July 19, 2019

Ms. Carly Todd
Bureau of Medicaid Policy, Operations, and Actuarial Services
Medical Services Administration
P.O. Box 30479
Lansing, MI 48909-7979
Email: ToddC1@michigan.gov

**RE: Neonatal Intensive Care Unit (NICU) Billing and Reimbursement Meeting Summary**

Dear Ms. Todd:

On behalf of its member hospitals, the Michigan Health & Hospital Association (MHA) appreciates the opportunity to provide comments to the Medical Services Administration (MSA) regarding the MSA's long-standing reimbursement policy for Medicaid neonatal intensive care unit (NICU) services provided by 23 hospitals throughout Michigan. Historically, the MSA has reimbursed hospitals for these services using an alternate weight methodology, acknowledging the higher cost incurred by hospitals to maintain NICU services for these vulnerable patients.

The MSA continued this policy in fiscal year (FY) 2015 with the implementation of the All Patient Refined-Diagnosis Related Groups (APR-DRG) system. As part of this process, the MSA established a workgroup comprised of representatives from hospitals, health plans, the Michigan Association of Health Plans, MHA and the MSA. Representatives recognized that while the APR-DRG system provided increased specificity for patient DRG assignment, continuation of alternate weights which results in higher reimbursement for NICU patients was vital for hospitals that provide NICU services.

Historically, the MSA has instructed designated hospitals to use revenue code 0174 for patients that were in the NICU in order to qualify for alternate weight payment. The MSA identifies a NICU episode as services with revenue code 0174 for at least one day, It is unnecessary for hospitals to bill revenue code 0174 for all days in order to receive alternate weight reimbursement.

This historical practice has resulted in increased scrutiny and claim denials since the National Uniform Billing Committee (NUBC) guidelines for using revenue code 0174 do not align with the MSA policy. The NUBC guidelines have not been updated for many years and reference guidelines adapted from Chapter 2 (Physical Facilities) of Guidance for Perinatal Care, Second Edition and published by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists from 1988. There have been numerous advances in medical practice since that time, particularly regarding the use of ventilators which were once commonplace but now have limited usage under today's best practices.

In general, the MSA's policy has worked well for many years with hospitals experiencing few payment denials or payment challenges for Medicaid alternate weight payment for NICU patients. Given that the MSA transitioned the majority of mothers and newborns from Medicaid fee-for-service (FFS) to managed care organizations (MCOs) over a decade ago, hospitals have experienced an increased administrative burden due to the daily utilization review and case management processes by the MCOs. These processes have increased hospital cost since hospital staff (clinical, utilization and billing) are diverted from patient care to administrative efforts to obtain proper reimbursement for the care provided.

In early 2018, some of the MCOs began using a vendor, Progeny, to review their NICU cases, including daily updates on patient status. We understand that Progeny efforts are to minimize length of stay (LOS), and potentially outlier payments for the MCOs. We also recognize that many insurers have implemented reviews in order to minimize outlier payments. However, with the APR-DRG system in use by most of the MCOs, the hospital payment, other than outlier cases, does not change with a higher or lower LOS. Many of the Progeny questions relate to the accuracy of the revenue code associated with individual patient charges, which does not impact the hospital payment unless 0174 revenue code is found to be not substantiated by Progeny. However, this challenge is in direct conflict to the MSA guidance to hospitals to utilize revenue code 0174 for patients in the NICU.

The increased focus on revenue code 0174 has resulted in excessive administrative effort by clinicians providing care to NICU patients (physicians, nursing and others), hospital care management staff, hospital billing staff and MCO utilization staff. When the hospital payments remain the same at the alternate weight amount, this is additional cost without any improvement in patient care, quality, or safety. Or stated otherwise, it is an unnecessary use of valuable healthcare resources that could otherwise be devoted to patients and their families.

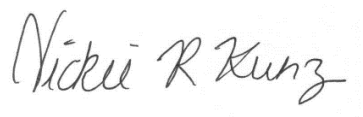
Hospitals recognize that the Medicaid MCOs have been tasked with instituting care management programs to reduce the cost of healthcare. It is our opinion that care management is concurrent in the care of the patient and not challenges to revenue codes assigned to patient charges or retrospective reviews. The MSA MCO capitation rates are developed based on prior year experience, which would include NICU patients paid at the higher alternate weight payment amounts. Any savings that results from an adjustment from alternate to regular APR-DRG weights by the MCOs would accrue to them, and not to the MSA.

The MHA recommends the following:

1. Rescind the guidance that revenue code 0174 is required for a patient in the NICU to receive alternate weight payment.
2. Issue guidance that any patient who is in a NICU bed at a NICU hospital qualifies for alternate weight payment.
    a. There have been concerns that patients are admitted to a NICU when they could be placed in a normal newborn nursery. At times, some NICUs are at full capacity caring for newborns that require these specialized services. Hospitals follow rigid admission requirements and generally keep the baby with mom unless the health status of the baby requires additional monitoring.
3. Create a workgroup comprised of representatives from hospitals, the MCOs, the MSA, the MAHP, and the MHA to identify a trigger mechanism other than revenue code 0174 for payment at the NICU alternate weight. We recommend that the MSA include clinical experts on the workgroup. A workgroup may not be necessary if the MSA guidance noted in #2 above is instituted.

Again, the MHA appreciates this opportunity to provide comments to the MSA. If you have any questions, please contact me by phone at (517) 703-8608 or via email at vkunz@mha.org.

Sincerely,



Vickie R. Kunz
Senior Director, Health Finance