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Paying The Costs of Complacency

Why AI-powered payment accuracy is key to safeguarding your plan's bottom line

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In the past decade, a series of policy reforms and events — from the Affordable Care Act to the COVID-19 pandemic — have put the profitability of US health plans at risk.

In fact, profitability has reached one of its lowest points since 2012 with underwriting margins at a seven-year low of 2%, according to an analysis by the Deloitte Center for Health Solutions.[1] Meanwhile, the healthcare industry is caring for an aging population that is living longer and includes a growing number of people with chronic conditions such as diabetes and kidney disease.[2]

Under these conditions, US healthcare spending — which reached $4.5 trillion in 2022 — will continue to rise.[3] So will improper payments and cases of fraud, waste and abuse (FWA), which together cost the US healthcare system $760 billion to $935 billion annually.[4]

"Health plans' financial future will likely depend on having the right business mix and making strong investments today," says the analysis, which also points to several areas that will make plans successful, including leveraging artificial intelligence.[1]

Using the same tools to fight the evolving landscape of improper payments will leave plans stuck with the status quo, struggling to see a return on investment for teams charged with investigating more complex and higher value cases. Today, the teams making the most meaningful impact are using AI and other machine learning tactics for improper payment detection.

Health plans leading the charge in using AI solutions to tackle improper payments can catch emerging trends before they become catastrophic. They will also: increase collaboration among departments that are traditionally siloed; reduce the burden on their technology teams; elevate efficiency across departments; and improve quality of care, which can lead to improved quality scores for providers, reduced medical costs and a growth in membership.

Consider a situation in which health plans, care providers and researchers stop innovating and developing new treatments because one treatment worked five years ago. The same can be said for finding and preventing improper payments. What worked years ago falls short when applied to today's fraud, waste and abuse and other improper payments.

Health plans that don't seek out new solutions to improper payment detection risk financial losses as schemes become more sophisticated and regulations continually change, creating new and more serious threats.

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Emerging threats

New technologies and services can improve care, but they also require increased vigilance and new methods to flag problems. Telehealth, for example, had been rising in popularity before the COVID-19 pandemic forced a rapid expansion.[5] That opened the door for increased rates in improper payments as well as fraud, waste and abuse.

In June 2023, the US Department of Justice reported charges of more than $1.9 billion in telemedicine schemes that involved claims to Medicare and other government insurers for orthotic braces, prescription skin creams and other items not medically necessary and not eligible for Medicare reimbursement.[6]

Meanwhile, behavioral health issues had already been on the rise and were exacerbated by the COVID-19 pandemic. Claim lines with behavioral health diagnoses increased from 1.3% to 2.7% from 2007 to 2017, a 108% increase. During that same period, claim lines associated with mental health diagnoses increased 86%, from 1.2% to 2.3%.[7] This surge in claims has opened the door for increased fraud, and in just one example from 2021, authorities charged 13 people in a $5.4 million Medicaid case in Minnesota for mental health and ancillary interpretation services that officials said were never rendered.[8]

Opioid misuse remains a national crisis six years after it was deemed an epidemic. More than 1 million Medicare recipients in 2021 received a diagnosis of opioid use disorder.[9] From 2007 to 2017, claim lines associated with substance abuse and dependence grew 405%, from 0.1% to 0.5%.[8]. One criminal case in May 2022 led to charges against 14 people in a scheme involving the illegal prescription and distribution of 5.1 million pills, which amounted to about $7 million in opioid-related fraud loss.[10]

With these new risks, health plans need new ways to analyze the relationships between providers and facilities and members. They need to examine schemes at a much more sophisticated level and uncover the links that can mean the difference between one provider's malfeasance and a nationwide network putting millions of dollars at risk.

If plans are still using a simplified, claim level, rules-based detection system only, they are limited to tunnel vision. But analyzing data with AI provides a broader view including dynamic scenarios, network level detection, relationship analysis and increased chances to save or recover exponential amounts of money. Like healthcare, improper payment detection technology has made significant advancements in the past decade. Plans can now see and detect so much more than was possible previously, and those that don't embrace these new technologies risk paying a high cost for inaction.

AI: An essential new tool

The traditional ways of detecting improper payments are outdated, more time-consuming for investigators and typically do not produce enough return on investment to justify the time spent. Investigators have historically reacted to improper payments rather than proactively catching issues at an earlier stage.

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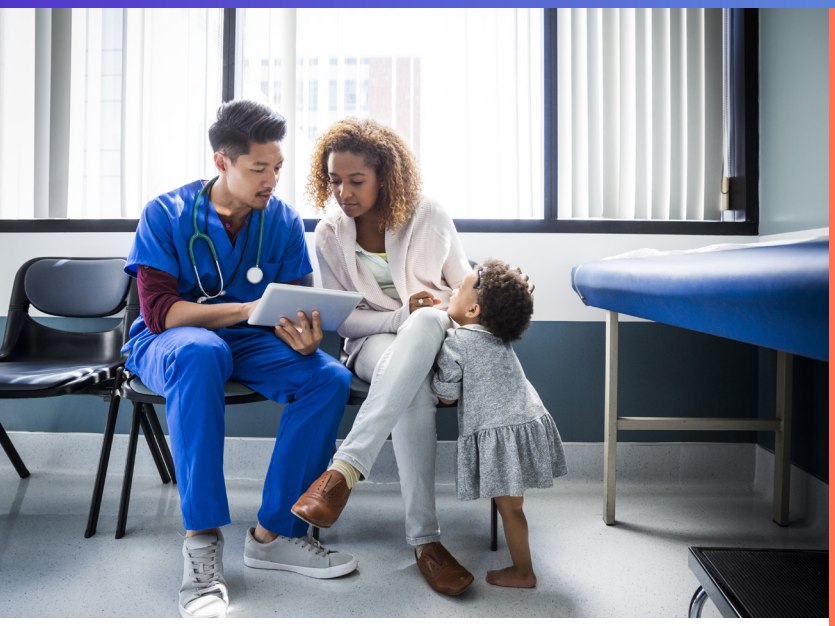

Investigators often use rules-based analysis, which can't keep up with the many new and updated codes easily. And investigators get bogged down following a single claim or miss connections pointing to a larger, costlier issue.

FWA and payment integrity teams also pull in other shared resources that a health plan could be using elsewhere, said Mark Starinsky, AHFI, CFE, CPC, a former investigator who is now head of product for Shift Technology, which offers AI solutions for insurers. There's a lot of manual input, tweaking and constant maintenance needed from an information technology department to support such systems, Starinsky said.

Small to midsize plans just don't have the resources, says payment integrity consultant Frank Condo. If they don't bring someone in to do some of that work, it's not getting done and they aren't getting a full view of the plan's risk in the shortest amount of time.

CASE STUDY: LOOKING BEYOND THE CLAIM TO SEE THE ($22M) BIG PICTURE

In one case flagged by Shift, a provider was submitting $50,000 claims for anesthesia of the head, an expensive procedure when billed separately from electroshock therapy by the same provider. If billed together, this code combination makes the complete treatment much less expensive due to a National Correct Coding Initiative (NCCI) edit. In this case, the anomalous billing pattern potentially circumventing the edit was flagged, raising suspicion of this provider and their subsequent claims.

A traditional approach may have just examined a single claim or series of claims from the individual provider with unusual unbundled NCCI edits. The automated network analysis found that this provider was connected to 20 additional providers, exposing potential collusion between providers who may also be billing separately for anesthesia of the head and electroshock therapy - and potentially providing kickbacks for circumventing the NCCI edit.

Shift incorporates extensive external data into its alerts to give investigators more information on each provider. This can include online provider reviews that note poor quality of care, facility information and other CMS data.

- Without AI and other advanced technologies, this additional research either wouldn't be available to investigators or would require many additional staff hours.

With AI and the power of Shift's network alerts, an individual exposure of $579,000 that had been reimbursed to the provider became part of a broader view, increasing the value of the investigation for the health plan. In the end, 20 additional providers were flagged, along with a total of $22 million in exposure. By moving unbundled claims to pre-pay edits, the health plan transformed a repeated $50,000 claim to less than $500.

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"Yesterday's solutions are no match for today's problems."

Fortunately, innovative use of AI can help cut through the noise to focus on emerging high-value cases while also automating time-consuming manual processes. AI solutions from a trusted partner like Shift Technology can gather much more diverse data for a broader look to flag patterns, which investigators can then focus on, making special investigations units (SIUs) more efficient.

Pre-investigative work can be significantly reduced, allowing investigators to focus on more urgent tasks and cases. Data and information that investigators need can be brought directly to them in one UI instantly, rather than teams having to hunt for it on their own or make requests to analytics or business intelligence teams, exhausting additional resources.

With Shift's AI solution, departmental data that was once siloed — everything from internal audits and customer service to contracting and network management — can now be brought into one system for faster, more accurate analysis. This advancement improves collaboration and provides an opportunity to detect larger patterns that might be missed when looking at data segmented by department.

AI can find high-value, emerging cases — including national schemes that a small investigations team wouldn't have the bandwidth to research — and detect relationships that would be missed going claim by claim manually.

Better integration between departments can also enable health plans to make important connections in member behavior. What if integrating data across various systems allowed a health plan to quickly see if a member is newly enrolled and is immediately tied to anomalous claims data and activity? Leveraging a plan's enrollment data could allow teams to find connections between membership enrollment data (such as timing, address, income level) and claims data - better determining if the claims a new member is submitting during an enrollment verification period are suspicious.

Driving down costs, driving up quality of care

Stopping improper payments benefits a health plan and its members in several ways. Investigations can help remove providers who aren't providing services they claim to be. If an orthopedic surgeon bills for post-operative care they're not actually providing, that plan member likely will end up back in the hospital, leading to more charges for the payer.

"It's not just about making sure that providers are being honest. It's about making sure the patients are getting the care they expect," said Ian Watters, head of sales for Shift Technology. "And that ultimately drives down the total cost of care for the payer and for the health system."

Watters added that every dollar a health plan finds that was improperly paid goes back into the system, and that money gets reinvested into quality of care.

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Of course, not all errors are due to fraud. In fact, fraud makes up a small fraction of money lost to health care systems annually. Waste accounts for the largest loss.[3] Investigative teams, keyed into the right focus areas, with the right tools, can find costly coding errors and overbilling.

"Improper payments normally occur because it's just a very, very complex system with all the rules and regulations that CMS and state agencies have," Condo said.

Once errors are found, plans can turn their focus to educating providers. This can decrease provider abrasion through more precise targeting of issues, allowing for faster resolution of payments. This helps maintain the quality of a plan's network, which benefits both the bottom line and patient care.

AI: The next step for today's health plans

As competition tightens in an evolving healthcare marketplace, a nimble solution that leverages AI is a payer's greatest chance to flag and defend themselves against emerging and high-value threats.

Some plans may already have their own homegrown solutions that have worked just fine in the past, or they may be complacent with a partner they chose 10 years ago because that relationship has also worked just fine in the past. Unfortunately, forward-thinking fraudsters and evolving schemes have demonstrated time and time again that yesterday's solutions are no match for today's problems. An improper payment solution that offers data mapping, data cleansing and data analysis requires significant technical expertise and resources that health plans need to rely on. This external expertise is an essential part of getting ahead and staying ahead in the current marketplace.

Shift Technology has been offering AI solutions since 2014, with large language models in place since 2020. It takes health plan data, everything from claims reports to provider education, and integrates it with external information — an online review of a health care experience, for example — to paint a broader, more accurate picture. This enhanced collaboration among departments paves the way for investigations teams to make connections that might otherwise be missed in the traditional, siloed data systems.

Investigators get data that has been automatically consolidated and grouped, reducing false positives and increasing alert impact threefold. Automated processes allow investigators to focus their efforts and boost their efficiency by 200%.

With smarter, automated decision-making solutions, payers can ensure their funds are going to the right place: helping them get ahead and provide the best care and experience to their members, now and in the future.

As improper payments and FWA continue to threaten health plans' profitability, it is increasingly important to manage risks and curb unnecessary spending. Plans that leverage innovative technologies and expertise for improper payment detection will be more nimble and better able to respond to both emerging threats and exciting opportunities.

Shift Technology delivers unparalleled AI-driven insights to help health plans take action with speed and accuracy.

Learn more here

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