HEALTH WEALTH CAREER

COMMUNITY BEHAVIORAL HEALTH INFORMATION SYSTEMS AND PROCESSES REVIEW

SEPTEMBER 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, 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 Community Behavioral Health (CBH). 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 CBH's site on August 1, 2019.

This report outlines CBH's operations and activities that can impact encounters and reporting related to the HealthChoices program. The review included two phases: first a desk review of key documents followed by onsite interviews focused on CBH's administrative operations (information system, reporting, claims data collection and payment management). The key areas of focus within the comprehensive review include 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 CBH 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 CBH'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 CBH 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 CBH. CBH was responsible for the validity and completeness of this information. The review team has 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

CBH was asked to complete an information request prior to the onsite review. The information request collected material on CBH'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, 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 CBH and included an online review that compared encounter data from PROMISe™ (PROMISe) with CBH's systems for claims and encounter submission tracking. This onsite review was conducted at the CBH site in Philadelphia, and the team consisted of members from Mercer and OMHSAS meeting with CBH staff.

KEY FINDING HIGHLIGHTS FROM THE REVIEW

During the onsite, the review team found that CBH 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 OMHSAS data analytics. The following highlights the most critical issues identified. Highlights are fully described in Section 2: Findings and Recommendations.

- Continue to review XeoRules® claim system edits to ensure payments between the primary carrier and CBH's payment do not exceed the amount billed by the provider for the service on coordination of benefit (COB) claims.

- Work with OMHSAS to develop a process to implement the Centers for Medicare and Medicaid Services (CMS) Coordination of Benefits Agreement (COBA) to receive claims and Medicare payments directly from Medicare and to ensure COB processing with Medicaid as the payer of last resort on Medicare covered services. This is a mandatory CMS requirement.

- Complete the encounter submission process to include the NTE segment as required by OMHSAS.
- Submit a copy of the crosswalk documentation of the outpatient UB-04/837I to inpatient/837I formats for OMHSAS review to verify data fields and expectations for submission to PROMISe.
- Implement policies and procedures (P&Ps) to correct PROMISe encounter denials to ensure complete and accurate data which support the analysis OMHSAS needs to perform.
- Perform complete reconciliation processes on claims to financials 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. Reconciliation may assist with uncovering claims that may have been paid in both the Brahms and XeoHealth systems.
- Work with OMHSAS on the process of where to properly report quality incentive payments to providers.
- Implement P&Ps to void PROMISe accepted encounters to ensure encounter data is accurate and matches the information in CBH’s claims system.

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FINDINGS AND RECOMMENDATIONS

CBH began implementing a new claims processing system in 2013 until 2017 that is still being completed today. Verification of the new system is being performed by processing claims in parallel on the old and new systems until all claims are completed successfully on the new system. OMHSAS wanted to more clearly understand the new system and database processes and any potential 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 regarding utilizing encounter data. This review was performed to assess CBH's internal data systems and processes for claims payment, encounter submissions and reporting quality and included the identification of data reporting improvement opportunities.

CBH's review was comprised of a desk review and onsite interviews/discussions with CBH 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.

CBH 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 CBH and include all relevant data elements. Additionally, validations through system edits and clinical review assist the overall claims process. Understanding CBH's system, processes and methodology helps OMHSAS with Medicaid data analyses. Claims reviewed onsite helped to verify the process of receipt of claims data and the accuracy of claims processes including adjudication and submission of encounters.

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 CBH:

- CBH processes claims internally on the XeoRules claims system located on Hosting.com. XeoRules is owned and maintained by XeoHealth in Newark, Delaware. CBH is responsible for handling specific rules based on the BHSRCC. CBH works with XeoHealth for system updates

and testing of configuration including regression testing. Brahms is the prior claims system but is still used for parallel testing processes. Even though CBH indicated that by 2017, the majority of claims were processed in XeoRules, it is unclear as to what claims are still in Brahms if processing was moved to XeoRules. Duplicates with 2017 dates of service reviewed during the onsite demonstration revealed that claims were processed by both Brahms and XeoRules and submitted as encounters.

- The claims staff enter paper claims and work with providers to resolve questions regarding claims that cannot pass preprocessing claims edits.

- The data warehouse is the main storage area used for reporting and holds all claims processed (paid and denied). The 837 Encounter files are extracted from the data in the data warehouse. A separate database is used for the 277U responses from the PROMISe encounter submissions to store the PROMISe internal control number (ICN). CBH plans to update the data warehouse with additional functionality and capture more provider and clinical information.

- PsychConsult is the clinical system that will be fully implemented in early 2020. CBH is already using this system for some processes within the clinical operations. PsychConsult is fully integrated with XeoRules claims.

Claims System Processing

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

- Claim Receipt:

  – CBH receives approximately 98.91% of claims via electronic data interchange (EDI) and the remaining 1.09% are paper. The paper claims are generated primarily from explanation of benefits submissions or adjustments.

  – CBH does not have a provider portal for providers to submit claims or review claim status.

  – Providers are only allowed to submit EDI claim voids with the “8” indicator to CBH on Wednesdays for processing. Once the provider receives the response indicating the void has passed, the provider may submit the applicable new claim to avoid the claim hitting a duplicate denial edit.

  – Providers may submit paper claims for adjustments and voids with an adjustment form at any time for CBH to manually enter and process.

- Claim Edits:

- Preprocessing edits are performed prior to claims loading into the XeoRules claims system. This consists of the following:
  - These edits are beyond the typical health plan EDI Strategic National Implementation Process (SNIP) claims validation edits. Editing is primarily defined by BHSRCC requirements prior to the claim entering into the claims system, which is prior to an ICN assignment to the claim.
  - Any errors are reported to the provider to correct and resubmit through the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 277 Health Care Information Status Response transaction. Since these claims are not in the claims system, the provider does not receive an 835 remittance and the claim is not tracked for timely claim turnaround or interest payment if applicable.
  - For claims that do not pass edits and the provider receives the 277 response indicating a rejection, if the provider does not resubmit the claim in a timely manner, the claim could be denied and not paid again due to timely filing edits. This could negatively impact claim appeals since an 835 denial is not on record. CBH does have the option of bypassing timely filing due to provider complaints/appeals.
  - The preprocessing of 277 rejects are not included in BH-MCO reports to OMHSAS such as the claim denial reports.
  - CBH staff does have view capability into the original EDI submissions that resulted in the 277 rejection notifications which allows for technical assistance.
  - Not all services require a prior authorization; however, XeoRules is dependent upon an authorization in the claims system. The clinical team inputs a blanket authorization for services for members so providers can be paid. Providers must input a valid authorization number on all claims to get past the preprocessor edits to forward on to XeoRules for claim processing.
- Additional edits in the XeoRules system include duplicate claims editing, no benefit available and maximum units exceeded for the authorization. No specific National Correct Coding Initiative (NCCI) edits are in place as CBH 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.
- Diagnosis code validity:
  - CBH confirms the validity of all diagnosis codes on institutional claims, but on professional claims, editing occurs only on the diagnosis codes pointed to on the line item details. As a result, some professional claim diagnosis codes were not included on

encounters. Providers may indicate additional diagnosis codes for a member that may impact treatment planning without directly relating the diagnosis to the service performed. When OMHSAS requested the BH-MCOs submit all diagnosis codes in April 2019, CBH incurred a high-level of errors in the encounter submissions due to invalid diagnosis codes. CBH plans to implement validation checks of all diagnosis codes received from providers on August 5, 2019.

  - If there is an invalid diagnosis code on an inpatient claim, the claim is rejected during preprocessing to the provider for correction.

  - Encounter submissions did not include all header level diagnosis codes but only reflected the diagnosis codes that were validated.

- Claims processing:

  - CBH pays for many of the services through federally qualified health center/rural health clinic (FQHC/RHC) providers. Contracts and claim submissions are based on the BHSRCC requirements. This does not allow for the submission of the specific procedure codes performed by the FQHC/RHC for BH services for claim collection or encounter submission. This impacts accurate analysis of service utilization for HealthChoices' members. CBH pays the FQHC/RHC prospective payment system (PPS) rates as required by OMHSAS.

  - CBH indicated that 24.57% of providers are considered out-of-network (OON). The county requires CBH to pay claims for many of the providers that are not in the CBH network. The OON providers must be known to PROMISe in order to be set up in XeoRules. CBH implements single case agreements (SCAs) for the OON providers. For new providers, the clinical team will flag the provider so that Provider Relations staff can reach out and set up the provider for claims to be paid. Typical reasons for OON utilization include patients traveling to see New York and New Jersey providers or patients living in residential treatment facilities. The turnaround time for SCA completion appears to be timely and P&Ps to manage OON utilization are in place.

  - CBH indicated that 99.96% of inpatient hospital claims are paid using per diem arrangements. The remaining hospital are paid via SCAs.

  - Crisis services are primarily provided by a hospital-based provider that submits claims in the 837I format. CBH has been working with the provider to implement an 837P format to submit these claims. CBH has made a settlement payment to the provider and will apply claims to the settlement once the claims are submitted in the 837P format.

  - During the claims demonstration, at least one claim was reviewed where the CBH payment exceeded the amount billed by the provider. System edits typically are in place to prevent

payment errors including an edit checking the amount paid by the plan plus the primary carrier not exceeding the provider billed amount.

- Provider data:
  - CBH does not have any sub-capitated providers.
  - CBH has some alternative payment arrangements (APA). APA providers are paid monthly based on an agreed upon budget determined in July for the year. For providers under an APA, claims are submitted with a $0 billed amount and encounters are submitted with an MCO payment of $0 as long as units for the services are greater than zero.

THIRD PARTY LIABILITY

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. CBH has processes in place to collect primary insurance data and the 834 file from DHS is utilized as the main source for TPL data. Claims information received is also used to identify additional primary information. Insurance information is verified and DHS is notified when any new TPL data is identified.
- CBH 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.
- CMS required 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 CBH to collect Medicare claims/payments through the COBA process.
- CBH does encourage providers to submit claims even though a payment is not expected due to the primary payer payment.
- During the onsite claim demonstration, CBH’s COB calculation indicated the system multiplies the number of service units by the patient liability amount reported by the primary carrier. This resulted in an overpayment of the claim based on the amounts in the encounter data for the billed amount, Medicare payment and MCO payment. This is likely an issue for all TPL claims whenever the units exceed one.

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.

- CBH has nine employees that work between 15% to 50% of their time on PROMISe encounter submissions.
- Claims are extracted from the data warehouse for 837 encounter creation weekly. Encounters submitted are based on payable claims since the last file submission. Since CBH's database holds the PROMISe ICN from the 277U response, if voids are performed, the corresponding PROMISe ICN can be submitted with the encounter.
- CBH tracks claims adjustments and voids for submissions of encounter data. CBH does not submit using the adjustment process to PROMISe. Encounter submissions by CBH are either an original claim or a void. CBH is not submitting voids to PROMISe which is causing duplicate encounters.
- OMHSAS requires BH-MCOs to submit specific information in the 837 NTE notes segment. CBH indicated that although the BH-MCO is not currently in compliance, a process is being developed to implement the required data information in submissions in September 2019.
- During the onsite claims demonstration, when the encounters submitted were compared to the claims system, there were differences in the type of bill submitted on some institutional encounters.
  - Some providers submit institutional claim formats for non-inpatient services such as observation stays. Since outpatient encounters are not accepted by PROMISe for BH services, CBH changes the type of bill for these services such as 131 (outpatient) to 111 (inpatient). PROMISe then assigns a claim type of "I" for inpatient to the encounter. This results in issues for data analytics such as inpatient statistics.
  - There was also an example of a claim in XeoRules that had a type of bill of 111 (complete inpatient) and the encounter data indicated type of bill 114 (inpatient, last claim). It was not clear what caused this data discrepancy.
- CBH indicated that DHS provider files PRV414 and PRV430 are used in managing providers in the XeoRules system so no additional processes are needed for encounter submissions. However, PROMISe denials indicate matching provider IDs and billing locations is in top 10 encounter denials. The PRV415 provider file is not used by CBH. The PRV415 provider file is a comprehensive file that may contain data missed in the daily incremental files.

- Processes to correct encounters that receive PROMISe denials are not in place at CBH. Complete and accurate encounter data is necessary for many processes including OMHSAS data analysis and submission of encounter data to CMS. This includes the correction of data that has not passed the PROMISe edits. OMHSAS primarily uses PROMISe accepted encounter data for analytics.

- Reconciliation of data should occur on at least a rolling 12-month period but even a greater period to ensure accuracy of encounter submissions, including voids and adjustments. Comparing at the date of service and date of payment level may point out potential data missing in encounter submissions or PROMISe denials that require additional corrective action. 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. *Note: an analysis to verify the data submitted in the claims PLE data was not included in this review.*

FINANCIAL REPORTING

Financial reporting must be consistent with DHS guidelines and definitions. To achieve accurate reporting, payment dates should correctly reflect the final resolution of claims. The claims system and financial reports should be compared to encounters accepted by PROMISe for accuracy and completeness of data submitted. OMHSAS may use encounter data to verify CBH quarterly and annual financial submissions and future rate setting efforts.

- 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 one week after the check write date. With 100% auto adjudication of claims, the week delay allows quality checks of claims payment and maintains timely payment of claims.

- Reconciliation of data should occur on at least a rolling 12-month period, but preferably even longer, to ensure accuracy of encounter submissions, including claim voids and adjustments. Compare at a detail level of date of service and date of payment to point out potential claims data missing in encounter submissions or PROMISe denials that require additional corrective action. 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. *Note: an analysis of the claims PLE data was not included in this review to verify the data submitted.*

- Encounter data should reflect what is paid to providers for services directly provided to members. CBH pays bonuses to providers based on quality measures. CBH indicated the possibility of repricing claims to account for the bonuses; however, this is a medical expense and should not be part of encounter data.

PROGRAM INTEGRITY

Plans are expected to have program integrity processes in place and perform post-payment claims reviews in an attempt to detect and recover payments as a result of 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. The following indicates notable processes.

- CBH has a team of 16 members that perform audits on providers. Audits include probe audits, targeted audits, provider self-audits (both provider-initiated and CBH Compliance requested), and extrapolation audits. If there are more than 500 claims over a three-year period, CBH will extrapolate the findings; otherwise actual result findings are used for recouped funds.
- CBH has data mining and manual processes to create reports of potential issues from trends, variances or other insurance. Internal referrals and stakeholder complaints about patient safety or services not performed are utilized to target potential specific provider issues.
- FWA cases are referred to DHS as directed.
- Program integrity recoveries are backed out of the finance system but not from the claims system. Subsequently, encounters would not be updated either as a result of a program integrity recovery.

SYSTEM SECURITY

Security and privacy concerns are always at the forefront of personal health information (PHI) for the Medicaid members and their data. No issues were identified. The following indicates notable processes.

- CBH is part of the city of Philadelphia infrastructure and is subject to Philadelphia's system controls and ransomware.
- CBH has penetration testing and indicated there has not been any successful outside data breach attempts.
- CBH has a Privacy Committee that handles any staff issues concerning system or privacy concerns or not following all policies such as not clearing fax machines timely.
- All laptops used by CBH are encrypted and mobile devices do not have capability to access CBH servers where PHI is stored.

RECOMMENDATIONS

Consistent BH-MCO understanding of reporting requirements for financial and encounter data provides 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 CBH.

- Review claims processed by Brahms during the transition period to XeoHealth to verify why duplicates were paid and submitted as encounters. Determine a process to resolve these duplicates.
- As a best practice, consider accepting EDI claim voids (with an 8 indicator) and adjustments (with a 7 indicator) and at any time versus only on a specified day of the week.
- As a best practice, consider front-end edits and what should be posted in the claim system as a denial so that the provider receives an 835 and is able to appeal the claims appropriately, such as authorization number not matching to the claims system. Complete the process of validating all diagnosis codes received from providers on professional claims and ensure this information is correctly applied to encounter data submissions.
- Finalize with the crisis provider the testing and submission of 837P formats and notify OMHSAS when the process is complete including the submission of the encounter data to PROMISe.
- Review edits to ensure payments between the primary carrier and CBH's payment do not exceed the amount billed by the provider for the service. The payments should be the lessor of the amount payable by Medicaid plus other carriers or the amount billed.
- Implement processes to fulfill the CMS requirements for COBA processes. CBH should be able 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.
- Review all claim payments where COB is involved and units exceed one to verify the payment does not exceed the patient liability indicated by the primary carrier.
- Utilize the PRV415 monthly provider files from DHS as an extra validation process to confirm provider data in the claims system or prior to submitting encounter data to PROMISe.
- Complete the encounter submission process to include the NTE segment as required by OMHSAS.
- Submit a copy of the crosswalk documentation of the 837I outpatient services to 837I inpatient formats for OMHSAS review to verify accuracy of encounter submission expectations.

- Implement P&Ps to correct PROMISe encounter denials to ensure complete and accurate data for all OMHSAS analytical activities.
- Perform reconciliation processes on claims to financials. 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 report should be compared to the PLE data to verify the encounter submission completeness to the data submitted for rate setting.
- Work with OMHSAS on how and where to properly report any quality incentive payments to providers.

APPENDIX A

AGENDA

Community Behavioral Health (CBH) Review
August 1, 2019
8:30 am to 4:00 pm

NOTE: *The following items are needed to be ready for review by the Office of Mental Health and Substance Abuse Services (OMHSAS)/Mercer staff upon arrival on August 1, 2019:*

1. Monthly tracking log for claim settlements indicated in response 11B.

NOTE: *System demos will be expected of the provider portal and the claims system. OMHSAS/Mercer will provide the details of which claims to review during the onsite.*

TIME	TOPIC	CBH ATTENDEES
8:30 am–8:45 am	Introduction and opening comments: • Overview of systems including claims and data warehouse	All
8:45 am–10:15 am	Survey responses discussion: • Systems: – Claims receipt and loading • Claims: – Claims processing standards – Claims edits – Claims staffing – Claims audits • Provider online access discussion	CBH IT and Claims
10:15 am–10:30 am	***Break***	
10:30 am–Noon	Encounters: • Encounter staffing • Provider file data • Encounter submissions • Encounter responses, tracking and corrections reporting Reporting in general Claims system demonstration: • Eligibility • Third party liability/other insurance and COBA for Medicare	CBH IT, Claims, and Encounter Team
Noon–12:30 pm	***Working lunch***	***All***

12:30 pm–2:15 pm	Claims system demonstration continued: • Claims review online • Claims payment • Authorization process and using OMHSAS Appendix V for hospitalization • Provider information: — Monthly provider files — Provider loads, addresses and fee schedules — Out-of-network providers	CBH Claims and Clinical and Network/Provider
2:15 pm–2:30 pm	***Break***	***All***
2:30 pm–3:15 pm	Claims system demonstration continued	CBH IT, Claims and Encounter Team
3:15 pm-3:45 pm	System Security Fraud, waste and abuse (FWA)	Claims, IT and Program Integrity/FWA
3:45 pm–4:00 pm	Closing and next steps	All

Attendees
OMHSAS
OMHSAS — 5

Mercer:
Consultants — 2

CBH:
Chief Information Officer
Chief Executive Officer
Chief Financial Officer
Manager of Provider Contracting
Director, Claims
Claims Division Specialist
Business Rules Management
Director, Data Informatics
IT Business Analyst
Director of Information Systems
Assistant Director of IT Applications
IT Applications Manager
IT Senior Business Analyst
Director of Finance
Special Assistant to Chief Financial Officer

XeoHealth:
Developer
Chief Technology Officer
Chief Executive Officer
Director of Analytics

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