

2007 Showcase in Excellence Awards Recipient

Banner Health – “Medical and Dental Claim Payment Turnaround Time and Process Improvement Methodologies”



Company Information:

Highest Ranking Official: Peter S. Fine, FACHE,
President and CEO of Banner Health

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Type of work: A part of Banner Health, Banner Plan Administration (BPA) provides self-funded and self-administered health and welfare benefit coverage for 47,000 employees and their family members. BPA receives an average of 4,000 claims per day. Paying claims in a timely and accurate manner is the key to the organization's success.

Workforce: 180 employees at Banner Plan Administration - 30 members of the Reimbursement Services Team

Testimonial of Value of Arizona State Quality Awards Program.

“As a large employer in Arizona, Banner Health is committed to offering excellent benefits to our employees. By providing medical and dental plan coverage for 47,000 Banner employees and their family members, we continually focus on best practices that improve outcomes and enhance service excellence. The AQA Award is recognition of the achievements of our health plan's Reimbursement Services team and their commitment to quality improvement. We are proud of their leadership and extremely pleased to have been selected as a recipient of the AQA Showcase in Excellence Award.”

-Bill Harris, Senior Director, Banner Plan Administration

Highlights of Organizational Process:

BPA operational performance is focused on the Banner vision of working smarter, faster, better, together. Timely and accurate claim payment allows for establishing stronger engagement from our provider community and eliminates unnecessary member concern about healthcare coverage and availability.

BPA realizes this vision by achieving the highest levels of industry performance through the continuous focus on our customers and process improvement. BPA effectively lessens claim errors, increases productivity, improves quality, and reduces the overall cost for our operations. BPA is responsive and flexible. Our cycle time has been decreased significantly by measuring and analyzing key processes, outputs, and results. Data is gathered routinely to support decision-making and develop ongoing process enhancement.

Process Improvement Methodology

Timely payment of claims

Establishing a workflow helped the team identify time lags in specified areas. By breaking down each step of the process, the team was able to create a timeline supported by data to document the process cycle time from start to finish. Within each segment, workflow processes were reviewed and specific areas of lag were identified. The team determined that meeting our goals of payment within 10 days of receipt would require reducing the length of time spent in each segment of the workflow. The team determined the mail must be opened, sorted, and imaged by 12:00 pm daily. Image validation must occur within 24 hours of receipt. Improving the ability of the claims system to auto-adjudicate with the use of improved payment rules and logic increased the rate of automatic processing to 80-90% for payment or denial within 48 hours. Another area of delay was in the printing and mailing of the checks. The check production process normally took days for printing due to the volume and the capability of the printer. Sorting, folding, and stuffing this material into envelopes added an additional 3-4 days processing time. The BPA team decided to outsource this function because electronic files could be submitted to the payment vendor on the day of completion and this vendor would have the payment printed and mailed within 48 hours.

Accurate payment of claims

Industry standards for quality require a 98% financial, 98% statistical and 98% payment accuracy. BPA was determined to meet and/or exceed this goal. Quality measures were identified by tracking the receipt of refunds, phone calls, and reconsideration requests. Trends were noted in areas of payment methodology, fee structures, and personal knowledge by auditing claims payments, reconsiderations, events, and refunds. An audit database was developed to track opportunities for improvement for both the individual staff member and for the Reimbursement Services team as a whole. The Team identified issues by tracking errors and used this knowledge to correct system payment logic and offer training where needed. Overall quality measures/trends are reviewed monthly by the management team. A continuous cycle of evaluating, learning, modifying, testing and review is our strategy.

Results

In 2004, there was a backlog of pending claims equaling approximately 160,000 claims. Over 60% of the claims exceeded 30 day payment requirements, per our contracts. In contrast, there is now an average of 400 claims pending on any given day and BPA maintains a goal of 95% of claim payments made within 10 days. We continue to review areas for improvement.

Annual increases in premium rates to Banner and it's employees has been reduced from the nationwide average of 12-15% per year to rate increases of 6% in 2007 and 4% for 2008. A significant portion of this reduction in cost is due to improved claims payment accuracy, ability to better analyze cost changes due to timely data, improved provider engagement, and reduced requests for payment increases.

Quality and accuracy rates are at an overall rate of 99.73% in the year 2007, saving Banner Health significant dollars in costly mistakes.

Banner Plan Administration has successfully increased the size of our provider network on an annual basis due to improved confidence in the ability for our organization to make timely and accurate payments and reduced administrative costs for the Banner provider network.