings, the provider is notified, and the vendor reviewing the claim attempts to recover the overpayment. Once the overpayment is recovered, the vendor charges a contingency fee, and the corrected claim is processed.[5] Also referred to as a "pay and chase approach," the post payment model is understandably characterized by low efficiency, low recovery rates, expensive administrative costs, and provider abrasion.

Clinical Management

As clinical management involves an increase in specialty Rx, behavioral health, home and virtual care, and other more complex aspects of healthcare, having PI solutions equipped to accurately face these changing management needs is critical. Given the growth of high-cost specialty drugs and complex cell and gene therapies with diagnostic-related groups (DRGs), medical benefit drugs now account for over 40% of employers' total drug spend. The current systems are not consistently designed for the interpretation of medical-based Rx utilization (e.g., J-codes), resulting in these claims presenting unique challenges that require the combination of coding and clinical expertise. Secondary diagnosis codes are an additional concern with regards to DRGs and are critical in the assignment of DRGs. The secondary diagnosis reflects the severity of the patient's condition. The more severe the secondary diagnoses, the higher the DRG code and reimbursement level. Alternatively, lower DRG codes and reimbursements may be the result of less complex secondary diagnoses. Accurate coding of secondary diagnoses ensures precise and appropriate reimbursements for providers and facilities. Secondary diagnosis errors are common in the current billing and coding environment. An analysis by U.S. Department of Health and Human Services Office of the Inspector General of Medicare claims from 2014-2019 found that some hospitals are increasingly charging at the highest severity and that over half of these claims contain only one secondary diagnosis code that would qualify for highest severity.[6] Risk Strategies Consulting has seen similar trends and has developed proprietary logic and algorithms to identify secondary diagnosis errors to potentially recover dollars with a lower DRG code or relative weight.

Risk Strategies Consulting endorses that, ultimately for PI to be meaningful and successful, the "claimant" or patient must be at the center of the evaluation equation as the industry continues to evolve. A paradigm shift is needed for a patient's care to be viewed as a **journey of care** rather than an episode of care. Paramount to this journey and the improvement of outcomes is the requirement to take a longitudinal view of the patient with a comprehensive picture of their historical data. Unfortunately, PI is often fragmented with only medical or Rx data utilized separately instead of being used in tandem. Risk Strategies Consulting is currently working on the next level of data logistics and management, with the goal of incorporating this longitudinal patient view to include medical and Rx data. Harnessing comprehensive audit tools and capabilities along with a more integrated, dynamic patient data view allows for opportunities to improve clinical management, risk stratification, emerging risks, and overall outcomes for the health plan, provider, and patient.



Claims Adjudication

Risk Strategies Consulting believes leveraging clinicians and specialists is vital to the claims review process, and we do so in our own QEC analytics process, recognizing that the use of such expertise promotes PI solutions to address shifts in the market in a timely manner. This integrated analytics approach of expertise and review also allows PI solutions to address flaws that are presented through the (sole) use of a software system. By solely using software programs, the user must rely on software updates and releases for the most accurate and renewed versions of the tool. These programs typically reflect the most recent version of CMS and/ or American Medical Association policies, which dictate medical coding and billing practices, ensuring that compliance is maintained. However, these programs often do not reflect state or plan sponsor specific rules and regulations. The use of human expertise allows for solutions to capture the nuances of different state and federal regulatory practices as well as changes and updates to numerous billing and coding methodologies and without the lag time associated with a software update.[3]

Recently, the Risk Strategies Consulting Audit team worked with a client to help them identify patients who were receiving dialysis treatments pursuant to an end stage renal disease (ESRD) diagnosis and ultimately provided information to them about any eligible dollars that were recoverable. Our assessment included reviewing a combination of DRGs, current procedural terminology codes, health plans, and dates of treatment that went into the final assessment of claimant data. Our algorithms took parameters into consideration such as ESRD diagnosis date, date of kidney transplant (where applicable), Medicare entitlement date, calculated transition date to Medicare as primary health plan, and the allowed and plan paid dollars. Risk Strategies Consulting provided estimated dollars that the health plan could potentially recoup, as well as identified a subset of patients who may need assistance in transitioning to Medicare, if desired. Of the 455 claimants reviewed, the possible recoveries exceeded $9 million.

Risk Strategies Consulting augments the work of our own Clinical Audit team via implementation of generative artificial intelligence (AI), ML, and data mining practices, and advocates for the continued implementation of these tools by viable PI solutions. Through the use of data and algorithms, ML allows the system to call out any patterns or errors that human analytics may have missed, thus potentially providing additional savings and transparency through each aspect of the PI process. As partners across the continuum of care gain confidence in solutions' competencies and data usage, data libraries will continue to grow, making the capabilities more robust. Continued integration of AI into systems to aid in pattern recognition around billing, admitting, and referrals will be an integral part of the industry's evolution, and understanding the interdependencies of these complementary approaches is of great importance.

The need for accessible, consistent data points where the data is cleaner and more accurate is paramount in the PI industry's continued evolution. The incorporation of longitudinal claim history can not only assist the field with regard to DRGs payment but can also allow the PI industry to address the potential for upcoding of diagnostic, revenue, and procedural codes.

Health Plan and Provider Contracting

Risk Strategies Consulting believes that deficiencies rooted in data logistics management, disparities in data sets, and antiquated systems augment the failures and further segment the pre- or post-payment environments. The segmentation of a claimant's journey, combined with misaligned incentives, results in low efficiency with varied audit types and functions, creating a significant amount of cost and abrasion for the health plan, provider, and sometimes, the member. We assert that the health plan-provider contracting method becomes an initial area of impact to determine how financial incentives are aligned, clinical management can be improved, and potential risks for abrasion can be minimized. Noteworthily, sometimes a limited systems infrastructure further limits the contract methods available to the contracting parties.

Even traditional health plan-provider contracting reimbursement is varied and requires a nimble approach to auditing, with anything from percent of charge, to case rate, Medicare-mimicking methodology, or per diem methods in place. In addition to these payment foundations, carve-outs, outlier clauses, out-of-network nuances, and provider policy or state-specific requirements exist as well, and capturing all of these within the payment process is far from streamlined.

As we witness the gradual movement of FFS contracting to more VBC arrangements, the need for an understanding of the clinical, quality, and financial performance metrics that underpin these constructs exists. The need for a systematic, data-driven approach to evaluating the claimant journey supports the additional necessity of delivering a PI model that can flex for the reconciliation complexities of determining provider payments that are aligned to improvements in quality, clinical, and financial performance.

In conclusion, healthcare auditing of administrative, compliance, financial, and clinical systems and platforms are integral to healthcare administration and have a decisive impact on care delivery. As discussed in this paper, consultants can play a critical role in facilitating efficient and diligent auditing processes of how these are independently and dependently functioning, internally and externally. And while traditional auditing functions can be used to inform a plan sponsor of cost-saving opportunities, the implementation of a ***strong and diverse auditing framework*** provides the opportunity for real-time savings and change. Viable auditing solutions reinforce a strong commitment to understanding the inherent value of ***clinical insights*** in evaluations as well as through additional, dynamic factors such as VBC arrangements. These solutions empower more efficiency and increase recoveries as well as bolster medical and specialty Rx opportunities. Additionally, the process will deliver beneficial outcomes from multiple perspectives across these key domains: clinical, financial, member experience, provider experience, and health equity.

In essence, healthcare auditing is an evolving industry that is foundational to the next generation of healthcare accountability. Emerging technology will help provide connectivity that adeptly places the patient journey at the center of care, resulting in improved patient experience. While the market is filled with strong players with specialty strengths, Risk Strategies Consulting believes the optimal auditing approach is architected with a heightened analytics process that pinpoints ***contracting, clinical management, and claim operations intersections***.

Of paramount importance, the solutions, tools, and diligent audit processes need to be supported by a ***core team*** of healthcare subject matter experts and conducted with ***integrity and complete, objective*** communications with stakeholders. These shifts are in everyone's best interest: health plan, plan sponsor, provider, and especially, patient. Risk Strategies Consulting and its partners are committed to providing future-ready solutions to our clients as we navigate this evolving landscape.

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Comprehensive Healthcare Auditing: Ensuring Transparency and Responsibility

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Risk Strategies Consulting is focused on assessing, managing, and abating clinical and financial risks for our clients. We continuously mine our large claims database to expose unseen key issues and extract actionable insights.

Risk Strategies Consulting is comprised of experienced consultants, actuaries, data scientists, auditors, pharmacists, accountants, and other experts able to help payers, providers, and plan sponsors clearly understand the risks of their business and ways to minimize and manage them. As a national consulting and actuarial services business, Risk Strategies Consulting provides high-touch consulting and state-of-the-art analytics services including strategy and consulting (encompassing health and welfare with deep pharmacy expertise, as well as mergers and acquisitions); actuarial services for plan sponsors, providers, and insurers; and benefit and claim audit services. Services are provided for a wide variety of industry segments including government entities, manufacturing and distribution, and self-funded organizations including corporations and trusts, healthcare organizations, national and regional insurance companies, and private equity firms, among others.

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