LEARNING & ANALYSIS BRIEF

PharmAccess FOUNDATION

DATA MANAGEMENT

IMPROVING THE TIMELY PAYMENT OF CLAIMS TO HEALTHCARE PROVIDERS

Timely claims settlement and payment are crucial to provider satisfaction with a certain health plan. This brief discusses means taken by Hygeia Community Health Care to decrease the number of days between a healthcare visit and the date of claims processing in Kwara State and Lagos State, Nigeria.

Prompt payment of claims to healthcare providers is key to building their trust in health insurance programs. Provider satisfaction with a health plan depends on timely claims settlement and payment. This is especially true for private providers who need money to cover operational costs, including drug supplies, and to reinvest in their business.

Hygeia Community Health Care (HCHC), supported by the Dutch Health Insurance Fund, is establishing sustainable systems of healthcare delivery and financing through private health insurance for individuals and communities in rural Kwara State and for market women in Lagos State, Nigeria. The Kwara State Health Insurance Program started in 2007 in the Edu Local Government Area (LGA). Between 2007-2015, the program expanded to include additional target groups in 11 LGAs and by May 2015 over 100,000 people were enrolled.

HCHC provides access to care through designated private and public healthcare providers enlisted in the program. These providers are reimbursed at the beginning of every month for patient visits via a Capitation Fee that covers basic primary healthcare. For higher levels of care, such as antenatal care, caesarean sections, or chronic care, providers are reimbursed on a Fee-for-Service basis after sending a reimbursement claim to HCHC. The contract between HCHC and healthcare providers specifies the maximum number of days for claims adjudication. Providers have to send their claims within 30 days of the date of patient discharge or encounter. HCHC has to process claims within 60 days of receipt.

As the number of enrollees increases, the number of claims to be processed increases as well. In the second half of 2013, HCHC had great difficulties in paying claims within the agreed time frame. The introduction of a new software system actually undermined HCHC capacity for timely claims settlement and payment. The system would reject an entire batch of claims if one of the claims had a formatting error or typo. In addition, it was difficult to link claims paid with the approval (pre-authorization) given to a provider for Fee-for-Service

Main findings

- **The number of claims processed in the Kwara program increased 86% from 16,904 in July-December 2013 to 31,359 in July-December 2014.**
- **The average number of days between the date of encounter and the date claims were processed decreased from 109 to 78.**
- **The percentage of approved claims paid within 3 months after the date of encounter increased from 1.5% in the second half of 2013 to close to 100% in the second half of 2014.**

KEY COUNTRY FACTS

173.6 m
population (54% are rural)

46%
of people live below the national poverty line

62%
of people live on less than USD 1.25/day

69%
of people's spending on healthcare is out-of-pocket

18%
general government expenditures on health (more than the 15% Abuja norm)

0.53
hospital beds per 1,000 people

– Based on 2012 and 2013 World Bank and World Health Organization data.

PROGRAM FACTS

The Kwara State Health Insurance program was launched in 2007 to increase accessibility and affordability of basic quality care for low income earners in the rural population of Kwara State, Nigeria.

105,501
enrollees

35
clinics

TOP 5 DIAGNOSES

1. Malaria
2. Hypertension
3. Pregnancy
4. Upper respiratory tract infections
5. Respiratory/Ear, nose, throat complaints

– Data up to May 2015.

Table 1 **Improving claims processing.**

Month of claim processing	2013	2014	2014
	Jul - Dec	Jan - Jun	Jul - Dec
Number of Kwara claims processed	16,904	21,828	31,359
Average number of days for processing a claim	109	91	78
Percentage of approved claims processed within 3 months after the data of encounter	1.5%	70.5%	99.7%

encounters. The pre-authorization codes generated by the system were in a different format from those issued to the provider by HCHC. Thus, these checks had to be done manually, which took a lot of time.

Methodology

In 2014, PharmAccess offered an incentive for HCHC to decrease the number of days between the healthcare visit and the date of claims processing. HCHC addressed the issue by taking the following measures:

- HCHC decided to stop working with the electronic system and to return to manual claims processing.
- The Centre for Management Development trained the data management team to improve their reporting skills using Microsoft Access.
- On-site training was conducted at provider sites to explain how to properly fill out the claims forms.
- A cut-off date for submission of monthly claims was agreed on with the providers.

Findings

Claims adjudication was clearly much faster after switching back to manual claims processing, however, this is not a cost-efficient solution in the long run. HCHC recently selected another electronic system for automated claims adjudication and this software will be implemented in 2015. The new software stores enrolment data, utilization/claims data, and pre-authorization data in one database. Business rules for claims adjudication are also included in the software. This is expected to decrease claims processing time even further.

Lessons learned

The introduction of an automated claims management system was not successful and caused delays in claims adjudication and payment. The data management team processed claims manually before the system was introduced. They had knowledge about which checks to perform and what errors are often encountered in claims. However, the team was not adequately involved in the design and implementation of the new system.

An effective change management strategy was lacking during the transition period from the manual system to the automated system. As a result, the system did not work well. The manual way of working turned out to be more efficient.

Capacity building is key for all parties in a health insurance program. This includes training on data management skills for local implementing partners and on claims form management skills for providers. Refresher training needs to be scheduled on a regular basis to improve competence in data capturing and trained colleagues can train new staff members.

An incentive offered to improve performance was very motivating for HCHC in general as well as for the data management team in particular. Healthcare providers are clearly motivated to submit claims on time, but it would be worthwhile to explore the use of penalties/incentives for submitting complete, valid claims forms.

TAKE HOME MESSAGES

- Incentives to improve performance are a good motivation.
- The data management team needs to be involved in the design and implementation of automated processes.
- Effective change management is important in the transition from a manual to an automated one process.
- Capacity building on data management is key and refresher trainings need to be scheduled on a regular basis to increase staff skill levels.

AUTHORS

Emeka Ajanwachuku, Alice Ogink, Dr. Olufunke Ijimakin

AFFILIATIONS

PharmAccess Foundation

MORE INFORMATION

For more information on this topic, please contact the author:
a.ogink@Pharmaccess.org

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Contact info@pharmaccess.org | www.pharmaccess.org

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