UPMC COMMUNITY HEALTHCHOICES ENCOUNTER DATA REVIEW

OCTOBER 11, 2019

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 UPMC Community HealthChoices (UPMC).

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 UPMC and an online review comparing encounter data from PROMISe™ to UPMC's systems for claims and encounter submission tracking. This onsite review was conducted at the UPMC site in Pittsburgh, Pennsylvania on July 23, 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 (UPMC, DHS and Mercer).

LIMITATIONS OF ANALYSIS

In preparing this document, Mercer used and relied upon data supplied by UPMC. UPMC 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 UPMC 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 UPMC to implement to address the issues uncovered during the review; these issues and others are described in detail in Section 2: Findings and Recommendations.

- Monitor Public Partnership LLC (PPL) for encounter submissions and verify self-directed home and community based services (HCBS) are delivered based on the UPMC authorizations from the plan of care.
- Exclude pharmacy spread pricing from the medical expenses of the lag triangle of Financial Report #4 and instead report on Line 39 (Pharmacy Benefit Manager [PBM] Adjustment). Pharmacy spread pricing should be considered within the Pharmaceutical service expense on Line 13 in Report #5.
- 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 warrant investigation.
- Share third party liability (TPL) data with dental and vision vendors for proactive cost avoidance through coordination of benefits (COB) and the chance for providers to investigate member's coverage during patient visits.
- Monitor cost-of-care amounts from the DHS 834 Enrollment files and compare them to the cost-of-care amounts reported on paid 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 billings.
- 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 that align with the 2016 DHS Systems Notice regarding inpatient readmission claims. 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 recalculate the All Patients Refined Diagnosis Related Groups (APR-DRG) will capture the full utilization. The combined claims should be appropriately documented in the claim notes. The processes should distinguish the steps taken for dual and non-dual members.
- Continue to work with the transportation vendor for accurate encounter submissions from January 1, 2018 forward.
- Implement an encounter tracking system to monitor vendor submission errors and subsequent corrections to ensure complete and accurate vendor encounter data.
- Verify the NF provider encounters to ensure the correct PROMISe provider IDs, including the service locations, are submitted for data processes by DHS.

- 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 UPMC'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 UPMC'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 UPMC 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 UPMC's vendor oversight are highlighted below:

- The UPMC vendors and payment methods include the following:
  - Avesis is paid an administrative fee for dental services plus fee-for-service (FFS) invoice for claims payment.
  - Coordinated Transportation Solutions (CTS) is paid an administrative fee for transportation services plus FFS invoice for claims payment.
  - Envolve is paid an administrative fee for vision services plus FFS invoice for claims payment.
  - Express Scripts, Inc. (ESI) is UPMC's PBM and is paid through spread pricing. Providers are paid based on FFS with an invoice for claims payment submitted to UPMC.
  - Public Partnership LLC (PPL) is paid a contracted administrative rate for financial management services and FFS for self-directed HCBS claims invoices.
- The vendors provide proprietary formatted files of paid and denied services with invoices for UPMC to load into the data warehouse (dwOAO). Weekly files are received from the PBM and PPL. Dental and vision files are received monthly. CTS data is received twice a month in an

Excel spreadsheet. UPMC validates the count of services and dollars to the vendor invoices. Limited analysis and oversight on PPL's data is an area of concern and future focus for UPMC.

- UPMC monitors vendors regularly for adherence to DHS requirements. The vendors' self-report financial, encounter and compliance information monthly, quarterly and annually that help UPMC monitor compliance and accuracy. UPMC monitors the PBM more closely by overseeing denials and trending of drug usage and costs. UPMC monitors vendor claim denials through monthly reporting. Encounter staff monitor vendors regarding PROMISe encounter data submissions. There are no current corrective action plans for any of the vendors. UPMC indicated there is room for improvement in oversight and monitoring efforts of CTS and PPL. Comparison of services delivered to authorizations has not been performed on PPL claims since this is not directly done in the UPMC claims/clinical system.

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

- UPMC's definition of a clean claim is a claim that can be processed without obtaining additional information from the provider or DHS. Unclean claims include pending claims for additional provider information and providers under investigation for fraud, waste and abuse. This is consistent with OLTL's Report #3a guidance.

- PBM reimbursement includes spread pricing and has been included in medical expenses in Report #4 (Lag Triangle) and Report #5 (Income Statement).

- UPMC is planning to develop a formal reconciliation process between the CHC encounter submissions and Reports #4, #5 and #6A. 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. UPMC found the encounters and dwOAO do not match for PPL data.

- For Report #6A, UPMC has identified challenges completing the monthly nursing facility unit and paid values due to claim submission delays by some nursing facilities. As a result, UPMC is reporting low unit and low dollar amounts for the latest month in the quarterly reports (e.g., March 2019 in the 1Q 2019 Financial Reports). In addition, the nursing facility transportation claims are received more quickly and this is causing the nursing facility Per Diem Cost and Days per User metrics in Report #6A to be lower than expected. UPMC is actively working with these facilities to improve claim submissions and reporting. However, with monthly NF billing, challenges may continue. UPMC believes NF submissions are currently up-to-date for the Southwest zone. For the Southeast zone, UPMC monitored new NF providers and reached out to providers if no claims were received.

- UPMC indicated it was a time consuming and manual process to implement and test the Report #6A Appendix B(1) and Appendix B(2) guidance requirements due to the level of detail. They do not use provider type/specialty fields in their claims adjudication system, so they must use an internal crosswalk to be able to summarize claims based on those fields. UPMC noted difficulty in classifying a claim by the referring provider type such as when DHS asks that services provided by a primary care physician (PCP) be classified as a specialty physician claim when the member was referred from another PCP.

- UPMC processes claims and pays providers three times per week. Electronic fund transfers (EFT) are sent the same day as processed and paper checks are sent within one business day. For DHS reporting purposes, the check date is appropriately used. UPMC continues to monitor payment distribution.

- In April 2019, UPMC began utilizing a quality incentive payment with a few NFs. The incentive payment is reflected through higher per diem rates for these NFs and these payments are included in the medical expenses in the financial reports and in the encounter data. Any other incentive payments are paid outside of the claims system.

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.

- The DHS 834 Enrollment file is the primary source of TPL information. If a claim is submitted to UPMC with TPL information that is not already on file with UPMC, the claim is held for internal review and validation, which ultimately lead to processing of the claim. Claims that do not contain the necessary TPL information are denied with a request from the provider to submit to the primary carrier first.

- 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. UPMC has the COBA process in place for the CHC duals.

- UPMC subcontracts CHC TPL services to the Council for Affordable Quality Healthcare (CAQH). CAQH uses a proprietary database to identify other TPL resources on a weekly basis. UPMC is considering adding two other vendors used for physical health HealthChoices to assist with the identification of other insurance and for cost avoidance activities. UPMC understands that any recoveries for TPL, except PBM claim recoveries, must be reflected in the claims system.

- UPMC does not share member TPL files with PPL or HHAeXchange (HHA) because other carriers generally do not exist for HCBS. UPMC does not currently share the CHC member TPL information with their dental and vision vendors. This is a missed opportunity in potentially identifying additional other insurance and reducing Medicaid liability.

- UPMC 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/services not covered by the other carriers.

- In situations where Medicaid payment is not expected to be made due to TPL, UPMC requires providers to submit the claim with the primary carrier amounts and a $0 paid Medicaid amount. This practice aligns with DHS expectations.

- UPMC indicated they do not formally assist CHC eligible members in obtaining Part D Medicare coverage. Section V of the CHC Agreement indicates that “the CHC-MCO must offer assistance to Dual Eligible Participants in selecting a Medicare Part D plan, including advising on the benefit of enrolling in a Medicare Part D plan with a zero co-pay.” These tasks are required to help ensure Medicaid is the payer of last resort.

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 LTSS 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.

- UPMC owns and maintains the MC400 as their claims system. The dwOAO receives claims data in real time from the MC400. The MC400 claims system and dwOAO also support the physical health HealthChoices program.

- UPMC receives approximately 95% of claims from electronic data interchange (EDI), 1% through direct UPMC's website portal entry and 4% in paper formats. UPMC does not have a Health Insurance Portability and Accountability Act (HIPAA) translator but utilizes an EDI mapping tool (Sybase ECMap) that converts EDI claims data into a format accepted by the claim processing system. This EDI processing contains the basic HIPAA edits and may reject before a claim is accepted into the MC400. UPMC can track the EDI rejections but currently has no formal processes in place related to these rejections.

- LTSS claims related processes:

  – UPMC utilizes the HHA platform to coordinate CHC authorization, claims and billing functions for HCBS under the CHC 1915(c) Waiver. HCBS providers receive UPMC authorizations in HHA and are able to apply the authorization number during the claim billing steps. HHA submits the HCBS to the MC400 for payment.

  – Although multiple diagnosis codes can be recorded as part of the member's plan of care, the HHA system only allows one diagnosis code to be included on the claims submitted.

  – Due to the complexity of NF claims, UPMC does not auto adjudicate claims from the NFs. Claims processors must review every NF claim.

  – UPMC 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. UPMC loads the cost-of-care information into the MC400. 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. UPMC reduces the amount of the payment to the NF by the self-reported amount.

  – 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, UPMC appropriately reimbursed providers based on claim submissions using the W1011 procedure code. UPMC made the decision to continue working with approximately 20% of the agency service coordinators beyond the six-month COC period. This decision was discussed with OLTL and essentially extended the COC period through October 2018 in the Southwest Zone and through July 15, 2019 in the Southeast Zone. Payments to these 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.

  - UPMC plans to use HHA for electronic visit verification with a soft implementation date of October 1, 2019 and a full implementation on January 1, 2020 to meet DHS requirements.

- Various inpatient claim items were discussed, including:

  - UPMC uses the APR-DRGs for acute care inpatient claims and pays per diem for inpatient rehabilitation services.

  - Interim billings occur when a facility issues a claim for a partial billing before a patient has been discharged. The interim bill is used for long stays, often to help the facility manage cash flow. Interim inpatient billings may cause duplicate claims, overpayments or incorrect reporting. UPMC denies interim bills from acute hospitals until the final bill is submitted. Payment exceptions may be made on a case by case basis for extended hospital stays.

  - 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. UPMC reported that CHC readmissions are not paid if they are received within 30 days of discharge.

  - UPMC edits present on admission (POA) flags on all diagnosis codes on inpatient claims as a requirement for APR-DRG pricing. When POA is not “yes” or on the diagnosis exception list, the claims are manually reviewed and denied for medically unnecessary services. The POA is an indicator for provider preventable conditions (PPC). Providers may resubmit claims for inpatient services without the additional hospital preventable conditions and expenses. Additional reviews are performed for PPC through monthly reporting and investigation by the quality department.

- UPMC uses the prospective claims editing software, ConVergence Point (CVP) from Cotiviti. This tool applies pre-payment edits to batch claim files for professional and outpatient institutional claims. For claims where Medicare is the primary payer, the claims are run through the Medicaid National Correct Coding Initiative (NCCI) edits. The CVP edits are not applied to HCBS claims due to the authorization requirements. There are rare instances when claims processors can override the CVP decisions.

- UPMC reported 1.4% to 3.5% of CHC claims are audited monthly to measure accuracy of claims processing and payment amounts. The overall audit level of approximately 1.9% for six months is acceptable. UPMC performs focused audits if issues arise such as low submission of diagnosis codes by providers. UPMC’s fraud, waste and abuse department performs several

types of audits on claims including medical chart audits. Recoveries may be made, but no claims are altered by UPMC due to any of the audits.

- UPMC applies edits to facility and professional claims for outpatient drug services for national drug codes (NDCs) associated with Healthcare Common Procedure Coding System (HCPCS) codes, primarily J-codes. NDC number, NDC units, NDC units of measure and a rebate drug indicator code are required and claims will be denied if the NDC elements are not supplied. Checks are made to ensure the HCPCS information correlates with the NDC information. First Databank is used to validate NDC data elements. On a quarterly basis, UPMC manually performs a review to verify the reported unit of measure is valid for the submitted NDCs.

- UPMC is in the process of modifying the MC400 system to expand the number of digits in the unit and dollar fields as an alternative to the current practice of splitting inpatient claim detail lines that may exceed the current field limits (e.g., units for hemophilia drugs). UPMC plans to implement the system modification in early 2020. UPMC is not aware of any CHC claims that have hit the limits to date but plans to monitor this and will work with DHS if necessary for encounters and the high cost risk pool.

- UPMC does not have documented processes for handling members' deaths, including notification and termination of open authorizations for a member to help prevent additional claims payment. A manual process exists for UPMC to notify the County Assistance Office (CAO) when the staff members hear a CHC member passes away. The CAO then updates DHS' systems to reflect the death date that will pass in the DHS 834 Enrollment file. UPMC relies on the service coordinator to apply an end date to the authorizations to assist in stopping claim payments. It was unclear if UPMC is currently performing any checks on whether claims are being reimbursed for service dates after the date of death.

- To meet the ordering, referring and prescribing (ORP) requirements, UPMC is in the process of determining how to move forward. 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 UPMC network.

- PBM pharmacy edits are used to combat overprescribing. Edits include identifying invalid quantities and identifying patterns of outlier quantities on products with historical patterns of submission with mistakenly entered large quantities.

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.

- Claims are extracted weekly from dwOAO and loaded into an Oracle encounter database within dwOAO for encounter submissions. In addition, submission data is stored along with the response files from PROMISe.
- Vendor encounter submissions:
  - All vendors are required to submit HIPAA compliant encounter files for pass through from UPMC to PROMISe. UPMC does not perform any editing on the vendor files.
  - CTS is responsible for creating the 837P file; however, there have been challenges in creating the file. A test 837P file is expected soon and UPMC will work with DHS for accurate submission to PROMISe. Once testing is complete, historical data beginning with January 1, 2018 will need to be submitted via the 837P format.
  - Vendors are expected to submit all claims related to TPL with COB amounts indicated.
- PROMISe returns U277 responses for encounter submissions. MCOs must have processes to review, track and resubmit corrections of encounters.
  - UPMC tracks submissions and PROMISe denials to ensure completeness of data and proper corrections and resubmissions for medical and LTSS claims. Most encounter corrections can be done and resubmitted the following week.
  - UPMC sends PROMISe denials to vendors but does not track the denied encounters or verify errors are corrected. Without a documented tracking process, there is no assurance of complete and accurate vendor data in the encounters in PROMISe.
- 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. 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, and all service lines associated with the bundled payment should be submitted on the encounter with $0 paid. UPMC is in the process of enhancing their technical specifications to align with the DHS requirements.
- Provider IDs are audited monthly by UPMC to monitor provider data for accuracy. UPMC compares DHS provider PRV414 and PRV430 files, for both participating and non-participating providers, to the active IDs in the MC400. More validation may be necessary for UPMC as PROMISe has challenges shadow pricing NF encounters due to service location issues.

- UPMC requires copays for some services. The claims demonstration indicated UPMC applies copays during claim processing and reports the copays in encounter submissions.

- J-code encounters were not covered in detail during the CHC review; however, when discussed with UPMC earlier in 2019 during the HC review, the following process changes were needed. J-code claim details must be submitted as separate encounters from other services paid on the claim from the provider with NDCs and associated units. PROMISe will send these one-line J-code encounters through the National Council of Prescription Drug Program (NCPDP) processing module. The NDC and units from the J-code encounter are used for the rebate process. Therefore, the J-code encounters cannot be adjusted regardless of claim system processing. Each J-code encounter correction must be voided and resubmitted as an individual encounter. If UPMC has adjusted claims with J-codes, processes may need additional review to ensure J-codes that are not associated with an all-inclusive payment are submitted independently and as an original encounter or a void only.

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 UPMC.

Vendor Data and Oversight Recommendations

- Develop monitoring and oversight procedures to ensure PPL has submitted complete and accurate data to meet CHC reporting requirements and to verify self-directed HCBS are delivered based on the authorizations from the plan of care.

Financial Reporting Recommendations

- Move the Report #4 pharmacy spread pricing component out of the lag triangle and onto Line 39 designated as the "PBM Adjustment" to align with OLTL guidance. Report this pharmacy spread pricing as a pharmaceutical service expense on Line 13 within Report #5.

- 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

- Share TPL data with dental and vision vendors for cost avoidance through COB and to give providers the opportunity to investigate member's coverage during patient visits.

- Develop a formal process to identify members who may be eligible for Medicare Part D coverage and assist the member in the enrollment process to ensure Medicaid is the payer of last resort.

Claim Processing Recommendations

- Establish P&Ps to monitor EDI rejections to identify providers that are having challenges and need proactive technical assistance in order to get their claims submitted successfully and timely. Specifically, monitor LTSS EDI rejections and claims denials to provide technical assistance for billing issues as many NF and HCBS providers are small organizations and the member's continued ability to be served may depend upon timely payments from UPMC.

- Monitor cost-of-care amounts in the DHS 834 Enrollment files 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 the remaining MCO NF paid amount is appropriate. UPMC should be reviewing this information to ensure the Medicaid liability is appropriate.

- Implement P&Ps that align with the 2016 DHS Systems Notice regarding inpatient readmission claims. 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 both dual and non-dual members.

- Implement NDC units of measure edits in the claims system. If not available, the NDC validation should occur more frequently than quarterly.

- Create P&Ps regarding deceased members with 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.

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

Encounter Submissions Recommendations

- Continue to work with CTS for accurate encounter submissions. Once testing is complete, submit all transportation claims from January 1, 2018 to current. Increase oversight and monitoring activities to ensure CTS submits complete data including new zones to meet CHC requirements.

- Implement an encounter tracking system for vendor submission errors and subsequent corrections to ensure complete and accurate vendor encounter data.
- Review FQHC/RHC encounters, including dental, for accurate submission of NPI, PROMISe IDs for the correct provider type, specialties and service locations, along with the correct modifier and detail service codes associated with the T1015 procedure code.
- Regularly review encounter processes to only submit paid J-code/NDC claims details separately unless part of an all-inclusive rate on medical claims. Denied J-codes should not be submitted to PROMISe.
- Verify the NF provider IDs and services locations on encounters to ensure the correct PROMISe provider IDs and service locations are submitted.

NEXT STEPS

DHS and Mercer thank UPMC for their participation in the onsite encounter data review for the CHC program. Given the program is still in the early stages of implementation, DHS appreciates UPMC'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 UPMC 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 determine next steps.

APPENDIX A

AGENDA

UPMC Community HealthChoices Encounter Data Review

July 23, 2019

9 am to 3 pm Eastern

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 submissions: — 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: — Claims 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) – 3 staff
Bureau of Data and Claims Management (BDCM) – 3 staff
OLTL Bureau of Finance – 3 staff
OLTL Bureau of Quality Assurance and Program Analytics

Mercer:
Consultants – 5 staff

UPMC:
Senior Vice President/CAOO
President, Govt Products
VP, Community HealthChoices
VP/GM, Govt Programs
VP Customer Eligibility and Enrollment
VP, Medicaid, Indiv and Exch Prd
CFO, CCBH
CFO, Medicaid Ass and CHIP
AVP, Govt Products Ops Support
AVP, Claims Operations HPL
AVP, LTSS Clinical Operations
AVP, Payment and Operation Integration
Lead Financial Analyst, CHC Finance
Manager, Statutory Reporting, CHC Rev Rec
Director, CHC Aff and Dev
QA Focused Review Coordinator
Sr. Director of Claims Ops HPL
Sr. Director CHC Operations
Sr. Manager, System Config and Support
Coordinator, Govt Products
Director, Govt Prod Analytics
Sr. Manager, Enrollment Services
Sr. Claims Manager, HPLAN
Lead Business Analyst
Lead Operations Analyst
Director, Quality Improvement
Manager, Vendor Contract and Relations
Director, Revenue Reporting
Director Claim Editing Vendor Management
Admin, Medicaid Compliance
Manager, Ancillary Network Services
Administrator, CHC Compliance
Sr. Dir Pharmacy Operations
Manager, Housing Strategy
Sr. Manager, IT Engineering
Director Analytics - Medicaid/CHIP
Sr. Manager, Govt Prod Operations
Administrator, Claims
Sr. Director Medicaid and MLTSS Compliance
Sr. Manager, Govt Prod Operations
Business Analyst, CHC Rev Rec
Manager, Hospital Reimbursement
Sr. Administrative Asst.
Director, Quality Ass/Ops Integrity
Sr. Manager QA Ops Integrity
Manager Medicaid Govt Compliance
Sr. Director, CHC Revenue Rec.

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