Achieving Accuracy and Efficiency in Claim Pricing

A toolkit



Optum

Forward

Claim pricing is complex. With provider contracts, claims data, federal and state regulatory requirements, industry trends and business policies all contributing to the claims pricing process, it can be challenging to coordinate payment accuracy and timeliness.

Automated claim pricing technology, services and solutions are a critical component to ensuring payment accuracy on the first pass. At Optum, we engage with leadership at our health plan partners across all lines of government and commercial business to understand the challenges they face. In this toolkit, our experts take that experience and share their viewpoints on creating a claim pricing framework that will drive both accuracy and efficiency.



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Claim pricing solutions and impacts

As claim adjudication platforms continue to evolve, it is important for health plans to develop a claim pricing framework that aligns with their broader claim lifecycle management strategy.

An effective claim pricing solution often includes three components:

- A contract management tool to manage and customize contracts, rates and fee schedules
- A claim pricing engine that integrates with your existing claim adjudication platform to group and price claims
- A claim pricing platform that allows you to reprice claims, investigate claim pricing results, provide transparency into claim pricing, and model or analyze new pricing changes

But even with a robust pricing solution, there are challenges. How can health plans coordinate multiple systems to ensure that rules, contracts and integrations are configured correctly? And how can they effectively synchronize their data to meet prompt payment requirements?



Key considerations for accurate and efficient claim pricing

Our experts have identified five key factors to consider when creating your claim pricing framework.

1. Improve efficiency and reduce your reliance on IT by shifting claim pricing software to a cloud-based delivery model
2. Increase auto-adjudication rates by configuring your contracts to maximize the flexibility of your pricers
3. Increase overall speed-to-market while reducing complexity and redundancy by creating repeatable and scalable processes to adopt new regulatory changes
4. Strengthen provider relations by creating transparency around how each claim is priced
5. Invest in the training and education of staff to effectively consume content changes and configure new agreements as needed



Claim pricing in the cloud

Procuring infrastructure, maintaining software and dedicating IT staff to support on-premises claim pricing solutions can be challenging for some health plans. For those looking to move claim technology off-site, a cloud-based, software-as-a-service (SaaS) delivery model often offers the same claim pricing functionality without the challenges.

Like on-premises solutions, cloud-based claim pricing software sits beneath a health plan's claim adjudication system and provides real-time claim pricing results via a secure https connection. But unlike on-premises technology, all content and pricer updates are automated and managed by the software vendor. This not only improves efficiency, but also reduces your team's reliance on internal IT.

Cloud-based solutions can also benefit organizations using multiple claim platforms, modeling and analytic tools. While each platform and tool may require a separate on-premises installation, SaaS pricing solutions allow for simple cloud-based integrations, ensuring that claim pricing doesn't vary by platform.

Determining if a SaaS delivery model is right for your organization

- Does your IT team have resources available to dedicate to on-premises infrastructure and software management?
- Is your current speed-to-production for updates to editing, mapping, grouping and pricing data impacting the accuracy of your claim pricing?
- If you use multiple claim platforms and tools, are on-site installations causing inconsistencies in pricing of the same claim between platforms?
- Can your on-premises technology scale to meet your future needs?



Creating pricing transparency

One of the biggest challenges facing claims operations and configurations teams today is the ability to provide verification to providers or auditors on why a claim priced the way it did.

Medicare, Medicaid and commercial rates are constantly changing, sometimes retroactively. For example, Medicare inpatient and outpatient facility rates are released 6-8 times per year and include both new contract effective dates as well as historical changes to a facility's wage index, cost to charge ratio or any of the other 50+ variables that make up a provider agreement.

To mitigate the pricing confusion caused by this constant flux in contract terms, heath plans need to create transparency into how individual claims are priced. One way to do this is through the creation of claim pricing worksheets.

Pricing worksheets outline the step-by-step calculations for how each claim is priced. Worksheets are created by a claims processing platform and can be exported and shared directly with providers. This provides defensible, detailed verification of the rates used and any pricing adjustments that were needed, and often exposes the root cause of pricing disparities between health plans and providers.

In addition, multiple iterations of a claim can often be stored in a pricing worksheet database. This allows health plans to easily review both the current payment amount for a claim and any prior payment amounts.



Claim pricing worksheets create transparency around how a claim is priced.

They often include calculations for:

- How an inlier was priced
- Evaluation of outlier add-ons
- Other pricing adjustments required



Modeling contracts, regulatory changes and financial forecasts

Regulatory updates or changes to provider agreements can have a significant financial impact on health plans. To better understand how these changes could affect their bottom line, health plans often utilize modeling tools. Modeling tools can sit within a payer's claims processing platform and are used to project the financial impact of updated provider agreements, regulatory changes or to forecast financials.



Contract modeling

When negotiating provider agreements, health care economics and actuarial teams often model out the financial impact of potential contract term changes. Many modeling tools can analyze contracts across a single provider, a multi-provider network or across a health plan's book of business. This analysis informs the negotiation process by giving health plans a clear line of sight into how contracting decisions could impact overall spend, as well as which changes could have the biggest impact. Contract modeling is also beneficial to providers, as this information could provide the transparency needed to expedite the contract negotiation process.



Regulatory change analysis

Actuarial and clinical policy teams are always working to better understand the financial impact driven by regulatory changes. Modeling tools can make this work more efficient and effective. By running a model of representative claims against the latest prospective payment system tools, health plans can better understand the impact of changes published by CMS or a state regulatory body.

In addition, modeling tools can help health plans understand if any previously paid claims are impacted by retroactive changes. This ability to accurately identify impacted claims and adjust payments is critical, especially if the retroactive adjustment results in a payout to the provider.



Financial forecasting

Having a clear understanding of the financial impact of regulatory or provider agreement changes will ultimately help health plans with their broader financial forecasting efforts, including setting reserves and projecting medical expenditures.

For example, when assessing the impact of new fiscal year changes, a health plan could run the previous year's claims against the new fiscal year rule set to identify if a higher percentage of claims may trigger high-cost outliers or group to higher acuity DRGs. This analysis would enable a health plan to project which changes may drive higher payment integrity services utilization, thus add additional costs.



What to look for in a claims modeling tool

1. The most effective modeling tools derive their claims data sets from claims history. This reduces a health plan's reliance on internal IT and empowers the end-user to perform modeling activities on their own.

2. Use a tool that is actively used to price claims in production. This ensures that the rules used for models are consistent with what is used to actually pay claims, reducing the likelihood of errors.

3. Ensure the modeling tool provides an adequate number of user licenses to meet your needs. When modeling is limited to certain business areas or teams, it can unintentionally add additional work to their already full plates.

4. Look for a tool with simple overrides and forward dating capabilities. This allows users to run the models they need without having to build custom data sets for each model or relying on data from other platforms, which may have limitations.

About Optum

With breadth of industry knowledge and depth of experience, Optum is uniquely positioned to offer comprehensive services that can not only help you deal with pricing challenges, but also support you across a wide range of interconnected strategic and operational domains. We bring together incomparable data and analytics with years of experience in both consulting and on the front lines of health care. Our team of experts is always available to work in partnership with health plans to improve health care and make the system work better for everyone.

Learn how Optum can help you determine and reach your organization's goals at optum.com/pi

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