AHCCCS Health Plan Technical Consortium

Tuesday, January 28, 2014
10:00 a.m.

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

Facilitator: Lori Petre

Handouts: Agenda

Attendees: Teleconference attendees are shown with an *

ADHS
Madonna Fritz
Ruth Zona

AHCCCS
Gina Aker
Deborah Burrell
Kim Bodary
Dwanna Epps
Robert Heppler
David Mollenhauer
Patrica PeersJacqueline Solomon
Terri Speaks

Bridgeway
Janine Kirkland
Nancy Maurer

Care1st
Brent Ratterree
Jason Solinsky

Cenpatico
Cindy Gaither
Sloane Steele

Centene
Chris Lotte *

CMDP
Susan Blackledge
Malynda Ryder
David Gardner

CPSA
David Edwards
Viviana Torres

CRO
Brent RuHernu

Health Choice
Vick Johnson
Elizabeth Hunt
Walter Janzen
Michelle Kalka
Kim Lanzi
Nicole Larson
Karl Maring
Sarah Sautler
Mike Sisson
Melissa Small
Angela Snodgrass
Mia Villa

Health Net
Jerry Allen
Menita Avila
Andrea Clapp
Sally Degnetch
Susan Gilkey
Robin Lemoine
Bill Suggs
Samit Thakur

Magellan
Matt Hau
Phyllis Knox
Pat Mayer

Mercy Care
Cindy Altman
Julie Dyer
Bradley Eervin
Dipu Gopinath
Heather Mrowiec
Gale Roby
Brandon Wilson
Pranav Gidwani
John Monte
David Vargas

NARBHA
Tia Martinez*
Mark Quincey

Phoenix Health Plan
Mary Kahler
JoAnn Ward

UAHP
Lee Coffman
Emory Heisler*

United Healthcare

Deb Alix
Jenna Palumbo
Mohan Basavapatna
Helen Browski
Kelly Kreiselmeier
Jeffrey Greenspan
Michelle Maclachlan

AHCCCS Health Plan Technical Consortium
Tuesday, January 28, 2014

Welcome Lori Petre

Lori Petre welcomed the attendees especially any new participants as this consortium has expanded. She also welcomed all RHBA's as this is their first meeting as well. She suggested that for some of the agenda items, there be smaller workgroups much like what was done for the PCP Rate Parity. This is because there is some detailed discussion that needs to occur. For example there is a lot of information coming out on the DRG's so there will be a future workgroup on this to make sure we are all on the same page. Other suggestions for workgroups are welcome.

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

New 1500 Claim Form Implementation Reminders Lori Petre

NUCC released the new claim form and instructions. There are some significant changes to this claim form. Most states have been waiting for this form as it has the ICD9 versus the ICD10 indicator. A notice was sent to all the key contacts on the plans. The approved timeline for the requirement of this new form is April 1, 2014 and adheres to when Medicare is going to roll this out. Providers can begin using this January 1, 2014 but as of April 1, 2014 the new form is the mandated and everyone must start using this form. Lori checked with our Fee for Service (FFS) folks and they are starting to see forms come in now.

Lori showed a PowerPoint for all to review and went over an email from January 8, 2014 regarding clarification on the new CMS 1500 Claim Form Diagnosis Code Pointer. This PowerPoint highlights the specific changes in regards to the paper form.

Lori mentioned we are continuing to get questions regarding when we are going to implement it. We have published the timeline for those to reference. If there are any questions regarding the new claim form, please let Lori know.

PCP Rate Parity Project Updates Lori Petre

In the past few weeks, there was an issue with the PCP rate parity schedule. There are a few interesting nuances to the CMS requirements for this project which resulted in this issue. One is that you have to implement the rates right away. When we implement the 1/1 rates for physician fee schedule (normal) we do a 4/1 implementation. This gives us time to get them in, get them into the tables and get them out to the group. This policy doesn't allow for that. So we are getting rates for 1/1 and they are supposed to be used starting 1/1. What it resulted in was a little bit of a delay getting that fee schedule out. Lori apologized as she didn't know this ahead of time and therefore didn't have time to send a pre-notification out. The final file was placed on January 22, 2014 and Lori hasn't heard about any problems. Lori forewarned all that this will happen again but she will send out a pre-notice about the new rate updates which will lag a little bit.

Q: Will the updates be quarterly?
A: Lori said they could be quarterly. Typically big updates are around January timeline but it could happen again in April or July or October. The July update tends to be the other one that is fairly good size. The other two in between are smaller.

- **ACTION ITEM:** Lori will send out a reminder in April to remind everyone these will be coming out.

Lori sent out an update awhile ago that had the new reference table for the modifiers. There are the codes listed on the email distributed regarding vaccine administration this list and the one modifier on the table but it was a way to tablize the values. Hopefully those who needed this table were able to address these claims based upon original communication based on the TBD for this table. This table is available on your reference extract.

Q: On page 2, it was noted that M2 should be M3.
A: Lori will let reference folks know this for them to correct it.

Lori mentioned she sent out a notice to let everyone know the timeframe we were looking at to turn the two edits associated with rate parity from internal pends to external pends. We are looking at no earlier than the first cycle of March. This allows for all to get those encounters in. The March cycle will be the earliest and we'll continue to assess at each cycle. We've been recycling the pends periodically and they are down from where there were overall. When you submit your replacement for your PCP parity, those should roll off naturally.

For the A655's, she will be talking to each plan individually to see about failures.

- **ACTION ITEM:** Lori will start scheduling those conservations regarding the A655 edit within the next week or so.

There are not a lot of pends for the A655's but there were some cases where the provider's indicator has changed over time or some minor rounding factors.

Q: Will there be some communication about changes to the providers PCP indicators?
A: Lori talked to the internal AHCCCS workgroup about this and said as it is happening; we need to open those communication mechanisms as it will be difficult to go through over 45,000 providers for the two that have changed. They are going through the first audit as the policy requires and they have to validate the 60%. They are discovering that there are some providers where although the attested at 60%, that isn't the case base upon the data. We need to be able to communicate to you in addition to the change that will eventually show upon the provider file.

- **ACTION ITEM:** Lori will send out a pre-notice based upon communications from the internal workgroup when providers PCP indicators are changed.

Q: Do we have to notify the providers that end up no longer qualifying. Will there be any type of notification process?
A: Lori said that AHCCCS is required to notify those providers and give them the opportunity to appeal. They won't actually be terminated until they had that window to appeal. She is hoping that by next month's meeting, she'll have an actual audit list to start to talk about that activity. It will be an ongoing project. There will be a letter going out explaining why providers are coming off and what their recourse is.

Lori included the layout for the PCP rate parity report which will be published to the group as a reminder. We are going through a final QC from what our IT department ran. It is for August through December. It has taken longer than anticipated to complete this reporting because there is a second piece to this report that has to calculate the claiming percentages.

Q: Should the copay amount be added to the PCP rate parity report?
A: Lori said based on looking at some of the examples and some of the questions she got from the plans, she may looking at adding this field so people have it as a point of reference.

- **ACTION ITEM:** Lori will make a note to see what it will take……Lori will send a notice out today or tomorrow so people know when to expect the first one of these.

Q: Do you have a timeline for the review of the report and the run of the first payment?
A: Lori said about a two week review but since it was a large quarter, then we are going to look more at the time the plans feel that they will need and a lot time accordingly. We don't want to hold anything up too long as we want to gets funds out as soon as possible.

Copay Updates for 1/1/2014 and Future Considerations Lori Petre

There are some minor changes effective January 1, 2014. There will be significant changes to copays either in July or October. The IT group is proposing October, but a final decision is pending.

- **ACTION ITEM:** Lori will let the group know as soon as a final timeline is agreed upon.

The second set of changes are things like the groups that are eligible for mandatory copays. This means you may see a new mandatory copay level. The intent is to follow the same design we did with the existing groups. You don't need to figure out how this person got copays you just need to use that copay indicator. There are also slight changes to the services eligible to the copays and to the amounts which can be collected for certain copay services. Most of the changes are minor.

The biggest change is related to tracking of copays to a persons income. AHCCCS decide with the copay implementations to do this tracking ourselves. This has to do with the tracking to ensure that copays collected from members don't exceed 5% of their income. Those tracking have become really tight and this has been our biggest challenge for developing those processes.
Another change is to the age limit, historically we applied copays to eligible members age 19 and above. The change will be to apply copays to eligible members age 18 and This change will also impact CRS members who were historically exempted across the board.
There is one new potential category of copays which is under evaluation which is inpatient copays. This allows for inpatient copays up to a value of 1 day of the stay. Lori is pushing that we don't do this for 10/1 and if we decide to go forward with this copay we do it more as a 1/1 or 4/1 item. We need to get DRG's up and running a little bit before we add nuances to them. There will be more detailed discussion on this. Lori will let group know how the conversation goes.

Lori highlighted the January changes. She sent out to everyone the changes in early Decembers.

The first of these wasn't related to the copays but to the essential health benefits, in that we could no longer require copays for well visits. Lori removed a set of codes on the matrix on the office visit category for each of the populations to accommodate this change.

The second change is that you should no longer see copay levels 40 and 45. There was an issue related to these copay levels continuing to be assigned after 1/1 in error and plans were instructed to treat these levels equal to 00 for dates on and after 1/1. An email was sent out regarding this and Lori thanked the plan who reported this to us and reminded everyone that if you see something odd, please bring it to our attention.

Encounter/Claims Data Exchange Project Updates Lori Petre

Our IS resources are working on putting the final touches on this right now both for the historical and ongoing. More information to come this week but Lori included the overview of who gets what and what the layout is. If you have suggestions on the layout, please let Lori know.

Last week, Lori sent out an email about capturing your DSNP encounters. As you go through this email, let Lori know of any questions. This is to cover the blind spots. It's unknown services to the Medicaid line of business. Along with that are the part D and fee for service Medicare services. The part D is what you are getting now as a separate file. Long term will also be integrated into the date exchange. So it will have the same field sand format and indicators.

We are still working on the fee for service Medicare piece and the logistics for that but that will flow the same way.

Q: Can a workgroup be set up to review the data exchange and the requirements/timeline for the DSNP Medicare data?
A: Lori said we can.

AHCCCS Security Audit Policy Update Lori Petre

Lori wanted to make sure everyone saw the minor changes to the security audit policy. We were getting questions about the timeline. On page 4 of section b, one sentence was added. This sentence clarifies the timeframe. If it is still not clear on how much flexibility you have, let Lori know. The timeframe for the audit could be for the calendar year, fiscal year, or contract year. Please let us know on your report what timeframe it was audited for.

Q: Was this audit intended to be more of a P and P type of review?
A: Lori said if you look at the details, it's a lot of policy and physical security type of things. We found though our audits (initial and subsequent) that there is room to improve. It's a worth while effort to extend beyond what we are doing to all of you. As an entity, you should be assessing the physical and data security per the policy by June 1, 2014.

AHCCCS >99 Encounter Lines Project Lori Petre

Lori met with IT last month in December and said we need to come up with some creative solutions. The work arounds that we have been doing historically are pretty ownerist for the plans and our FFS staff. Lori has a follow-up meeting with our IT folks tomorrow. She asked ISD in December to come back with some solutions and things we can talk about in terms of a timeframe in this meeting tomorrow. Lori hopes to have a better idea of things we are proposing then we'll have a follow-up conversation which Lori will send out the group. Meanwhile, keep following the status quo of how we've indicated these things need to be handled.

ICD10 Project Updates Lori Petre

Lori discussed the current project milestones. Coding systems implementations are all complete in terms of our readiness for ICD10. She mentioned they are going through and doing the final QC on the indicators within the ICD10 tables for all the policies. Dr. Leib and his staff are currently reviewing all the codes and Lori will send out to the group when she receives approval from them. She will send the codes isolated and as a reference extract.

We have been lucky not to have a lot of hard coded logic in our systems centering around either ICD9 diagnosis or procedure codes. Most of this is table driven which what has allowed us to do many of our changes through table updates.

Early on, we determined that we didn't want to do a lot of policy changes.

External testing started on January 15, 2014 for 837 submissions, so our front end is fully ICD10 remediated and 837's can be submitted (get acknowledgements back) and providers can submit claims (get acknowledgements back).

Around March 15, 2014, we can do full end to end testing. We'll be able to get 837's in, take them into PMMIS where they will be edited, providers will get remittance advice back, encounters will be edited and you will get 277U's back so you can see how that is reacting. Internal reporting changes are targeted for June as is the integrated effort for hospitals to be able to test ICD10 and DRG.

Hospitals are welcome to start testing now for ICD10 or to wait and do a more integrated test, then they won't have to do it twice.

All changes are scheduled to implement in September with a October 1st effective date for outpatient and professional dates of service and inpatient dates of discharge. So far everything is tracking very well.

Q: When will the reference tables be coming out? Any idea on the changes?
A: Lori said the biggest thing you will see in regards to the reference extracts is that you will get as set of tables for ICD10. Historically you received very little data for ICD9 because of the licensure that was available from the code sources for that. Basically we are hoping to share our ICD10 tables with the group.

Q: Will those replace existing reference tables or be completely new?
A: Lori commented they will be completely new.

Q: Will we be able to get the definitions of those tables possibly sooner?
A: Lori said yes.

- **ACTION ITEM:** Lori will follow-up on ICD10 table layouts.

Lori thanked all those who have been submitting their ICD 10 projects status reports. They are very helpful. We are proposing a slight modification to the ongoing reporting, we have added one additional page to summarize status information as presented to the group.

- **ACTION ITEM:** Lori will be sending out this information.

Once we receive this back, it'll turn into an internal summary and they will go at a high level in an external summary for providers to see on the web page.

Lori mentioned she'll show the group what the summary will look like and will also send the proposed format for those summaries. Good news is that we use your status reports and that we like them and continue to want to enhance them.

She would like to see these for the February report but if it takes you until March to get the changes in, then that is fine also.

Q: So when you say February are you talking the February reporting period?
A: Lori said yes your 2/15. If she starts seeing them by March, then that is ideal.

We have been working on the ICD10 webpage and did add some FAQ's. Please review and let her know if you want anything added to the list.

Lori discussed the PowerPoint which is the basic overview of what they present to the provider groups. This will also be posted to the website. Let Lori know of any questions or concerns.

Q: In terms of the payment policies, do you have an ETE when those will be public?
A: There aren't a lot of "payment" policies impacted by ICD10 since we are moving away from the Tier methodology. Most of our system changes are to indicators associated with the codes. We are down to a handful of things and those indicators are done and based upon indicators in the reference files. As soon as Dr. Leib tells her it's okay to send out, she will.

Q: So for example, reporting of gestation period for maternity claims that will be required.
A: Lori responded saying it is not an ICD10 change, it is a billing requirement change.

Q: So we accept gestations as an additional diagnosis?
A: Lori said the additional diagnosis is part of the only true payment policy that used diagnosis and procedure was the tiers. There are some alterations to billing guidelines as a result of the ICD10 project and there will be a set related to the DRG also.

Testing Overview – These are available on the webpage. There is a testing overview for the encounters testing which is pretty standard. Reminder to make sure you put the "T" for testing in the file and please see webpage for detailed instructions.

There is also a calendar to show what we are running in our acceptance test environment through September. If you need beyond that, let Dave or Lori know. We are also going to run the reference and provider extracts and Dave will update the calendar to reflect when we will run these.

You can test your 837's with your ICD10 data now or when you are ready. Just a reminder for every large scale project, we are going to give you a set of test scenarios and ask you to execute them and let us know the results. Lori is going to try and do the ICD10 and DRG projects test scenarios together. She has approximately 200 UB claims which have been coded as a scenario under both ICD9 and ICD10. Lori has the paper claims which we will provide to the plans electronically.

Q: The DRG and ICD10 are tied together from your perspective?
A: No, Lori said they are to be implemented at the same time and we've been working on the ICD10 for awhile and we only got legislative authority to move forward with the DRG last year. So it is lagging a little bit. It is still being coded and so we couldn't tie them together as strongly as we could have.

Lori has the paper claims which we will provide to the plans electronically.

Q: The scenarios cover both ICD10 and DRG?
A: Lori responded yes. Lori tried to pull and include things that would fail like age and gender limits. Lori said she will make sure everyone has the expected answers. If you disagree with the answer provided, it is open for discussion.

Q: You said the DRG is still in development so if we begin testing areas ICD10, should it not have DRG in it initially?
A: Correct, Lori said pending completion of the DRG changes, we will value everything on our side and will process it under the tier methodology. This is all that exist for hospital reimbursement currently.

Q: When did you say the scenarios would be released for ICD10?
A: Lori said her intent was to release them around the same time as you need them for DRG. If you want to see them sooner she will have them in paper for sometime in March or April.

The other question was if you start ICD10 testing now, is it ok to include the DRG information. It is but we will ignore it as we don't have any processing to use the DRG information. It will continue to be processed under the tier until June when DRG logic is in our test region.

APR-DRG Project Discussion Lori Petre

Lori sits on an internal workgroup and they have been meeting for several months, several times a week specific to DRG and trying to define related payment policies. Several months ago she sent out a matrix to everyone to say here's the payment policy questions that we thought of that we want to make sure are covered in our processes and asked for any additions to this or any feedback. This matrix then became the basis for internal policy discussions and the resulting policy document. This DRG overview as well as other DRG information is available on the DRG web page which is accessed through the fee for service rates page under hospitals and you will see the DRG tab.
Milestone Reporting – Lori provided the format for plans to begin using to report their DRG milestones. Lori will send out electronically today asking for feedback. The reporting should start as soon as possible, ideally no later than March or April.

- **ACTION ITEM:** Lori will be sending out email for comment and proposed timelines for when the reporting should start.

Lori discussed the presentation Shelli gave to the CEO meeting last week. Some policy decisions were included, these are not an all inclusive list, but are some of the key considerations.

Key Highlights –
Slide 1: New provider type: Specialty Per Diem Non DRG provider. We are going to take this list of the rehab and ALTCS hospitals that have been identified who will be moving to this new provider type and share it with the group. This way you know which groups are coming out of provider type 02 and going into the new provider type. Psych hospitals (provider type 71) are exempt from DRG's also. Transplants will continue to use contract methodology.

Q: Is this for Re-insurable transplants only?
A: Lori said yes.

Slide 2: There are 59 items on the policy matrix currently under review for all policy decisions. For the pricing logic, it will be discharged based. For example if a member is hospitalized from 12/15 to 1/15, and is in Dave's plan from December 15th-31st and then transfers to Lori's plan and gets discharge on January 15th, then Lori gets the discharge claim and pays the full DRG. If Dave got an interim claim because he didn't realize the member was going to switch to Lori's plan, then he will have to recoup that because Lori's payment is in full.

Q: Does this apply to behavioral health stay at 02 also?

A: Lori said it applies to all claims paid by acute care contractors but not to behavioral health paid by the T/RBHA's as ADHS is going to continue to pay it's rates. They will not be switching to DRG's, at this time for behavioral health services.

Q: If a person is on behavioral health at the end of their stay, what happens?
A: Lori mentioned this is a specific policy discussion and will be included in the policy documentation.

Q: With this DRG, are we still doing a 25 day limit for adults?
A: Lori said the 25 day limit goes away with DRG. DRG's are not length of stay based so in concept it really doesn't apply to DRG.

The strong statement related to readmissions is really subject to claims review by medical staff.

Q: Someone wanted to clarify that as discussed during the CEO meeting, that it is the actual same hospital facility, not the same hospital network.
A: Lori replied yes it does have to be the exact same hospital. We may look at additional factors in the future.

Q: How do I know if I'm getting someone transferred to my plan that is already inpatient and that I am going to have to pickup that date of discharge?
A: Lori said we will have to look at the transition information and make sure that those members still in the hospital that this is a component that is clearly communicated.

- **ACTION ITEM:** Lori will talk to clinical staff in DHCM about making sure the plan responsible at discharge has all that information that is needed.

Slide 3: This may apply to those such as high risk pregnancies (for example a person who lives in the middle of no where is placed in Flagstaff Medical Center (FMC) for 30 days prior to deliver. You negotiate with FMC for a low per diem rate because all they are doing is having her there and checking her vitals a couple times a day). We wanted to still allow you to have that ability. Lori said we'll be talking about the logistics of this but it will need to be prior authorized. On your encounter when you enter your PA number, you will need to put ADMN following the PA number so we can recognize it and value it correctly. There is some detail when we look at the policy document behind these decisions.

Slide 4: This has been simplified. If you are a same day admit and discharge and same day admit and transfer, you go to OPFS. The second piece comparing newborn and maternity rates is being eliminated.

If you transfer a patient to a psych bed and it becomes a fully psychiatric stay, then we are asking hospitals to split those.

Slide 5: When we look at the policy documents, there are formulas and how to identify these and we'll will review in more detail in the workgroup.

Slide 6: For encounters, if you are getting those $500/day interim bills from the hospitals prior to discharge, those won't roll into reinsurance until it becomes that final discharge bill. You will get credit for timely submission of those interim bills.
The encounters which cross contract years are really small volume
These are not by any means all inclusive and are just summaries. Patricia will make sure all of this will be in her Reinsurance manual updates for October.

The APR-DRG Payment System Design Payment Policies handout is something that should be very useful to all. One of the things Lori wants people to think about is what you need to have from us to move forward with the implementation of DRG's for 10/1/2014 dates of discharge forward. Are there certain policy decisions that you absolutely have to have to move forward? In addition to these design documents, we've talked to our Navigant consulting group and they are willing to come in and give some overview and technical training. Lori will work with them to set something up. There is also a DRG calculator which is a tool they put out for hospitals and payers.

- **ACTION ITEM:** Lori will be sending the calculator out to everyone and working on additional training/overview sessions.

So taking that policy document provided, this is actually a policy and basis for the systems design document. So you will still get a copy of the AHCCC R&D in addition that will outline what we are doing in PMMIS to accomplish the implementation of DRGs. This document as provided today is not complete and you will see that in the table of contents. Lori only put anything that was final in the provided version of the document.
This document is intended for several things. It's intended for our ISD staff to be able to interpret the decisions and Navigant's documentation of those. It is intended to be something we can use to educate the providers on those requirements. It's intended to be the basis for Rules associated with the DRG's. It's also intended as a document and a tool for this group. As sections are finalized, Lori will send those out. Let Lori know of any questions as soon as possible.

They've also tried to list out if there are codes in the policy that determine discharge and gave those to the group.

Please read through in detail and let Lori know what you need and when you need it.

Q: If the provider bills a DRG and it's either ungroupable or you want medical records to support it, can we pay an assumptive DRG until such time as it's an ?
A: Lori said we did reserve the right on the fee for service side to allow them to medically review.

There are some interesting nuances to the DRG plan like if it fails age or gender in the DRG and can't qualify. What if it was medically appropriate for this member to have this? Or it was an ambiguous gender trial which occurs in the CRS population? Lori mentioned they didn't really get a good answer so we have a really interesting approach to how we think we are going to do this and will discuss this further with the DRG workgroup we are going to form..

Q: Cost outlier – Is it clear in the policy what's allowable under the cost outlier and what maybe is not?
A: Lori said cost outliers are a pretty standard policy. You can still review cost outliers and non covered charges just as you could do now so they have to be medically appropriate charges. You can still ask for the documentation to substantiate them.

Lori mentioned that there are two different versions of the 3M APR-DRG software one is for web and one is for mainframe. They aren't quite the same though so there are some technical challenges for AHCCCS.

Please think about topics for the workgroup that we want to make sure we cover.

Lori mentioned this a lot to throw at people but it's going to come fast and furious because we were behind getting the project rolling because we needed that legislative authority to do so. So we need to get information to this group so that you can get rolling to make the timeframes.

Q: Did I hear that this original matrix document which contains the questions that had been finalized?
A: Lori responded yes.

In regards to the workgroups, please only try and send no more than 3-4 people from each entity as we'd really like these to be information sharing and working sessions. These work groups will probably meet weekly or every other week until people feel comfortable to move forward.

MISC Items: Lori Petre

She also wanted to remind everyone that provider registration is terminating providers for inactivity. Every time they do this, it never fails that the next day they start billing you guys. Heads up this will happen.

Other changes include the HPV coverage expansion under essential health benefits. HPV coverage needed to be extended to members aged 21 through 26 for both males and females. This was effective January 1, 2014. Prior to this, we had ended it at age 21.
Lori discussed Kari Price's email. Under the essential health benefits, we are required to offer both a rehab and hab benefit for physical therapy, both 15 days. Since it's difficult to tell the difference, the PT benefit limit will change from 15 to 30 days. This starts March 1, 2014.

Q: The only thing changing on that is the 15 to 30 day effective March 1, 2014. So if they have exhausted the 15 days before March, they do not get another 15 days.
A: Lori responded yes, but this policy has since been clarified to allow members to have up to an additional 15 days of PT under the hab benefit after 3/1/14.

Q: Can we start doing a re- insurance work group so we can review some of the changes like DRG and how they will look in reinsurance.
A: Patricia Peers said certainly once everything has been finalized.

Open Topics Lori Petre

None

Next Meeting Lori Petre

The next Technical Consortium will be held in late February or March. 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.