CMS 23038

Agency or Department Name Health Care Policy & Financing Department or Agency Number UHA Contract Routing Number 3511-9082

BILATERAL CHANGE ORDER LETTER

Date: **July 20, 2010** State Fiscal Year: **10-11** Bilateral Change Order Letter No. **16**

In accordance with Paragraph 9 of contract routing number 1407-0120 between ACS State Healthcare, LLC, 9040 Roswell Road, Suite 700, Atlanta, GA 30350 and the State of Colorado acting by and through the Department of Health Care Policy and Financing covering the period of December 28, 2006 through June 30, 2015, the undersigned agree that the supplies/services affected by this change letter are modified as follows:

Price/Cost

The maximum amount payable by the State for the services described below is $475,146.00 and is based on the unit pricing table (CSR Hour Cost column) in Paragraph 1.B.4 of the contract, as amended. The total contract value to include all previous amendments, change orders, etc. is $195,076,462.30.

Description of Service

The Contractor shall perform these activities upon notification by the State and in accordance with performance expectations outlined in the contract, as amended. All activities related to this project shall be directed and approved by the State. Unless indicated otherwise, payment for services shall be based upon unit costs as set forth in the contract. Payment for services will occur monthly for completed project hours, and upon State approval and acceptance of the services rendered and Contractor's invoice. The Contractor shall complete the project for the Cost Not to Exceed amount for the project.

The Contractor shall perform the following project.

Description of Project	1293 – All Patient Refined Diagnosis Related Group (APR DRG) and Never Events
Project Cost Not to Exceed	$475,146.00
Estimated Quantity	3,771 hours @ $126/hour

Project Statement of Work:

1. Objective.

The Contractor shall implement the Department's 3M™ APR DRG solution into the Colorado MMIS and remediate other interfacing functions as specified by Department's requirements for implementing DRG Hospital Rate Reform.

The Contractor shall identify system impacts to the Colorado MMIS during the coding and testing phase of changes identified. The Department's Rates Section will perform the analysis of changes to the inpatient rates related to the more specific DRGs returned by the APR DRG solution and will identify the reimbursement methodology/inpatient pricing changes required to meet Department policies. The Department will identify required modifications to the existing reimbursement business rules housed in the current mainframe application program to ensure system compatibility in implementing the requested changes.

2. Project Timeline.

The Contractor shall plan work effort so that the project timeline represents an overlapping sequence of phases, or overlapping waterfall. Hence, the timeline of some phases will overlap the timeline of other phases where the work on a later phase begins before the work on an earlier phase is 100% complete. The Contractor shall use a System Development Methodology (SDM) to incorporate an iterative approach and utilize prototyping where possible to accommodate an overlapping sequence of phases.

3. Project Requirements/Description.

The Contractor shall perform the tasks outlined below.

Task 1: Plug in the 3M™ APR-DRG Module (provided by the Department)

a. Create new list parameter for diagnosis codes that the Department determines to be Serious Reportable Events (SRE).

b. Build batch interface program.

c. Filter out diagnosis codes matching those maintained on SRE list parameter and don't send to APR-DRG.

d. Build online interface program.

e. Install batch version of APR-DRG module in source code management tool.

f. Develop online version of APR-DRG module.

g. Test batch and online versions of APR-DRG (outside of the Colorado MMIS).

h. Review results of each iteration with project team and stakeholders.

Task 2: Expand Reference Database and Windows

a. Expand the DRG tables and windows to reflect pricing by peer group to include the severity of illness (SOI) and risk of mortality (ROM).

b. Alter the DRG tables and windows to allow PAs/PARs (Prior Authorizations/Prior Authorization Requests) to be required for certain DRGs and other DRGs exceeding a specific length of stay that is user updatable via the reference windows.

c. Expand the revenue tables and windows to increase the size of the revenue code.

d. Change the reference MMIS-DSS extracts to include additional fields and larger fields.

e. Alter reference DSS tables.

f. Change the DSS reporting package to include additional fields and larger fields.

g. Review results of each iteration with project team and stakeholders.

Task 3: Expand Claims Internal Record and Database

a. Expand claims internal record to include additional diagnosis code fields, surgical procedure code fields, expand the size of type of bill (TOB) field, revenue code fields, DRG field (including SOI), ROM field, and days awaiting placement field. Other additional fields and/or larger field sizes will be considered as well, which Contractor shall perform at no additional charge.

b. Alter claims current and history database tables to store more and larger fields.

c. Change claims windows to include additional diagnosis code fields, surgical procedure code fields, expand the size of type of bill (TOB) field, revenue code fields, DRG field (including SOI), ROM field, and days awaiting placement field. Other additional fields and/or larger field sizes will be considered as well, which Contractor shall perform at no additional charge.

d. Change claims archive and unarchive processes to include additional fields and larger fields.

e. Change the claims MMIS-DSS extracts to include additional fields and larger fields.

f. Alter claims DSS tables.

g. Change the DSS reporting package to include additional fields and larger fields.

h. Review results of each iteration with project team and stakeholders.

Task 4: Expand EDI HIPAA X12 837 Institutional Maps and Internal Record Layout

a. Expand batch 837I (institutional) claim map to include additional diagnosis code fields, surgical procedure code fields, expand the size of TOB field, revenue code fields, and days awaiting placement field. Other additional fields and/or larger field sizes will be considered as well, which Contractor shall perform at no additional charge.

b. Expand EDI internal record layout to include additional diagnosis code fields, surgical procedure code fields, expand the size of TOB field, revenue code fields, and days awaiting placement field (other additional fields and/or larger field sizes will be considered as well, which Contractor shall perform at no additional charge).

c. Test batch and online (Colorado Medicaid Web Portal – CGI/OIT) submissions of HIPAA X12 837 claims transactions.

d. Review results of each iteration with project team and stakeholders.

Task 5: Remediate Claims Editing and Auditing Application Components

a. Consolidate current diagnosis code edits into four unique edits for diagnosis not covered, diagnosis not on database, age conflict, and sex conflict.

b. Include the additional diagnosis codes into the consolidated diagnosis code edits.

c. Determine a solution to display and store in the database a mechanism to show diagnosis codes in error and the specific edit that applies.

d. Evaluate HIPAA billing requirements and national code sets and compare to current valid values to determine where changes are required to be in compliance with CMS rules. The changes could impact application logic, system lists, and copybooks.

e. Review results of each iteration with project team and stakeholders.

Task 6: Remediate Claims Pricing Application Components

a. Change pricing methodology to exclude non-covered days from outlier calculations, utilize the peer group specific DRG relative value weights, and consider days awaiting placement past the trim point in an outlier logic using a percentage on a new system parameter.

b. Change existing system lists, pricing edits, and pricing methodology for inpatient hospital claims to address updated diagnosis codes, DRG codes, expanded TOB, revenue code, DRG (including SOI), and days awaiting placement field. The changes to valid values for existing fields to be in compliance with HIPAA code sets could impact application logic in the pricing components.

c. Change re-grouping logic for claims using the new DRGs and only re-group per Department policy (as defined by Department's Rates Section, ex. DRG 936).

d. Evaluate HIPAA billing requirements and national code sets and compare to current valid values to determine where changes are required to be in compliance with CMS rules. Examine the transfer pricing logic and covered days versus non covered days processing to ensure the codes used are consistent with Department policy and determine if a more user updatable solution can be developed to control these calculations.

e. Develop pricing algorithms to account for payment changes for hospital providers whose reimbursement should be reduced for conditions acquired after admission and withholding (reducing) payment for never events as defined by Department's Rates Section.

f. Review results of each iteration with project team and stakeholders.

Task 7: Reports

a. All reference reports including Rate Reports that currently reflect DRG data will be duplicated for the APR-DRGs.

b. Provider Claim Reports need to be changed to reflect DRG methodology used.

c. All Medicaid Administrative Reports (MARs) need to be updated to incorporate APR-DRG changes.

Task 8: Operation Impact

Identify changes and update Billing Provider Manuals, training material, and other publications as needed to incorporate APR-DRG changes.

For all tasks, the Contractor shall maintain staff with expert knowledge of HIPAA standardized claim form billing requirements and national standardized code sets in order to provide guidance and recommend changes to the Department for the purpose of achieving HIPAA compliant standards in all electronic and paper billing requirements.

Contractor must pass all testing criteria developed by the Department's claims system and policy staff in a testing environment. Project completion date is no later than 6/30/12.

Financial obligations of the State payable after the current fiscal year are contingent upon funds for that purpose being appropriated, budgeted, and otherwise made available.

The effective date of this change order is upon approval of the State Controller or delegate or August 31, 2010, whichever is later.

Please sign, date, and return all copies of this letter within 5 days of receipt.

APPROVALS:

CONTRACTOR:
ACS State Healthcare, LLC

By: Brett Jakovac
Signature of Authorized Officer

BRETT JAKOVAC
Printed Name Authorized Officer

VP OF OPERATIONS
Printed Title of Authorized Officer

STATE OF COLORADO:
Bill Ritter, Jr., Governor

By: T Bartholomew for
Joan Henneberry, Executive Director
Department of Health Care Policy and Financing

Date: 9/21/10

ALL CONTRACTS REQUIRE APPROVAL BY THE STATE CONTROLLER

CRS §24-30-202 requires the State Controller to approve all State Contracts. This Contract is not valid until signed and dated below by the State Controller or delegate. Contractor is not authorized to begin performance until such time. If Contractor begins performing prior thereto, the State of Colorado is not obligated to pay Contactor for such performance or for any goods and/or services provided hereunder.

STATE CONTROLLER:
David J. McDermott, CPA

By:

Date: 9/21/10