HEALTH WEALTH CAREER

PERFORMCARE FOR PENNSYLVANIA INFORMATION SYSTEMS AND PROCESSES REVIEW

NOVEMBER 2019

Commonwealth of Pennsylvania

FINAL REPORT

MAKE TOMORROW, TODAY MERCER

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 PerformCare for Pennsylvania (PerformCare). 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 PerformCare's site on November 14, 2019.

This report outlines PerformCare'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 PerformCare'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 PerformCare 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 PerformCare'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 PerformCare 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 PerformCare. PerformCare 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

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

KEY FINDING HIGHLIGHTS FROM THE REVIEW

During the onsite, the review team found that PerformCare is operating appropriately in most areas, but some opportunities for improvement exist. This document focuses on these opportunities and other specific items in which 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 claims processing for Medicare claims to determine what differences exist between Medicare and Medicaid to accommodate coordination of benefits (COB) processing without asking providers to submit claims differently between the two carriers.

- Review the timely filing calculation, specifically on inpatient claims, as the discharge date should be used as the starting point for calculating the 60 days providers have for timely claim submission.

- Review claims denied when a primary carrier does not allow all services or days of the admission when PerformCare authorized all services.
- Ensure all providers are enrolled in PROMISe, per the OMHSAS program Standards and Requirements (PS&R), specifically regarding members in out-of-state residential treatment facilities (RTF).
- Implement policies and procedures for a recovery process when retroactive third party liability (TPL) resources are discovered to appropriately recover Medicaid monies paid as primary.
- Review PROMISe encounter denials and update business rules to ensure the root cause of the denial is uncovered to help prevent the same type of issues in the future, such as provider ID and service location. If the provider has moved or changed service locations, ensure Facets has the current address by contacting the provider if necessary.
- Review processes for submitting encounters with the place of service ‘99 – other’ at the header level.

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

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

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

- PerformCare processes claims internally on the Facets system for the past five years. Facets is software owned and maintained by Trizetto. AmeriHealth, the Corporate entity for PerformCare, is responsible to oversee the Trizetto contract and system upgrades.

- Jiva, an externally maintained product, is the primary tool for utilization management (UM), care management (CM) and maintaining authorizations. There is an interface between Facets and

Jiva which allows for the transfer of authorizations for claims processing matching. Provider and eligibility data is fed to Jiva nightly so that system data is consistent. In addition, providers can enter in most service authorizations via NaviNet, a web portal that connects to Jiva. However, inpatient and substance abuse authorizations are required to be submitted telephonically due to the additional information needed in order to make a determination. Jiva is expected to be upgraded in 2020. This is a corporate level update that is subject to standard project management and testing prior to implementation.

- Provider credentialing and management is performed within the Cactus Provider Management System software. Clinical staff also have real-time access that allows them to view data within Facets.

- PerformCare developed and maintains their own electronic data warehouse (EDWH) separate from the corporate data warehouse. The EDWH is the primary source of data for reporting.

- Encounter data maintenance, validation and processing is done by PerformCare's external vendor, Allan Collautt Associates, Inc. (ACA) using ACA MASTRR tools and systems.

Claims System Staffing and Processing

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

- PerformCare has 11 full-time employees responsible for claims processing and nine staff that perform audit functions. PerformCare claims staff are located in Harrisburg, Pennsylvania.

- PerformCare receives approximately 93% of claims via electronic data interchange (EDI) and the remaining 7% are paper. PerformCare contracts with Change Healthcare to use the Provider WebConnect portal to allow providers real-time data entry capability for claims submissions.
- Electronic claims are edited and validated thru Health Insurance Portability and Accountability Act (HIPAA) Strategic National Implementation Process (SNIP) level 5 using PerformCare's contracted clearinghouse, Change Healthcare. Errors are conveyed to the provider using the HIPAA X12 277CA claims acknowledgement transaction. Although there is a low volume of errors, most errors that are reported are related to new provider claim submissions. Review of these types of errors by PerformCare would enable proactive technical assistance with provider claim submissions.
- Claim edits:

  – PerformCare applies claims edits according to the specifications outlined in the BHSRCC chart to ensure that services provided align with provider licensure.

  - Medicaid national correct coding initiative (NCCI) procedure to procedure (PTP) edits are evaluated during claims adjudication and applied before claims payment is made.

  - Additional validations in PerformCare's claims system include checking presence of the present on admission (POA) indicator, diagnosis code validity for all code occurrences, duplicate claims checking, denial when no benefit available, checking maximum authorized units and validations against gender and age are applied when appropriate. Bed hold days are configured to max out at 15 days per year. The primary diagnosis code must be a behavioral health diagnosis.

  - Even though COB claims can be automatically processed, Medicare may allow different modifiers or place of service codes than are allowed by PerformCare. This results in a denial and a resubmission by the provider to accommodate PerformCare rules. This is an extra burden for providers.

- Claims processing:

  - Facets functionality includes auto adjudication at approximately 89.8% of all claims received. The remaining 10.2% of claims requires analyst intervention in order to be processed.

  - Approximately 8.23% of all claims result in denials, which includes denials related to alternative payment arrangements (APA). Excluding APA and duplicate claims, the claim denial rate is 6.36%.

  - Timely filing for claims payment with PerformCare is 60 days from the date of service. This also means from the first date of service on inpatient claims rather than the discharge date. If hospitals do not submit interim bills to PerformCare, they may not get paid for the services to HealthChoices members since the standard for timely filing is based on the date of discharge for inpatient claims.

  - Claim payment amounts are calculated based on fee schedules for professional claims, per diem for hospital claims and single case agreements for out-of-network provider submitted claims.

  - PerformCare does recognize services that are not covered by Medicare or commercial insurance for some Medicaid covered services. However, during the review, claims were reviewed where the primary carrier did not pay for all services, PerformCare authorization indicated prior approval, yet the claim was not fully considered for payment.

- Provider data:

  - PerformCare indicated that DHS provider files PRV414 and PRV430 are used in managing providers in the Facets system. The review of these files should include provider information

such as when providers merge or are bought by another entity. Billing and rendering provider information should match the provider claim submissions and then match fully to the PROMISe system as identified during the claims review. The PRV415 file that contains all provider data is not used by PerformCare and may be useful for a full review of Facets' provider demographics.

– Approximately 1% of providers are out-of-network (OON). Of these OON providers, only around .04% are not known to PROMISe. Most OON providers are due to geographic areas of service not in PerformCare's direct counties. OON providers will have a single case agreement (SCA) for claims processing and service authorization. The SCA provides information to Facets to process the claim.

– OMHSAS recently distributed a newsletter indicating that out-of-state RTFs must be known to PROMISe for better reporting purposes. This will require some communication by PerformCare with providers to ensure reporting of the correct NPI data.

– PerformCare has sub-capitated providers for the crisis intervention services and psychological rehabilitation. There is only one provider in 2019 capitated for psychological rehabilitation. Facets indicates a zero payment for the capitated services and the encounters are submitted to PROMISe.

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. PerformCare has processes in place to collect primary insurance data, including Medicaid, commercial and other insurance types, and the 834 file from DHS is utilized as the main source for TPL data. Other sources of data include member calls and from claim submissions.

- PerformCare has a dedicated TPL unit that is responsible for researching and verifying other insurance information and updating Facets when new resources are identified. DHS is notified when any new TPL data is identified.

- Retroactive TPL resource data is collected and loaded to Facets. However, PerformCare is not performing analyses to see if claim payments were made when primary TPL should have been billed. If notified of TPL termination dates, PerformCare will reprocess claims if requested through the provider resubmission.

- CMS required health insurance organizations to have Cost of Benefits Agreement (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. PerformCare implemented this capability in August 2019.

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.

- PerformCare has three encounter staff that work approximately 15% of the time on HealthChoices' encounters. The vendor, ACA, performs most of the encounter submission work. ACA has four employees that work approximately 25% to 60% of the time on PROMISe encounter submissions.

- Claims are sent to PerformCare's encounter data business partner, ACA, twice a month with the data used to create the 837 encounter files. ACA developed processes to mirror PROMISe encounter editing. Any predetermined errors are researched prior to the encounter submission to PROMISe.

- PerformCare tracks claims adjustments and voids for submissions of encounter data and use the 277U to attach the appropriate PROMISe internal control number (ICN). PerformCare tracks all claims that have not resulted in a successful encounter submission; however, these are not always resubmitted since there is a small quantity. Even though PerformCare's overall average encounter pass rate is 99.98%, without submitting the corrections, PerformCare is not compliant with complete and accurate encounter submissions. Corrections are made without necessarily getting to the root cause of issues to assist in future submissions. PerformCare indicated most issues are likely due to provider issues between PROMISe and PerformCare's Facets system.

- Encounters contain valid place of service on all detail lines; however, PerformCare does default to value '99 – Other' at the header level. This is not the standard encounter practice for OMHSAS. The header should reflect what is in the details except when there are multiple places of service in the detail lines of the claim. This can impact any data analysis when comparing using header level services in the reports.

- PerformCare converts outpatient 837I claims to the professional 837P format prior to sending the claims data to ACA for encounter submissions to reflect the BHSRCC requirements.

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 PerformCare quarterly and annual financial submissions and future rate-setting efforts.

- For reports submitted to OMHSAS, including timely payments of claims, the check date is the date used for reporting. Check runs occur weekly on Wednesdays with claims held for seven days prior to check runs. There is approximately four days prior to mailing of checks to allow for the counties to fund the account. Change HealthCare sends the electronic fund transfer (EFT) information to providers.

- 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 claim voids and adjustments. Comparing at a level of date of service and date of payment may 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 person-level encounter (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.*

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 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 FWA processes:

- PerformCare has data mining and manual processes to create reports of potential issues from trends, variances or other insurance. Internal referrals and stakeholder complaints regarding 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 should reflect the FWA recovery. Recently, there was a project that covered 2016 dates of service.

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 PerformCare.

- Review errors from Change HealthCare reports when providers are having submission issues, especially if there is a trend with a current provider or a new provider. Follow-up should occur with providers when appropriate to proactively provide technical assistance. This will assist new providers with their encounter submission efforts and reduce the number of errors or providers dropping claims to paper due to submission issues.

- Review claims processing for Medicare claims to determine differences between Medicare and Medicaid, so providers do not need to submit a modified claim to PerformCare for COB purposes.

- Evaluate the calculation for timely filing to use the ending incurred date (through date) as the start for calculating timely filing. This is especially important for lengthy inpatient stays as well as when coordination with Medicare and Commercial payers occurs. The discharge date should be considered to start the count of the 60-day filing limit for inpatient services.

- Review claims denied when a primary carrier does not allow all services or days of the admission when PerformCare authorized all services.

- Use the DHS PRV415 file to ensure Facets and encounters align with the provider billing name. The PRV415 is a complete provider file and may assist PerformCare with discrepancies in the data in the Facets system prior to receiving encounter issues.

- Review OMHSAS PS&R regarding members in out-of-state RTFs to ensure the provider is known to PROMISe.

- Implement a recovery process, including policy and procedures when retroactive TPL resources are discovered, to appropriately recover Medicaid monies. Coordinate with DHS for the period of historical data that should be researched and reprocessed, as the DHS TPL Division may have recouped some of the older overpayments.

- Review encounter denials from PROMISe and update business rules to ensure the root cause of the denial 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 Facets has the current address and contact the provider if necessary.

- Review processes for submitting encounters with the place of service ’99 - other’ at the header level.
- 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

PerformCare Review
November 14, 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 14, 2019:*

1. A current reject report indicated in Question 7B of the survey response.
2. The number of claim processing audits and results performed during the month of September 2019 as referred to in question 14 of the survey.
3. The reports indicated in question 15 of the survey for FWA.

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	PERFORMCARE 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 — each county was represented

Mercer:
Consultants — 2 staff

PerformCare:
Business Analyst Senior
Claims Manager
Claims Research Analyst
Manager Information Systems
Manager Informatics
Clinical Director
Special Investigation Unit Manager
IS Lead Developer
Quality Performance Specialist
Vice President of Operations
Director, Quality Management
Executive Director
Director, Compliance
Supervisor, Care Management, Utilization Management
Manager, Provider Network Operations

AmeriHealth (Corporate):
Vice President, Application Development
Business System Analyst Lead
Director of Applications Development
Enterprise Data Warehouse
Director IS, Info Systems Development Management
Director, FACETS Solution Center
Director, Information Solutions
Manager, Enterprise Enrollment
Enterprise Care Administration (FACETS)
Business System Analyst Lead
Manager, Operations TPL & Subrogation
Claim Director, Enterprise Operations - Health Services Payment
Business System Analyst Lead

ACA:
Data Operations Manger
Chief Operating Officer

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