AMERIHEALTH CARITAS COMMUNITY HEALTHCHOICES ENCOUNTER DATA REVIEW

OCTOBER 11, 2019

Commonwealth of Pennsylvania

Office of Long-Term Living

FINAL REPORT

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1
INTRODUCTION

PURPOSE

The Commonwealth of Pennsylvania, Department of Human Services (DHS), Office of Long-term Living (OLTL) recently implemented a managed long-term services and supports (LTSS) program called Community HealthChoices (CHC). Recognizing the importance of timely and accurate encounter data from CHC managed care organizations (CHC-MCOs), DHS engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to conduct an onsite encounter review at each MCO participating in CHC. The purpose of the review was to assess the initial quality of claims and encounter data processing, the accuracy of claims processing and reporting, the completeness and accuracy of encounter data compared to financial reporting and to identify best practices and opportunities for improvement with a primary focus on encounter submissions and reporting. This report describes the CHC review conducted for AmeriHealth Caritas/Keystone First Community HealthChoices (AHC).

BACKGROUND AND APPROACH

The CHC program provides acute medical and LTSS to nursing facility (NF) clinically eligible individuals who are dually eligible for Medicare, as well as to individuals who are only Medicaid eligible. CHC also provides acute medical services to dual individuals who are NF ineligible. The CHC program is limited to adults (ages 21 and over) and is being phased in across various geographic zones of Pennsylvania. OLTL initially implemented the CHC program on January 1, 2018 in the Southwest Zone and on January 1, 2019 in the Southeast Zone. The program is scheduled to be implemented in the remaining zones (Lehigh/Capital, Northeast and Northwest) on January 1, 2020.

Encounter data is used by DHS for many purposes including rate setting, high-cost risk pool reconciliation, utilization reporting and monitoring, validation against financial reports and various other data analyses. With greater confidence in the encounter data quality, complying with the Centers for Medicare and Medicaid Services (CMS) requirements to use encounter data will be more successful. DHS recognizes that CHC-MCOs are in the midst of rolling out this new program and that encounter data operational processes are still being refined. At the same time, DHS believes this is a perfect time to conduct an encounter data review because any findings will help the CHC-MCOs adapt their practices early in the program (prior to rolling out to additional zones) with the goal of improving encounter data quality and completeness as quickly as possible.

At DHS' request, Mercer completed CHC encounter data reviews to assess each CHC-MCO's claims payment system, encounter submissions and reporting quality. These reviews included the identification of data reporting improvement opportunities. Each review was comprised of two components: a desk review conducted prior to the onsite and onsite interviews/discussions with CHC-MCO staff to determine how data and encounter submissions are reported and validated. This section summarizes the findings and recommendations from both the desk review and the onsite review.

DESK REVIEW

Each CHC-MCO was asked to complete an information request prior to the onsite review. This request collected information regarding the CHC-MCO's claims, encounter and financial reporting 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 by Mercer's subject matter experts in finance, claims management processes, information systems and encounter data submissions. This information was used to tailor the onsite portion of the review, where any potential deficiencies within the desk review were addressed, and was also used to inform the findings within this report.

ONSITE REVIEW

The onsite review consisted of interactive discussion with AHC and an online review comparing encounter data from PROMISe™ to AHC's systems for claims and encounter submission tracking. This onsite review was conducted at the AHC site in Philadelphia, Pennsylvania on July 31, 2019, and the team consisted of members from Mercer and DHS. Appendix A contains an agenda of the topics that were discussed, and it also provides the number of staff and the roles of the attendees from each of the three organizations (AHC, DHS and Mercer). Questions not otherwise addressed during the onsite review were subsequently addressed by AHC on August 6, 2019.

LIMITATIONS OF ANALYSIS

In preparing this document, Mercer used and relied upon data supplied by AHC. AHC was responsible for the validity and completeness of this information. We have 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. 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.

KEY FINDING HIGHLIGHTS FROM THE REVIEW

During the onsite, Mercer and DHS found that AHC is operating appropriately in most areas, but there were some opportunities for improvement. This document focuses on these opportunities and specific items where information may be helpful for DHS data analytics. The following bullets highlight the most important recommendations for AHC to implement in order to address issues

uncovered during the review; these issues and others are described in detail in Section 2: Findings and Recommendations.

- Oversee vendor processes by collecting denied claim encounter detail from all vendors and monitor them to ensure claim denials are appropriate and are resubmitted timely.
- Reconcile the paid claim portion of the lag triangle in Financial Report #4 to accepted encounters for at least a rolling 12-month period to measure completeness and accuracy by category of service or claim type. This comparison should include vendor services, as well as voids and adjustments. Any mismatches warrant investigation.
- Monitor cost-of-care amounts from the 834 Enrollment file and compare them to the cost-of-care amounts reported on claims to ensure that providers are reporting the correct amount for the date of service. In addition, verify monthly costs are appropriately assigned for partial month billing.
- Review claims processes for NF claims that cross over months of service. This process will ensure appropriate application of cost-of-care amounts and eliminate PROMISe denials for the service dates on NF encounters.
- Review payment of service coordination in each zone for proper reporting in encounter data. Services paid through the claim system should not be included in encounter submissions after the six-month continuity of care (COC) period has ended for a given zone.
- Monitor encounters for completeness of data including proper submission of interim inpatient claims, third party liability (TPL) from vendors and proper federally qualified health center/rural health center (FQHC/RHC) submissions.
- Create policies and procedures (P&Ps) for processes regarding deceased members to ensure Medicaid funds are not used for any claim payments subsequent to a deceased date.

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FINDINGS AND RECOMMENDATIONS

This report describes AHC's operations and activities related to claims, encounters and reporting for the CHC program. The key areas of focus within the review were vendor data and oversight, financial reporting, TPL, claims processing and encounter submissions. Detail on AHC's current practices in each of these areas is included in subsequent paragraphs of Section 2. At the end of Section 2, a detailed list of recommendations for AHC is included.

VENDOR DATA AND OVERSIGHT

As specified in 42 CFR § 438.230(c)(ii), CHC-MCO vendors are required to comply with the same contract requirements that exist between the CHC-MCO and DHS. The CHC-MCO is expected to oversee its vendors, including activities for encounter data submissions. Encounter data submitted to PROMISe from the CHC-MCO or in encounter ready files from the CHC-MCO's vendors should be monitored for timeliness, accuracy and completeness. General observations from AHC's vendor oversight are highlighted below:

- The AHC vendors and payment methods include the following:
  - SkyGen, the dental vendor, is paid based on a Per Member Per Month (PMPM) rate for administrative fees, plus Fee-For-Service (FFS) invoice for claim payments.
  - Davis Vision is paid for vision services based on a full risk PMPM capitation rate.
  - PerformRx is AHC's Pharmacy Benefit Manager (PBM) and is paid based on an administrative PMPM and FFS for drug claims.
  - Medical Transportation Management (MTM) provides non-medical and non-emergent transportation services and is paid via invoice.
  - Public Partnership LLC (PPL) provides financial management services and is paid a contracted administrative rate and FFS for self-directed home and community based service (HCBS) claims invoices.
  - National Imaging provides utilization management for specific radiology services and is paid a PMPM rate for administrative fees.

- Vendor claim files are received and loaded into AHC's data warehouse. SkyGen, Davis Vision and MTM files are received monthly, while PPL files are received weekly. AHC performs a monthly financial reconciliation comparing the invoice to the encounter data. Reconciliation is currently in development for PPL. AHC receives pharmacy denials from PerformRx, but is unsure if they receive denials from the other vendors.

- CHC members experienced some challenges with MTM ride scheduling, especially during evenings and weekends. AHC recently updated their processes to allow members to call MTM directly for ride scheduling, and this has improved the members' experience.

- The Delegation Oversight Team annually reviews AHC's vendor systems P&Ps to ensure they follow DHS requirements. File audits may be performed. Monthly Delegation Oversight Reports are reviewed as part of the ongoing monitoring process with additional monthly and/or quarterly Quality Committees reviewing reports. The ability to escalate issues to Corporate Compliance is part of the process to put corrective action plans (CAP) in effect when necessary. Currently none of the vendors for AHC's CHC program are on a CAP.

FINANCIAL REPORTING

Financial reporting must be consistent with DHS guidelines and definitions. Payment dates should accurately reflect the final resolution of claims. The claims system and/or financial reports should be compared to encounters accepted by PROMISe for accuracy and completeness of data submitted. CHC-MCOs are expected to reconcile accepted encounter data to various financial reports, including:

- Report #3a: Claims Processing Report
- Report #4: Electronic Lag Reports
- Report #5: Income Statements
- Report #6A: Nursing Facility and Personal Assistance Statistics
- Report #6B: Pharmaceutical Price and Utilization Statistics
- Report #8: Coordination of Benefits

- AHC classifies a clean claim in Report #3a as any claim that is not pending Fraud and Abuse Review. This is consistent with DHS guidance.

- AHC reconciles the Report #4 lag triangle to the general ledger on a monthly basis. The lag reports are reconciled against the claim data by major category of service on a quarterly basis. AHC is developing lag triangles for data verification of vendor data in the data warehouse.

- Encounter data is validated at the total level only in comparison to claim data in the data warehouse. AHC is not currently performing a reconciliation between the PROMISe accepted encounters and the financial lag data. Reconciling accepted encounters to paid claims in the lag reports will help to identify any discrepancies such as missed encounter submissions or corrections such as voids and adjustments.

- AHC indicated service coordination expenses are appropriately reported on the care management/service coordination line of Report #5 (Income Statement) and are not reflected in Report #4 (Lag Triangle).

- AHC does not have any challenges utilizing the Appendix B(1) and Appendix B(2) crosswalks to determine how to report each service category. They are also comfortable populating the new CHC Report #6A on NF and personal assistance statistics.

- AHC did not identify any issues with Report #6B.

- PPL pays direct care staff under the self-directed model through a payroll process. AHC advances money to PPL and once checks are issued, provides additional funds to PPL so direct care staff paychecks are not delayed.

- AHC does not currently operate any payment incentive programs with CHC providers. AHC monitors providers and data in claim submissions through internal quality monitoring programs.

- AHC does not currently have sub-capitation arrangements with any CHC service providers, but may consider this option in the future with more data analysis from the program.

THIRD PARTY LIABILITY

TPL is an important process to ensure Medicaid is the payer of last resort. Processes for identifying TPL and applying coordination of benefits (COB) logic during claims payment should be performed for all claim types. TPL should be consistently and accurately reported in encounter data and be consistent with the financial reporting, specifically in Report #8.

- AHC collects TPL information from the DHS 834 Enrollment files, claims data and the call center.

- CMS required health insurance organizations to have Coordination of Benefits Agreement (COBA) processes in 2019. CMS defined the criteria for transmitting enrollee eligibility data and Medicare adjudicated claim data for the purposes of COB. This process helps to provide accurate and timely data for dually eligible members with Medicare approved services and Medicaid as the payer of last resort. AHC has the COBA process in place for the CHC duals.

- AHC subcontracts with Health Management Systems (HMS), Council for Affordable Quality Healthcare (CAQH), and Syrtis Solutions (Syrtis) to help maximize cost savings due to TPL. These vendors are aware of the dually eligible participants in the CHC program but identify other carrier data to ensure Medicaid is the payer of last resort.
  - All three vendors provide regularly scheduled files of identified TPL data to AHC. Other insurance submitted by vendors is verified by AHC.

  - Any new or corrected TPL information is submitted to DHS weekly.
  - CAQH uses a proprietary database to identify other insurance overlapping with AHC eligibility and sends information to AHC on a weekly basis.
  - Syrtis identifies other insurance sources for PBM claims once a member has had a claim.
  - In addition to identifying other medical insurance, HMS also pursues recoveries. HMS performs COB recoveries on CHC claims directly from other carriers for medical claims only. Since the CHC implementation, AHC recorded recovered COB dollars in the claims system, submitted the recoveries in the encounter data and netted the recoveries against the lag claim costs in the financial reports due to the updated claims data.

- Member TPL files are sent to vendors daily and monthly. The dental vendor also receives a weekly file and performs TPL recovery on a case by case basis when initiated by AHC or the provider. The dental vendor does not currently have a system generated, automated recovery based on retroactive TPL information; AHC is currently reviewing recovery initiatives related to dental.

- AHC uses “lessor of” logic appropriately to apply COB to claims with TPL to ensure Medicaid is the payer of last resort and reimbursement above the Medicaid rate is avoided.

- AHC 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.

- AHC’s service coordination staff advise dual eligible participants on the benefit of enrolling in a Medicare Part D plan and provide assistance in selecting a Medicare Part D plan.

CLAIM PROCESSING

Claims received from clearinghouses, direct electronic submission, or in paper formats from providers should be the full claims documentation to support all services paid by the CHC-MCO with all relevant diagnosis codes. Validations through system edits and clinical review assist claims processing. Understanding the CHC-MCO’s inpatient and long term care payment pricing methodology provides insight to DHS for Medicaid data analyses. Claims reviewed onsite help verify the receipt of claims data and the accuracy of claims processes through encounter submissions.

- AHC uses the Facets claims system with internal corporate and AHC staff responsible for system configuration and software updates. Facets is also used for the physical health HealthChoices program.

- About 97.5% of CHC provider claims are received by AHC via clearinghouses and direct electronic data interchange (EDI), while the remaining 2.5% are received via paper. The

clearinghouse uses HIPAA Strategic National Implementation Process (SNIP) compliance edits levels 1 through 6 with error responses sent directly to providers.

- AHC reviews rejected claim volumes for any situations that merit provider outreach and technical assistance.
- LTSS claims-related processes:
  - AHC utilizes HHAeXchange (HHA) to coordinate CHC authorization, billing and claim functions for HCBS under the CHC 1915(c) Waiver. HCBS providers receive AHC authorizations in HHA and are able to apply the claims to the applicable authorization number. Providers then submit claims into HHA for submission to AHC for claims payment.
  - HHA had issues submitting claims in 2018. Due to the lack of claim submissions, research was performed to discover HHA's clearinghouse edits were not allowing the claims to flow to AHC, which needed additional edit modification. AHC issued cash advances for 10-12 providers that were resolved once claims were able to flow through the clearinghouse and AHC could process them.
  - AHC plans to use HHA for electronic visit verification, with expected testing in October 2019 for implementation on January 1, 2020. Currently, the service coordinators verify visits through phone calls and visits with the participants.
  - Claims paid by PPL are not in the Facets system; however, reporting can be done from data warehouse data.
  - AHC has one Provider Network member solely dedicated to NF providers, and outreach is made quickly upon review of the rejections report. AHC monitors NF claim submission levels and will reach out to NFs proactively if claim levels are unexpectedly low or high. Weekly calls are held with NFs.
  - Based on OLTL policies, CHC NF residents can stay in the NF they were in prior to CHC implementation. Any NF providers who are not in AHC's network have single case agreements in place for continued services and payment of CHC members.
  - For NF residents, AHC receives the cost-of-care (patient liability) amount from DHS on the 834 Enrollment file. The amount varies by member and can change during the year. AHC loads the cost-of-care information into Facets with the appropriate effective and termination dates. The cost-of-care data is not used for claims processing or compared to provider reported cost-of-care amounts.
  - NFs are expected to collect any applicable patient cost-of-care amount from CHC members in their facility. The NFs are required to submit this cost-of-care amount on institutional

claims using the amount collected with value code 66. AHC reduces the amount of the payment to the NF by the self-reported amount.

  - NF claims are typically billed based on a calendar month. Some small providers may bill on a weekly or bi-weekly basis. AHC will not split NF bills that have two months in the same claim. These claims should be based on monthly billings especially if there is a cost-of-care involved.

- AHC reimburses HCBS and NF claims based on OLTL's FFS rates.

- AHC uses a hybrid model for service coordination. During the initial 6-month COC period in a given zone, legacy participants may continue to access external service coordination agencies. Members are allowed to select an AHC service coordinator as an alternative. After the COC period ended in each zone, AHC continued to contract with a few of the external service coordination agencies.

  - After the COC period ended in the Southwest and Southeast Zones, AHC reimbursed the external service coordination agencies either via FFS or on a PMPM basis. AHC indicated these claims were not submitted through encounters. However, some encounters were found during the onsite claim demonstration. Once the COC period ends in each zone, AHC may continue to contract with service coordination agencies; however, the guidance from OLTL states these costs should be considered administrative in nature and not submitted through encounters.

- Several inpatient claims items were discussed including:

  - Inpatient claims are paid using various payment methodologies including All Patients Refined Diagnosis Related Groups (APR-DRGs), percent of billed charges and per diems.

  - All inpatient claims require an authorization, including claims where Medicare is the primary payer.

  - Interim inpatient billings may cause duplicate claims, overpayments or incorrect reporting. AHC denies interim bills from acute hospitals paid by APR-DRG until the final bill is submitted. AHC monitors for interim claims prior to claims adjudication to ensure they are not paying interim claims. Inpatient claims reimbursed under a per diem are paid as each claim is received. Since encounters are generated off of "paid claims", interim denials are not submitted in encounters.

  - In 2016, DHS issued Systems Notice #SYS 2016 014 to clarify procedures for inpatient hospital readmissions for encounter processing. When related inpatient claims occur within 30 days of discharge (as defined in Medical Assistance Bulletin 01-11-44) from the same hospital for the same diagnosis, the original inpatient claim should be adjusted to add the

additional days, with days not spent in the institution classified as non-covered. For CHC, AHC implemented a manual process to combine the applicable claims from readmissions before running them through the grouper. They also have a retraction process in place to ensure that only the combined claim makes its way into the encounter data, and therefore complies with the Systems Notice.

  - AHC identifies provider preventable conditions (PPC) using diagnosis codes. If the claim is billed without medical records, the claim will automatically deny for medical records. If the claim is billed with medical records, the claim will pend for clinical review to determine whether payment should be made. Any PPC diagnosis codes remain on the claim and are submitted on the encounters but the grouper ignores them for pricing.

- AHC's monthly CHC percentage of claims audited ranged from 1.8% to 8.4% per month. For the six-month period, this resulted in an overall audit percentage of roughly 2.7%, which is in the acceptable range of 2% to 5%.

- Claims editing software from Cotiviti Health Services, Inc. (Cotiviti), is used for pre-payment edits through integrated batch claim files exchanged daily. These edits apply to professional and outpatient facility claims. Annually, AHC works with Cotiviti to review edit accuracy for the Medicaid program.

- Various edits are applied to claims with medical J-codes and national drug codes (NDCs). First Databank is used to verify edits for NDC validity. Verification includes NDC validity on the date of service, NDC units are appropriate, unit of measure is appropriate and the prescription is for CMS rebate-able drugs. AHC created a table to check validity of NDC and J-code combinations. Prior authorizations for some J-code NDCs are performed by PerformRx. In April 2019 AHC implemented a process to prevent medical doctor prescribed J-codes from being duplicated with NDCs submitted to the PBM if the drug needs a prior authorization.

- A manual process exists to notify the County Assistance Office (CAO) when a CHC member passes away. AHC relies on the service coordinator to apply an end date to the authorizations to assist in stopping claim payments. It was unclear if AHC is currently performing any checks on whether claims are being reimbursed for service dates after the date of death.

- Provider data:

  - AHC does not have the referring provider information on LTSS claims. Atypical provider data does not flow though AHC.

  - The PBM does not have a hard edit for prescribing providers as there could be issues with access to care if claims are denied at the point of sale. Some PBM claims are from behavioral health providers not in the AHC network.

  - For the CHC program, AHC has some out-of-network providers with single case agreements. In the Southeast Zone, there is an expectation of more providers that are not in the AHC network. AHC is working with providers to ensure they are known to PROMISe.

ENCOUNTER SUBMISSIONS

Since encounter data is used for a variety of purposes, the CHC-MCO's management and oversight of encounter submissions is critical. CHC-MCOs should monitor accuracy, timeliness and completeness of encounter submissions including their vendor data. Data should be validated prior to submission and errors should be corrected and resubmitted in a timely manner.

- CHC medical and LTSS claims are extracted from Facets and loaded into the encounter data management (EDM) system weekly. MTM encounters are received directly from MTM for submission to PROMISe. The PBM submits National Council for Prescription Drug Program (NCPDP) files to AHC that are passed through to PROMISe. All other vendors submit encounter files to AHC; AHC staff load these files into EDM, create the 837s and submit them to PROMISe.

- AHC compares the PRV414, PRV415 and PRV430 provider files to Facets. Additionally, the PRV720 is monitored monthly by the provider network department to send reminder letters to providers for revalidation with PROMISe due within 60 days. AHC previously had an issue with submitting all “8s” as the provider number, but this was fixed for CHC encounters in the summer of 2018.

- AHC has internal editing prior to submission of medical encounters to PROMISe. The edits are to give AHC an opportunity to avoid PROMISe issues by correcting the issue first. During the onsite claim demonstration, some MCO denials were labeled as “non-covered” instead of “no authorization.”

- The vision vendor is not currently reporting TPL information on the encounters, but AHC has a work order in place to obtain this information in the future with an expected implementation of October 2019.

- Under the self-directed model, PPL will submit adjustment encounters containing a direct care worker's third shift in a calendar day; these shifts are not submitted with the original shifts from the day in order to prevent services from receiving duplicate edit denials in PROMISe.

- FQHC/RHC encounters:

  - Encounters for FQHC/RHC providers must match the PROMISe system billing provider national provider identifier (NPI) and service location for provider type 08 and provider specialty 080/081.

- A paid amount should be included on the T1015 line, with supporting claim lines also submitted with $0 paid for use in utilization analyses.
- On dental FQHC/RHC encounters, the T1015 procedure codes must be submitted with modifier U9, but all service lines associated with the bundled payment should be submitted on the encounter with $0 paid.
- Per Systems Notice #SYS-2018-010, the rendering provider should be left blank.
- AHC completed a project with the dental vendor to correct FQHC claim processes and will continue to monitor the encounters.

RECOMMENDATIONS

One of DHS's key goals is for all CHC-MCOs to have a consistent understanding of reporting requirements for financial and encounter data. This consistency will help ensure that DHS has complete and accurate information that can be used for various analyses. From the onsite review, the following recommendations are provided to support the CHC program oversight and future analyses using encounter data provided by AHC.

Vendor Data and Oversight Recommendations

- Obtain denied claims from all vendors and monitor denial reasons to ensure the appropriateness of claims denials.

Financial Reporting Recommendations

- Reconcile the paid claim portion of the lag triangle in Report #4 to accepted encounters for at least a rolling 12-month period to measure completeness and accuracy by category of service or claim type. This comparison should include vendor services, as well as voids and adjustments. Any mismatches should be investigated and resolved.

TPL Recommendations

- Continue to review potential capabilities to recoup primary carrier payment for vendor processed claims.

Claim Processing Recommendations

- Monitor cost-of-care amounts in the 834 Enrollment file and compare them to the cost-of-care amounts on claims to ensure that providers are reporting the correct amount for the date of service and that the remaining MCO NF paid amount is appropriate.
- Review AHC processes for NF claims that cross over months of service. This will help to ensure appropriate application of cost-of-care amounts.

- Review payment of service coordination in each zone for proper reporting. Services paid through the claims system should not be submitted in encounter submissions after the COC period ends in each zone.

- Monitor interim inpatient claims that were paid to ensure a final claim has been submitted with recovery of interim payments. Verify any encounter submitted for an interim claim has been reversed upon submission of a final claim.

- Create P&Ps regarding deceased members to document these processes:

  – The service coordinators should update authorizations timely when a member dies to prevent additional claim payments.

  – Work with PPL if services are billed and paid after a member's date of death to stop or recover payments.

  – Determine recoupment processes for other services after a member's date of death.

Encounter Submissions Recommendations

- Continue to monitor PROMISe denials to ensure proper submission of MCO denials in encounter submissions.

- Work with the vendors to ensure accurate reporting of encounters including TPL information.

- Continue to monitor FQHC/RHC encounters, including dental, for accurate submission of NPI and PROMISe IDs for the correct provider type, specialties and service locations, along with the correct modifier and detail services codes associated with the T1015 procedure code.

NEXT STEPS

DHS and Mercer thank AHC for their participation in the encounter data review for the CHC program. Given the program is still in the early stages of implementation, DHS appreciates AHC's willingness to collaborate on these reviews and looks forward to continuing to work together on increasing the quality and consistency of claims and encounter data processes, as well as improving the completeness and accuracy of the encounter data. DHS requests that AHC work to address the recommendations outlined in the report over the coming months. DHS will contact each CHC-MCO within the next 6-12 months to understand the progress that has been made and discuss any subsequent steps in the process.

Appendix A
AGENDA

AmeriHealth Caritas Community HealthChoices Encounter Data Review

July 31, 2019
9 am to 3 pm

NOTE: *We kindly request the following items be ready for the review team upon arrival on the day of the review:*

1. Tracking of CHC Encounter submission reports.
2. Tracking of PROMISe encounter denial and correction reports, including vendor encounters.

NOTE: *System demonstration will be expected of the production claims system. Mercer will not be providing claim information prior to the on-site meeting.*

TIME	TOPIC
9 am – 9:30 am	• Introduction and purpose • CHC-MCO opening comments – no presentation: – The MCO can provide overall comments/information about challenges with CHC encounters and changes in their organization or processes that may have or will impact CHC claims receipt, claims processing, encounter submissions or financial reporting.
9:30 am – 10:15 am	• Review of the CHC-MCO survey responses: – General systems and data storage related discussion – General claims related discussion – Vendor related: › Pharmacy benefit manager › Dental › Vision › Transportation › Self-direction › Monitoring efforts › Collection of vendor data

	› Submission of vendor encounter data – Federally qualified health center (FQHC) payments
10:15 am – 10:30 am	• Break
10:30 am - Noon	• Eligibility and 834 in regards to patient cost sharing data • CHC service coordination • Claims and encounter data submission: – J-codes and national drug code processing and encounter submissions – Status of submission completeness – PROMISe denials • Provider: – Provider file – Ordering, referring and prescribing providers – Out of network providers – Provider incentives • Financial questions: – Reconciliation of encounters to financials – Financial Reporting Requirements – Third party liability (TPL) and coordination of benefits • Start claim system demonstration: – Claim receipt – Diagnosis collection and encounter submission – Claim edits – Payment Processes: › Inpatient › Nursing facility including ancillary charges and cost sharing › Home and community based services (HCBS)
Noon – 12:30 pm	• *Working lunch*
12:30 pm – 2:00 pm	• Claims system demonstration continued
2:00 pm – 2:15 pm	• *Break*
2:15 pm – 2:45 pm	• Claims system demonstration continued
2:45 pm – 3:00 pm	• Closing and next steps

Attendees

DHS:
Bureau of Fiscal Management (BFM) – 2 staff
Bureau of Data and Claims Management (BDCM) – 3 staff
OLTL Bureau of Finance – 3 staff
OLTL Bureau of Quality Assurance & Program Analysis

Mercer:
Consultants – 5 staff

CHC-MCO:
Director, Regulatory Affairs
Manager, Regulatory Affairs CHC
Regulatory Affairs Analyst
VP, CHC Administrator Pennsylvania
Director, LTSS
Director, Pharmacy
Pharmacy Analyst
Manager, Compliance
Director, Provider Network Ops
Director, Provider Network Ops MLTSS
Director, Provider Network Management
Manager, Provider Network Management
Director, Finance Administration
Director, Dental Administration
Director, Regulatory Reporting
Manager, Regulatory Reporting
Director, Claims
Manager, Business Process Analysis
Manager, Corp Delegation Oversight, Vendor and Delegate Management
Manager, Payment Integrity Analysis
Director, Information Systems
Director, Information Systems Encounter
Manager, Information Systems Encounter
Encounters Business Systems Analyst
Regional Director, Pharmacy Account Management
Manager, Facets System Configuration and Testing
Team Lead, Claims
Manager, TPL/Subrogation
Director, Corporate Audit
Director, Special Investigation Unit
Director, Actuarial Services
Director, Applications Develop
Director, Internal Quality Assurance
Director, Client and Vendor Management

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