**MEDICAID MINUTES**
**March 7, 2016 RIC/RAC Meeting**

**MEDICAID REPRESENTATIVES PRESENT:**
**Mr. Solomon Williams**
**Ms. Jan Sticka**
**Ms. Aletra Adair-Smith (HP)**
**Mr. Mal Ferguson (Navigant)**

**FACILITATORS PRESENT:**
**Mr. Wesley Ashmore**
**Ms. Karen Northcutt**

MR. ASHMORE: We have with us from Medicaid Solomon Williams and Jan Sticka, and with HP we have Aletra Adair-Smith, and with Navigant we have Mal Ferguson, who is going to update us on the APR-DRG transition for Medicaid; but we'll start out with the Q&A portion.

1. Follow up from Question #3 from November 9, 2015 RIC/RAC meeting.
   Is there a list available of chemotherapy drugs and/or other highly complex drugs/biologic agents that when given in their subcutaneous form should be billed using the drug administration CPT code 96372 (THER/PROPH/DIAG INJ SC/IM) and not the chemotherapy administration codes 96401-96549? For example, Cahaba posted a list of some of these drugs on their website on March 26, 2015 (http://www.cahabagba.com/news/drugs-administration-coding/).

   **Response: No. Please refer to Medicaid's current guidelines for chemotherapy drug administration in Chapter H of the provider billing manual.**
   http://www.medicaid.alabama.gov/documents/6.0_Providers/6.7_Manuals/6.7.2_Provider_Manuals_2016/6.7.2.1_January_2016/Jan16_H.pdf.

2. Follow up from Question #4 from November 9, 2015 RIC/RAC meeting.
   Regarding CPT 77061, 77062 and 77063 for screening digital breast and diagnostic tomosynthesis: Medicaid's response in November indicated a change request had been submitted, with an effective date of January 1, 2015, to cover these in a hospital setting. At the time of our meeting, the system had not been updated. Has the system been updated? If so, what date was the update?

   **Response: Yes. The update was completed on 11/20/2015.**

3. Follow up from Question #6 from November 9, 2015 RIC/RAC meeting.
   Please give us a general update as to when the issue of random assignment of duplicate numbers might be resolved.

   **Response: System enhancements have been made and most duplication issues have been resolved. If you are still having issues, please contact:**
   Paul.McWhorter@medicaid.alabama.gov.

4. AL Medicaid continues to provide 835 transactions that don't balance. The remittance advice code values don't sum up to the total charges billed on all inpatient claim responses. This is also happening on all secondary claim responses as well. The values associated with each claim segment on an 835 file when added up should balance back to the total charges processed for the claim. We're having to do a good deal of manual intervention on these 835 responses in order to get them to post correctly. What is the timeline to rectify this issue?

   **Response:** **System updates were made in July 2015 and most EOB code related issues have been resolved. If you are still having issues, please contact:** Stephen.Mahan@medicaid.alabama.gov.

**Discussion at meeting**

MR. WILLIAMS: Now, there were some system updates made back in July. And with this question, we did have some examples from I think Children's Hospital that we had researched, and we could not create the same issue that you're seeing at your facility. But if you're still having issues, please email those to Stephen Mahan.

By the way, Stephen is the replacement for Betty Payne. So any type of system issues that you have, you can email him those as well.

5. When a patient has Medicaid coverage for OB benefits only and has Blue Cross as primary (without OB coverage) do we have to bill Blue Cross first as primary to receive a rejection before billing Medicaid?

   **Response:** **No. The Provider can file the claim directly to Medicaid because the system should reflect that the recipient does not have OB coverage through Blue Cross.**

6. As noted in the Hospital Medicaid manual chapter 19:
   Prosthetic/Orthotic devices are covered only when services are rendered to a recipient as a result of an EPSDT screening or to a QMB recipient. Use revenue code 274 when billing L codes. *Do we use the fee schedule for all the L codes under the EPSDT fee schedule?*

   Orthotics provided by hospitals is limited to the L codes listed on the Outpatient Fee Schedule found on the Medicaid website: www.medicaid.alabama.gov . There currently are no L codes on the fee schedule. *Do we use another fee schedule or are none of the L codes covered?*

   **Response:** **No. Medicaid is currently reviewing L codes for outpatient hospital billing and expects to have an updated fee schedule on its website and/or in the provider billing manual**

**soon. Until then, please contact the provider assistance center at 1-800-688-7989 for help with a code.**

**Discussion at meeting**

MR. WILLIAMS: The answer to both of those questions would be no. We know at one time we had a listing out there with L codes under the outpatient fee schedule; but that list has gone away, and we're looking at updating that list. It's currently a project that Jan and I have, and we will, hopefully by the next time we have a meeting, have a list out there that's current for everybody. So I would like to table this question until our next meeting. Hopefully, we'll have it resolved by then.

7. Rehab CPT codes 97761 and 97762 are shown as covered in the Hospital Manual Chapter 19 but these codes are not represented on the fee schedule. *Do they need to be added for payment?*

   **Response: CPT codes 97761 and 97762 are covered under the EPSDT contract only and will not appear on the OP fee schedule. They will only pay to providers with an active EPSDT contract on file.**

MR. ASHMORE: Okay. And actually, our very last question is to get a report or presentation on the APR-DRGs, which Mal Ferguson with Navigant is going to do for us. So before I turn it over to him, do we have any additional questions for Medicaid?
(No response)

MR. ASHMORE: Okay. With that, I turn it over to Mal.

MR. FERGUSON: Well, good afternoon, everyone. Again, my name is Malcolm Ferguson. I am from Navigant Consulting, which is a healthcare consulting company that's worked with the Agency and with the Hospital Association in developing a DRG payment method for Medicaid.

So really, our intent today is just to kind of announce the fact that Alabama Medicaid is planning to go to a DRG payment method for hospital inpatient services starting October 1st of 2016. We've been thinking about it for a while, and there's been lots of meetings over actually probably about a year and a half. So for some of you at least, hopefully this is not news; but if it is news to any of you, anyway, this is the plan effective October 1st of 2016.

It will be a date of admission cutover, which means any admits on or after October 1st get paid the new way. Any admits prior to October 1st would be paid the old way. The payment method is specifically going to be implemented for the fee-for-service population. And there is no absolute requirement that RCOs use a DRG payment method, but there's going to be some pressure from the Medicaid Agency to have them use a DRG payment method as well. We don't really know for sure at this point. We are expecting many of the RCOs to also follow this same payment method.

We will be using the all-patient-refined diagnose-related groups, or APR-DRGs. They are a product of three health information systems. We have selected those over the other very popular and common DRG method, which is the Medicare severity DRGs, simply because of the fact that the APR set is designed for a complete full population, whereas, the Medicare DRGs - and Medicare would admit this

publicly - is designed for an elderly population, so there's very little for newborns and obstetrics and pediatrics. So the APR is simply a better fit for a Medicaid population.

Just quickly, I thought I'd offer a little history - some of you may know the history significantly better than me, in all honestly - but a little bit of history of this change. There was a Medicaid Advisory Commission formed I believe by the Governor in 2012 to study the Medicaid program and try to consider suggestions of things that could be improved. There were several recommendations that came out of that report.

One of the recommendations I've listed here says that they are suggesting a move away from a per diem type payment method for inpatient hospital services and to a DRG payment method. So that was a recommendation out of this commission.

In addition, the Medicaid Agency, as you all know, is moving toward this RCO type implementation or Medicaid managed care type implementation. As part of that, the Medicaid Agency has to fill out something called a waiver, an 1115 demonstration waiver that the federal government has to approve. Included in that waiver is a stipulation that Alabama Medicaid will move to a DRG payment method. And it's something that the Feds and CMS feels is a healthy change, a good change, and so it's one of the selling points of this demonstration waiver that we shift to a DRG payment method.

And then quickly, I'm listing here the characteristics of a DRG payment method. Many of you, I'm sure, do business with Medicare, so really none of this would be news to those who are familiar with DRGs.

APR is slightly different than the Medicare MS-DRGs, but conceptually, it's very similar. Payments based on acuity, not length of stay. There's a single payment per hospital stay. Each DRG has a relative weight. The relative weights are designed to represent resource usage or cost to a hospital to care for a patient. So the more complicated the patient, the sicker the patient, the higher the relevant weight; the less sick, the lower the relative weight; and that relative weight is used to determine a payment amount. And there's a few more complexities to it than that, but that's the basic idea. Again, the same as it is with Medicare DRGs.

So I offer a very simple example here. If we've got a DRG base rate or base price of 7,000 and a DRG that's assigned to the claim has a relative weight of .5, then payment is $3500. Similarly, if you have a second claim where the DRGs assigned has a relative weight of 2.0, then the base payment is $14,000. So it's simply base rate times the relative weight. And we do have a couple of extra little multipliers in there that we can talk about in the future, but that's the basic concept of how the relative weights affect payment.

Specifically, just one slide here to talk about APR-DRGs, which may be less familiar to some of you. With Medicare DRGs, which, again, I assume many of you are very familiar with, there are complications and comorbidities, so most DRGs tend to have three values. The APR system is similar, but it happens to have four values. So every what I would call base DRG has four different severities of illness: one through four, from minor, moderate, major, and extreme. So each base DRG has four values. Each of those four values gets a separate relative weight.

Generally the way it works is the primary diagnosis code in the claim determines the base DRG. Then the secondary diagnosis codes on the claim determine severity of illness. So again, similar to Medicare DRGs. If there are complications, those result in a higher severity of illness.

So I've given a very simple example here. And there's probably several clinicians in this room. I am not a clinician, so I risk getting myself in trouble here. But the simple example is if the secondary

diagnosis to this diabetes scenario is more and more complicated, then the severity of illness increases. And again, that would result in higher payment under the assumption that there was more work involved with caring for this patient.

And in this example, we're really using one secondary diagnosis and changing what that is, but it could be a second or third or fourth or fifth secondary diagnosis that has the effect of increasing severity of illness.

This next slide I'm sure you're not going to be able to read on the screen, but I understand you all have a hard copy thanks to Peggy. This is to show you an example of what the APR-DRGs look like. So we just print screened the first few in there. They happen to be mostly transplant related. That's simply because that's what the first few numbers are in the APR system.

But as you can see, there's a base number, a three digit number, and then a fourth character, which is either 1, 2, 3, or 4, which are those severities of illness, and you can see the relative weights change with each severity of illness.

We are planning to have some training sessions on this. We have a tentative schedule here. There's no finite dates yet, so we owe you some information on when we will have specific trainings. But now, again, with help of the Agency, it's going to offer a couple of training sessions over the next few weeks on APR-DRGs where we'll go into more detail specifically about the payment method and how payment is calculated and some of those little complexities: outliers, transfers, things like that.

We're planning to have one, hopefully, towards the middle or end of March; another one in early April. That will be the same training session, so if you can't make the first, hopefully you can make the second. And then we thought, because you're liable to forget this over the next six months before we go live, that we'll have a couple of refresher sessions in September, assuming that everything goes on schedule and we go live on October 1st.

As a sample of what the training sessions will offer, I did put in a couple of slides here that again we will go over in these training sessions but I thought would be specifically of interest to this group. There are a couple of billing changes that will be required under the move from per diem to APR-DRG. There's not a huge amount of billing changes, but there are some. So I thought I would highlight those here.

First of all, for deliveries of a baby, you will now need to bill the baby and the mother separately all the time. Even if it's a healthy baby that's in the hospital the same amount of time as the mom, under our DRG system, the mother and the baby are paid separately, so they need to be billed separately.

Just a couple more here. We actually haven't formally decided yet. I need to get an answer on this, but there is a chance we may require you to have birth weight on all babies up to a certain age. The age will be either 14 days or 28 days. You can always, of course, submit a diagnosis code that identifies the birth weight of a baby, but there's a separate field value code where you can put in the birth weight. And the Agency is considering requiring that as a field. It actually is in your interest to include birth weight on any low weight babies because that translates into a DRG with a higher relative weight and there's higher payment. So really, there is incentive from your point of view to track birth weight and include it on your claims anyway.

The next change may be one of the bigger ones related to this. We are going to allow interim claims. As we mentioned at the beginning of this, a DRG payment is a single payment for a complete

hospital stay, which is different than per diem where interim claims and per day is really a very straightforward thing to do. So we had to make a decision on whether we were going to allow interim claims.

The decision is yes, we are, but the minimum length of stay needs to be 30 days. So your first claim for a patient has to wait until the patient has been in the hospital for 30 days. After that, then you can submit additional claims if the patient does happen to stay for, you know, additional weeks or months in your hospital.

The additional claims would be billed as an adjustment to the original. So unlike standard billing under per diem where you would have a type of billing 113 for a secondary interim claim, we will not allow that. We're going to ask you to adjust the original claim and put in dates of service from date of admission all the way through to whatever the current date is that you're billing through, and then in each case, whether it's the first interim claim, the second or so forth, each will be calculated as a full DRG payment.

Another one we're going to require is "present on admission" indicators, they're used for hospital-acquired conditions, which really is a very small number of scenarios, I think. But I believe you're allowed to bill those now. However, I don't think there's a lot of editing on it. The plan is that we will now be editing and denying claims for invalid present on admission indicators.

And one last one, and then I will be done and open to questions. This is kind of a unique scenario or unusual scenario. But if a patient is dually eligible in Medicare and Medicaid and they exhaust their Part A benefits during a hospital stay, Medicare, of course, will pay up to the point where they exhaust their benefits. From that day forward, you can bill Medicaid, and Medicaid will cover the patient's stay. And we're going to ask you to use occurrence code A3 with a date to identify when Medicare's benefit is exhausted so that payment calculated by Medicaid may be prorated and cut back because of the fact that Medicaid was really only responsible for some portion of that stay, not for the entire stay.

I believe that to be the complete list of billing changes. And, again, I kind of highlighted those because I thought that would be of interest to this particular group.

The last thing is we will be sending out a list of dates for these training sessions. But if you have further questions, I remember Solomon first, and then if not, we, Navigant, will be involved through implementation. So we're happy to help out in any way we can. And Wesley is actually quite an expert on this stuff at this point too.

Thank you.

**Discussion at meeting**

AUDIENCE: My question is our facility has MS DRG software. Are we going to have to purchase APR-DRG software?

MR. FERGUSON: Technically, the answer is no. In other words, you do not have to assign a DRG code to get paid under the system. However, if you're a hospital that's carefully tracking your accounts receivable, then the answer is probably yes, that you would purchase software from 3M. And they will offer a version that even includes the specific pricing method that we will implement with Alabama Medicaid.

AUDIENCE: Will we be notified on the webinars through the Medicaid alerts or through another mechanism?

MR. WILLIAMS: Kind of a combination. We'll have an alert coming that we will send out soon. We may or may not include the dates, but in any regard, we will notify you when the sessions are, maybe through AlaHA . There are a couple of different avenues, but we will let you know when.

MR. ASHMORE: All right, we will conclude our Medicaid session. So I would like to thank our panel here. Thank you, Solomon.

MR. WILLIAMS: Thank you.