AHCCCS Health Plan Technical Consortium

Thursday July 24, 2014
10:30 a.m.

AHCCCS 701 E. Jefferson St. – 3rd Floor - Gold Room

Facilitator: Lori Petre

Handouts: Agenda

Attendees: Teleconference attendees are shown with an *

ADHS

AHCCCS
Gina Aker
Gurpreet Bhinder
Kim Bodary
Kira Buss
Maria Goll
Robert Heppler
Lynn Hopkins
Ester Hunt
Cheryl Kelly*
Dan Liberator
Deb Liles
David Mollenhauer
Lisa Odle
Lori Petre
Jacqueline Solomon
Terri Speaks
Rhonda Zollars

Bridgeway

Care1st
Jason Solinsky

Cenpatico
Cindy Gaither
Sloane Steele

CMDP
David Gardner

CPSA
Cathy Karson

DDD

Health Choice

Health Net

Magellan

Mercy Care
Julie Dyer
John Monte
David Vargas

Mercy Maricopa
Sean Banqert
Brad Hargens
Vickie Payah

NARBHA
Lindsay Miller*
Laureen Simpson

Phoenix Health Plan
Mike Flynn
Shawn Hunt
Vincent Menezes
Joann Ward

United Healthcare
Deb Alix
Denise Hardestry
Helen Bronski*
Ruth Garcia McCaw*
Jeff Greenspan

UFC/MHP

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Welcome — Lori Petre

Lori Petre welcomed the attendees and any new participants.

…email comments and questions to lori.petre@azahcccs.gov

System Updates — Lori Petre

Lori presented a PowerPoint presentation covering various AHCCCS technical projects.

A. Cost Sharing (Copay) Updates:
   a. New effective date for next set of changes will be January 1, 2015
      i. Still working on the rule
      ii. SPA approval is needed from CMS
      iii. Premium considerations that are now part of law have resurfaced and are being evaluated for the future
   b. Most of the issues with the SPA and the waiver have to do with tracking associated with copays. We have to do a 5% household tracking on copays against incomes. We do this behind the scenes based on your encounter data.
   c. With the implementation of HEA+, we will ultimately have this. It's a progressive process and only get it for those going through the HEA process. These time lines are predicated on this.
   d. Effective date will be 1/1/2015 and there will be following that a second set of changes at some point. This is the piece that is really predicated on getting those incomes because we need to be able to track the 5% for nominal or optional copays.
   e. For January 1st, we will add two new mandatory copay levels. They are 60 and 65 and the detail will be coming out. Matrix will be coming out soon. These new copay levels will have some unique services associated with them that we haven't applied co-pays to before.
   f. The new copay levels are for the expansion population above 106% and Transplant option 1 and 2 members (truly state specific eligibility categories).
   g. For all other copay categories, we stepped back and looked at the codes to see if the codes are still valid. For surgeries, we did an extensive review to see how much of the big range of codes are truly surgeries in what we are trying to apply copays to. We refined these too.
   h. Lori reviewed her copy of the draft Copays Matrix and reviewed a few key items on it.
      i. For the two new categories for 60 & 61, they will have copays currently proposed in our rule and what we've sent to CMS. They will have copays for pharmacy, office visits, outpatient professional therapy, & outpatient surgeries, just like the current copay groups.
      ii. They also propose to have copays for nonemergency use of the ER, inpatient stays, and non-emergency transportation in a taxi.
      iii. The taxi will look similar to how this was done in the past for other groups in the urban and rural model.
      iv. We are proposing the inpatient be a flat rate for inpatient admission. The law allows a lot of flexibility around this. Right now it's defined as a flat $75 copay rate for inpatient admission.
      v. Non-emergencies through the ER – We outlined how we could get to these. The copay is proposed to be $8.

vi. Non-emergency transportation (taxi), it should be same as other with a $2 copay per trip (taxi base). It is urban verses rural which is why you have a 60 & 65.

The other big change under how these copays are structured for these groups is rather than having single flat office copay, for example. There are now 2 possible office copays. They will either be $5 or $10 depending upon the code. Therapies will have 3 different copay levels $2/$4/$5 depending on the code. Surgeries will have 2 copays, $30/$50 again depending on the code. We've also dropped every surgical code that pays less than $300 and these won't have copay.

Q: In the DRG project, should we plan on reducing final payment by that amount for this group?
A: Yes, 1/1/15 and after this is our intent pending CMS approval..

Q: So the things you are talking about will only apply to only to the new 60 & 65 copay levels?
A: Yes, these changes will apply to only 60 and 65 at this time. Once we can capture income and track the 5% for the other populations, we'll begin to move towards those reflecting the same services and copay structures as appropriate.

i. There will be lots more to come on copays but for now the important update is the change of the effective date of the next set of changes to 1/1/15.

Q: Are we still going to have the same groups that are exempt from copays?
A: Lori said all the exemptions remain and the rule package is coming out on this because we did need to reflect these new groups. They are just working on refining the language.

Q: Are you expecting the copay table to change at all?
A: There will be new values in it but no structural changes.

j. Lori will hopefully have the draft Copay Matrix reflecting the proposed 1/1/15 updates ready for the next meeting.

B. Encounter/Claims Data Exchange/Blind Spots Updates:

a. Most recent 1/4ly file (April, May and June) on the data exchange went out last week.

Q: Are you asking us to do the data exchange or submit encounters?
A: We do the actual exchange of the data between contractors based on your encounter submissions.

b. The group should now have 2 quarters: Jan – March and April – June These files will normally be run the month after the end of the ¼, between the two Encounter cycles. The only time you won't see it on a standard calendar is when there is a delay in the cycle and Lori mentioned we would try and notify you.

c. There are two specific contract sections related to how the plans are supposed to be using this. One of which is a specific Medical Management Plan which is an annual reporting requirement.

Q: Question was asked about what AHCCCS would want back.
A: Lori replied that we don't expect anything back from the exchange. We do expect the aforementioned Medical Management Plan and that the contractors utilize the data as outlined in the contract.

d. Still working on getting the Medicare paid claims data for the part D, D-SNP and Medicare FFS.
   i. Part D will be ready the soonest; this is the data you currently get as a separate file.

   ii. The FFS is one we gone least far with since it's a tricky one. We can get the Medicare data from the carriers and intermediators but we don't want to load it in unless we have a way to take it back out if you ultimately cross over that encounter.

e. October 1st is still the targeted date for Contractor submission of DSNP data for dual members as previously outlined. One plan has asked for an extension which AHCCCS granted. Please let Lori know if you think you need an extension and they will evaluate your situation.
f. You should be seeing this every quarter. For this quarter and the last quarter, we actually went out and physically made sure they were there before we notified you. Going forward we hope to make this an automated process.

C. APR-DRG's:
   a. On schedule for 10/1/2014 implementation, based on dates of discharge.
   b. We've had several technical workgroups and will have more on an as needed basis. One will be scheduled in the new few weeks to review in detail the testing scenarios we are going to provide you.
   c. There are 3 Key Forms of Project Documentation: AHCCCS Policy Document, AHCCCS Rule, & AHCCCS DRG Calculator.
   d. The DRG calculator had a couple of minor updates. Please make sure you always use the most up to date calculator.
   e. We are continuing our testing efforts and they seem to be going well. NO major issues identified. Biggest challenge was creating the scenarios which don't happen a lot.

Q: Will we still be able to see the historical rates?
A: Lori said yes. The provider extracts we are putting out in tests already reflect this. These are the same provider files that our testing staff have been testing against.

Q: Will there be any changes to the DRG related fields to be submitted on the 827II?
A: You will see some very minor changes that will be reflected in the Companion Guide that we will try to get published next week.

Q: Will you still be using the existing fields?
A: Yes. Dave said he will update the companion guide and send a separate email with just the fields we are looking at.

f. Internal testing is going very well.
g. External testing has been open since June and there are some providers testing.
    i. The testing will vary a lot by hospital because if they can mimic the calculator they are pretty comfortable with the process because the process is the calculator.
h. ICD-10 DRG testing – They make take some of the testing scenarios, recoding them under ICD-10 and making those available to you sometime after October.
i. System Implementation will be in late September.

Q: Will there be a release of frequently asked questions on the DRG?
A: Lori said we could put something together but have received very few provider questions. Many of the questions that have come in are very similar.

j. Look for an invitation for a meeting to walk through the testing in more detail.

D. ICD 10 Project Updates:
    a. Project was impacted by federal legislation – we received verbal direction from CMS that specified a delay for Medicaid to 10/1/2015. The actual legislation implementing that delay is still pending but is expected to be published any day.
    b. No impact to the APR-DRG timelines and you'll be able to test DRGunder ICD 10 as a part of the ICD10 testing.
    c. Reminder, don't stop work on ICD-10 projects without first discussing revisions to your timeline with us.
    d. Reviewed Milestones
    e. Our programs are ready. They will get promoted with the 10/1/2014 dates we just won't have anything that exercises them in production until 10/1/15. We will continue to test over the next year. Issues will be addressed as they are identified.
    f. Ongoing external testing supported through at least 9/30/2015.
    g. Please continue to send in your ongoing milestone reporting as we do track this.

E. FQHQ/RHC Project:
    a. This is a payment alignment project and will require contractors to pay the FQHC/RHC PPS rates as published by AHCCCS.
    b. The timeline just changed on Tuesday so executive leadership may or may not be aware of this date shift yet.
    c. New date is 1/1/2015.
    d. Fee schedule is still being worked on and a test version of this will be sent out as soon as it ready.
    e. This will allow more testing and set up time for the providers, us and all of you.
    f. Still hope to be in a testing window in late August or early September.
    g. Providers have been registered as they get the applications in to us.
    h. Lori included the key points for this project in the PowerPoint presentation.

There will be two new provider types: One for FQHC and one for RHC's. (29 & C2). We are working with all the providers to get them registered under those.

i. All of the FQHC sites will be registered and have an unique id.
ii. FQHCs and RHCs must have a unique NPI which isn't already being used.
iii. Provider registration has been streamlined.

Q: There was a question on provider IDs and health claims having more than one provider ID.
A: Lori said each FQHC will have a unique provider ID. Some FQHCs are billing under the physician who does the service but they will no longer be able to do this. They need to reflect this under the FQHC and everyone will do it the same.

iv. You will get a claim that will detail the procedure code associated with the service. Example: if you had a visit and a lab and these two x-rays, that claim is going to show those 4 services.
v. It will look like other claims, have place of service, units, costs, etc. The one issue is that because the FQHC will be the service provider as well as the paid to in this case, we are exploring some options for capturing not losing who that physician was within that claim. There is a state specific field on the 1500 that we've been looking at options on the 1500 claim form/layout. We will try and finalize the decision as soon as we can and share it with contractors
vi. Bills with normal codes, bill with level of detail.
vii. Payment will be at the visit level.

Q: For dental services they don't typically bill the E&M to designate a visit.
A: Lori said we have defined what the dental visits are and since we had the same issues for some of the behavioral health did so for this this service category also.

Q: Billing will need to change to as they don't always bill E&M for an office visit
A: Lori responded saying we've been having these conversations with them since January and the FQHC/RHC's should be aware of these requirements.

Q: Are we still to apply the standard CCI?
A: Lori responded yes as appropriate.

Q: If the FQHC has behavioral health services, would this be coming to the RBHAs or would it go to the acute care health plan?
A: Lori replied the FQHCs to the extent that the RBHAs contract with them would follow the same FQHC rules with the RBHA.

Q: If they have multiple services, would that be multiple lines?
A: Lori replied yes.

Q: We have a restriction with DBHS about those multiple lines though.
A: Lori has a note about that and said it is a restriction within their processing not ours and we will ensure that they are aware of these requirements and the impact of the restriction.

viii. Current FQHC pharmacy (340B) billing will remain the same.

Q: There was a question about challenges with duel members since FQHC's bill Medicare on a UB.
A: It is kind of like the ASCs. ASCs are the other place that we say you bill on this form type and Medicare says you bill on the opposite.

Lori said one of the things she didn't include a bullet point on but we are working on, is a FQHC question matrix. We are meeting internally and going through to answer those questions and will share these with the contractors as soon as possible.

Q: Will there be a workgroup on this?
A: There certainly can be if you all would like one.

ACTION ITEM: Lori will send an email out reflecting new date.

F. PCP Rate Parity Project Updates:
   a. You should have received initial reports fort the catch up period which is August through December and January through March adjudication quarters.
   b. Shelli & Devra sent out an explanation of the process.
   c. The error free is the important piece each of the plans received.
   d. There is a handful of issues that our ISD team is working on right now which will release some of the encounters held as internal pends once we can get those issues resolved.
   e. Unfortunately there is a large error list of things that when we ran your data back through in the backend reporting we found to be in error.
      i. Many plans are reporting the same amount as their health plan approved and their health plan paid. Once you do the calculation on that, it comes out to where you get nothing for PCP Rate Parity.
   f. Lori will find out how soon she could share these error reports by plan because there are things you will need to take care of.
      i. There are also 3-5 questions out to CMS that relate to claiming percentages for the Federal match. We put any of those encounters with these questions on the error report also for now.
   g. There is a pre-call this week to discuss internally and then a call with CMS to run these by them the following week.
      i. You need to add these 3 pieces together to get what your potential payment is. 1 – Items on the Error Free listing provided to all plans which outlines what is payable now; 2 – Items on the Error Listing placed there either for plan correction or pending CMS confirmations for claiming %; and 3 – Items forced to internal pend status, pending AHCCCS corrections.
   h. We will be running the April through June quarter in mid August, which will run under the same concept (as the two time periods just completed) where we scrub it before we send it out. Remember the encounter goes in the time period that it adjudicates.
   i. Also remember that the majority of what you see on the error reports is going to be something you will have to do something about and replace each of these encounters.
      i. Lori cannot do anything with those that net to zero.

ii. Lori will summarize the errors when she sends them out.

Q: So for past data, do we need to go back and correct if our health plan paid and health plan approved amounts both equal the parity amount?
A: Lori said if you want to get the parity payment that is the only way to get it.

G. Security Audit
   a. Thank you for getting those in. They were very interesting and informative.
   b. The IT staff have finished the initial review of the results and emails will be going out late this week or early next week with each plans individual feedback..
   c. Don't anticipate any changes to the policy or contract as associated with those.

ACTION ITEM: Lori will send everyone an individual email with feedback and request for additional information in some cases.

H. AHCCCS CRN Expansion Project (999 Lines):
   a. This is further out but Lori wants to keep it in everyone's mind.
   b. Hope to start on this project, mid-year next year.
   c. Why do you care? Every CRN will be expanded by 1 digit (it will go from 14 to 15)
   d. This will impact and require testing with contractor and trading partners.
   e. Detailed timelines are in development.

I. TPL Workgroup
   a. Everything is getting posted to the website.
      i. http://www.azahcccs.gov/commercial/EDIresources/EDITechnicalWorkgroups.aspx
   b. The goal is to work towards the identification of concerns with the TPL processes and or opportunities to do things differently or better or more expediently.

J. Other Updates
   a. Greater Arizona RFP is out.
      i. We are looking at internal planning for how we will support this.
   b. We are also looking at reverse integration of the general mental health and substance abuse dual members going back into the acute care plans. There will be more information coming out about both of these projects as the timelines progress.

Q: There was a question on the EP modifier.
A: It was actually a policy change and didn't necessarily come through our group because there were no system changes associated with it. There were some changes to the tables because the EP modifiers weren't on a lot of those codes.

ACTION ITEM: Lori was going to look for notes as someone was going to issue communication possibly from Kim Elliott's group.

Open Discussion/Questions Lori Petre

- FQHCs are something everyone is interested in.
    - **ACTION ITEM: Lori will get a FQHC/RHC workgroup on the calendar.**

Q: There was a question on more anticipated benefit changes for 10/1/14 .
A: Lori mentioned there was one code that is becoming covered again.

- **ACTION ITEM: Lori will get this code out to everyone.**

- Think about topics that would be helpful to discuss.

Breakout Workgroup Meetings (DRG. TPL, Others?) Lori Petre

- FQHC Meeting
- DRG Testing Meeting

Next Meeting Lori Petre

The next Technical Consortium will be held in mid-September, watch your emails for more information.

There being nothing further, the meeting was adjourned.

Corrections to the minutes should be directed to Kimberly.Bodary@azahcccs.gov.