HEALTH WEALTH CAREER

BEACON HEALTH OPTIONS INFORMATION SYSTEMS AND PROCESSES REVIEW

APRIL 2019

Commonwealth of Pennsylvania

FINAL REPORT

CONTENTS

1 INTRODUCTION

PURPOSE

Recognizing the importance of timely and accurate encounter data from Behavioral Health Managed Care Organizations (BH-MCOs), the Commonwealth of Pennsylvania (Commonwealth or Pennsylvania), Department of Human Services (DHS), Office of Mental Health and Substance Abuse Services (OMHSAS) Bureau of Quality Management and Data Review engaged Mercer Government Human Services Consulting (Mercer) to conduct an onsite systems and associated processes review at Beacon Health Options (Beacon), formerly known as Value Behavioral Health of Pennsylvania (VBH-PA). The purpose of the review was to assess the capture of claim, clinical and related financial data, historical and future, to support claims payment and all required reporting and administrative functions. This review was conducted at Beacon's site on January 23 and 24, 2019.

This report outlines Beacon's operations and activities that can impact encounters and reporting related to the HealthChoices program. The review included two phases: a desk review of key documents and onsite interviews focused on Beacon's administrative operations (information system, reporting, claims data collection and payment management). The key areas of focus within the review were comprehensive including eligibility, provider, clinical (authorizations, utilization management/care management), claims, system edits, encounter submissions, data warehouse and reporting.

BACKGROUND AND APPROACH

This report describes the information collected as part of the Beacon review. Data collection and submission of encounter data is necessary for rate-setting activities and other monitoring and reporting projects. The team collected information to understand Beacon's overall system, processes and strategy for improving and submitting complete and accurate encounter data, including validation processes for reporting to OMHSAS.

Prior to the onsite, Mercer requested and received specific documentation from Beacon to provide detail about encounter data operations and to target the onsite interviews to specific areas. Information gathered from desk review materials and the onsite visit informed this report.

LIMITATIONS OF ANALYSIS

In preparing this document, Mercer has used and relied upon data supplied by Beacon. Beacon was responsible for the validity and completeness of this information. We have reviewed the information for consistency and reasonableness. In our opinion, it is appropriate for the intended purposes. If the information is incomplete or inaccurate, the observations shown in this analysis may need to be revised accordingly. All estimates are based upon the information available at a point in time, and are subject to unforeseen and random events. Any findings, observations or recommendations found in this report may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

DESK REVIEW

Beacon was asked to complete an information request prior to the onsite review. The information request collected material regarding Beacon's reporting, claims and encounter systems, procedures and key metrics regarding encounter volume (including denials and acceptance levels). The information collected through this request was reviewed prior to the onsite review by Mercer and OMHSAS' subject matter experts in information systems and claims management processes and encounter data submissions. This information was used to inform the findings within this report and to tailor the onsite portion of the review to clarify and address any potential deficiencies noted within the desk portion of the review.

ONSITE REVIEW

The onsite review consisted of an interactive discussion with Beacon and included an online review to compare encounter data from PROMISe™ (PROMISe) with Beacon's systems for claims and encounter submission tracking. This onsite review was conducted at the Beacon site in Cranberry Township, and the team consisted of members from Mercer and OMHSAS meeting with Beacon cooperative and knowledgeable staff. Beacon addressed follow up questions and provided additional requested documents on the Mercer secure Connect site by January 25, 2019.

KEY FINDING HIGHLIGHTS FROM THE REVIEW

During the onsite, the review team found that Beacon is operating appropriately in most areas, but some opportunities for improvement exist. This document focuses on these opportunities and other specific items where information may be helpful for DHS data analytics. The following highlights the most critical issues identified and are fully described in Section 2: Findings and Recommendations.

- Look into the Centers for Medicare and Medicaid Services (CMS) Coordination of Benefits Agreement (COBA) to receive claims and Medicare payments directly from Medicare to ensure coordination of benefits (COB) processing with Medicaid as the payer of last resort on Medicare covered services. This is a mandatory CMS requirement.
- Submit a complete encounter with one claim number in the patient account number for all detail lines. This should include zero pay lines due to third party liability (TPL) and ancillary inpatient services that are part of per diem payments.

- Perform complete reconciliation processes on claims to financials for each County based on a rolling 12-month basis to ensure encounter completeness and accuracy in financial fields for encounter submissions. In addition, verify the person level encounter (PLE) data to PROMISe accepted encounters to ensure the two data sets match.
- Submit a copy of the crosswalk documentation of the outpatient UB-04/837I to 837P formats for OMHSAS review to verify complete data fields are included in encounter submissions.
- Review the 837 creation process to combine encounters to match claim submissions to the Connections Administrative System (CAS), including services that may be provided by Edifecs in the future.
- If a claim has 3 detail lines, the encounter submitted should be 3 encounter lines. One encounter should match the claim submitted by the provider when multiple detail claim lines are submitted.

2
FINDINGS AND RECOMMENDATIONS

Changes have occurred within Beacon's information technology area and OMHSAS wanted to understand the systems and database processes and the impact on claims payment, encounter data and reporting. Encounter data is used for many purposes including rate setting comparisons and various other data analyses. OMHSAS continues to expand the use of encounter data to monitor the HealthChoices program. Additionally, with greater confidence in encounter data quality, OMHSAS will be more successful in complying with CMS requirements to use encounter data. This review was performed to assess Beacon's internal data systems and processes for claims payment, encounter submissions and reporting quality and included the identification of data reporting improvement opportunities.

As stated above, Beacon's review was comprised of a desk review and onsite interviews/ discussions with Beacon staff to assess systems used, how data and encounter submissions are reported and how data validation is addressed. This section summarizes the findings and recommendations from both the desk review and the onsite review.

Beacon uses the OMHSAS Behavioral Health Services Reporting Classification Chart (BHSRCC) to drive coding of covered services, billings by providers and encounter submission requirements for procedures and modifiers along with place of service codes.

DATA SYSTEMS AND CLAIMS PROCESSING

Health claims received from clearinghouses, through direct electronic submission, or in paper formats from providers, should reflect complete claims documentation that supports all services paid by Beacon and includes all relevant data elements. Additionally, validations through system edits and clinical review assist the overall claims process. Understanding Beacon's system, processes and methodology helps OMHSAS in Medicaid data analyses. Claims reviewed onsite helped to verify the process of receipt of claims data and the accuracy of claims processes through encounter submissions.

Systems, Staffing and Tools

Understanding claims systems, staffing and tools are necessary for OMHSAS to work efficiently and effectively with each BH-MCO. The following highlights review findings for Beacon.

- Beacon processes claims internally on the ValueOptions legacy claims system, CAS. CAS is solely owned and maintained by Beacon. CAS is a green screen interface system written in

COBOL. For customer service, there is an Internet interface (Connect) that exists in a friendly format for viewing claim information. There are no plans for Beacon to move off CAS to Beacon's other claims system platform, Flexcare, which is table driven.

- There are ten dedicated claims/TPL employees that work remotely processing claims that cannot pass automated claim system edits in CAS. Staff use processing guidelines posted on Beacon's Intranet with supervision by Beacon's management staff.
- Locally, for the individual contracts, Beacon has Sequel Server as data repositories for some reporting with daily updates of claims data. Encounters have already been moved to the national data warehouse. Beacon is moving more of the local reporting to the national data warehouse in the last quarter of 2019. Using a central data warehouse reduces redundancy, avoids local database issues and provides more consistent reporting and data validation activities by a larger team.
- The national data warehouse is the main storage area for the reporting function. The data warehouse is refreshed weekly with a complete replica of the claims system. The data warehouse holds all claims processed (paid and denied) with two years of historical data plus the current year. Older data is archived and can be accessed easily if necessary. Beacon has 1.2 full-time employees dedicated to encounter processing in the claims department to cover the five HealthChoices BH-MCO contracts. Other staff in claims, eligibility and provider network departments assist with the corrections of PROMISe denied encounters. Beacon is reviewing processes and staffing needs to determine if additional staff are necessary for the administration of the HealthChoices program.
- Report submissions are verified by different people depending on contractual requirements. Reports may require County/Primary Contractor approval, local team approval and/or the Vice President approval of management reporting.
- Beacon has tools in place and is in the process of implementing additional tools to help improve quality during claims processing and to track receipt and loading of inbound files and successful export of outbound files.

Claims System Processing

Claims received by Beacon are validated through system edits with clinical prior authorization assistance for claims processing decisions. Discussion with Beacon staff, along with claims reviewed during the onsite, verified the procedures Beacon utilizes to process pay claims and submit encounters.

- Beacon receives approximately 82% of claims via electronic data interchange (EDI), 14% use the provider portal and the remaining 4% are paper. The paper claims are mostly from small providers or result from explanation of benefits (EOB) submissions. If the portal is utilized, the provider can upload attachments along with the claim submission including EOBs. The portal also allows providers to check eligibility, including other insurance indicators, view claim status and submit/view prior authorizations.

- CAS editing is primarily defined by BHSRCC requirements. Additional edits in CAS include duplicate claims editing, member eligibility and maximum units per day. No specific National Correct Coding Initiative edits are in place as Beacon believes the services are driven by the prior authorization requirements. No editing is performed on BH codes to verify the submission of Evaluation and Management (E&M) codes when required with certain codes. Some edits have been implemented for the ordering, referring and prescribing (ORP) providers requirements. These edits advise providers impacted by ORP so the providers can submit applications or update necessary information in PROMISe.
- Claims are loaded as they are received from providers. Normally, a claims system would process an inpatient claim based on the room and board revenue center associated with header-authorized dates and units of the prior authorization. Ancillary lines would be zero paid if included in the room and board unless additional outlier pricing is allowed for a service, such as electroconvulsive therapy (ECT). Beacon claim processing is performed based on the individual lines within an authorization. If an authorization requires updates every three days of an inpatient stay, the claim is divided manually into multiple lines. The units reflect each day of inpatient even though date spans do not normally include the final date in the payment calculation. This processing method negatively impacts downstream processes, including encounters.
- Beacon auto adjudicates approximately 73% of claims received, which allows for consistent processing. Beacon indicated that 3% of all claims processed are audited post payment. Since Beacon has a high level of manually processed claims, a 3% auditing rate is an acceptable percentage of claims to audit.
- Beacon indicated that single case agreements (SCAs) occur infrequently for out-of-network (OON) providers; Beacon reported that 3.52% of claims are processed using SCAs. Some of these OON providers are already enrolled in PROMISe. Typical reasons for OON utilization include patients traveling to see Ohio providers, patients living in residential treatment facilities or obtaining certain services from Medicare providers, which Beacon allows. The turnaround time for SCA completion appears to be timely and policies and procedures (P&Ps) to manage OON utilization are in place.
- For reports submitted to OMHSAS, including timely payments of claims, the check/claim finalization date is the date used for reporting. Checks are sent to providers the same day as the check write date for risk accounts and for those specific contracts when the account is funded by the county, usually within a few hours.
- Services sub-capitated by Beacon are crisis services, blended case management and drug and alcohol case management. These services are correctly paid by the finance department and not through the claims system since it is a per member per month payment and not a direct service payment.

Third Party Liability

TPL is an important process that ensures Medicaid claims are paid as the payer of last resort. Processes for identifying TPL and applying COB logic during claims payment should be performed for all claim types. TPL should be consistently and accurately reported in encounter data.

- Medicaid should be the payer of last resort. Beacon has processes in place to collect primary insurance data, utilizing the 834 file from DHS as the main source. Additionally, clinical staff ask members about other insurance and inbound claims may identify insurance not previously known to Beacon. Beacon also verifies this information with the provider and with the other insurance company. Insurance information is verified and DHS is notified when the new TPL data is identified.
- Beacon utilizes a list of services that Medicare and commercial plans do not cover so that claim payment is not delayed waiting for a primary carrier denial for issues such as Medicaid qualified providers not covered by the other carriers.
- TPL recovery processes are in place for claims paid prior to Beacon learning about a member's TPL.
- CMS requires health insurance organizations to have COBA processes in 2019. CMS defined the criteria for transmitting enrollee eligibility data and Medicare adjudicated claim data for the purposes of coordinating benefits. This process helps to provide accurate and timely data for dual members with Medicare approved services and Medicaid as the payer of last resort. There are no processes at Beacon to collect Medicare claims/payments through the COBA process.
- TPL claims resulting in a zero payment are not submitted to PROMISe. Without the complete encounter, the data cannot be included in utilization reporting of Medicaid members if the Commonwealth is using encounter data.

ENCOUNTER SUBMISSIONS

Since encounter data is used for a variety of reasons including rate setting and quality measures, the management and oversight of encounter submissions is critical. MCOs should monitor accuracy, timeliness and completeness of encounter submissions. Data should be validated prior to submission, and errors should be corrected and resubmitted in a timely manner.

- Claims are extracted directly from CAS for 837 encounter creation weekly. Encounters submitted are tracked in CAS with an indicator of submitted and the date of submission. Since Beacon's data warehouse holds the PROMISe internal control number (ICN) from the U277 response, if adjustments or voids are performed, the corresponding PROMISe ICN can be submitted with the encounter. Reports can be run from the data warehouse to identify claims that have never been submitted as encounters or that have not been corrected.
- Prior to submitting encounter data, Beacon has processes to review the data for issues that may result in denials in PROMISe, such as retro-termination of members, covered and non-covered

days reporting, voids outstanding for adjusted claims or missing provider service location (zip+4).

- Beacon indicated that DHS provider files 414 and 415 are used in managing providers and encounter submissions. Beacon adds the PROMISe provider ID and service location (13 digits) information to CAS and also captures provider NPI and taxonomy. In mid-2018, working with OMHSAS, Beacon stopped submitting encounters for a few months to correct provider ID issues where all 8s were previously submitted for network providers that are known to PROMISe. Historical corrections were expected to be completed by the end of January 2019.
- Beacon indicated that all service locations associated with a provider are not collected during the credentialing process. This may cause denials in PROMISe if the locations do not match between the invoice and the data within the system. Additionally, it impedes the ability to accurately note where members are receiving services, which may affect network development, customer services assisting members and members to know what providers are available in their area when searching Beacon's website.
- Encounters should be submitted as they appear on the provider's claim regardless of payment splitting rules in the claims system. However, Beacon encounter submissions do not look like the claim that was received from the provider because of CAS-specific processes of splitting dates of service. Beacon uses the CAS claim number plus the detail line number for the patient account number and submits one line encounters. This results in multiple issues:
  - As indicated in the claims section, Beacon pays claims based on how the claim is prior authorized. Beacon submits encounters as one line encounters based on paid encounter detail lines. This process excludes some information in the encounter from the inpatient claim received. For instance, the full billed amount from the provider, ancillary zero paid services and non-covered days that are denied, if not authorized. In addition, the encounters are submitted with a "type of bill" designation of 111, indicating it is a complete encounter. Shadow pricing cannot properly occur in PROMISe due to the format of the encounter submission. Data analysis would indicate multiple inpatient admissions instead of one continuous stay. OMHSAS reporting to CMS would not be accurate.
  - The process to adjust a claim in CAS is to void the detail line being adjusted in the claims system, and the replacement line creates another detail line number. If Beacon does not identify the original PROMISe ICN or properly submit a successful void for the originally submitted encounter, the claim would have multiple encounters submitted for the same member on the same dates of service with the same provider, but the patient account number (MCO ICN) would be different for each since PROMISe rules use MCO ICN as part of the duplicate encounter determination. With new MCO ICNs reported in the patient account number for voids and adjustments, duplicates are difficult to detect.
  - Professional claims are also submitted on an individual detail line basis per encounter by Beacon. This impacts cases that require add-on E&M codes to be included with certain procedure codes and detailed utilization services, for example, as support for FQHC submissions that are part of the T1015 HE payment. With single detail line encounter

submissions, Beacon cannot submit the zero paid supporting E&M procedure codes for the T1015 HE, which impacts the ability of OMHSAS to accurately analyze service utilization performed at a FQHC/RHC BH services. An encounter should match the claim that was received from the provider with all paid lines on one encounter such as one inpatient stay.

  - When Beacon submits paid PLE data to Mercer, Beacon indicates they are able to keep the entire claim intact as one claim, for example, an inpatient hospitalization with ECT. Note: an analysis of the claims PLE data was not included in this review to verify the data submitted.

- Encounters that receive PROMISe denials are sorted for correction activities, as well as to determine where the error was made. Most of the claim processing related errors are due to a processor manually adjudicating a claim and not following through to review all of the edits received. Those claims are sent to the manager for correction. Trends are reviewed to use as opportunities for retraining of the claim processors.
- Reconciliation of data should occur on at least a rolling 12-month period but possibly even a two-year period to ensure accuracy of encounter submissions, including voids and adjustments. Comparing at a level of date of service and date of payment may point out potential data missing in encounter submissions. This reconciliation process should include accepted encounters to financials reported to OMHSAS. Since PLE data is submitted to Mercer for rate setting, there should also be a comparison of PLE data to accepted encounters. It was unclear during the onsite how complete monthly or quarterly reconciliation processes are for each of the five contracts for HealthChoices.
- Beacon reported there are 12–15 providers that bill their services as outpatient on the 837I (institutional format). These must be cross-walked to the 837P for encounter submission. The review team did not receive documentation from Beacon to review to verify the completeness of the cross-walk from the 837I to 837P formats. In addition, OMHSAS would like to know who the providers and the provider specialties that are billing on the 837I format.
- Beacon provided draft P&Ps for the encounter data process, which included encounter data governance. The encounter data governance policy indicates oversight by executive management; however, there was not clear indication as to what executive team members are accountable for in the encounter data reporting processes.

Edifecs

Edifecs is an external vendor providing tools and processes to assist Beacon. There are two processes from Edifecs for Beacon that were discussed:

- The first process is the standard Edifecs edits for claims prior to entry into the claims system implemented in 2017. Paper and electronic claims have been processed through Edifecs since June 2018 prior to CAS processing. Edifecs looks for basic claims transaction submission edits for quality purposes with edits, such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) formats, member eligibility and provider data. Eligibility is current with real-time

data sharing with CAS. Beacon reported the number of rejects, but the report was based on all Pennsylvania providers, not necessarily HealthChoices-specific providers.

- The second is a new process under development and testing for encounter submissions that will assist with encounters. The intent of the Edifecs Service Level Agreement (SLA) is to improve encounter submission, identifying and correcting many potential errors prior to submission. Edifecs expands their knowledge-based product to create processes to include issues that may cause an encounter to deny in PROMISe. Edifecs will create the 837 encounter files for PROMISe and store the return U277 information. The flow document provided was high level and due to multiple requirements documents, the review team did not review this new product development in detail. The SLA implementation date has yet to be determined by Beacon, possibly Q2, 2019. Due to onsite discussions, Edifecs needs to review encounter 837 creation processes, such as combining individual claim lines processed to submit as a complete all-inclusive encounter to match the inbound claim received from providers.

PROGRAM INTEGRITY

Plans are expected to have program integrity processes in place and perform post-payment claims are performed to detect and recover fraud, waste and abuse (FWA). Post-payment analysis of data is often done through data mining and comparison of key data fields including, but not limited to, place of service, diagnoses, procedure codes and units provided. Systems/processes are necessary to track potential issues for trending, documentation support, tracking recoveries and reporting. No issues were identified and the following indicates notable processes.

- Beacon has data mining and manual processes to create reports of potential issues, such as too many hours of therapy in a day or excessive services performed on holidays and weekends. Internal referrals and member complaints about patient safety or services not performed are utilized to target potential specific provider issues.
- Beacon added a case management system in the Spring of 2018 for use in FWA. This helps to track cases, such as date case opened, communication dates with providers and recoveries. In addition, the system can hold documents.
- FWA cases are referred to DHS as directed.
- Program integrity recoveries are posted in the claims system.

RECOMMENDATIONS

Consistent BH-MCO understanding of reporting requirements for financial and encounter data provide OMHSAS with complete and accurate information used for various analyses. From the onsite review, the following recommendations are provided to support future analyses using encounter data provided by Beacon.

- Consider changing CAS to match claim payments to match the header level of the prior authorization. For example, pay inpatient claims on the room and board lines for the complete

stay and total units rather than splitting each line to replicate the frequency of authorization updates.

- Look into CMS COBA to receive claims and Medicare payments directly from Medicare to ensure COB processing with Medicaid as the payer of last resort on Medicare covered services.
- Submit zero pay encounters when the primary carrier paid more than what is allowable under Medicaid in cases with TPL.
- Review and update credentialing processes to include collecting all service locations of the provider. This may also assist in verifying prior violations at provider sites, such as patient safety issues and in matching multiple PROMISe IDs and service locations in the encounter submissions.
- Submit encounters intact with all claim lines submitted from one claim by the provider on the same encounter submission. This includes zero pay services, such as ancillary charges on an inpatient bill that are not paid separately, as the costs are included in the per diem payment rates. The patient account number should claim the CAS ICN and not include the detail line number as part of the number submitted.
- Require FQHC/RHC providers to submit all services that support the T1015 HE submitted services.
- Perform reconciliation processes on claims to financials for each county. Comparisons of financial reporting should be performed to PROMISe accepted encounters. This should be done on at least a rolling 12-month basis to ensure encounter completeness and accuracy on financial fields for encounter submissions. In addition, the PROMISe accepted encounters should be compared to the PLE data to verify the encounter submission completeness to the data submitted for rate setting.
- Submit a copy of the crosswalk documentation of the 837I to 837P formats for OMHSAS review to verify complete data fields are included and which providers and specialties are submitting outpatient services on the 837I format.
- Finalize P&Ps for encounter data processes and for governance, including what executive team members are accountable regarding the completeness and accuracy of encounter submissions.
- Beacon should specifically track Pennsylvania HealthChoices provider claims that are rejected through upfront Edifecs processes to assist providers with technical assistance if necessary.
- Review the Edifecs 837 creation process to combine encounters to match detail lines on claim submissions to CAS.

APPENDIX A

AGENDA

Value Behavioral Health/Beacon Review
Cranberry Township
January 23 and 24, 2019
9:00 am–4:30 pm Eastern and 9:00 am–Noon Eastern

NOTE: *The following items are needed to be ready for review by OMHSAS/Mercer staff upon arrival on January 23, 2019:*

1. 277 reject report copy indicated in 6b response of the survey.
2. A copy of a recent comprehensive report as indicated in 6c of the survey.
3. A provider remit copy, including one for an adjustment or voided claim.

NOTE: *System demos will be expected of the provider portal and the claims system. OMHSAS will provide the details of which claims to review during the on-site.*

Day 1

TIME	TOPIC	VBH-PA ATTENDEES
9:00 am–9:45 am	• Introduction and opening comments: — Presentation of overview of systems including claims, data warehouse and Edifecs	All
9:45 am–10:30 am	• Survey responses discussion: — Systems — Claims receipt and loading — Claims edits — Claims staffing — Claims audits — Claims settlements	VBH IT and Claims
10:30 am–10:45 am	Break	
10:45 am–Noon	• Provider portal demonstration and discussion • Data warehouse • Claims system demonstration: — Eligibility — TPL/other insurance and COBA for Medicare	VBH IT, Claims and Eligibility
Noon–12:30 pm	Working lunch	OMHSAS/Mercer separate
12:30 pm–2:15 pm	Claims system demonstration continued: • Claims payment • Authorization process and using OMHSAS Appendix V for hospitalization • Claims review online • Provider information: — Monthly provider files — Provider loads, addresses and fee schedules — Out-of-network providers	VBH Claims and Clinical and Network/Provider
2:15 pm–2:30 pm	Break	All
2:30 pm–4:15 pm	Claims system demonstration continued	VBH IT, Claims and Encounter Team
4:15 pm–4:30 pm	Review of follow-up items	All

Day 2

TIME	TOPIC	VBH-PA ATTENDEES
9:00 am–9:15 am	Review of prior day as needed	
9:15 am–11:00 am	Encounters: • Encounter staffing • Provider file data • Encounter submissions • Encounter responses, tracking and corrections reporting	VBH IT, Claims and Encounter Team
11:00 am–11:15 am	Break	All
11:15 am–11:45 am	Fraud, waste and abuse (FWA)	Claims and Program Integrity/FWA
11:45 am–Noon	Closing and next steps	All

Attendees
OMHSAS
OMHSAS — 3 plus 1 on the phone

Regional field office — 2

Mercer:
Consultants — 2

Pennsylvania VBH/Beacon:
Director, Eligibility
Director, Provider Relations
Director, Claims and Customer Service
AVP, Clinical Manager
AVP, Business Relationship Manager
AVP, Claims Operations
AVP, Network Engineering
AVP, Reporting
Chief Executive Officer
Chief Financial Officer
Chief Operating Officer
Edifecs 873 Implementation Program Manager
EOI Team Lead Manager, Claims
Manager, Provider Network
Manager, Program Integrity
RCPO

MERCER (US) INC.
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
www.mercer.com