PENNSYLVANIA HEALTH & WELLNESS, INC. COMMUNITY HEALTHCHOICES ENCOUNTER DATA REVIEW

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Commonwealth of Pennsylvania

Office of Long-Term Living

FINAL REPORT

CONTENTS

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 Pennsylvania Health and Wellness, Inc. (PHW). PHW, a subsidiary of Centene Corporation (Centene), entered the Pennsylvania Medicaid market and began serving OLTL's CHC Medicaid members in January 2018 using a combination of local, regional and community-based staff resources and Centene's corporate infrastructure, managed care systems and staffing.

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 (and 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 PHW and an online review comparing encounter data from PROMISe™ to PHW's systems for claims and encounter submission tracking. This onsite review was conducted at the PHW site in Camp Hill, Pennsylvania on July 24, 2019 and July 25, 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 (PHW, DHS and Mercer). Questions not otherwise addressed during the onsite review were subsequently addressed by PHW on July 31, 2019.

LIMITATIONS OF ANALYSIS

In preparing this document, Mercer used and relied upon data supplied by PHW. PHW 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 PHW has 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 PHW 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.

- Collect complete vendor data (paid and denied) in the Enterprise Data Warehouse (EDW). Use the data to monitor vendors with financial validation checks on at least a monthly basis. 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.

- Review payment of service coordination in each zone for proper reporting in encounter data. Services paid through the claim system should not be reported in the encounter submissions after the 6-month continuity of care (COC) period has ended for each zone.

- Monitor cost-of-care amounts from the DHS 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.

- Create job aids for claim processors for NF claims including monitor metrics for NF leave days/bed hold days and ensure the correct payment percentage is made and the maximum number of bed leave/hold days allowed per year are not exceeded.

- Establish policies and procedures (P&Ps) for Electronic data interchange (EDI) claim rejects, inpatient readmissions and deceased members to ensure Medicaid funds are not used for any claim payments subsequent to a deceased date.

- Implement P&Ps for tracking and correcting PROMISe encounter denials.

- Update encounter processes to comply with DHS requirements for federally qualified health centers/rural health centers (FQHC/RHC), PROMISe IDs, for correct provider type, specialties and service locations, along with correct modifier and detail service codes associated with the Health Care Common Procedure Coding System (HCPCS) T1015 procedure code.

- Review encounter extract processes for claim denials versus zero payment. Plans may zero pay all-inclusive services with J-codes. When J-codes are part of an all-inclusive rate on medical

claims, the whole claim should be maintained and submitted completely under one claim number in the encounter submission to PROMISe.

- 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 PHW'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, third party liability (TPL), claims processing and encounter submissions. Detail on PHW'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 PHW 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 PHW's vendor oversight are highlighted below:

- PHW's vendors and payment methods include:
  - Envolve™ Pharmacy Solutions (EPS) — Pharmacy Benefit Manager (PBM), administrative fee per claim plus prescription dispensing fee and additional ancillary fees. EPS contracted with CVS for pharmacy claims processing until March 31, 2019 and moved to RxAdvance as the claims processing system.
  - Envolve Vision — Vision, administrative per member per month (PMPM) amount for claims processing and FFS for claims.
  - Envolve Dental — Dental, administrative PMPM amount for claims processing and FFS for claims.
  - Medical Transportation Management (MTM), flat fee per trip provided.
  - Public Partnerships, LLC (PPL) — Financial management services (FMS), paid a contracted administrative rate for FMS and via FFS invoice for the self-directed home and community-based waiver services (HCBS).

  - National Imaging Associates (NIA) — Radiology authorization only, administrative rate paid per authorization. Providers are paid by PHW at negotiated rates.
  - Envolve Peoplecare (EPC) — Nurse Advice Line, administrative PMPM.
  - Note: Envolve is a subsidiary of Centene.

- PHW has multiple staff that oversee vendors weekly and monthly depending on issues. Specific performance reports are due monthly from the vendors to PHW. A Joint Operations Committee meets quarterly and reviews vendor performance and findings of the staff oversight to ensure contractual compliance.
- Paid and denied dental claim data is received and stored in the EDW. PHW performs EDW validation checks by claim counts and trending of claims volumes on a month over month basis. PHW does not receive complete claim data for Vision, Pharmacy, PPL or Transportation services. Consequently, PHW is unable to complete validation of the services provided to the CHC members.

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 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

- On Report #3a, PHW classifies a “clean claim” as a claim that does not require additional information for adjudication purposes. Any remaining claims would be “non-clean” and are expected to be low volume, such as cases where claims are pended for medical records. If providers are on hold for fraud and abuse investigations, the claims may be considered unclean. PHW meets the expectations for the DHS requirements for Report #3a.
- Timely claims payment is contractually required and measured via CHC Financial Report #3a:
  - PHW has internal inpatient claim manual reviews for high dollar claims that add time to claims processing timelines. While PHW reported high auto-adjudication rates and a dedicated claims staff for prior authorization claims, PHW received sanctions related to timeliness of claims payment in the Southwest region due to these additional reviews

exceeding timely payment requirements. High dollar claim reviews are standard practice in the MCO industry. Additional oversight of claims turnaround reports is typically performed to ensure timely payments of all claims including those on internal review holds.

  - PHW initially had provider set-up issues and incurred timeliness of payment issues in 2018. From lessons learned, PHW set up workgroups to handle provider issues more timely which will help with future implementations for CHC.

- PHW populates Reports #4 and #5 using the EDW data. No reconciliation is done to compare encounters to reported financial data. Reconciling the paid claim portion of the lag triangle in Report #4 for at least a rolling 12 months to submitted accepted encounters for appropriate combinations of incurred and paid periods would help to measure completeness and accuracy by category of service. Any mismatches warrant investigation.

- PHW's prior PBM contract with EPS paid CVS as the claim administrator based on a spread pricing methodology. Effective April 1, 2019, EPS receives a $1.69 administrative fee to support the general costs of administering the pharmacy benefit. PHW is reviewing their financial reporting and encounter processes to ensure alignment with OLTL's spread pricing guidance effective February 1, 2019.

THIRD PARTY LIABILITY

TPL is an important process to ensure Medicaid is 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 and be consistent with the financial reporting, specifically in Report #8.

- PHW's primary source of TPL information is from the DHS 834 Enrollment files. Claims with other insurance previously not known to PHW are validated and entered into Amisys Advance (Amisys). PHW sends DHS weekly updates to TPL information.

- PHW sends TPL information weekly to all of the vendors for use in claims processing.

- Health Management System (HMS) identifies other TPL information monthly for PHW. 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 CHC implementation, recovered COB dollars have been recorded in the Amisys claims system, submitted in the encounter data and netted against the lag claim costs in the financial reports due to the updated claims data.

- EPS also contracts with HMS to identify TPL opportunities and recover payment from primary carriers for historical claims. EPS retains 5% of all dollars recouped through the COB program. HMS PBM recovery information is reported monthly to PHW for summarization and reporting in

the financial reports. Since PBM claims are point of sale, encounters cannot reflect the HMS recovery.

- PHW subcontracts TPL services to Cotiviti for data mining to identify Medicare claims that should have had COB. Cotiviti sends a notification to the provider, instructing them to bill Medicare as primary and informs PHW to recoup funds for any previously paid claims from the provider.

- EPS contracts with Health Management System (HMS) to identify TPL opportunities and recover payment from primary carriers for historical claims. EPS retains 5% of all dollars recouped through the COB program. HMS PBM recovery information is reported monthly to PHW for summarization and reporting on Report #6B(1). Since PBM claims are point of sale, encounters cannot reflect the HMS recovery.

- PHW indicated they use lessor of logic appropriately to apply COB to claims with TPL. However, one claim reviewed during the onsite indicated the provider was paid more than billed.

- PHW utilizes a list of services that Medicare and commercial plans do not cover so claim payment is not delayed waiting for a primary carrier denial for issues such as Medicaid qualified providers not covered by the other carriers.

- When a dual member is identified as having Medicare Part A and B but not Part D, active outreach through mailings, phone calls and service coordination contact occurs on a monthly basis to enroll the member in PHW's Allwell DSNP (Medicare Special Needs Plan) product. Members have an option of whether or not to sign up for Allwell.

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.

- PHW uses the current version of Amisys claims adjudication system and maintains the system internally. No major system updates are expected within the next year. CHC paid claims from Amisys are loaded nightly to the EDW for reporting.

- PHW receives 95.1% of the claims through Electronic data interchange (EDI), 1.3% of the claims through direct data entry in PHW's web portal and 3.6% of claims are paper.

- Clearinghouses perform HIPAA Strategic National Implementation Process (SNIP) level 1 and 2. PHW uses Edifecs to perform SNIP-like compliance edits up to SNIP level 5 and additional

information such as a valid PROMISe ID from the DHS provider files. Error responses are sent directly to providers. This process can lead to denial of out-of-network providers that are not known yet to PROMISe. There may be services for out-of-network providers that should not be rejected or denied such as emergency services or a member needing an emergency fill on medications. PHW can track these rejections but does not do any proactive outreach to providers.

- 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 dual members with Medicare approved services and Medicaid as the payer of last resort. PHW has the COBA process in place for the CHC duals. The COBA claims are not subject to the SNIP-like edits. In addition to COBA, if any duals have PHW/Centene as their Medicare carrier, paid claims are nightly applied to Amisys for Medicaid claims processing.

- PHW claims are processed by Centene's Corporate claims department in Ferguson, Missouri by 30 staff members who handle claims processing and special projects for claim adjustments and claim appeals.

- PHW automates claim processing when possible; however, based on potential issues, some claims are not set up to fully adjudicate, such as NF claims that are manually reviewed. Auto adjudication levels are about 75% for NF, 99% for HCBS and 97% for other claims. Due to NF claim denials, more claims are reviewed manually even though the denials are primarily due to provider billing issues.

- PHW collects all diagnosis codes submitted by providers up to 25 on institutional formats and 12 on professional claims. Subsequent information from PHW indicated only the first 18 diagnosis codes are validated for claim adjudication. All diagnosis codes received are submitted on encounters to PROMISe.

- PHW utilizes Change Healthcare's ClaimsXTen™ (CXT), PriceWaterhouseCoopers's Health Research Institute (HRI) and Cotiviti software to perform claim edits for professional and outpatient services. CXT software is real-time editing during claims processing in Amisys for edits such as National Correct Coding Initiative (NCCI) edits and procedure code bundling. Due to the prepayment processes, HCBS are not subject to the CXT edits. HRI is software run nightly for potential fraud prevention with claims prior to claim payments. Cotiviti is used on a post payment basis for additional claim editing for correct coding.

- LTSS claims related processes:

- PHW utilizes HHAeXchange (HHA) to coordinate CHC authorization, billing and claim functions for HCBS under the CHC 1915(c) Waiver. HCBS authorizations are created from the member's plan of care. Authorizations are entered at PHW with nightly feeds to HHA and PPL. HCBS providers are able to submit the claims with the applicable authorization number in HHA for submission to PHW for claims payment.

- There have been SNIP-like claims denials for HHA HCBS claims due to unknown rendering service providers. Research indicates these are often a result of providers who register in HHA using dummy/generic information rather than valid PROMISe identifiers.

- PHW indicated that they established a special queue for processing NF claims; however, the review team was not able to assess claims processors instructions for processing.

- PHW receives the cost-of-care (patient liability) amount for NF residents from DHS on the 834 Enrollment file. The amount varies by member and can change during the year. PHW indicated the cost-of-care (patient liability) amount for NF residents is not loaded into the claims system. 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. PHW reduces the amount of the payment to the NF by the self-reported amount. PHW indicated they plan to engage HMS to review the cost of care amount billed by the NF and DHS' 834 Enrollment file cost-of-care amount for the date of service.

- NF leave days/bed hold days are allowed with payments of 33.33% of the per diem rate. In 2018, PHW was not paying the full 33.33% allowed amount and corrections in October 2018 did not accurately represent the correct amount either. A full review of NF leave days/bed hold days' payments did not appear to have been completed by PHW at the time of the review.

- During the initial six months of CHC implementation in each zone (defined as the continuity of care (COC) period), members are allowed to continue to work with the service coordination agency they were accessing prior to CHC. During this COC period, PHW appropriately reimbursed providers based on claim submissions using the W1011 procedure code. Once the COC period ended, payments to agency service coordination providers continued to be made through the claims system and were reported in the encounter data. The use of the W1011 procedure code after the COC period does not meet OLTL's guidance, as the expectation is that the service coordination payments were shifted to an administrative expense after the initial six-month COC period and should no longer be submitted through in encounters.

- Several inpatient claims items were discussed including:

- Inpatient claims are paid using various payment methods including All Patients Refined Diagnosis Related Groups (APR-DRGs) for acute hospital services and per diems for rehabilitation hospitals.

- 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. PHW outlined the determination process for readmission claims, which varies for dual and non-dual participants.

    - For dual participants, since PHW is deemed the secondary payer, they do not authorize procedures on the front-end for inpatient services and follow how the claims were paid by Medicare.

    - For non-dual participants, determination of readmission is currently done post-payment based on a review of medical records. PHW documented P&Ps were not shared to indicate clearly defined readmission processes for the dual and non-dual populations.

- PHW handles present on admission (POA) validation in two places. The SNIP-like edits may reject the inpatient claim if the POA indicator is not populated. Amisys will deny inpatient claims if the POA indicator is not “y” (yes) for all diagnosis codes unless the diagnosis is on the POA exception list. PHW uses the POA indicator to help determine claims that may be provider preventable conditions (PPC) that should not be paid. PHW did not provide any clinical review processes involved to ensure PPCs expenses are not paid using Medicaid funds.

- PHW is in the process of developing a process with HMS to do inpatient post-payment medical record reviews. HMS will review hospital medical records and report to PHW unverified diagnosis codes, incorrect ordering of diagnosis codes and codes that HMS clinical teams decide are more appropriate. Letters are sent to providers to allow them to appeal the decision. Claims will be reprocessed with the diagnosis code omitted from the APR-DRG grouper. Corrected claims from the provider are not required by PHW. DHS’ approval of this process should be obtained prior to implementation.

- For J-code and national drug code (NDC) processing, Amisys validates that the NDC is appropriate for the HCPCS code, is populated with appropriate units and unit of measure and that the NDC is valid for the date of service. NDCs are compared to the website Medicaid.gov to validate the drug is covered under the rebate program.

- PHW does not have documented processes for handling members' deaths, including notification and terminating open authorizations for a member to help prevent additional claims payment. The 834 Enrollment file from DHS typically has the member's date of termination as the last day of the month rather than the actual date of death. There is a time lapse in the process until the DHS 834 Enrollment file is updated with termination information. Additional steps by service coordinators would help to prevent claims payment and subsequent encounter denials from PROMISe.

- PHW internal audits are performed on only about 0.1% of processed claims, and PHW did not indicate any special audits related to the CHC program implementations. These audit percentages are very low and do not fall within the recommended audit range of 2.0% to 5.0% of claims volume. PHW indicated they do review claim denials for the first six months following zone implementation and reach out to providers. Due to the large number of claim denials, trend analyses would help determine the effectiveness of outreach and provide additional provider training opportunities.

- The PBM uses diagnosis codes reported by physicians to assist in performing automatic prior authorization for some NDCs. PHW is in the process of developing procedures to compare medical claims diagnosis codes to PBM drug claims.

- PHW has CHC copays of $3.00 for brand drugs through the PBM.

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.

- PHW claim system encounters are stored in the TriZetto Encounter Data Manager (EDM) product with Amisys claims from the EDW extracted for weekly submission to PROMISe. A new EDM version is expected to be implemented later in 2019. Encounters are processed by a team of Corporate staff with three main staff supporting PHW for CHC.

- PHW stores vendor encounter files in a separate database within EDM.

- Vendor created encounter files and processes:

  – Vendor encounter files are only validated for HIPAA compliance. Compliance errors are sent back to the vendor for correction.

  – The vision vendor is responsible for the creation of the bi-weekly 837P encounter files.

  - The PBM vendor is responsible for the creation of the weekly National Council for Prescription Drug Programs (NCPDP) encounter files. PHW did not appear to have any mechanisms in place to ensure that voids and adjustments made to pharmacy claims are reflected in the PBM's encounter submissions.
  - PPL submits encounter information weekly. PPL had issues with the submitter ID for file submissions when CHC was implemented, but this was fully resolved in June 2019 with complete historical submissions.
  - The transportation vendor submits encounter 837P files on a monthly basis.
  - Vendors are expected to submit TPL information in the encounter files; however, no validation is performed by PHW.

- Note that the creation of the 837D file became becoming PHW's responsibility in 2019 (no longer completed by Envolve).
- PROMISe response data (U277s and NCPDPs) are loaded to another EDM database. Vendors are expected to review the PROMISe response files. PHW only tracks the encounter denials for the claims processed in Amisys. PROMISe denial reports are run and shared with other departments for resolution; however, there is not a formal process for staff to review and act upon the reports timely. PHW was also instructed to work with DHS for issues such as members in the wrong region code.
- Encounter data in PROMISe is used to apply Prospective Payment System (PPS) shadow pricing on encounters. Without proper identification, FQHC/RHC encounters cannot be shadow priced with correct PPS rates for validation of federal requirements. Although FQHC/RHC dental claims were not specifically reviewed during the onsite, this topic was discussed during the meeting. Encounters for FQHC/RHC providers must match to the PROMISe system billing provider national provider identifier (NPI) and service location that have provider type 08 and provider specialty 080/081. In addition, on dental FQHC/RHC encounters, the T1015 procedure code must be submitted with modifier U9 without a tooth number on that line. All service lines associated with the bundled payment should be submitted on the encounter with $0 paid. Additional edits to verify dental vendor FQHC/RHC encounter submissions may be necessary to meet DHS requirements. Refer to DHS systems requirement documents SYS-2018-002 and SYS-2018-010 for detailed guidance.
- PHW excludes J-codes/NDC lines in encounter submissions if there is not a payment on the detail line. This includes instances when a J-code/NDC is calculated to pay $0 since it is part of a combined, all-inclusive payment such as outpatient surgery or emergency room services. DHS expects to receive all details lines associated with the all-inclusive payment. When a denied

J-code/NDC is not part of any all-inclusive payment, the denied line should not be submitted in the encounter data.

- Provider IDs, including the service location in the encounter submissions, are important for multiple purposes such as the high cost risk pool. At least one claim example reviewed during the onsite indicated the claim was a duplicate but paid under a different provider ID than the original claim. This may have been from a provider matching process during the load of the claim into Amisys. An additional encounter example was denied due to a provider ID submission issue with two outpatient claims at different facilities.

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 PHW.

Vendor Data and Oversight Recommendations

- Collect complete vendor data (paid and denied) in the EDW. Use the data to monitor vendors with financial validation checks on at least a monthly basis. Claim should be monitored for accuracy and appropriateness of claim payment or denial.

Financial Reporting Recommendations

- Reconcile the paid claim portion of the lag triangle in Report #4 to accepted encounters for rolling 12-month period or longer 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 a detailed analysis.

TPL Recommendations

- Review claims that have a paid amount greater than the billed amount to ensure "lessor of" logic is properly enforced.

- For dual members who do not have Medicare Part D coverage, assist them with the enrollment process. Members should be able to pick any available Part D plan and may need assistance to ensure Medicaid is the payer of last resort.

Claim Processing Recommendations

- Establish P&Ps for EDI claim rejections for the following:

  – Review SNIP-like edits to ensure that out-of-network providers not previously known to PROMISe can submit claims through EDI processes to PHW.

  - Review EDI claim rejection reports and proactively reach out to providers or HHA to correct billing issues. Additional Provider Relations outreach and training may be warranted to ensure proper claim submission for payment for providers with submission issues.

  - Monitor NF EDI rejections and claims denials and provide technical assistance for billing issues. Many NFs are small providers and ensuring the member's continued ability to reside in the NF may depend upon timely payments from PHW.

- Review diagnosis code denials. There should be a validity check for all diagnosis codes submitted by providers.

- Develop specific job aids for claims staff to ensure they are processing NF claims appropriately and auditing is performed according to the instructions.

- Monitor member's cost of care amounts from the DHS 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.

- Perform a complete review of NF leave days and bed hold days to ensure that the correct payment was made and that the number of days allowed per year is not exceeded.

- Review the payments made to service coordinators after the COC period and modify processes so these are not submitted as encounters.

- Implement P&Ps that align with the 2016 DHS Systems Notice regarding inpatient readmission claims (SYS-2016-014). The process of combining two related inpatient claims within 30 days as defined in Medical Assistance Bulletin 01-11-44 in the claims system to re-calculate the APR-DRG will capture the full utilization. The combined claims should be appropriately documented in the claim notes files. The processes should distinguish the steps to take for dual and non-dual members.

- Review claims received that replace POA claim denials. Providers may be resubmitting claims by dropping diagnosis codes. If the claims POA indicator was missing or not a yes due to PPC, the amount billed may continue to include the expenses for PPC.

- Create P&Ps for processes regarding deceased members with these steps:

  - The service coordinators update authorization 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.

  - Follow-up with reports to determine recoupment processes for other services besides PPL after a member's date of death.

- Increase claim audits to 2.0% to 5.0% of submitted claim volume to confirm accurate payment of claims. This may assist with the identification of additional issues such as NF denials.

Encounter Submissions Recommendations

- Create P&Ps to ensure all paid encounters are submitted to PROMISe, including TPL, voids and adjustments for Amisys and claims processed by vendors.

- Implement P&Ps for staff to review PROMISe denials and determine resolution processes for issues that may be system edits, provider education, staff training or recouping claim paid amounts. Resubmit encounter corrections to PROMISe timely.

- Implement encounter denial tracking processes for all vendors to ensure the PROMISe denials are corrected and resubmitted timely. Implement regular meetings to review any PROMISe denials and steps needed to improve the denial rate.

- Review FQHC/RHC encounters, including dental, for accurate submission of NPI, PROMISe IDs for correct provider type, specialties and service locations, along with correct modifier and detail service codes associated with the T1015 procedure code. Refer to DHS System Notice documents SYS-2018-002 and SYS-2018-010.

- Review encounter extract processes for claim denials versus zero payment. J-codes that are zero paid because they are part of an all-inclusive rate on medical claims should be maintained and submitted as part of the whole claim in the encounter submission to PROMISe.

- Review processes and reference tables for submission of provider IDs, and in particular, the accompanying service location when submitting encounters to PROMISe to reduce encounter denials.

NEXT STEPS

DHS and Mercer thank PHW 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 PHW'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 PHW 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

Pennsylvania Health and Wellness Review
Encounter Data Review

July 24, 2019 9 am to 4 pm
July 25, 2019 8:30 am to Noon

NOTE: The following items are needed to be ready for the review team upon arrival on the day of the review:

1. *Reports used to track and monitor CHC encounter submissions.*

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

DAY 1

TIME	TOPIC
9 am–9:30 am	• Introductions — meeting purpose and review site visit schedule • CHC-MCO opening comments — no presentation: — The MCO can provide overall comments/information about challenges with CHC encounters or 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 PHW survey responses: — General systems and data storage related discussion — Vendor related: – Monitoring efforts – Collection of vendor claims data and validation – Submission of vendor encounter data — General claims questions including claim audits
10:15 am–10:30 am	*Break*
10:30 am–10:45 am	• Specific questions for vendors • FQHC claims and encounters

10:45 am–Noon	• Encounter data: — Status of submission completeness — J-codes and national drug code processing and encounter submissions — Diagnosis collection and encounter submission — PROMISe denials — Senior management involvement in encounters • Provider: — Provider file — Ordering, referring and prescribing providers — Out of network providers — Provider incentives
Noon–12:30 pm	*Working lunch*
12:30 pm–1:00 pm	• Financial questions: — Financial Reporting Requirements — Third party liability — Reconciliation of encounters to financials • Third party liability (TPL) and coordination of benefits
1:00 pm–2:15 pm	• Start claim system demonstration (if time allows): — Claims receipt — Claim edits — Payment processes: – Inpatient – Nursing facility including ancillary charges and cost sharing – Home and community based services (HCBS)
2:15 pm–2:30 pm	*Break*
2:30 pm–4 pm	• Claims system demonstration continued

DAY 2

TIME	TOPIC
8:30 am–8:45 am	• Review outstanding items from Day 1
8:45 am–10:15 am	• Claims system demonstration continued
10:15 am–10:30 am	*Break*
10:30 am–11:30 am	• Claims system demonstration continued
11:30 am–11:45 am	• Meeting of Mercer and DHS only
11:45 am–Noon	Closing and next steps

Attendees:
DHS:
OLTL Bureau of Finance – 3 staff

OLTL Bureau of Quality Assurance and Program Analytics – 3 staff
Bureau of Data and Claims Management (BDCM) – 4 staff
Bureau of Fiscal Management (BFM) – 4 staff

Mercer:
Consultants – 5 staff

PHW (In Person):
Vice President, Finance
Vice President, Compliance
Vice President, Systems and Data Analytics
Vice President, Pharmacy Operations
Manager, Provider Relations
Director, Claims
Data Analyst III, Claims Operations
Supervisor Encounter Business Operations
Business Analyst Encounters
Financial Analyst I
Financial Data Analyst II

PHW (Via Phone):
Vice President, Systems and Data Analytics
Controller
Director, Client Implementation and Benefit Operations, Envolve
Manager, Service Coordination – 2 staff
Project Lead Business System Analyst (EDI)

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