مجلس الضمان الصحي
Council of Health Insurance

DRG IMPLEMENTATION GUIDELINE

(Version 1.0)

Council of Health Insurance (CHI)

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Contents

Executive summary

The Council of Health Insurance (CHI) is implementing Diagnosis-Related Groups (DRGs) as the standard reimbursement methodology for inpatient and day-case services within the private health insurance sector. This reform, approved by His Excellency the Minister of Health and Chairman of the Saudi Health Council, forms a central component of the Health Sector Transformation Program.

The transition from the current fee-for-service (FFS) model to a DRG-based framework establishes a standardized payment approach that aligns reimbursement with patient case mix and resource utilization. Under this model, clinical episodes are classified into groups with comparable clinical characteristics and cost profiles, with payment determined through a defined base rate and relative weight.

DRG Payment = Base Rate × Relative Weight (subject to applicable adjustments)

Implementation will proceed in three phases:

Market Preparedness (2022–2025): Development of coding standards, NPHIES integration, and market readiness

Shadow Billing (2026–2027): Parallel submission of DRG and FFS claims for validation and financial modeling, without reimbursement impact

Full Implementation (from 1 January 2028): Mandatory adoption of DRG-based reimbursement for all admitted care

This Guideline establishes the operational framework for the shadow billing phase and defines the readiness requirements for full implementation across all stakeholders.

A key element of the model is the Market Reference Price (MRP), developed by CHI using national claims data. The MRP provides a transparent benchmark to support structured and evidence-based negotiations between providers and payers.

Stakeholders are expected to meet the following requirements:

Providers: Ensure accurate clinical documentation and coding, supported by audit and clinical documentation improvement practices

Payers and TPAs: Establish DRG validation processes, undertake financial modelling, and implement structured contracting approaches

Vendors: Deliver certified DRG grouping solutions and ensure system integration with NPHIES

CHI: Provide regulatory oversight, market monitoring, and ongoing refinement of DRG parameters

The implementation of Diagnosis-Related Groups (DRGs) is intended to strengthen financial sustainability by improving coding accuracy, enabling case-mix–adjusted reimbursement, and enhancing cost predictability and system-wide planning. DRGs provide a standardized basis for measuring activity, complexity, and efficiency, while reducing unwarranted variation in payments. This Guideline introduces a uniform payment framework and does not influence clinical decision-making, medical necessity determinations, or coverage policies.

Section 1: Introduction

1.1 Purpose of This Guideline

This Guideline has been developed by the Council of Health Insurance (CHI) to provide clear, actionable, and standardized instructions for all stakeholders participating in the implementation of Diagnosis-Related Groups (DRGs) in the Saudi private health insurance market.

The primary audience includes private-sector hospitals, day-case centers, payers, third-party administrators (TPAs), health information system (HIS) vendors, coding companies, DRG software vendors, clinicians, and clinical documentation improvement (CDI) teams. Each stakeholder group will find within this document the specific obligations, processes, and technical requirements that apply to their role.

This Guideline is the authoritative operational reference for the shadow billing phase (2026–2027) and serves as the readiness framework for full DRG-based reimbursement in 2028. It translates the strategic direction published by CHI, together with its broader DRG implementation guidance, into practical, day-to-day instructions.

1.2 Background and Strategic Context

Saudi Arabia's private health insurance market has historically operated under a fee-for-service (FFS) reimbursement model. While FFS is familiar to all participants, it has increasingly shown limitations: it incentivizes volume over value, creates unpredictable costs, and lacks the transparency required to support meaningful comparisons of provider performance.

As part of Vision 2030 and the Health Sector Transformation Program, CHI is spearheading a structural transition toward value-based healthcare (VBHC). A central pillar of this transformation is the adoption of Diagnosis-Related Groups (DRGs) as the payment methodology for all admitted care in the private sector.

DRGs are internationally proven patient classification systems that group inpatient episodes based on clinical diagnoses, procedures, age, comorbidities, and expected resource use. Each DRG carries a relative weight that reflects the expected complexity and cost of treatment. This ensures a reimbursement model that is clinically meaningful, financially fair, and aligned with the actual needs of patients rather than the volume of services delivered.

Saudi Arabia was among the first countries in the Gulf Cooperation Council (GCC) to introduce Australian Refined DRGs (AR-DRGs) following the Saudi Health Council mandate to adopt the ICD-10-AM/ACHI/ACS coding system in 2009. AR-DRG has already been successfully implemented for Article 11 care through NPHIES. The 2026 implementation builds on this foundation, extending DRG-based payment to the entire private insurance market.

1.3 Regulatory and Legal Basis

The implementation of DRGs is grounded in the following statutory and regulatory foundations:

- Council of Ministers Resolution No. 333 (19/10/1434 AH): Grants the National Center for Health Information (NCHI) authority to license medical coding, approve national coding standards, and supervise ICD implementation.
- Cooperative Health Insurance Law (Article 99): Requires the use of CHI-approved medical coding systems for describing cases and submitting insurance claims.
- CHI Mandate under Article 5: Authorizes CHI to prepare executive regulations, issue decisions governing implementation, and supervise the health insurance market. This provision empowers CHI to mandate DRG adoption for all admitted care in the private sector.
- Saudi Health Council Mandate: Designates AR-DRG version 9.0 as the national patient classification system for admitted care.

1.4 How to Use This Guideline

This Guideline is organized into ten sections, each addressing a distinct area of DRG implementation. Stakeholders shall refer to the sections applicable to their roles as outlined below:

Stakeholder	Most Relevant Sections
Private-sector hospitals & day-case centers	Sections 3, 4, 5, 6, 7, 8, 9
Payers (insurance companies)	Sections 3, 6, 7, 8, 9, 10
Third-Party Administrators (TPAs)	Sections 3, 5, 6, 8, 9, 10
HIS & DRG software vendors	Sections 5, 6, 8, 9
Coding companies	Section 4, 5
CDI teams	Sections 4, 5
Clinicians	Section 4

> **NOTE:** This Guideline does not alter clinical decision-making, coverage rules, or the contracting freedom between providers and payers. DRGs change how admitted care is reimbursed, not how care is delivered.

1.5 Document Governance

This Guideline is issued by CHI and will be reviewed and updated on an annual basis, or as required by regulatory change, market feedback, or system enhancements. Feedback on this Guideline may be submitted through CHI's official communication channels. The version history is maintained at the back of this document.

Section 2: Overview of DRGs in Saudi Arabia

2.1 What Are DRGs?

Diagnosis-Related Groups (DRGs) are a patient classification system that groups admitted hospital episodes into clinically coherent categories based on the patient's principal diagnosis, secondary diagnoses, procedures performed, age, sex, birth weight, and discharge status. The underlying principle is that patients within each DRG consume similar types and amounts of hospital resources.

The Australian Refined DRG (AR-DRG) system, currently at version 9.0, is the classification mandated by the Saudi Health Council and adopted by CHI for the private health insurance market. AR-DRG v9.0 contains 803 DRGs organized into 399 Adjacent DRGs (ADRGs) across 23 Major Diagnostic Categories (MDCs).

2.2 The AR-DRG Grouping Process

When a patient is discharged from a hospital, the following clinical and administrative data from the Minimum Data Set (MDS) is submitted and processed by the DRG grouper software:

1. Demographic and clinical edits: All submitted diagnoses and procedure codes are validated. Errors result in assignment to one of three error DRGs (960Z, 961Z, or 963Z).
2. MDC Assignment: The principal diagnosis determines assignment to one of 23 Major Diagnostic Categories, which are broadly organized by body system or condition type.
3. Pre-MDC Processing: High-cost or high-complexity episodes (e.g., long-term mechanical ventilation, tracheostomy, ECMO, bone marrow transplants) may override the standard MDC assignment.
4. ADRG Assignment: Each episode is assigned to an Adjacent DRG based on whether general interventions (GI), specific interventions (SI), or only medical management was provided.
5. DCL and ECCS Scoring: Diagnosis Complexity Levels (DCLs, ranging 1–5) are assigned to each diagnosis. These combine to form the Episode Clinical Complexity Score (ECCS, ranging 0–31.25), which determines the final DRG split (A, B, C, D, or Z).
6. DRG Assignment: The final AR-DRG is assigned, representing the episode's clinical and resource classification.

> **NOTE:** Accurate DRG assignment is only possible using certified DRG grouper software. Manual classification is not permitted. The ICD-10-AM 10th Edition must be used for all diagnosis and procedure coding.

2.3 The Role of Relative Weights

Each AR-DRG is assigned a relative weight (RW) that reflects the expected resource use of that episode relative to the average inpatient episode. A relative weight of 1.00 represents the average; a weight of 2.00 indicates a case expected to require twice the average resources; a weight of 0.50 indicates a simpler case.

Relative weights are the mechanism that ensures hospitals treating more complex patients receive proportionally higher reimbursement. They are derived from national and international evidence on how different patient groups consume hospital resources.

The core DRG payment formula is:

DRG Payment = Base Rate × Relative Weight (with length-of-stay adjustments where applicable)

2.4 The Market Reference Price (MRP)

The Market Reference Price (MRP) is a national benchmark developed by CHI to support fair, evidence-based contracts between providers and payers. It does not constitute a mandated tariff; rather, it is a transparent reference point reflecting the typical cost of delivering care for each DRG across the private sector.

The MRP was developed using NPHIES claims data, clinical coding outputs, and sector feedback. It is composed of a base price multiplied by the relative weight of each DRG.

2.4.1 What the MRP Includes

The MRP covers all costs typically associated with an inpatient episode, including:

- Clinical staffing (physicians, nurses, allied health professionals)
- Diagnostics (laboratory, imaging, pathology)
- Consumables and medical supplies
- Medications administered during the admission
- Room and board
- Operating theatre and ICU services
- Indirect costs (administration, IT infrastructure, utilities, depreciation)

2.4.2 What the MRP Excludes

The following high-cost items are excluded from the MRP and must be billed separately under existing billing rules:

- Prostheses and implants (e.g., pacemakers, stents, joint prostheses)
- Chemotherapy drugs
- Specialized devices
- Pre-admission emergency room services

- Follow-up care beyond 14 days post-discharge

2.5 DRG Implementation Timeline in Saudi Arabia

Phase	Period	Key Activity
Market Preparedness	2022–2025	Education, NPHIES integration, coding standards, capacity building, pilot implementations
Shadow Billing	2026–2027	Parallel DRG claim submission alongside FFS; no financial consequences; readiness validation
Full Implementation	2028 onwards	DRG becomes mandatory payment model for all admitted care in private health insurance

2.6 What DRGs Do Not Change

For clarity, the following are not impacted by DRG implementation:

- Clinical decision-making remains fully in the hands of physicians and treating teams.
- Providers continue to deliver care based on clinical need, not payment rules.
- Payers continue to perform medical necessity and coverage compliance reviews.
- NPHIES remains the national platform for all claims exchange.
- Contracting freedom between providers and payers is preserved; the MRP is a reference, not a mandate.
- Quality and safety standards remain unchanged.

Section 3: Shadow Billing Requirements (2026–2027)

3.1 Definition and Purpose of Shadow Billing

Shadow billing is the process by which providers submit DRG-coded claims in parallel with their standard FFS claims during the 2026–2027 period. Payers and TPAs adjudicate and validate the assigned DRG code without this affecting the outcome of the FFS claim. No payment is made based on DRGs during the shadow billing phase.

The purpose of shadow billing is to enable all stakeholders to validate systems, assess data quality, and support financial and operational readiness for DRG-based processes without incurring financial consequences. That constitutes a structured readiness program with defined operational objectives.

3.2 Shadow Billing Process Flow

The shadow billing process follows these steps:

1. Provider shall submit a complete inpatient or day-case claim via NPHIES, including all required MDS data fields, ICD-10-AM diagnoses, ACHI procedure codes, and other clinical variables.
2. The DRG grouper software at the provider or system level assigns the AR-DRG code based on submitted data.
3. The AR-DRG code and relative weight are appended to the claim submission as a parallel data element.
4. The FFS claim proceeds through standard adjudication by the payer or TPA with no change to the existing process.
5. The payer or TPA validates the DRG assignment (clinical plausibility, coding quality, data completeness) and records the shadow DRG result.
6. Once a base rate has been agreed between provider and payer, both parties shall compare the DRG-based payment amount with the FFS amount for analysis and planning purposes.
7. Discrepancies, errors, or disputes are flagged and reviewed through the governance subcommittee structure described in Section 10.

3.3 Stakeholder Obligations During Shadow Billing

3.3.1 Providers and HISs

- Providers shall submit all admitted inpatient and day-case claims via NPHIES with complete MDS data.
- Ensure all diagnoses are coded using ICD-10-AM 10th Edition and all interventions are coded using SBS v3.
- Use CHI-certified DRG grouper software to generate the AR-DRG code prior to submission.

- Submit AR-DRG code, as per the latest mandated version (AR-DRG v9.0) for each inpatient or day-case (same-day) transaction.
- Monitor DRG assignment rates, error DRG rates, and Case Mix Index (CMI) monthly.
- Identify and remediate documentation and coding gaps identified through shadow billing results.
- Participate in CHI-organized shadow billing review sessions and workshops.
- Provide feedback on the shadow billing process, including operational challenges, concerns, lessons learned, and recommendations for improvement.

3.3.2 Payers and TPAs

- Establish DRG validation capability within adjudication platforms before the shadow billing start date.
- Validate the clinical plausibility of DRG assignments submitted by providers.
- Record and store shadow billing results for analysis and audit purposes.
- Use shadow billing data to compare DRG-based payments with current FFS payments and prepare for contracting discussions.
- Provide feedback on the shadow billing process, including operational challenges, concerns, lessons learned, and recommendations for improvement.

3.3.3 DRG Software Vendors

- Ensure all DRG grouper products are certified under AR-DRG v9.0 and SBS v3 before the shadow billing start date.
- Support issue resolution and software updates identified during the shadow billing period.

3.4 Shadow Billing Data Elements

Every claim submitted during shadow billing must include the following DRG-specific data fields in addition to existing NPHIES MDS requirements:

Data Element	Description	Mandatory
AR-DRG Code	The assigned AR-DRG code (e.g., O60B, F62A)	Yes
AR-DRG Description	The descriptive text label corresponding to the AR-DRG code	Yes

3.5 Services Covered During Shadow Billing

Shadow billing applies to:

- All inpatient admissions (elective, emergency, and transfer) at private-sector hospitals.
- All day-case (same-day) admissions at private hospitals and licensed day-case centers.
- All clinical specialties and MDC categories covered by AR-DRG v9.0.

Shadow billing does not apply to:

- Outpatient or ambulatory care does not result in admission.
- Emergency room visits that do not lead to hospital admission.
- Rehabilitation or sub-acute episodes not classified under an inpatient admission.

3.6 Dispute Resolution During Shadow Billing

3.6.1 Purpose and Principles

Disagreements between providers and payers may arise during the shadow billing phase regarding the assignment, documentation, or grouping of a DRG-coded claim. This section establishes a structured, non-financial process for identifying and resolving such disputes.

Consistent with the purpose of shadow billing, this process is designed to build confidence and surface gaps without financial consequence. No payment adjustments, penalties, or financial liabilities arise from a dispute raised during the shadow billing phase. The goal is corrective, not punitive: to identify documentation gaps, coding inconsistencies, grouping errors, or data quality issues, and to resolve them collaboratively before full DRG-based reimbursement begins in 2028.

3.6.2 Dispute Categories

Disputes raised during shadow billing fall into one or more of the following categories:

Category	Description
Documentation	Clinical documentation is incomplete, ambiguous, or insufficient to support the assigned diagnosis or procedure codes
Coding	Disagreement over the ICD/SBS codes applied, code sequencing, or principal diagnosis selection
Grouping	Disagreement over the DRG assigned by the grouper based on the submitted codes and case data
Data quality	Errors or inconsistencies in Minimum Data Set (MDS) fields submitted with the claim

3.6.3 Workflow Steps

Step 1: Issue identified. Either the provider or the payer may identify a potential discrepancy in a DRG-coded claim submitted during shadow billing.

Step 2 Bilateral review. The provider and payer jointly review the disputed claim, examining:

- The medical record
- Coding and documentation
- Grouper output
- MDS data fields

This step is intended to resolve the majority of disputes directly between the two parties without CHI involvement.

Step 3: Resolution check.

- If the issue is resolved bilaterally, the case is closed, and no further action is required.
- If the issue remains unresolved, it is escalated to CHI.

Step 4: Escalation to the CHI subcommittee. Unresolved disputes are escalated to the relevant CHI subcommittee:

- The **Coding Steering Committee** for disputes concerning coding, documentation, or principal diagnosis selection
- The **Arbitration Subcommittee** for disputes concerning grouping outcomes or claim-level billing discrepancies

Step 5: Subcommittee review. The relevant subcommittee reviews the escalated dispute and provides:

- Technical clarification on the correct application of coding or grouping rules
- Root cause analysis of why the discrepancy occurred
- Corrective actions for the provider, payer, or both
- Guidance to both parties to prevent recurrence

Step 6: CHI oversight. Beyond individual case resolution, CHI monitors dispute activity across the market to:

- Monitor repeated or recurring issues across providers and payers
- Identify systemic gaps in coding standards, grouping logic, or MDS specifications
- Issue market-wide clarifications where a pattern is identified
- Update this Guideline where necessary to reflect lessons learned

3.6.4 Roles and Responsibilities

Stakeholder	Role in the dispute process
Provider	Raises or responds to disputes; participates in bilateral review; supplies medical record and coding rationale; implements corrective actions

Payer	Raises or responds to disputes; participates in bilateral review; supplies adjudication and grouping rationale; implements corrective actions
CHI Coding Steering Committee	Reviews escalated coding and documentation disputes; issues technical clarification and corrective guidance
The Arbitration Subcommittee	Reviews escalated grouping and billing disputes; issues technical clarification and corrective guidance
CHI (oversight)	Monitors systemic trends across all disputes; issues market-wide clarifications; updates the Guideline as needed

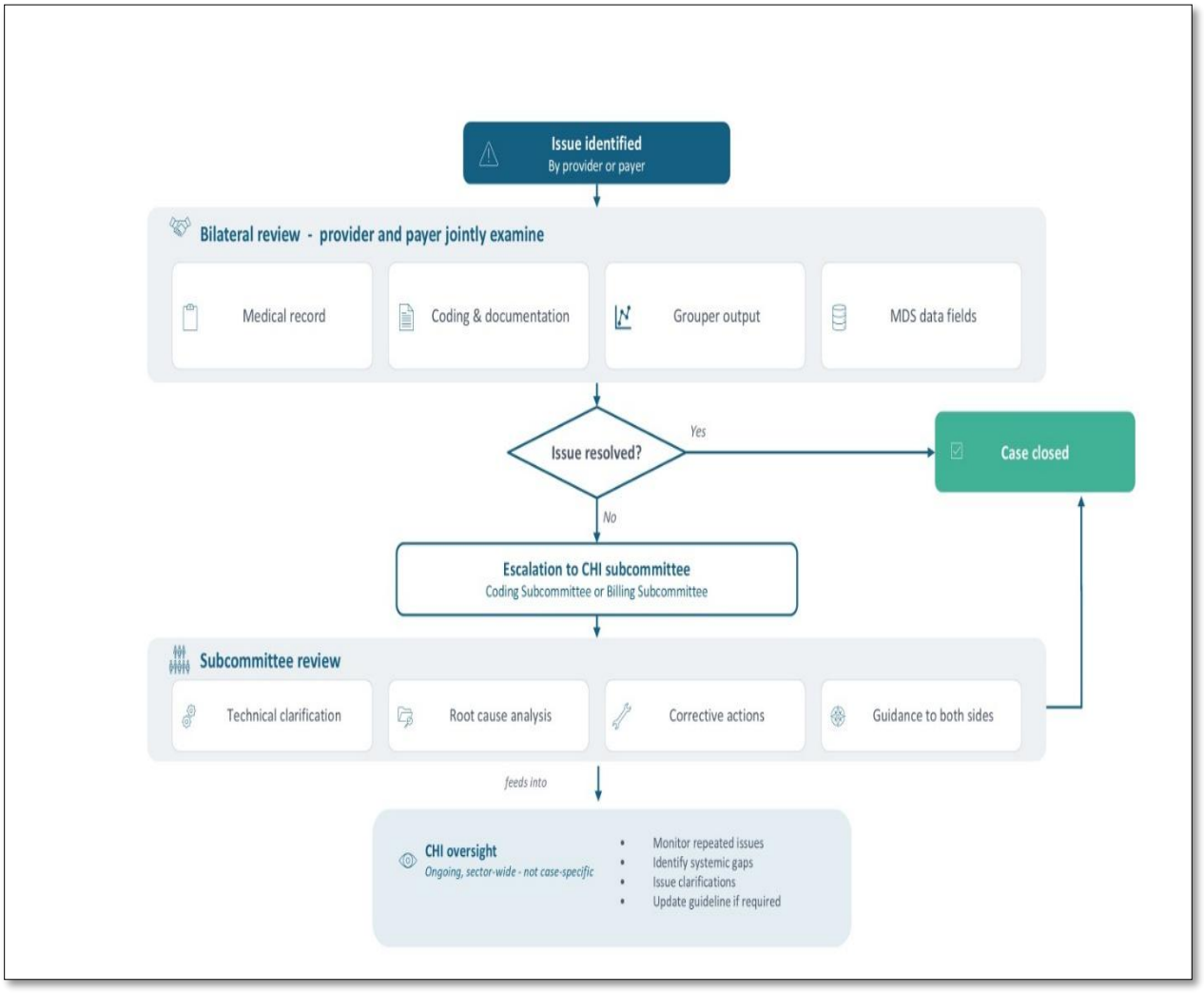

Figure: Dispute resolution workflow during shadow billing

> **NOTE:** During the shadow billing phase, disputed DRG assignments do not affect FFS claim payment outcomes.

Section 4: Clinical Documentation and Coding Requirements

4.1 Importance of Clinical Documentation for DRG Accuracy

DRG assignment is entirely dependent on the quality and completeness of clinical documentation. Accurate documentation of the principal diagnosis, additional diagnoses, procedures, complications, comorbidities, and other clinical variables directly determines which DRG is assigned and therefore the relative weight associated with that episode.

Incomplete or imprecise documentation leads to DRG under-assignment (incorrect lower complexity), which results in lower reimbursement than clinically appropriate. It also distorts Case Mix Index calculations and hampers meaningful benchmarking.

Accurate and complete clinical documentation is a prerequisite for valid DRG assignment.

4.2 Coding Standards

4.2.1 Diagnosis Coding

- All diagnoses must be coded using ICD-10-AM 10th Edition as mandated by the Saudi Health Council and CHI.
- The principal diagnosis shall be coded in accordance with ICD-10-AM and ACS 0001 (Principal Diagnosis) definitions.
- The principal diagnosis (reason for admission, determined after evaluation) must be clearly identified and coded separately from additional diagnoses.
- All clinically significant additional diagnoses, complications, and comorbidities present during the episode must be coded in accordance with ICD10-AM and ACS 0002 (Additional Diagnoses) definitions.
- Unacceptable principal diagnoses (as defined in the AR-DRG Definitions Manual) must not be used as the principal diagnosis; doing so results in error DRG 961Z.

4.2.2 Procedure Coding

- All clinical interventions must be coded using the Saudi Billing System V3, in accordance with ACS.
- All general interventions (GIs) that may affect DRG assignment must be coded, including those performed in operating theatres, procedure rooms, and ICUs.
- Same-day (day-case) procedures must be clearly distinguished from overnight admissions.

4.2.3 Coding Quality Requirements

- All inpatient coding must be performed by coders who hold or are progressing toward CHI-recognized coding certification.
- **Internal Coding Audits:**

- All Healthcare Providers are required to implement and maintain a structured internal coding audit program, conducted on a quarterly basis, to ensure ongoing monitoring and improvement of coding quality.
- Internal audits must be performed using the standard audit template and guidelines issued by CHI.
- Routine sampling for internal audits shall be conducted in accordance with the CHI Coding Audit Methodology (Version 2), ensuring consistency, standardization, and comparability across all providers.
- **External Coding Audits:**
- All Healthcare Providers are mandated to undergo an annual external coding audit by contacting CHI-approved audit vendors, effective from 1 January 2027, to ensure independent validation of coding quality and DRG compliance.
- External audits must be conducted using the standardized audit methodology and template issued by CHI.
- Routine sampling for external audits shall also strictly follow the CHI Coding Audit Methodology (Version 2) to ensure alignment with internal audit practices and sector benchmarking standards.
- Error DRG rates (960Z, 961Z, 963Z) must not exceed 3% of total submitted episodes in any reporting month for the shadow billing phase. Providers exceeding this threshold for two consecutive months must implement a mandatory improvement action plan, including targeted coder training, CDI review, and correction of HIS/NPHIES data quality issues.

4.3 The Minimum Data Set (MDS) Requirements

For AR-DRG grouping to function correctly, the following MDS variables must be accurately captured and submitted for every inpatient episode:

All fields listed below are mandatory unless explicitly stated otherwise.

MDS Variable	Description	Notes
Principal Diagnosis	Primary reason for admission (ICD-10-AM)	Must reflect the condition chiefly responsible for the admission after evaluation. Drives MDC assignment. Incorrect PDx may trigger error DRG 961Z
Additional Diagnoses	All significant comorbidities and complications (ICD-10-AM)	Must include all clinically significant comorbidities/complications that affect treatment, monitoring, or resource use. Required for ECCS scoring and DRG split (A/B/C/D).

MDS Variable	Description	Notes
Procedures	All ACHI and SBS-coded interventions	All interventions must be coded. Drives ADRG assignment. Certain procedures trigger Pre-MDC overrides (e.g., tracheostomy, ECMO). Missing procedures may incorrectly classify the episode as medical instead of surgical.
Age	Age of patient at admission	Age at admission determines neonatal eligibility (≤28 days), pediatric vs adult DRGs, and specific age-dependent DRG splits. Incorrect age may cause MDC misassignment.
Sex	Patient sex	Required for sex-specific DRGs (obstetrics, gynecology, prostate, testicular). Incorrect sex coding may cause grouping errors or assignment to error DRGs.
Date of Admission	Admission date and time	Used to calculate LOS. Incorrect values distort LOS-based adjustments (short-stay/long-stay outliers) and same-day separation logic.
Date of Discharge	Discharge date and time	Used to calculate LOS. Must reflect actual discharge time. Incorrect discharge date may incorrectly trigger outlier flags or same-day DRG variants.
Discharge Status	Discharge destination (home, transfer, death, etc.)	Required for transfer DRGs (e.g., B70D, F60B), death-related DRGs, and LOS adjustments. Must match clinical documentation.

MDS Variable	Description	Notes
Birth Weight	For neonatal admissions only (child under 1 year of age)	Mandatory for neonates (≤28 days). Determines DRG assignment within MDC 15. Missing or inconsistent values trigger 963Z.
Mechanical Ventilation Hours	Total hours of mechanical ventilation	Required for Pre-MDC DRGs involving ventilation (e.g., A06A/B). Must reflect total documented hours. Incorrect values may prevent assignment to ventilation DRGs.
Encounter Type	Inpatient vs. same day	Determines eligibility for DRG grouping and whether same-day DRG variants apply. Incorrect classification may misassign ADRG/DRG.
Leave Days	Total days the patient was temporarily absent during the admission	Reduces LOS for DRG outlier logic. Must be recorded when patient is temporarily absent (e.g., home leave). Incorrect leave days distort LOS-based adjustments.

4.4 Clinical Documentation Improvement (CDI) Program

All private-sector hospitals submitting DRG claims must establish a Clinical Documentation Improvement (CDI) program. The program must include the following minimum components:

4.4.1 CDI Team Structure

- Clinical Documentation Specialists (CDS) — credentialed clinical staff (e.g., RNs) or coders with clinical documentation training, responsible for day-to-day concurrent review and query generation.
- Collaboration structure between CDI team, attending clinicians, and the coding department.
- Clear escalation pathway for documentation queries.

4.4.2 CDI Processes

- Initial assessment: Baseline evaluation of clinical documentation quality across the organization (or target service lines) to identify gaps, risk areas, and opportunities prior to program launch or major revision.
- Improvement plan/program: A formal CDI program plan defining scope, target DRGs/service lines, staffing model, query templates, training plan, and success metrics.
- Concurrent review of inpatient records during the episode of care (not only at discharge).
- Query process for requesting clinician clarification on ambiguous, incomplete, or contradictory documentation.
- All queries and responses must be documented in the medical record with clinician signature.
- Retrospective record review for identified high-volume or high-cost DRGs.
- Quarterly reassessment: Recurring review of documentation quality and program performance against the baseline, at minimum quarterly.
- Improvement metrics: Defined KPIs (e.g., query response rate, query agreement rate, CC/MCC capture rate, case mix index impact, DRG mismatch rate, physician engagement rate) tracked and reported to leadership on a regular cadence.

4.4.3 CDI Metrics to Monitor

- Query rate (number of queries issued per 100 admissions)
- Query response rate and response time
- DRG change rate following query response
- Case Mix Index (CMI) trend over time
- Error DRG rate

4.5 Training Requirements

The following training obligations apply during the shadow billing phase:

Role	Required Training	Minimum Frequency
Attending physicians	DRG awareness: how documentation affects DRG assignment, complication/comorbidity capture	Once before shadow billing start; refresher annually
Medical coders	ICD-10-AM/ACHI 10th Edition, AR-DRG v9.0 logic, ECCS scoring, MDS requirements	Before shadow billing start; quarterly refreshers
CDI coordinators	CDI methodology, ACS documentation standards, query management, DRG logic fundamentals, documentation impact on DRG/CMI	Before shadow billing start; annual refresher

Role	Required Training	Minimum Frequency
HIS/IT teams	NPHIES DRG data elements, grouper integration, claim transmission requirements	Before shadow billing start; refresher after any system update
Revenue cycle managers	DRG-based financial modeling, MRP and base rate concepts	Before shadow billing start; annual refresher

Section 5: DRG Grouping Requirements

5.1 Certified Grouper Software

All AR-DRG assignments submitted during the shadow billing phase and for full implementation must be generated by CHI-certified grouper software.

Certified grouper software must:

- Implement AR-DRG v9.0 logic as defined in the AR-DRG Definitions Manual published by the Australian Consortium for Classification Development.
- Process all required MDS data elements as inputs.
- Produce the full grouping output including AR-DRG code, ADRG code, MDC, ECCS score, Diagnosis Complexity Levels, and error flags.

5.2 Grouper Integration with HIS and NPHIES

The DRG grouper must be integrated within the provider's workflow in a manner that ensures:

- Grouping occurs automatically at the point of claim submission, using the coded MDS data from HIS.
- The AR-DRG output is attached to the NPHIES claim as a structured data field before submission.
- Providers cannot manually override a DRG assignment generated by the certified grouper without documented clinical justification reviewed by the CDS and Coding Specialist.

5.3 DRG Error Management

Error DRGs indicate data quality or coding problems and must be actively managed:

Error DRG	Description
960Z – Ungroupable	Episode cannot be assigned to an MDC
961Z – Unacceptable PDx	Principal diagnosis is on the Unacceptable Principal Diagnosis list
963Z – Neonatal Inconsistency	Neonatal diagnosis not consistent with patient age or birth weight
801 – GI Unrelated to PDx	Procedure (GI) is not clinically related to the principal diagnosis

5.4 Length of Stay and DRG Adjustments

The AR-DRG system includes provisions for adjusting payments when a patient's length of stay (LOS) differs significantly from the norm for that DRG. These adjustments are handled automatically by the certified grouper software and do not require manual calculation. The key concepts are:

- Same-day separation: Some ADRGs are partitioned to create a same-day DRG variant for episodes that begin and end on the same calendar day. Providers must ensure the encounter type (inpatient vs. same day) is accurately recorded.
- Short-stay outliers: Episodes with LOS significantly below the DRG trim point may attract a reduced payment. The grouper will flag these automatically.
- Long-stay outliers: Episodes with LOS significantly above the DRG trim point may attract additional payment. The grouper will flag these automatically.
- Transfer rules: Episodes transferred to another acute facility within a defined time period (e.g., B70D, F60B: transfer within 5 days) are assigned to a specific DRG variant. Discharge status must be accurately coded.

Section 6: DRG Billing and Claims Requirements

6.1 Claim Structure During Shadow Billing

During the shadow billing phase, providers submit one claim for every qualifying inpatient or Day-case (Same-day) episode including the following:

1. The standard FFS claim: submitted via NPHIES using the existing Saudi Billing System (SBS) structure. This claim is adjudicated normally and is the basis for payment during the shadow billing phase.
2. New field regarding the DRG shadow claim: submitted alongside the FFS claim as a structured data attachment, including all DRG-specific data elements listed in Section 3.4. This part is validated but does not result in payment.

6.2 Claim Submission Requirements

All DRG claims submitted via NPHIES must comply with the following requirements:

- Completeness: All mandatory MDS fields must be populated. Incomplete claims shall be rejected by the NPHIES validation engine.
- Coding accuracy: Diagnoses and procedures must be coded using ICD-10-AM 10th Edition, and SBS v3. Invalid code submissions will be blocked.
- Timeliness: Claims must be submitted within the mandated and regulated timeframe.
- Version control: Claims must be submitted using AR-DRG v9.0. claims using other versions will be blocked.

6.3 Claim Validation by Payers and TPAs

Payers and TPAs are required to validate DRG shadow claims using the following framework:

6.3.1 Technical Validation

- Confirm all mandatory DRG data fields are present and complete.
- Confirm no error DRGs (960Z, 961Z, 963Z) are present without an explanatory flag.

6.3.2 Clinical Validation

- Assess the clinical plausibility of the assigned DRG relative to the submitted diagnoses and procedures.
- Flag cases where the DRG assignment appears inconsistent with the documented clinical scenario.

6.4 Items Billed Separately (Outside the DRG)

The following items must be billed separately and will not be included in the DRG payment under full implementation:

- Prostheses and implants
- Chemotherapy drugs
- Specialized devices
- Pre-admission emergency services
- Post-discharge follow-up

Section 7: Market Reference Price (MRP) and Relative Weights

7.1 Role of the MRP in DRG Contracting

The Market Reference Price (MRP) is a nationally consistent reference point developed by CHI to support transparent and evidence-based contracting between providers and payers. It is not a mandated payment tariff. Providers and payers retain full freedom to negotiate a base rate that reflects their specific circumstances.

By providing a shared reference grounded in national cost data, the MRP reduces the information asymmetry that has historically made tariff negotiations difficult and contentious. Both parties can enter negotiations with a common understanding of what an average episode of care costs across the private sector.

7.2 How the MRP Is Calculated

CHI develops the MRP through the following process:

- Collection of claims data from NPHIES, including clinical coding outputs and episode-level resource use information.
- Application of the AR-DRG v9.0 grouper to classify all episodes.
- Calculation of the average resource consumption per DRG expressed as a relative weight indexed to the market average case (RW = 1.00).
- Determination of a base price reflects the average total cost of an inpatient episode across the private sector.
- MRP per DRG = Base Price × Relative Weight for that DRG.

7.3 Using the MRP for Base Rate Negotiation

The base rate is the single monetary value that anchors all DRG payments between a specific provider and payer. The negotiated base rate is multiplied by the DRG-specific relative weight to produce the payment for each admission.

7.3.1 Factors Influencing Base Rate Negotiations

Providers and payers may adjust the negotiated base rate above or below the MRP reference level based on:

- Hospital characteristics (size, service mix, case complexity)
- Quality and patient safety performance indicators
- Geographic location and operational costs
- Efficiency metrics (LOS compared to norm, readmission rates)

- Historical utilization patterns and case mix profile
- Network strategy and volume commitments
- DRG high-quality performance increases transparency and reliability during negotiations and confirms the CMI of the provider.

7.3.2 How Providers Should Use the MRP

- Benchmark internal episode costs against the MRP to identify efficiency gaps or areas of cost advantage.
- Use Case Mix Index (CMI) data from shadow billing to demonstrate the complexity of their patient population relative to market average.
- Use shadow billing financial analysis to model the revenue impact of different negotiated base rates.

7.3.3 How Payers Should Use the MRP

- Evaluate whether proposed provider base rates are consistent with market norms for the provider's case complexity and service mix.
- Use DRG-based performance benchmarking (CMI, LOS, readmissions) to support value-based contracting strategies.
- Model DRG-based expenditure projections using shadow billing financial comparison data.

7.4 Relative Weight Tables

CHI publishes the complete AR-DRG v9.0 relative weight table for all 803 DRGs. Relative weight is a key component of the DRG payment formula and reflects the expected resource use of each DRG relative to the average inpatient episode. Providers and payers should refer to the relative weight table published on the CHI website when conducting DRG-based financial analysis and contracting discussions.

7.5 Length-of-Stay Adjustments to Payment

Under full DRG-based reimbursement, adjustments to the standard DRG payment may apply when a patient's length of stay deviates significantly from the norm (trim point) established for that DRG. These adjustments ensure financial fairness for both providers and payers when cases fall outside the expected range. The specific trim points and adjustment formulas will be published prior to full implementation in 2028.

Section 8: Reporting Requirements

8.1 Overview of Reporting Obligations

Regular and structured reporting is essential to monitor the progress of shadow billing, identify gaps, and build the evidence base for full DRG implementation. The following reporting obligations apply to all stakeholders during the shadow billing phase.

8.2 Provider Reporting Obligations

To minimize the reporting burden, CHI will extract and monitor most DRG activity and performance indicators directly from SHIP and provide market-level insights through Daman Intelligence dashboards. Monitored indicators include total admissions, DRG distribution, Case Mix Index (CMI), error DRG rate, average LOS by DRG, LOS/outlier metrics, DRG vs. FFS variance, and timeliness of DRG submissions. Providers are encouraged to calculate and monitor these indicators internally.

Indicators Monitored via NPHIES/SHIP Extraction (No Submission Required)

Indicator	Description
Total admissions	Total number of admitted episodes submitted in the reporting period
DRG distribution	Breakdown of admitted episodes by assigned DRG
Case Mix Index (CMI)	The average relative weight of all DRGs billed, reflecting overall case complexity
Error DRG rate	Proportion of episodes resulting in an error, ungroupable, or unacceptable-principal-diagnosis DRG
Average LOS by DRG	Average length of stay for each DRG, compared against expected norms
LOS / outlier metrics	Identification of cases falling outside expected length-of-stay ranges
DRG vs. FFS variance	Comparison between the DRG-based payment amount and the equivalent fee-for-service amount for the same episode
Timeliness of DRG submissions	Whether DRG-coded claims are submitted within required timeframes

However, providers must submit audit results for the following two indicators, which require formal audits carried out by providers and approved vendors:

Mandatory Reporting Requirements (via Audit)

Indicator	Description
Coding accuracy	Rate of correct code assignment, validated through internal and external codingaudits

Indicator	Description
CDI performance	Indicators reflecting the effectiveness of the provider's Clinical Documentation Improvement program

Providers must also submit quarterly readiness reports and notify CHI of any critical system or data issues within 5 working days.

All reporting must follow CHI's MDS definitions, AR-DRG v9.0, and ICD-10-AM/ACHI/ACS standards. Reporting results will be used to assess provider and market readiness for full DRG implementation in 2028.

8.4 Key Performance Indicators (KPIs) for Shadow Billing

KPIs for the shadow billing phase measure DRG data quality, coding/documentation accuracy, operational timeliness, system integration performance, and payer validation accuracy. These KPIs will be monitored monthly and used to assess provider and payer readiness for full DRG implementation in 2028.

KPI	**Proposed target (pending CHI confirmation)**
Error DRG rate	≤ 3%
First-pass coding accuracy	≥ 80%
Coding accuracy	≥ *80%*
MDS completeness	≥ 98%
DRG submission timeliness	≥ 95% within 7 days
DRG mismatch rate	≤ 5%

8.5 CHI Market-Level Reporting

CHI will aggregate provider and payer submissions to produce quarterly market-level reports covering:

- National Case Mix Index trends
- Top DRGs by volume and by total relative weight
- DRG error rates by facility type and region
- Aggregate DRG vs. FFS financial comparison
- Shadow billing readiness assessment by stakeholder category

These reports will be shared with market stakeholders through the CHI governance structure and will inform readiness decisions ahead of the 2028 transition.

Section 9: Readiness Criteria for Full Implementation (2028)

9.1 Provider Readiness Criteria

9.1.1 Clinical Documentation and Coding

- Error DRG rate equal to or below X3% for three consecutive months prior to assessment.
- First-pass coding accuracy rate equal to or above 80X% or above, verified by internal audit.
- CDI program fully operational with designated CDI coordinator, documented query process, and CMI monitoring.
- All coding staff shall hold current certification in ICD-10-AM / ACHI / ACS (10th Edition) from a CHI-approved training provider or equivalent Certification must be renewed or refreshed every 3 years, or earlier if CHI adopts a new edition of the classification. X.

9.1.2 Technical and System Readiness

- HIS integrated with a CHI-certified AR-DRG v9.0 grouper.
- NPHIES DRG submission tested and validated in the production environment.
- DRG reporting dashboards operational, providing CMI, LOS, DRG distribution, and error rate analysis.

9.1.3 Financial and Contracting Readiness

- Financial modeling of DRG impact completed, using shadow billing data.
- Revenue cycle management processes updated to support DRG-based adjudication and payment tracking.
- Internal budgeting and forecasting processes aligned with DRG revenue model.

9.1.4 Training and Change Management

- Clinician DRG awareness training completed for all admitting physicians.
- Coders and CDI staff must complete a mandatory refresher training within 3 months of DRG shadow billing go-live.
- Administrative and finance staff must complete DRG-based revenue cycle training before shadow billing go-live, with annual refreshers thereafter. Training must cover DRG workflows, NPHIES requirements, DRG claim submission, and financial implications. .

9.2 Payer and TPA Readiness Criteria

- Claims adjudication systems updated to process DRG-based claims and apply relative weight calculations.
- Major provider contracts renegotiated to align with the DRG base-rate reimbursement structure.

- DRG validation rules are integrated into adjudication workflow.
- Clinical review teams trained in DRG validation methodology.
- Financial forecasting models updated to reflect DRG-based expenditure projections.
- Reporting capability in place to monitor DRG performance metrics (CMI, LOS, readmissions, outliers).

9.3 Vendor Readiness Criteria

- AR-DRG v9.0 grouper certified by CHI and deployed in production environments for all client hospitals.
- NPHIES DRG integration certified and tested in production.
- DRG analytics modules providing CMI, LOS, and coding quality dashboards available to clients.
- CDI and coding audit tools available and deployed.

9.4 Market Readiness Assessment Process

To ensure a successful transition to the DRG reimbursement model, providers and payers must meet measurable indicators across six foundational pillars prior to full implementation.

Pillar 1 — Clinical Documentation & Coding Readiness

KPI	Recommended Threshold	Rationale
Coding Accuracy (First Pass)	≥ 80%	International benchmark is 90-95%; KSA needs a realistic starting point.
Error DRG Rate (960Z, 961Z, 963Z)	≤ 3%	Global best practice is <2%; 3% is lenient but safe.
CDI Query Response Rate	≥ 85%	Ensures physician engagement without being overly strict.
Clinical Documentation Completeness (PDx/ADx/Procedures)	≥ 90%	Allows for variability in smaller hospitals.
Neonatal & Ventilation Data Accuracy	≥ 95%	Critical for MDC 15 and Pre MDC DRGs.
DRG Change Rate After CDI	Monitored (no threshold)	High variation expected early; use as a trend indicator.

Readiness Pass Criteria: Provider meets 4 out of 6 KPIs, including coding accuracy and error DRG rate.

Pillar 2 — Data Quality & NPHIES Integration Readiness

KPI	Recommended Threshold	Rationale
MDS Completeness	≥ 98%	Mandatory for DRG grouping; high threshold required.

KPI	Recommended Threshold	Rationale
NPHIES DRG Related Rejection Rate	≤ 3%	International best practice is <1%; 3% is lenient for KSA.
Correct Grouper Version Usage	100%	Non-negotiable.
Mapping Accuracy (PDx/ADx/Procedures)	≥ 95%	Allows for HIS variability across providers.
DRG Submission Timeliness (≤ 7 days)	≥ 90%	International standard is 95-98%; 90% is realistic for KSA.
System Error Resolution Time	≤ 7 working days	Allows flexibility for smaller providers.

Readiness Pass Criteria: Provider meets 4 out of 6 KPIs, including MDS completeness and grouper version compliance.

Pillar 3 — Operational & Revenue Cycle Readiness

KPI	Recommended Threshold	Rationale
DRG Workflow Implementation (HIS -> Grouper -> NPHIES)	Fully implemented	Mandatory.
Registration & Eligibility Accuracy	≥ 95%	Needed for clean claims.
DRG Claim Submission Workflow Compliance	≥ 90%	Allows for operational variability.
Denial Management Process Maturity	Documented & active	Qualitative KPI.
CMI Stability (Month to Month)	± 10% variation	International standard is ±5%; KSA needs leniency.
Outlier Management Capability	Documented process	Qualitative KPI.

Readiness Pass Criteria: Provider meets 4 out of 6 KPIs, including workflow implementation.

Pillar 4 — Clinical & Administrative Workforce Readiness

KPI	Recommended Threshold	Rationale
Physician DRG Documentation Training Completion	≥ 90% of admitting physicians	International standard is 100%; 90% is realistic for KSA.
Coder Certification (ICD 10 AM/ACHI/ACS)	100% of coding staff	Mandatory.
CDI Coordinator Training Completion	≥ 90%	Allows for staffing variability.
Admin/Finance DRG Revenue Cycle Training	≥ 80%	Lenient for smaller hospitals.
Post Go Live Refresher (within 3 months)	Completed	Mandatory.
Annual Refresher Training Compliance	≥ 80%	Realistic for KSA.

Readiness Pass Criteria: Provider meets 4 out of 6 KPIs, including coder certification and physician training.

Pillar 5 — Governance, Compliance & Audit Readiness

KPI	Recommended Threshold	Rationale
Internal (Quarterly) and External (Annually) Coding Audit Program	Active & documented	Mandatory.
Coding Audit Accuracy	≥ 80%	Matches coding accuracy KPI.
CDI Governance Structure	Established	Qualitative KPI.
DRG Compliance Policies	Approved & implemented	Mandatory.
Critical Incident Reporting (≤ 5 days)	≥ 90% compliance	Allows for operational variability.
Monitoring of DRG Shifts / Upcoding Risks	Active monitoring	Qualitative KPI.

Readiness Pass Criteria: Provider meets 4 out of 6 KPIs, including audit program and compliance policies.

Pillar 6 — Financial & Contracting Readiness

KPI	Recommended Threshold	Rationale
DRG Revenue Modeling Capability	Completed	Mandatory.
Understanding of RW, Base Rate, MRP	≥ 80% of finance team trained	Realistic for KSA.
Variance Analysis (DRG vs FFS)	Performed monthly	Mandatory.
Outlier Cost Monitoring	Active	Qualitative KPI.
Contracting Readiness for DRG	Documented plan	Mandatory.
Financial Risk Mitigation Plan	Completed	Mandatory.

Readiness Pass Criteria: Provider meets 4 out of 6 KPIs, including revenue modeling and variance analysis.

Section 10: Governance and Subcommittees

10.1 CHI's Authority

CHI holds final authority over all DRG classification and policy determinations, consistent with its statutory mandate under the Cooperative Health Insurance Law and its Article 5 regulatory powers.

10.2 Governance Structure

To be determined

Appendix A: Glossary of Key Terms

Term	Definition
ADRG (Adjacent DRG)	A broad clinical category that groups patient episodes before final DRG split based on complexity level.
AR-DRG	Australian Refined Diagnosis-Related Groups – the national patient classification system mandated by the Saudi Health Council.
ACHI	Australian Classification of Health Interventions – the procedure coding system used alongside ICD-10-AM in Saudi Arabia.
Base Rate	The negotiated monetary value per average episode that, when multiplied by the DRG relative weight, determines the DRG payment.
Case Mix Index (CMI)	The average relative weight of all DRGs assigned to a facility's episodes over a given period. Higher CMI = more complex patients.
CDI	Clinical Documentation Improvement – a program to improve the completeness and accuracy of clinical documentation for coding and DRG purposes.
CHI	Council of Health Insurance – the regulatory body governing health insurance in Saudi Arabia.
DCL	Diagnosis Complexity Level – a score (1–5) assigned to each coded diagnosis reflecting its contribution to episode complexity.
DRG	Diagnosis-Related Group – a classification of inpatient episodes into groups sharing similar clinical characteristics and resource use.
ECCS / ECSL	Episode Clinical Complexity Score – the sum of DCL scores for all diagnoses in an episode; determines the final DRG split.
Error DRG	One of three DRG codes (960Z, 961Z, 963Z) indicating a data quality or coding problem preventing valid DRG assignment.
FFS	Fee-for-Service – the current reimbursement model, being replaced by DRGs.
GI (General Intervention)	A surgical or procedural intervention that drives partition of an ADRG into an interventional DRG.

Term	Definition
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, 10th Edition, Australian Modification – the diagnosis coding system.
MDC	Major Diagnostic Category – one of 23 broad clinical categories (MDC 00–23) to which episodes are first assigned based on principal diagnosis.
MDS	Minimum Data Set – the set of clinical and administrative variables required for AR-DRG grouping.
MRP	Market Reference Price – CHI's national benchmark price for each DRG, equal to the base price multiplied by the relative weight.
NCHI	National Center for Health Information – responsible for licensing and supervising medical coding in Saudi Arabia.
NPHIES	National Platform for Health Information Exchange Services – the national claims submission and exchange platform.
Principal Diagnosis	The diagnosis established after investigation to be chiefly responsible for the patient's admission to hospital.
Relative Weight (RW)	A numerical value assigned to each DRG reflecting its expected resource use relative to an average inpatient episode (RW 1.00 = average).
SBS	Saudi Billing System – the national itemized billing schedule used alongside ICD-10-AM/ACHI.
Shadow Billing	The parallel submission of DRG-coded claims alongside FFS claims for learning and readiness purposes, without financial consequences.
TPA	Third-Party Administrator – an entity that administers health insurance claims on behalf of payers.
VBHC	Value-Based Healthcare – CHI's strategic framework for aligning healthcare incentives with quality, efficiency, and patient outcomes.

Appendix B: Major Diagnostic Categories (MDC 00–23)

MDC Code	MDC Description
MDC 00	Unassignable to MDC
MDC 01	Diseases and Disorders of the Nervous System
MDC 02	Diseases and Disorders of the Eye
MDC 03	Diseases and Disorders of the Ear, Nose, Mouth and Throat
MDC 04	Diseases and Disorders of the Respiratory System
MDC 05	Diseases and Disorders of the Circulatory System
MDC 06	Diseases and Disorders of the Digestive System
MDC 07	Diseases and Disorders of the Hepatobiliary System and Pancreas
MDC 08	Diseases and Disorders of the Musculoskeletal System and Connective Tissue
MDC 09	Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast
MDC 10	Endocrine, Nutritional and Metabolic Diseases and Disorders
MDC 11	Diseases and Disorders of the Kidney and Urinary Tract
MDC 12	Diseases and Disorders of the Male Reproductive System
MDC 13	Diseases and Disorders of the Female Reproductive System
MDC 14	Pregnancy, Childbirth and the Puerperium
MDC 15	Newborns and Other Neonates
MDC 16	Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders
MDC 17	Neoplastic Disorders (Haematological and Solid Neoplasms)
MDC 18	Infectious and Parasitic Diseases

MDC Code	MDC Description
MDC 19	Mental Diseases and Disorders
MDC 20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorder
MDC 21	Injuries, Poisoning and Toxic Effects of Drugs
MDC 22	Burns
MDC 23	Factors Influencing Health Status and Other Contacts with Health Services

Appendix C: Shadow Billing Readiness Checklist

Providers must complete this checklist before commencing shadow billing submissions. A completed signed copy must be submitted to CHI via the DRG portal.

#	Readiness Criterion	Status (Yes/No/In Progress)	Target Date
1	CHI-certified AR-DRG v9.0 grouper procured and installed		
2	Grouper integrated with HIS for automated claim submission		
3	NPHIES DRG submission tested in sandbox environment		
4	NPHIES DRG submission tested in production environment		
5	ICD-10-AM 10th Edition coding system active in HIS		
6	All mandatory MDS data fields populated in HIS workflow		
7	CDI program established with designated CDI coordinator		
8	Clinician DRG awareness training completed		
9	Coding staff trained on AR-DRG v9.0 and DCL/ECCS logic		
10	DRG reporting dashboard operational (CMI, error rate, LOS)		
11	Error DRG rate below 5% on pilot submissions (pre-shadow billing)		
12	Internal coding QA program documented and active		
13	Finance team briefed on DRG payment formula and MRP		

#	Readiness Criterion	Status (Yes/No/In Progress)	Target Date
14	Payer/TPA notified of shadow billing start date		

Appendix D: Document Version History

Version	Date	Summary of Changes	Approved By
1.0	2026	Initial release for shadow billing phase	CHI Secretary General