Pennsylvania's Office of Mental Health and Substance Abuse Services

2022 Information Systems Capabilities Assessment

Beacon Health Options of Pennsylvania

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Introduction

The Pennsylvania (PA) Department of Human Services (DHS), Office of Mental Health and Substance Abuse Services (OMHSAS) has partnered with its external quality review organization (EQRO), IPRO, to conduct a Behavioral Health (BH) managed care organization (BH MCO), system and process review in 2022 in accordance with the Centers for Medicare & Medicaid Services (CMS) external quality review (EQR) protocol as part of an encounter data validation task.

IPRO customized and uploaded the information systems capabilities assessment (ISCA) worksheet provided in Appendix A of CMS's protocols to REDCap®. The worksheet was emailed to all the MCOs on April 20, 2022, and the MCOs were requested to complete and return the responses by June 20, 2022. During the months of August and September 2022, IPRO conducted a meeting with OMHSAS and the BH MCOs via a remote meeting.

Knowledge of the capabilities of a BH MCO's information system (IS) is essential to perform the following task elements effectively and efficiently:

- assess an MCO's IS;
- validate MCO encounter data;
- calculate or validate BH MCO performance measures (PMs);
- assess an MCO's capacity to manage the health care of its enrollees; and
- review the MCO's encounter data submission and reconciliation processes.

The purpose of this assessment is to pose standard questions used to assess the strength of the BH MCOs with respect to these capabilities. Responses to these questions will assist the EQRO in assessing the extent to which the BH MCO's IS is capable of producing valid encounter data, PMs, tracking encounter data submissions and other data necessary to support quality assessment and improvement, as well as managing the care delivered to its enrollees.

The remote meetings and ISCA completed by the BH MCOs were organized into five sections:

1. Enrollment System(s) and Processes,
2. Claims/Encounter Data System(s) and Processes,
3. Provider Data System(s) and Processes,
4. Oversight of Contracted Vendor(s), and
5. Data Integration and Systems Architecture.

The results and findings presented here are based on data IPRO collected through the completed ISCA worksheet and subsequent remote meetings.

General Information

Beacon Health Options has participated in the Pennsylvania Behavioral HealthChoices Medicaid Managed Care product line since 1998. Table 1 lists the average monthly enrollment for Beacon Health Options from January 2018 through December 2020.

Table 1: Average Monthly Enrollment Counts, 2018–2020

Insurer	Year 1 – 2018	Year 2 – 2019	Year 3 – 2020
Privately insured	66,324	65,924	60,822
Medicaid/CHIP without Medicare or private insurance	261,256	255,583	258,986
Medicaid/CHIP with Medicare coverage with other insurance organization or FFS	55,297	56,134	55,752
Medicaid only	261,256	255,583	258,986

CHIP: Children's Health Insurance Program; FFS: fee-for-service.
Source: Beacon Health Options ISCA response

Beacon Health Options provided IPRO a completed ISCA and supplemental documentation on June 21, 2022. A 2-hour remote meeting was held on August 30, 2022, to discuss the ISCA responses and review of Beacon Health Options' systems. Beacon Health Options, Allan Collautt Associates, Inc. (ACA), Behavioral HealthChoices Contractors (BHHCs), OMHSAS and IPRO staff attended the remote meeting.

Beacon Health Options uses Connections Administrative System (CAS), for claim adjudication and enrollment processing.

Information Systems Capabilities Assessment

Enrollment System(s) and Processes

Beacon Health Options' enrollment system process involves eligibility being updated based on files received from DHS. Eligibility files are received and processed daily. Designated eligibility staff members also have access to the Provider Reimbursement and Operations Management Information System (PROMISe) and can look up eligibility and manually update their system.

Enrollment is determined from the 834 files received from the state on a daily and monthly basis. The member eligibility segment records are imported and processed into their CONNECTS system, and the member tables are populated. Due to the nature of the data and the many breaks, changes, and updates involved, Beacon Health Options orders the records contiguously in its database management system (DBMS) to determine if a continuous segment can be created.

Beacon Health Options' systems can track enrollees who switch from one product line (e.g., Medicaid, commercial plan, Medicare) to another. Beacon Health Options has the ability to track an enrollee's initial enrollment date. A Medicaid member can exist under more than one identification number (ID) with Beacon Health Options' IS.

Beacon Health Options transfers the daily 834 file to a proprietary file system and loads to their eligibility system. The daily volume of errors and members bypassed from the eligibility file load that are reviewed and worked manually averages approximately 110 records. Commonly seen errors are: missing street/city/state/ZIP code in address, county code, Beacon Health Options begin date greater than the Medicaid end date, invalid group/member active, covered under different parent, and member group effective date after member group expiration date. Beacon Health Options processes all errors manually by reviewing the member in DHS's electronic client information system (eCIS) website and updating the member record accordingly.

Beacon Health Options stores the race and ethnicity values received using a crosswalk table for the CONNECTS system. For example, a value of "C" for Caucasian is mapped to a value of "W" for White in CONNECTS, but a value of "B" as Black and "A" as Asian or Pacific Islander remains the same.

Claims/Encounter Data System(s) and Processes

Beacon Health Options receives and processes claims from providers in electronic and paper formats. 96.1% of data in 2021 are submitted electronically and 3.9% on paper. The formats used are Institutional Inpatient (837I) and Professional (837P). Beacon Health Options advised that all outpatient and non- revenue code claims be submitted on an 837 Professional or CMS 1500 (HCFA) claim form. Beacon Health Options has advised their providers that all outpatient services claims received after 8/31/2019 that are on an 837I/UB 04 will be rejected by Beacon Health Options regardless of the date of service. All claims are subject to batch adjudication upon receipt. All claims that do not auto-adjudicate are considered suspended or pended. The percentage of suspended and pended claims for calendar year 2021 was approximately 28%. The vast majority (99.71%) of all claims are adjudicated, clean and unclean, within 30 days of receipt.

Beacon Health Options' systems and procedures handle validation and payment of Medicaid claims when procedure codes are not provided (missing or invalid) by having the claim denied for that reason. Table 2 details data source and types received for paper claims.

Table 2: Claims/Encounter Data Sources and Types

Data Source	Data Type
Hospital	UB-04
Physician	CMS-1500
Nursing home	CMS-1500
Home health	CMS-1500
Behavioral health	CMS-1500 and UB-04

Source: Beacon Health Options ISCA response

Beacon Health Options receives and stores International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) procedure codes; the "principal procedure" code along with the first three "other procedure" codes are stored in their claims system.

Beacon Health Options claim processors are restricted from modifying any incoming claim data from either Institutional or Professional claims. Any missing or invalid data that are required will cause the claim to be denied for that reason.

The suspend/pend process is the same for all claims. Beacon Health Options indicated, if all required elements for the service/procedure are not in place when the claim goes through the auto-adjudication process, the claim will pend with a hold code indicating what needs to be investigated to resolve and finalize the claim. The claim is then assigned to a claims processor to investigate and finalize the claim for payment or denial. Please state why the claim will pend if all required data elements are "in place."

The Beacon Health Options' quality performance monitoring standards for claims processing is 99% financial accuracy, 98% administrative or procedural accuracy and 95% overall accuracy. For 2021, the Beacon Health Options Claims Team processed approximately 39,000 claims each week, maintaining more than 99.95% administrative accuracy, 99.95% financial accuracy, and 98.05% overall accuracy.

Beacon Health Options takes into consideration the department goals for performance review. The claims processors are reviewed based on their monthly numbers for production as well as quality. Special projects are also noted for each processor throughout the year. A rating is given to each claim processor based on a 5-level rating: does not meet expectations, partially meets expectations, meets expectations, exceeds expectations, and significantly exceeds expectations. The higher the rating, the higher the compensation is to that claim processor.

Provider Data System(s) and Processes

The provider profiles are maintained on Beacon Health Options' website and IS, Network CONNECT.
Beacon Health Options' provider record contains: mailing address, phone number, email, vendor addresses, national provider identifier (NPI) numbers, licensure/certification, clinical expertise, PROMISe number, PROMISe provider type, PROMISe specialty, PROMISe effective date, PROMISe revalidation date, contract, fee code schedules, insurance, education, correspondence, credentialing, tax ID number, title, gender, race, cultural competency training, languages, ethnicity, ages treated, board certification, hospital privileges, taxonomy, provider types, types of service, hours of operation, disability accessibility, accessibility by public transportation, fax, website, accepting new patients indicator.

Beacon Health Options utilizes Quest Analytics Suite to assess network adequacy. Beacon Health Options runs and reviews GeoAccess reports on a quarterly basis.

Oversight of Contracted Vendor(s)

Beacon Health Options does not subcontract with any vendor(s) that provide services to members. Beacon Health Options advised that there are no contracted vendors that provide services to members which would require oversight of vendor policies and activities.

Data Integration and Systems Architecture

During the remote meeting, Beacon Health Options provided a comprehensive walkthrough of their IS and all the data sources maintained by the BH MCO for operations and reporting. Beacon Health Options follows a system development life cycle model (SDLCM). Beacon Health Options outlined the following steps of the maintenance cycle for Beacon Health Options' reporting requirements for the mandated reports developed by the Data and Analytics Team (DAT); reports are developed using SAP Crystal Reports and Structured Query Language (SQL).

- Project Charter/Project Request – Overview of change and summary of expected outcome ends in submission of project request
- Intake – Validate project request and scope level of effort
- Initiation – Project planning, staffing, timeline establishment
- Requirements – Detailed business and system requirements are documented and approved.
- Functional (Technical Design) – Detailed technical system requirements are documented and approved.

- Development – Coding begins based on technical design.
- Unit Testing – Developer testing in development environment
- Level 1/Integration Testing – Business systems analyst (BSA) tests in release (integration) environment, ends with approval to move to user acceptance testing (UAT).
- Level 3/UAT – Business requestors test in release environment, ends with approval to implement.
- Migration & Deployment – Development Team completes approval documentation and provides materials to Change Management Team who deploys to production environment.
- Post deployment Testing – BSAs test post deployment to ensure successful production deployment.

Data sources included transactional systems for claims processing, enrollment processing, provider data, vendor data and supplemental sources, such as registry data, and lab values received from the state and their providers.

Medicaid claims are stored in an IBM® iSeries server. The Medicaid encounter, claim, and enrollment details are extracted into the Oracle Enterprise Data Warehouse for analytic reporting purposes and are refreshed from the transactional system on a nightly basis.

Beacon Health Options' minimum data retention requirements currently conform to all federal and state regulatory requirements. All data for all years are maintained on the system; however, it is possible that, in the future, data will be archived once the retention requirement timeframe is exceeded.

Disaster Recovery

Beacon Health Options has a disaster recovery (DR) plan and DR system that is located in Las Vegas, Nevada, which provides failover capabilities. Beacon Health Options DR system is tested annually. It takes Beacon Health Options approximately 8 hours recovery time objective (RTO) to switch over to the DR system when the primary system fails. Backups are performed daily and weekly, and in addition, data are replicated from primary data center to backup data center. Backup data or media are stored at Recovery Point/First Federal, Gaithersburg, Maryland. Backups are tested at a minimum annually. Data are replicated to the backup site as needed throughout the year, so they are always available besides being on the backup media. Medicaid data corruption due to system failure or program error is prevented via multiple avenues of redundancy, including data replication between primary and backup. Data on backup media are available in case of primary system failure or program errors. In addition, data are clustered across multiple servers to prevent single source failures.

Access to System

Beacon Health Options has role-based access granted based on the staff positions role. This enables access to various screens within the application, and all access is controlled through the backend support system for IBM iSeries (NetIQ). Programming and analysis staff can access the development system only.

Performance Measures

Beacon Health Options uses Inovalon, a National Committee for Quality Assurance (NCQA)-certified Healthcare Effectiveness Data and Information Set (HEDIS®) vendor, to calculate HEDIS and PA-specific PMs, Follow-up After Mental Health Hospitalization (FUH) and Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA). Claims, enrollment, member, and provider data are transferred monthly from the Beacon Health Options data warehouse to Inovalon through File Transfer Protocol (FTP). Data are loaded into the software where they are used for HEDIS and IPRO measure rate calculations. Once calculations are complete, results are exported from the Inovalon platform and uploaded into Beacon Health Options' data warehouse for reporting.

Beacon Health Options' repository structure contains all the key information necessary for Medicaid PM reporting. Required documents are reviewed and organized within their own data space. Related programming code, notes, and documents are added, and run schedules are tracked electronically. Log files and interim data tables are kept for review and validation, and the final PM data files are stored with the existing documents. Submission screens are recorded electronically to verify timing and project completeness. Beacon Health Options' Medicaid PM report generation process involves data being received from Inovalon data export and required fields being added based on IPRO specifications.

Medicaid report generation programs are documented through remark statements which are used throughout programming code where needed. These assist with explaining a subroutine or data stamping code updates. After the code is validated against the specifications, historical code is archived based on the project and the recurrence. Beacon Health Options tests the process used to create Medicaid PM reports through code debugging, trending, end-user testing, third-party validation, control tables, and duplicate checks. Independent review of the data involves utilization of techniques used when PM data are being produced. Depending on the complexity of the request, the system development life cycle (SDLC) can dictate the depth of level 1, level 2, and end-user testing. Medicaid PM reporting programs are reviewed by supervisory staff.

OMHSAS is requiring that Primary Contractors and its BH MCOs contract directly with National Committee for Quality Assurance (NCQA) or with an NCQA-certified HEDIS® vendor to verify the measure logic used to run HEDIS® measures. The Primary Contractor and its BH MCO are responsible for assessing and completing all necessary related steps and must plan appropriately to ensure compliance with this requirement for HEDIS® MY 2023.

Physical Health Service History Files

Beacon Health Options incorporates data into the repository on an as-needed basis as required. Inovalon utilizes some service history data for calculating quality measures. The medical claims data are used for the Integrated Care Plan (ICP) program initiative, and the data are imported into the Inovalon HEDIS software to calculate measures that include medical claims. Beacon Health Options noted that the medical and inpatient claims have the substance use disorder (SUD) diagnosis redacted from the physical health (PH) service history files received.

Encounter Data

PA BH MCOs are required to submit encounter data files to DHS. Beacon Health Options does not submit encounter data directly to CMS T-MSIS. Beacon Health Options has a separate repository for encounter data to be submitted to the state's Medicaid Management Information System (MMIS), PROMISe. The repository would be characterized by a relational DBMS, indexed, and proprietary process. Beacon Health Options utilizes ACA to handle the submission and reconciliation of the encounters submitted to PROMISe. ACA submits encounters to PROMISe on a weekly basis.

The timeliness and acceptance rate of June 2022 and July 2022 for each BHHC was between 99% and 100%. The top reasons for encounter denials were: recipient not eligible with Beacon Health Options as of the date of service (error code 847), or an invalid combination for professional BH encounter (error code 708). Beacon Health Options' standard regarding timeliness of processing in 2020 required processing encounters no later than 3 weeks after the paid date and running financial completeness reports weekly.

Beacon Health Options utilizes OMHSAS's Behavioral Health Services Reporting Classification Chart (BHSRCC) to assign service code and modifier combinations prior to submission to PROMISe.

Summary of Findings

CMS requires that, at the conclusion of the ISCA review, the EQRO compiles and analyzes the information gathered through the preliminary ISCA review and from the BH MCO staff interviews. After completing its analysis, the EQRO writes a statement of findings about the BH MCO's IS. Table 3 summarizes the EQRO's findings.

Table 3: Summary of Findings

Findings	Results (Met, Not Met or Partially Met)	Review Notes
Completeness and accuracy of encounter data collected and submitted to the state	Met	Beacon Health Options' IS has processes in place that generate encounter data for submission to OMHSAS's MMIS, PROMISe, for all encounter types. Beacon Health Options utilizes Allan Collautt Associates to handle the submission and reconciliation of the encounters submitted to PROMISe.
Validation and/or calculation of PMs	Met	Beacon Health Options utilizes Inovalon, an NCQA certified HEDIS repository, to produce OMHSAS's three annual PMs.
Utility of the IS to conduct MCO quality assessment and improvement initiatives	Met	Beacon Health Options' IS supports various data reporting requests both internally and externally.
Ability of the IS to conduct MCO quality assessment and improvement initiatives	Met	Beacon Health Options' IS has the ability to conduct quality assessments and conduct improvement initiatives.
Ability of the IS to oversee and manage the delivery of health care to the MCO's enrollees	Met	Beacon Health Options receives and processes the daily 834 files. The daily 834 files are transferred to a proprietary file system that is loaded to Beacon Health Options' eligibility system, CONNECTS.
Ability of the IS to generate complete, accurate and timely T-MSIS data	Not applicable	Beacon Health Options does not submit encounter data to T-MSIS. Beacon Health Options submits encounter data to OMHSAS's MMIS, PROMISe.
Utility of the IS for review of provider network adequacy	Met	Beacon Health Options utilizes Quest Analytics Suite software and reporting to monitor provider network adequacy across geographic areas.
Utility of the MCO's IS for linking to other information sources for quality-related reporting (e.g., immunization registries, health information exchanges, stat vital statistics, public health data)	Met	Beacon Health Options' IS has processes in place to receive, validate and incorporate claims data, and produce internal and regulatory reports.

IS: information system; OMHSAS: Office of Mental Health and Substance Abuse Services; MMIS: Medicaid Management Information System; PROMISe: Provider Reimbursement and Operations Management Information System; PM: performance measure; NCQA: National Committee for Quality Assurance; HEDIS: H
ealthcare Effectiveness Data and Information Set; MCO: managed care organization; T-MSIS: Transformed Medicaid Statistical Information System.