SIERRA SOLUTIONS

FACETS
BATCH OPTIMIZATION

WHITE PAPER

Improving Core Claims and Enrollment Processing
at a New York Health Plan

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Big Picture Overview

Sierra Solutions partnered with a New York-based regional health plan to resolve recurring FACETS batch errors that were stalling operational efficiency. By analyzing over 470K+ processing errors across enrollment, claims, billing, and accumulators, Sierra identified systemic root causes and developed an enterprise remediation roadmap. This strategic intervention reduced manual rework, improved data integrity, and strengthened the foundational processes essential for member and provider satisfaction.

The Situation

The organization relies on the FACETS core administration platform for its most critical workflows: member enrollment, medical claims adjudication, billing, and accumulator management. These automated batch processes are the "engine room" of the plan. However, persistent errors across these jobs began creating significant backlogs, requiring heavy manual intervention and delaying vital services like ID card generation and premium payments.

The Challenge

Initial diagnostics revealed a massive volume of fallout across critical FACETS modules. The complexity of these errors created a "bottleneck effect," where automated jobs failed and defaulted to manual processing, straining departmental resources:

- Enrollment & Eligibility (227K Errors): Predominantly driven by MMS (Member Management System) batch failures. The root issues involved overlapping effective/termination dates and inconsistent eligibility segments that prevented the automated generation of ID cards and member kits.
- Claims Adjudication (171K Errors): High failure rates in CLCL jobs were linked to missing provider reference data and misconfigured Coordination of Benefits (COB) rules. This forced a high percentage of claims into manual pended queues, delaying provider reimbursements.
- Billing & Financials (70K Errors): BIL0 batch processes suffered from rate table configuration errors and subscriber data gaps. This led to "billing bypass" events, where invoices were either inaccurate or not generated, directly impacting premium cash flow.
- Accumulator Drift: Inconsistencies between the claims engine and member benefit accumulators resulted in inaccurate deductible and out-of-pocket balances. This required claims examiners to perform manual "look-backs" and adjustments to maintain financial integrity.

Our Approach

Sierra collaborated with the health plan's operational and IT leadership to conduct a high-fidelity assessment. We structured the engagement into four strategic workstreams:

- Batch Processing & Log Analysis: A deep dive into MMS (Enrollment), CLCL (Claims), BIL0 (Billing), and ABIX/FATX (Accumulator) batch job outputs to quantify patterns of failure.
- Root Cause Identification: Isolating whether issues stemmed from processing logic or upstream data quality gaps (e.g., inconsistent validations or invalid reference table values).
- Operational Impact Assessment: Evaluating the "human cost" by measuring manual workload increases and departmental friction caused by exception processing.
- Remediation Roadmap Development: Creating a phased, prioritized timeline to harden systems, standardize subscriber data capture, and audit FACETS configuration tables.

Framework for Operational Excellence

Domain Specific Batch Analysis

Sierra performed a forensic evaluation of batch job outputs and error logs across the health plan's four primary operational pillars. By dissecting error patterns within MMS (Enrollment), CLCL (Claims), BIL0 (Billing), and ABIX/FATX (Accumulator) jobs, we moved beyond surface-level symptoms to quantify the specific financial and operational drag within each domain. This data-driven audit allowed leadership to visualize exactly where automated workflows were breaking down and provided the empirical baseline needed to prioritize remediation efforts across the enterprise.

Root Cause & Data Lineage Identification

The Sierra team conducted a deep-seated analysis of configuration tables, data mapping rules, and complex system dependencies to isolate the true drivers of batch failure. Our investigation shifted the focus from processing logic to upstream data integrity, identifying that a majority of errors were "imported" into the system rather than created by it. Key findings included inconsistent eligibility validations, missing provider reference data, and invalid values within FACETS reference tables. By pinpointing these specific data quality gaps, we enabled the health plan to transition from reactive error correction to a proactive strategy of "fixing at the source," ensuring cleaner data entry and more reliable downstream adjudication.

Cross-Departmental Impact & Friction Analysis

Sierra conducted a comprehensive evaluation to quantify how batch failures rippled through the organization's downstream workflows. By measuring the manual workload required to resolve recurring fallouts and the delays inherent in exception processing, we mapped the true cost of "operational friction." The assessment highlighted critical pain points in the member and provider experience—specifically how systemic processing gaps led to service delays and administrative burdens for internal teams. This analysis proved that these issues were not merely technical glitches but avoidable business risks that could be mitigated through modernized validation protocols and rigorous configuration management.

Strategic Remediation & Systems Hardening

Based on the diagnostic findings, Sierra engineered a phased remediation roadmap designed to systematically eliminate batch friction and restore processing reliability. The strategy moved beyond simple error correction to implement structural safeguards, including the strengthening of upstream eligibility validations and the introduction of automated provider reference checks prior to adjudication. By standardizing subscriber data capture and auditing core FACETS configuration tables, we provided a clear path toward a hardened system environment. This roadmap was carefully aligned with the health plan's operational priorities, ensuring that high-impact "quick wins" were balanced with long-term architectural stability.

The Facts

Batch Errors Identified

470K+

TOTAL FALLOUT ANALYZED ACROSS ENROLLMENT, CLAIMS, AND BILLING

Operational Domains

4 CORE

INDEEP-DIVE AUDIT OF ENROLLMENT, CLAIMS, BILLING, AND ACCUMULATORS

Processing Visibility

100%

COMPREHENSIVE AUDIT OF ALL FACETS ERROR LOGS TO ELIMINATE "BLIND SPOTS" IN CLAIMS ADJUDICATION.RAINING ASSETS

Strategic Impact & Business Value Delivery

The remediation of the FACETS batch environment has transitioned the health plan's core administration from a state of constant manual intervention to a high-performance automated workflow. By aligning technical configurations with upstream data standards, the organization has mitigated financial risks associated with inaccurate billing, enhanced operational transparency, and established a scalable foundation for future membership growth and plan complexity.

Business Impact

Reduced Operational Rework & Fallout

The audit and subsequent system hardening provided leadership with granular visibility into the root causes of batch failure. By eliminating systemic "bottlenecks," the organization significantly reduced the manual burden on enrollment and claims teams, allowing resources to shift from error correction to high-value member services.

Enhanced Financial Integrity & Revenue Cycle

Addressing the BIL0 billing bypass events and rate table gaps secured the plan's premium revenue cycle. Standardizing subscriber data capture ensures that invoices are generated accurately and on time, reducing the risk of delayed payments and improving the overall financial reliability of the billing department.

Optimized Claims Adjudication & Accuracy

The implementation of pre-adjudication provider and procedure reference checks has established a "single source of truth" for the claims engine. This reconciliation of disparate data records has increased auto-adjudication rates and ensured that member accumulator balances remain accurate and synchronized in real-time.

Strengthened Governance & System Reliability

The development of standardized validation protocols and updated configuration playbooks has institutionalized rigorous governance across the FACETS environment. This initiative ensures that all core administrative operations are executed with consistent precision, full regulatory alignment, and a significantly reduced risk of downstream processing errors.

The Result

Through its strategic partnership with Sierra Solutions Group, the health plan has successfully transformed its FACETS batch environment into a reliable, automated asset. By institutionalizing rigorous configuration governance and optimizing upstream data quality, the team has achieved a state of technical readiness that supports both current operational requirements and future enterprise scaling. This engagement ensures the organization's technology ecosystem is architected to deliver a seamless experience for members, providers, and internal stakeholders alike.