

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section P: Third Party Liability (Section § 5 of RFP)	25		
P-1	A, B, and C	<p>P.1 Describe how you will coordinate with DHH and comply with the requirements for cost avoidance and the collection of third party liability (TPL), including:</p> <ul style="list-style-type: none"> ○ How you will conduct diagnosis and trauma edits, including frequency and follow-up action to determine if third party liability exists; (2) How you will educate providers to maximize cost avoidance; ○ Collection process for pay and chase activity and how it will be accomplished; ○ How subrogation activities will be conducted; ○ How you handle coordination of benefits in your current operations and how you would adapt your current operations to meet contract requirements; ○ Whether you will use a subcontractor and if so, the subcontractor's responsibilities; and ○ What routine systems/business processes are employed to test, update and validate enrollment and TPL data. 	25		

Question P.1

Cost Avoidance and Collection of Third Party Liability

Section P: Third Party Liability

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- How you will conduct diagnosis and trauma edits, including frequency and follow-up action to determine if third party liability exists; (2) How you will educate providers to maximize cost avoidance;
- Collection process for pay and chase activity and how it will be accomplished;
- How subrogation activities will be conducted;
- How you handle coordination of benefits in your current operations and how you would adapt your current operations to meet contract requirements.
- Whether you will use a subcontractor and if so, the subcontractor's responsibilities; and
- What routine systems/business processes are employed to test, update and validate enrollment and TPL data.

Experience With Medicaid TPL Processing

Louisiana Healthcare Connections (LHC) is a partnership between Centene Corporation (Centene) and the Louisiana Partnership for Choice and Access (LPC&A). As a trusted administrator of public sector programs since 1984, Centene has designed Third Party Liability (TPL) claims processes and data interfaces around the requirement that Medicaid programs are the "payer of last resort." In addition to managing the Management Information System (MIS) for LHC, Centene has a successful history of managing cost avoidance for our managed Medicaid health plans, as well as recovering payments made for our members who were subsequently found to have Other Insurance (OI) with TPL. Our experience with cost avoidance and TPL processing continues to improve as we introduce increasing levels of automation with our providers, in our internal systems, and with our OI and TPL partners. For example, across all of our operations in 11 states, from 2009 to 2010, our cost avoidance figures rose 17% and our TPL recoveries increased 19%, with both figures adjusted for increase in membership.

Taking the Pre-Emptive Approach

Our experience has shown that the best approach to cost avoidance is to *minimize the need to recover costs in the first place* and we employ several methods to support our "pre-emptive" strategy. These methods use the eligibility subsystem in our Member Relationship Management (MRM) System. MRM is our enterprise based, master data management application for member data, containing our master member indices and "all things member related," including history. MRM is tightly integrated with our AMISYS Advance claims processing system to support the collection and maintenance of OI information at the "member level." Once in AMISYS Advance, we use OI information to automatically recognize and prompt the suspension of claims that may be submitted without required Explanation of Benefits (EOBs) or payment information from a primary payer. In cases where we discover the existence of OI with TPL through any of the efforts below, we will update DHH each month on or before the 15th working day of the month. Our pre-emptive strategy includes the following processes:

- **Reconciling the HIPAA 834 Eligibility File.** Upon receipt of the 834 eligibility file, coordination of benefits (COB) data will be automatically loaded to MRM. MRM houses current and historical member information and maintains our master member index to assure member data integrity. MRM systematically promulgates updated eligibility data, including COB data obtained from the 834, to our other applications requiring that data, including the eligibility subsystem of AMISYS Advance and the claims processing system of OptiCare Managed Vision

(OptiCare), LHC's vision benefits affiliate and subcontractor. This is the first step in our approach to ensure the eligibility subsystem contains current information necessary to identify members who might have OI. If at any time, the OI data we receive from DHH differs from the information we have received from any other source, we will ensure that DHH receives that updated information through DHH's fiscal intermediary (FI) to synchronize data between LHC and DHH's FI. We will work with DHH's FI to determine the best way in which to support sending OI data to DHH, for example, via the HIPAA 834 transaction.

- **Diagnosis and Trauma Edits.** Consistent with our affiliate health plans, we will load accident related ICD-9 diagnosis code edits into our AMISYS Advance claims adjudication system, creating another way LHC will intercept claims that may be the liability of a third party. If a claim is received without documentation to support the liability or non-liability of a third party, and the claim contains an accident- or injury-related diagnosis code and/or trauma indicator of "Y," we will pay the claim and request that the provider submit accident-related documentation or payment information from the third party. We will then send this information to Health Management Systems, Inc. (HMS), our partner for post-payment recovery services, for further investigation. Please see below for more information on HMS. The flexible nature of our claims configuration rules tables allows claims with services related to prenatal or preventive pediatric care, including EPSDT services, to bypass the "trauma" edits, and continue processing to ensure compliance with DHH and federal requirements. If after processing, LHC discovers a third party is liable for those services, we will bill the third party within 60 days and offset the original claims payment by the amount received from that third party.
- **Educating Providers.** Through our regular provider orientations, ongoing training meetings, and our online Provider Manual, we will inform and educate providers about the importance of submitting denial notices from third parties, accident details, and medical records corroborating no other liable parties, or EOB or payment information from a third party where member liability exists. We are also introducing a new capability on our secure Provider Portal, allowing our network providers to submit to us requisite TPL documentation by uploading images, PDFs, Microsoft Word documents, or other digitally formatted TPL related documents electronically. This information will be accessible by our claims processors to expedite finalizing claims with TPL. In all circumstances, LHC will review submitted documentation, validate the initial findings, and expedite the processing of the claim.

We will educate our providers about the importance of identifying OI information at the time the member receives service. We will also provide them with any additional instruction needed related to including OI payer and payment information in the COB and other payer segments of their HIPAA 837 EDI claim submissions, or their paper claim submissions. In addition, a provider may enter a claim directly via our HIPAA compliant Direct Data Entry (DDE) online claim entry facility available through our secure Provider Portal. Our online claim entry application has logical field checks so that, for example, if a provider indicates that the member has other insurance, but no entry is made concerning third party payments, our claim entry application will alert the provider about this missing information at the time the provider is entering the claim. We also are introducing our EDIFECS Ramp Manager to providers, allowing EDI claim submitters to test the sending of COB and other payer information to us via the HIPAA 837 transaction, with instant and detailed test results immediately sent back to the provider, all through our Provider Portal. We will have our HIPAA 5010 EDIFECS Ramp Manager available for LHC providers on January 1, 2012.

- **Identify and Address Billing Errors.** Centene's Claims Department continuously examines claims submissions for patterns of billing errors from providers, including those related to TPL, through the use of decision support tools within our Centelligence™ Insight reporting system. Please see Section R.10 for more information on Centelligence™. When we identify providers

having problems related to billing primary payers, our Provider Relations staff will outreach to the provider to offer targeted provider education.

- **Our Provider Portal** will allow authorized provider users to see any current TPL information we have collected for a member. TPL checking by the provider thus becomes a routine part of the member eligibility verification process before the claim is created and submitted.
- **OI Information on Claims Received.** Claims may contain OI noted on the claim form itself as information populated in the appropriate boxes on the CMS 1500 or CMS 1450 claim forms, or on an attachment to the claim, such as an EOB from another carrier, or in the COB and other payer segments of the HIPAA 837 EDI claim submission. In this case, our Automated Work Distribution (AWD) claims workflow system, integrated with AMISYS Advance, will electronically route the claim to our COB/TPL Analyst to investigate and validate the existence of OI. Upon confirmation of OI, the COB/TPL Analyst will update the member's OI information in MRM, which will then electronically update AMISYS Advance for future claims payment determination and allow our claims processor to coordinate benefits for the pended claim and finish adjudication.
- **Notification from LHC Staff.** LHC staff may become aware of OI during member and provider interactions, chart reviews, etc. When LHC staff learn about OI that is not already included in the member's eligibility record, they will submit a notification via MRM to the COB/TPL Analyst, requesting that the member record in MRM be updated. When the COB/TPL Analyst updates the MRM master member record, AMISYS Advance will update automatically with the OI information to ensure accurate handling of future claim submissions. Additional coverage information also may be discovered through the authorization, concurrent review, or case management processes. In these situations, the local Case Manager or Referral Specialist creates a claims note in TruCare, our case management and clinical documentation system. The claims note indicates the name of the insurer, the policy and group number, the name of the member, and the effective date. This information is then transferred to the COB/TPL Analyst for updating in MRM, and subsequently AMISYS Advance and our other applications, and transmitted to subcontractors dependent on this information.

Coordination of Benefits (COB). LHC will capture all results of COB/TPL investigations at the member level within the member's eligibility record in MRM which electronically feeds to AMISYS Advance. During the claims adjudication process, AMISYS Advance checks for OI and will pend or deny the claim based on the information contained within the record. A dedicated team of resources within our claims operations team, who have extensive knowledge and expertise in COB and TPL administration, will process COB. When we become aware of other coverage, we will use AMISYS Advance's table driven parameters to configure the system to coordinate benefits in accordance with DHH's "lesser of the difference between" standard for professional and outpatient claims. For inpatient claims where the TPL paid amount is *less* than the Medicaid allowed amount and there is member liability, we will pay up to member liability, not to exceed our allowed amount. Finally, as required by DHH, for inpatient claims where the TPL paid amount is *more* than the Medicaid allowed amount, no additional payment will be made. If third party liability cannot be established or third party benefits are not available, we will process the claim for payment to the provider.

LHC complies with all coordination requirements, including but not limited to, Federal Regulation 42 CFR 433.135; Louisiana Revised Statutes, Title 46; and specifically those related to medical services provided to pregnant women and children, as specified in 42 CFR 433.139 (b)(2)(i) and (3). For these services, we will pay the provider and pursue recovery from a liable third party, if one exists. We can enforce this "pay and pursue" rule for pregnant women and children because we identify appropriate procedure codes on the inbound claim and through member information housed in AMISYS Advance (sourced from MRM's master member data). We can also set up other exceptions for specific services that

are not covered by TPL, most notably, non-emergent transportation (e.g. taxi). This allows such claims to automatically adjudicate even if TPL is indicated for the member.

Pay and Chase, and Subrogation. LHC will augment our prepayment COB processes with the post payment recovery services of HMS for recoupment when OI is not known at the time we pay the claim, and for subrogation to parties with TPL. On a weekly basis, we will provide HMS with a claims detail report of claims processed the previous week. If HMS determines that a claim is related to OI or subrogation, they will initiate steps to recover the overpaid TPL dollars. HMS will bill the primary insurer on behalf of LHC within 60 days after TPL information is confirmed. When HMS confirms that a member's claim has TPL and we have paid the claim as primary, they will submit a claim to the primary insurer and request reimbursement to LHC for their amount of payment. Our recovery efforts are transparent to the provider, easing the provider's administrative and financial burden, as there is no need for LHC to recoup previous claim payments or request the provider attempt to obtain payment from the primary carrier. We will obtain approval from DHH when the claims settlement is equal to or greater than \$25,000. Centene's Director of Operations Support will provide oversight of HMS and monitor adherence to these requirements. In addition, we will provide DHH with our established procedures for COB and subrogation processes during readiness review. LHC will comply with DHH requirements and federal regulations for the distribution of TPL recoveries "and we will report to DHH any recoveries collected and accounted for, outside of AMISYS Advance, as offsets to medical expenses.

Subcontractors. LHC will rely on Centene Management Company (CMC), our subcontractor, to provide post payment recovery services. CMC will provide these services through their relationship with HMS.

Systems/Processes for Testing, Updating and Validating Enrollment in OI and TPL Data. Centene uses automated processes to support efficient and accurate cost avoidance by systematically identifying members with OI and other third parties responsible for payment. Centene's Claims Department regularly identifies COB and TPL cases by data mining through our Centelligence™ informatics platform and using diagnosis and trauma edits, in addition to member outreach, to confirm the presence of OI based on these edits. We augment our OI identification processes with established national recovery vendors through our partnership with HMS. Each month, we securely send member demographic data to HMS. By matching this data to HMS' database of national insurance eligibility information, HMS can identify other available coverage. HMS verifies coverage directly with the carrier through a combination of online tools and telephone contact, and sends the resulting data back to Centene. We then load this "member level" OI information into MRM and from there the data automatically, and electronically, feeds AMISYS Advance. We validate OI and TPL data we receive from HMS by systematically matching member identifiers in the OI and TPL files we receive from HMS with the corresponding identifiers we have on members in MRM. MRM is our system of record for "all things member" and houses our master member index, linking all records related to the member across the member's historical relationship to our health plan. DHH's use of HMS' services means that LHC and DHH will literally be working "off the same data," which will ensure communications and reporting clarity between LHC, DHH, and DHH's FI, as well as less opportunity for labor intensive reconciliations in OI, COB, and TPL information.

We also validate TPL whenever we receive a first time claim with an EOB attached, or an adjustment request from the provider. Both of these situations are detected systematically through Centelligence™ Insight. A claims analyst regularly reviews standard Insight claims operations reports focused on first time claims with EOB attachments and claim adjustments. The claims analyst routes this information (member contact information, plus other insurance from EOB or adjustment request) to our Claims Department Phone Call Team (Phone Call Team) to verify enrollment with either the third party and/or the member to ensure we are coordinating benefits appropriately. The Phone Call Team is dedicated to making calls to insurance companies and updating the member's record in MRM with accurate OI and TPL information.

Support for Audits. Centene and LHC will cooperate with DHH and DHH's vendor regarding cost recovery. We will support any periodic, annual or more frequent, TPL audits of LHC and Centene's

operations conducted by DHH or its authorized agent, and we will make available specific data as requested by DHH or its agent as required.

COB/TPL Reporting. LHC will report all OI information to DHH in the format and medium prescribed by DHH, for all members, by the 15th day of the month after discovery. Additionally, we will submit, via our encounter data submissions, post payment TPL recoveries we make to DHH's FI by the 15th of the month from after we discover any TPL. We currently submit TPL information and adjustments for retrospective findings in our encounter submissions to most of our state partners and will also do so for DHH. We will make available any supporting documentation not submitted on the encounter within 30 days of any request made by DHH.