HEALTH WEALTH CAREER

MAGELLAN BEHAVIORAL HEALTH OF PENNSYLVANIA INFORMATION SYSTEMS AND PROCESSES REVIEW

NOVEMBER 2019

Commonwealth of Pennsylvania

FINAL REPORT

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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 Magellan Behavioral Health of Pennsylvania (Magellan). 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 Magellan's site on November 21, 2019.

This report outlines Magellan'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 Magellan'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 Magellan 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 Magellan'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 Magellan 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 Magellan. Magellan 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

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

KEY FINDING HIGHLIGHTS FROM THE REVIEW

During the onsite, the review team found that Magellan 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.

- Review system edits to develop and implement an edit for bed hold/therapeutic leave days so that the maximum number of 15 days is not exceeded with payments made within a calendar year.

- Review federally qualified health center/rural health center (FQHC/RHC) claims denied due to the rendering provider not matching Magellan's Claim Adjudication and Payment System

(CAPS) or PROMISe since the information is not required and should not be a reason to deny service.

- Review continuous inpatient stay encounters for accurate type of bill submissions. In addition, review other derived changes made to data fields during the encounter process ensuring complete and accurate data in encounter submissions. Correct encounter submissions to reflect any complete payments.
- Review and identify encounters for outpatient services submitted by providers on an institutional format and identify those with incorrect place of service submitted on professional encounters or those submitted inappropriately to PROMISe on the 837I format indicating an inpatient service was rendered.
- Complete the development, testing and implementation of the Coordination of Benefits Agreement (COBA) process to receive and process cross-over Medicare claims and payments.
- Identify all encounters that should have been voided but were not yet submitted. The goal should be that encounter submissions reflect complete and accurate data and that the data matches Magellan's claims system payments.
- For third party liability (TPL) claims, encounters should be submitted when the payment results in a zero payment. In addition, submit the other insurance/Medicare allowed and payment amounts for the encounter both at the header and detail levels.
- If a claim has three detail lines, the encounter submission should also have three detailed lines if all lines were payable. Encounters should match the original claim submitted by the provider, including when multiple detail claim lines are submitted.
- Complete a full review of the Behavioral Health Services Reporting Classification Chart (BHSRCC) requirements for systems edits and encounter processes to ensure no changes have been missed with all prior and current changes.
- Identify the claims with diagnosis codes that were not appropriately submitted to PROMISe and submit as either voids and new claims or adjustments to previously submitted encounters.

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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 Magellan's internal data systems and processes for claims payment, encounter submissions and reporting quality and includes the identification of data reporting improvement opportunities.

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

Magellan uses the OMHSAS 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 supporting all services paid by Magellan and including all relevant data elements. Additionally, validations through system edits and clinical review assist the overall claims process. Understanding Magellan's system, processes and methodology helps OMHSAS with Medicaid data analyses. Claims reviewed on site 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 Magellan:

- Magellan processes claims internally on the CAPS, software that is owned and maintained by Magellan at their St. Louis headquarters. Magellan uses HealthAxis as the imaging system for paper claims and documents. There have been no major system updates recently and no major releases are expected.

- Provider credentialing uses the Integrated Provider Database (IPD). OnBase is used for workflow and document imaging. IPD is integrated with CAPS for up-to-date changes to the provider data.

- The clinical team use the Integrated Product (IP) and Total Member Record (TMR) systems for tracking member health information. For authorizations, the clinical team performs direct data entry into CAPS to allow for reporting and claims payment.

- The data warehouse is an Oracle/SQL server. A separate SQL server is used for encounter processes.

- Fraud waste and abuse (FWA) monitoring is tracked in the Perspective System.

Claims System Staffing and Processing

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

- Magellan has seven staff dedicated to processing Pennsylvania BH claims. The claims processors manually adjudicate 13.6% of claims that cannot be automatically processed by the system.
- Magellan receives approximately 86.6% of claims via electronic data interchange (EDI), 4.2% are paper and 9.2% are through direct data entry through the provider portal. Many of the paper claims are due to providers submitting primary carrier information even though Magellan can accept COB information electronically. Providers have 60 days to submit claims from the date of service, discharge date on inpatient claims or the date of the primary carrier explanation of benefits.
- Magellan maintains a provider portal with secure access and functionality that allows providers to view eligibility, note the presence of primary insurance, claim submission, submitting authorizations for non-inpatient services and viewing status of claims and authorizations.
- Claim edits:
  - Magellan uses Edifecs and EDI Strategic National Implementation Process (SNIP) claims validation edits levels 1–7 for claim editing prior to submission to CAPS. Providers are notified of claim rejections through the HIPAA 999 and 277 responses. Providers may call regarding submission issues, but Magellan does not monitor the rejections to proactively work with providers.
  - Edits are primarily defined by BHSRCC requirements prior to the claim entering into the claims system, which is prior to the internal claim number (ICN) assignment. These claims are flagged to deny in CAPS.
  - Additional edits in CAPS 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 Magellan believes the services are driven by the prior authorization requirements.

  - Magellan edits all diagnosis code iterations submitted by providers for validity.
  - Members may leave an inpatient hospital or residential treatment facility (RTF), and the days can still be billed by the facility holding the bed for the member. There is a maximum number of 15 days that are allowed to be paid for this purpose, and the payment is made at one-third of the per diem rate. Magellan relies on manual intervention by claims processors to not exceed the annual benefit paid. A system edit could ensure no additional days are paid.

- Claims processing:
  - Magellan pays for many of the services through 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. Magellan pays the FQHC/RHC prospective payment system (PPS) rates as required by OMHSAS. In addition, Magellan is not consistent with the processing of FQHC claims. As demonstrated during the claims review, if the rendering provider information is submitted and it does not match CAPS, the claim is denied. However, if the provider submits the claim without the rendering provider information, the claim will process through.

  - Magellan indicated that 91.3% of inpatient hospital claims are paid using per diem arrangements. Single case agreements (SCAs) are used for about 2.9% of the claims and the remaining hospitals, 5.8% are paid via case rates. Crozier and Mercy Hospital make up the majority of the case rate type of payments, which is partially paid as per diems and part of the stay is paid under case rate provisions. Due to the different payment schedules, separate encounters may be submitted with the appearance of new admits.

  - For outpatient claims received on an institutional format, prior to loading the claim into CAPS, Magellan crosswalks the claims into the professional claim format/module. If the type of bill is 13x, CAPS would show POS 99 (generic unknown). For bill type 73x, the POS would be loaded as 57. Type of bill 73x represents FQHC, and POS 57 is non-residential substance abuse treatment facility. Without looking at additional information, such as diagnosis code, indicating a POS of 57 would not be a logical crosswalk. These claims are processed based on procedure code fee schedules. The data warehouse stores these processed claims in the professional format for reporting and data analysis.

  - For the outpatient/professional services, Magellan pays based on procedure code fee-for-service (FFS) rates 90.65% of the time and through SCAs for 9.35% of the claims.

- Provider data:
  - Magellan has approximately 4% of services rendered through out-of-network (OON) providers. The OON providers are not necessarily out-of-state providers. The OON providers may be new locations or services not previously offered at an existing location or providers

in other counties outside of the Magellan contracts. Services for all OON providers must have prior authorization in order to be considered for payment.

– For RTF services, and to meet the OMHSAS requirements to have these facilities enrolled with PROMISe, Magellan has already implemented this requirement prior to approving the authorization of RTF services.

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. Magellan 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.

- Magellan's COB process with Medicare is to pay the coinsurance and deductible as long as the Medicaid allowable is not exceeded.

- Magellan 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 implemented 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. Magellan is developing their COBA processes and is currently in the testing phase with CMS to receive and collect Medicare claims/payments directly through the COBA process. The goal is to complete the process by the end of 2019.

- If TPL is discovered after an initial payment is made, Magellan will void the previously processed claim and tell the provider it is their responsibility to resubmit a new claim with the primary carrier payment. If the provider does not resubmit the claim, the encounter system will not reflect the correct payment amount, since voids are not submitted.

- Magellan does submit encounters for claims that are denied due to needing other insurance. However, if there is no payment due from Magellan through the COB process, the encounter is not submitted. These should be considered as zero pay and are expected in encounter submissions to PROMISe. Mapping of these zero payment claims to encounters is done through the claim action reason codes (CARC) mapping which was not present in any documentation provided by Magellan or encounters reviewed.

- During the onsite claims demonstration, Magellan's COB calculation indicated that encounters do not contain all of the fields populated for commercial and Medicare amounts. The header record should contain information about the primary carrier allowable and payment amounts.

- Magellan has not been submitting encounters when there is a TPL payment in which Magellan's responsibility is zero. This omission impacts utilization reporting done by OMHSAS for services rendered to Medicaid members.

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.

- Magellan has four employees dedicated to PROMISe encounter submissions, encounter data analytics and encounter corrections.

- Claims are extracted from a SQL database for the 837 encounter creation. Encounters submitted are based on payable claims since the last file submission. Encounters should match the inbound claim from providers; however, Magellan submits every detail line as a separate encounter to PROMISe. The following are findings from the Magellan encounter submission review:

  – Per the documentation submitted after the onsite review, Magellan derives many fields for encounter submissions, such as:

    › Defaulting the discharge time to 1200 rather than the actual time a patient left a facility

    › Deriving the diagnosis related group (DRG) code based on the admitting diagnosis code. The admitting diagnosis is not always the real reason a person was in the facility; the primary diagnosis code is more reliable

  – 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. Documentation supports that Magellan is deriving the submission type of bill code rather than using the claims data. In addition, when encounters are submitted with a 'type of bill' designation of 111, this indicates it is a complete encounter. The claims demonstration confirmed that Magellan is changing the type of bill, such as a 113 to a 114, causing the encounter to look like a final bill rather than a continuing inpatient bill. 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. As a result, OMHSAS reporting to CMS would not be accurate.

  - Encounters are submitted using the Magellan-allowed amount in place of the provider billed amount. Without having accurate provider billed amounts, PROMISe shadow pricing may be affected.

  - Even though outpatient facility services submitted to Magellan are converted to professional formats in CAPS, during the encounter extract/creation process, Magellan converts these claims to 837I format encounters. These appear as inpatient services in the encounters submitted to PROMISe, such as electroconvulsive therapy (ECT) services that were actually performed in an outpatient facility.

- Since Magellan's database holds the PROMISe ICN from the 277U response, the corresponding PROMISe ICN can be submitted with the encounter adjustments. Reports are run for the business analyst to review PROMISe encounter denials, and the encounter is modified and resubmitted. This can cause corrections to be made without necessarily getting to the root cause of issues or to assist in future submissions without errors.

- Changes by OMHSAS to the BHSRCC are updated in encounter submissions; however, a full review of the BHSRCC is not done and may not be caught during the encounter denial reviews. Corrections needed in CAPS may not be identified if the full analysis is not done based on corrections for encounter denial issues.

- Magellan started to submit encounters with up to 26 diagnosis codes as received from providers. Recently, Magellan discovered a bug in the system that resulted in only up to 23 diagnosis codes being submitted since April/May 2019. Encounters should be submitted as they appear on the provider's claim, regardless of payment splitting rules in the claims system. However, Magellan encounter submissions do not look like the claim that was received from the provider because of CAPS-specific processes of splitting dates of service. Magellan uses the CAPS claim number plus the detail line number for the patient account number and submits one-line encounters. This results in multiple issues:
  - Magellan pays claims based on how the claim is submitted. Magellan 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.

  - The process to adjust a claim in CAPS is to void the detail line being adjusted in the claims system, and the replacement line creates another detail line number. If Magellan 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. An encounter should match the claim that was received from the provider, with all paid lines on one encounter, such as one inpatient stay.

- OMHSAS requires BH-MCOs to submit specific information in the 837 NTE notes segment. Magellan indicated they store the data necessary for the "notes" field in a table for use with the encounter submission.

- Magellan indicated that DHS provider files PRV414, PRV430 and PRV720 are used in managing providers in CAPS. PROMISe denials indicate matching provider IDs and billing locations are in the top 10 encounter denials. The PRV415 provider file is not used by Magellan. The PRV415 provider file is a comprehensive file that may contain data missed in the ~~daily~~ weekly incremental files.

- Magellan has not submitted voids of encounters to PROMISe. Currently, there are $1.4 million in 2018 and $849,000 in 2019 dates of service over-reported or potentially causing duplicates in PROMISe due to not submitting the encounter voids. 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.

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 Magellan 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. Check runs occur daily, with each county having a specific day of the week. Checks are sent to providers one business day after the check write date. With no lag in processing checks weekly, Magellan 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 accepted 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. Magellan indicated they have a process to compare person level encounter (PLE) data files received back from Mercer for rate-setting purposes. *Note: an analysis of the claims PLE data was not included in this review to verify the data submitted.*

- Magellan does have some sub-capitated providers and calculates bonuses based on quality measures or capitation services. These payments are processed in the claims system but are not submitted to PROMISe™ as encounters. CAPS has the payments listed under unidentified members (special dummy identification number), which would not make it through PROMISe™ edits. Magellan indicated these are listed as medical expenses as 'other' in financial reporting.

PROGRAM INTEGRITY

BH-MCOs 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, 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 FWA processes:

- Magellan 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 and the claims system. Subsequently, encounters may reflect the program integrity recovery if there is a partial recovery; however, with the absence of submitting encounter voids, not all recoveries may be properly reflected as encounters.

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 Magellan.

- Develop front-end error reports and review claim rejections that do not make it into CAPS. This will assist providers proactively with claim submissions to help prevent paper submissions, provider calls or claims missing the timely filing limits.

- Review system edits to implement an edit for bed hold/therapeutic leave days so that the maximum number of 15 is not exceeded for payments made within a calendar year.

- Create processes to ignore the rendering provider information for FQHC providers, if submitted, for consistency in claim processing, since it is not currently a required field and Magellan does not have the FQHC rendering providers registered in CAPS.

- Review processes for submitting continuous inpatient stay encounters, regardless of the contractual payment methodology and ensure inpatient stays have the same admit date until discharged.

- Review the logic for the outpatient services submitted on an institutional format when a type of bill 73x is submitted. Determine the correct place of service for the outpatient services received on an 837I format.

- Complete the development, testing and implementation of the COBA process to receive and process the Medicare claims and payments.

- Identify all claims voided that had a previous encounter submission. This should include claims denied due to late notification of a primary carrier. Work with OMHSAS to determine the length of history to be analyzed. OMHSAS needs the voids to be submitted and a schedule to get current on encounter void submissions. Regardless of the significance of the amount, PROMISe encounter data must be complete and accurate for data analysis by OMHSAS or other associated entities.

- Develop a process to submit claims processed that result in a zero payment due to COB with a primary carrier. These may be classified in the claims system as a denial; however, Magellan may need to look at denial reasons to verify zero pay versus denial to include the claims in encounter submissions.

- Submit the other insurance/Medicare allowed and payment amounts for the encounter, both at the header and detail levels.

- 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.

- Submit accurate encounter data to match what the provider submitted, such as the following data elements: type of bill for inpatient services, billed amount, discharge time and any other fields that were changed from standard coding not specifically indicated in the BHSRCC.

- Identify the claims for outpatient services that were submitted as inpatient services with a type of bill 11x. These should be voided and resubmitted in the professional 837P format.

- Review encounter denials from PROMISe and update business rules to ensure the root cause of the rejection is found and processes are in place to help prevent the same type of issues in the future. One issue may be the need for correct provider ID and service location. If the provider has moved or changed service locations, ensure CAPS has the current address and contact the provider if necessary.

- Complete a full review of the BHSRCC requirements for systems edits and encounter processes to ensure no changes have been missed.
- Identify the claims with diagnosis codes that were not appropriately submitted to PROMISe and submit as either voids and new claims or adjustments to the previously submitted encounters.
- 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.
- Submit a complete encounter with one claim number in the patient account number for all detail lines.
- 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.

APPENDIX A

AGENDA

Magellan Behavioral Health of Pennsylvania (Magellan) Review
November 21, 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 November 21, 2019:*

1. The Magellan Behavioral Health Standard document referred to in question 19 of the survey response.
2. A copy of the encounter reports referred to in question 34 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 ICNs that may be reviewed during the claims demonstration*

TIME	TOPIC	MAGELLAN 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 • COBA 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 and
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	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 — 6 staff
County — 10 staff

Mercer:
Consultants — 2 staff

Magellan:
Vice President, General Manager
Senior Director, Service Operations
Vice President, Finance
Director, Network Management
Manager, Network Management
Director, Analytics
Data and Reporting Analyst
Quality Improvement Director
Senior Clinical Director
Senior Manager Compliance
Director, Claims
Senior Director, Claims
Supervisor, Claims
Project Manager II
Senior Manager Software Engineer
Quality Specialist
Lead Software Engineer
Vice President, Special Investigation Unit

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