HEALTH WEALTH CAREER

COMMUNITY CARE BEHAVIORAL HEALTH ORGANIZATION INFORMATION SYSTEMS AND PROCESSES REVIEW

NOVEMBER 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), 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 Care Behavioral Health Organization (CCBH). 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 CCBH's site on November 13, 2019.

This report outlines CCBH'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 CCBH's administrative operations (e.g., information system, reporting, claims data collection and payment management). The key areas of focus within the comprehensive review include eligibility, provider, clinical (e.g., 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 CCBH 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 CCBH'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 CCBH 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 used and relied upon data supplied by CCBH. CCBH 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

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

KEY FINDING HIGHLIGHTS FROM THE REVIEW

During the onsite, the review team found that CCBH 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.

- Validate all diagnosis codes received on claims. This is necessary for reporting and will help to successfully pass encounter edits in PROMISe.

- Develop and implement edits in the MC400 for the bed hold/therapeutic leave days so that the 15-day maximum allowed per year is not exceeded during claims payment determination.

- Utilize the 834 daily eligibility file Third-Party Liability (TPL) information to compare to the MC400 TPL data for more timely eligibility and termination dates for Coordination of Benefits (COB) coverage.
- Complete the development process and implement solution for the Centers for Medicare & Medicaid Services (CMS) Coordination of Benefits Agreement (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.
- Change processes so that encounter submissions match the claims submitted by the provider including when multiple detail claim lines are submitted. The same level of detail should be evident in the MC400 claims system, encounter submissions submitted to PROMISe and the detailed files used in rate setting.
- Review the DHS matrix for encounter submissions specifically for the denied encounters that should be submitted. If inpatient claims are denied in the MC400 for lack of authorization, non-covered services, timely filing or TPL, encounters must be submitted to PROMISe reflecting those claim denials. Work with OMHSAS to determine the time period for historical encounter data denials that need to be submitted.
- Perform verification activities to ensure that encounters are voided and resubmitted where appropriate so that encounter information mirrors the service and payment activity in the claims system.

2
FINDINGS AND RECOMMENDATIONS

OMHSAS wants 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 CCBH's internal data systems and processes for claims payment, encounter submissions and reporting quality and included the identification of data reporting improvement opportunities.

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

CCBH 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 CCBH and include all relevant data elements. Additionally, validations through system edits and clinical review assist the overall claims process. Understanding CCBH'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 and Tools

Understanding claims systems and tools is necessary for OMHSAS to work efficiently and effectively with each BH-MCO. The following highlights review findings for CCBH:

- CCBH has a Third-Party Administrator (TPA), University of Pittsburgh Medical Center (UPMC), that processes claims on the MC400 system. The MC400 software is owned and maintained by UPMC. CCBH participates in testing prior to production software releases. CCBH staff have direct access into the MC400 system.

- CCBH's clinical functions are performed using Askesis PsychConsult software. Interfaces between MC400 and PsychConsult allow access into all claim, provider, eligibility, authorization and utilization information.

- CCBH maintains and owns the provider portal, which allows entry for service authorizations for non-inpatient services. The MC400 portal is used for claims, claims status, eligibility inquiries and remittance advice. The portals were updated in June 2019 to provide more information to providers, such as status of authorizations and claim processing. A future improvement for the portals is expected in early 2020 to allow a single sign-on for providers to access all of the data.

- CCBH uses Statistical Analytics Software (SAS) Data Integration Studio as part of their data warehouse processing technology. The SAS technology resides on an Oracle backend to fully support data warehouse processing. The CCBH data warehouse is used for operational reporting but CCBH uses a SQL database for the regulatory reporting, which includes 837 reporting and the production of rate setting files.

Claims System Staffing and Processing

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

- UPMC has 45 dedicated staff responsible for claims for CCBH. These staff include claims processors, TPL, Fraud, Waste and Abuse (FWA), quality and managers. All claims processing, including adjustments and TPL maintenance, are performed by UPMC staff.

- CCBH receives approximately 88% of claims via electronic data interchange (EDI), 9% are keyed directly into the web portal and the remaining 3% are received on paper. EDI claims primarily come through Change HealthCare, but CCBH will accept claims from any clearinghouse the provider chooses to use or direct 837 submissions from providers. COB information and claim voids cannot be submitted through the web portal; however, TPL claims can be sent via EDI submissions as well as on paper formats.

- Claim edits:

  – For electronic claim submissions, CCBH edits and validates the transactions using Health Insurance Portability and Accountability Act Strategic National Implementation Process levels 1 and 2, which is consistent with the minimum recommended standard editing. Errors that are discovered during upfront editing are sent back as notifications to the submitter using the 277CA Health Care Claim Status Response transaction set.

  – CCBH does not use National Correct Coding Initiative edits, but the MC400 system edits include checking for duplicate claims, validating eligibility and benefits, confirming a valid

procedure code is present, ensuring maximum units have not been exceeded for the authorization, and that the claim has been filed according to requirements. Provider contracts and the BHSRCC drive the MC400 edits set up for CCBH claims.

  - The MC400 verifies that the primary diagnosis code is valid within the 'F' series codes. Only the first diagnosis code is validated, not subsequent diagnosis codes on the claim. Even though the diagnosis codes are not validated, CCBH started to submit all diagnosis codes received on claims in encounters to PROMISe in January 2018.

- The MC400 does not systematically track bed hold/therapeutic leave days. CCBH performs quality reviews post-adjudication to determine any over usage and overpayments of this benefit. CCBH may initiate additional discussions with County oversight, OMHSAS and providers to update the Reserve Bed Hold — Residential Treatment Facility policy. The current policy has been developed based on prior guidance from the DHS and CCBH has identified they have additional flexibility in regard to reserve bed days.

- Claims processing:

  - The MC400 claims system auto-adjudication rate is 84%. The remainder pend for claim processer review and determination.

  - CCBH does not require an authorization for all services; however, for services that do not require an authorization, CCBH asks providers to go through a registration process for the services they intend to provide. This is a clinical registration and used internally as a modified authorization process. The registration can occur through the provider portal. The providers are encouraged to register and use the registration as a tool to monitor and manage patient care. Since the registration process is not a requirement, claims can be paid without the registration.

  - CCBH audits 3% of all claims processed by UPMC staff, up to a maximum of 25 claims per month. Only about 70 system-paid claims are audited weekly. CCBH does perform multiple additional focused audits on a monthly basis. Increasing the number of claims audited overall may detect system issues or training opportunities for staff. Audits can be utilized to ensure all processes are working properly even when minor system updates are performed.

- Provider data:

  - CCBH has some capitated providers that receive settlement payments based on retainer amounts. The settlements may be case rates rather than per member per month type of payments to providers. If these settlements are not paid directly for services rendered, CCBH is correct in not submitting encounters to PROMISe for these services.

  - CCBH has processes for Out-of-Network (OON) providers. The clinical team must authorize the services, and the network department will execute Single Case Agreements (SCA). The SCA drives the payment process for the claims system for the OON providers.

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. CCBH has processes in place to collect primary insurance data. The 834 eligibility file from DHS is not utilized for TPL; however, the monthly TPL file from DHS has more information and is the main source for TPL data. The annual TPL file is used by CCBH to reconcile TPL in the MC400. Claims information received or phone contacts with members and providers may identify additional primary insurance information. Other insurance information is verified and DHS is notified when any TPL updates are identified.

- CCBH indicated that TPL investigations have increased lately. Recoveries are a concern for CCBH since there are recovery rules in place such as timely filing with the primary carriers, with Medicare and with the DHS TPL Division for the time period when BH-MCOs can request recoupment for any overpayments due to TPL.

- CMS required health insurance organizations to have COBA processes in 2018. 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. CCBH is developing the COBA processes to collect Medicare claims and is planning to implement this by the second quarter of 2020.

- Providers do not always submit claims to CCBH when the primary insurance pays more than Medicaid allows. However, this information needs to be collected, submitted as encounters and made available for reporting. Subsequent to the meeting, CCBH will add language to the Provider Billing Manual instructing providers to submit claims in those instances a claim is paid in full by a primary insurance carrier.

ENCOUNTER SUBMISSIONS

Since encounter data is used for a variety of reasons, including rate setting and quality measurement, 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.

- UPMC has three employees that work approximately 15% of their time on PROMISe encounter submissions. CCBH is a liaison for questions regarding encounter issues.

- Claims are extracted from the database for 837 encounter creation weekly. Encounters submitted are based on payable claims since the last encounter file submission. Reconciliation between the MC400 and the encounter database is done via record counts; exceptions are resolved directly by the TPA. For some of the CCBH counties, 837 files are sent to the county for submission to PROMISe. Some of these files have been submitted twice which resulted in high denials of duplicate encounters earlier this year.

- CCBH pays claims based on how the claim is submitted. CCBH submits encounters as one-line encounters based on paid encounter detail lines.

- Encounters that do not pass PROMISe edits are worked by the TPA for resolution. When the TPA cannot resolve, the encounters are sent to the departments responsible for the issues such as claims or provider network. Corrections are usually submitted within 30 days.

- Claims denied that meet the DHS encounter matrix criteria are required to be submitted. It does not appear that inpatient claims denied for timely filing, not authorized or not submitted timely are submitted to PROMISe. This is not consistent with expectations from OMHSAS per the matrix submission requirements.

- CCBH creates a database with information from the DHS provider file PRV414 to manage providers in the MC400 that flows to the encounter submissions. CCBH does not use the PRV415 file.

- Subsequent to the meeting, CCBH modified their Place of Service (POS) logic that was based on the BHSRCC to instead send the valid POS codes submitted by the providers on the claims in the encounter.

- Subsequent to the meeting, CCBH categorized additional ‘not covered’ codes for submission as denied encounters. All encounters for newly categorized codes that had not been previously submitted were sent to PROMISe. This amounted to over 100,000 encounters over all contracts and all contract years.

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 CCBH 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 finalized and mailed within 24 hours.

- 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 Provider-Led Entity (PLE) data is submitted to Mercer for rate setting, there should also be a comparison of PLE data to accepted encounters. ***Please note****: An analysis of the claims PLE data was not included in this review to verify the data submitted.*

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 FWA. Post-payment analysis of data is often done through data mining and comparison of key data fields including, but not limited to, POS, 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 FWA processes.

- FWA activities are performed by UPMC for CCBH. Activities include 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 tracked in a separate database and are referred to DHS as directed.

- Audits are performed on EDI COB submissions to verify the primary carrier payments reported accurately by providers. Providers must submit the explanation of benefits to the auditors for the review as part of the verification process.

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 CCBH.

- Validate all diagnosis codes received on claims. The use of the diagnosis codes is important for the overall care of a member and for reporting of co-morbidity conditions. All diagnosis codes are used in data analysis by OMHSAS.

- Develop and implement edits in the MC400 for the bed hold/therapeutic leave days so that the 15-day maximum allowed per year is not exceeded during claims payment rather than relying on the post-adjudication validation currently performed.

- Increase audit procedures to increase the quantity of audits based on adjudicated claims of at least 3% to ensure all service types are audited to verify system setup and manual procedures are followed.
- Finalize the development, testing and implement processes to fulfill the CMS requirements for COBA processes. CCBH 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.
- Use the 834 daily eligibility file TPL information to compare to the MC400 TPL data for more timely eligibility and termination dates for COB coverage.
- Utilize provider newsletters to promote the need for complete data, including submitting claims with TPL information even when a payment is not expected from Medicaid for members with primary carrier coverage. CCBH could emphasize the need to collect service utilization data.
- Work with the counties that handle encounter file submissions to PROMISe to develop a file tracking process to eliminate duplicate file submissions to PROMISe.
- If a claim has three detail lines, the encounter submitted should be three encounter lines. One encounter should match the claim submitted by the provider when multiple detail claim lines are submitted. The same level of detail should be evident in the MC400 claims system, encounter submissions submitted to PROMISe, and the detailed files used in rate setting.
- Review the DHS matrix for encounter submission specifically for the denied encounters that should be submitted. If inpatient claims are denied in the MC400 for lack of authorization, non-covered services, timely filing or TPL, encounters must be submitted to PROMISe. Work with OMHSAS to determine the time period for historical denials that need to have encounters submitted.
- 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.
- Ensure that encounters are voided and resubmitted where appropriate so that encounter information mirrors the service and payment activity in the claims system.

APPENDIX A

AGENDA

Community Care Behavioral Health Organization (CCBH) Review
November 13, 2019
8:30 am to 4:00 pm

Note: *The following item is needed to be ready for review by the Office of Mental Health and Substance Abuse Services (OMHSAS)/Mercer staff upon arrival on November 13, 2019:*

1. The Fraud, Waste and Abuse (FWA) attachment indicated in question 14 of the survey response.

Note: *System demos will be expected of the provider portal and the claims system. OMHSAS provided a sample list of the Internal Control Numbers that may be reviewed during the claims demonstration.*

TIME	TOPIC	CCBH ATTENDEES
8:30 am–8:45 am	Introduction and opening comments: • Purpose of review • Overview of systems including claims, clinical and data warehouse	All
8:45 am–10:15 am	Survey responses discussion: • Systems: – Claims receipt, front end edits and loading • Claims: – Claims processing standards – Claims edits – Claims staffing – Claims audits • Provider online access discussion	IT and Claims
10:15 am–10:30 am	Break	All
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 • Coordination of Benefits Agreement for Medicare	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	Claims and IT
2:15 pm–2:30 pm	Break	All
2:30 pm–3:15 pm	• Claims system demonstration continued • Provider information: – Monthly provider files – Provider loads, addresses and fee schedules – Out-of-network providers	IT, Claims, Encounter Team and Network/Provider
3:15 pm-3:45 pm	FWA	Claims, IT and Program Integrity/FWA
3:45 pm–4:00 pm	Closing and next steps	All

Attendees
OMHSAS:
OMHSAS — 5 staff
Regional representative
County representative

Mercer:
Consultants — 2 staff

CCBH:
Director, IT
Chief Information Officer
Director, Provider Reimbursement
Data Analyst
Chief Operating and Administrative Officer
Senior Director, Community Care Program Operations
Chief Finance Officer
Executive Director
Programmer
Program Rep. 2
Director, Network Technical
Director, Fraud and Abuse

UPMC:
Manager IT
Senior Manager Quality Assurance
Director Quality Assurance
TPA Performance Analyst, Senior
Senior Claims Manager

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