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State/Territory Name: Washington, D.C.

State Plan Amendment (SPA) #: 12-002

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, M/S S3-13-15
Baltimore, MD 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and CHIP Services (CMCS)

Ms. Linda Elam, Ph.D.
Deputy Director/Medicaid Director
Department of Health Care Finance
899 N. Capitol St., NE
Washington, D.C. 20002

JUL 26 2012

RE: State Plan Amendment (SPA) 12-002

Dear Ms. Elam:

We have completed our review of State Plan Amendment 12-002. This SPA modifies Attachments 4.19-A and 4.19-B of the District of Columbia's Title XIX State Plan. Specifically, SPA 12-002 implements regulations for provider preventable conditions and related payment adjustments for Medicaid.

We conducted our review of this amendment according to the statutory requirements at sections 1902(a)(3), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We are approving SPA 12-002, effective July 1, 2012. Enclosed are the approved HCFA-179 and the amended state plan pages.

If you have any questions, please call Gary Knight at (304) 347-5723.

Sincerelv.

/s/

Cindy Mann
Director, CMCS

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER: 12-02	2. STATE District of Columbia
	3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act	
TO: Regional Administrator Centers for Medicare & Medicaid Services Department of Health and Human Services	4. PROPOSED EFFECTIVE DATE July1, 2012	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION 42CFR434,438,447 and 1902(a)(4),1902(a)(6)and 1902(a)(b) and 1903	7. FEDERAL BUDGET IMPACT a. FFY 13 $0 b. FFY 14 $0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Section 4, p. 57(a)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)* NEW

10. SUBJECT OF AMENDMENT:

Payment Adjustment for Provider Preventable Conditions

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Resolution Number: 19-695

12. SIGNATURE OF STATE AGENCY OFFICIAL /s/	16. RETURN TO Linda Elam, Ph.D. Deputy Director/Medicaid Director Department of Health Care Finance 899 N. Capitol St., NE Washington, DC 20002
13. TYPED NAME Linda Elam, Ph.D.	
14. TITLE Deputy Director/Medicaid Director	
15. DATE SUBMITTED June 6, 2012	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: JUL 26 2012
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 1 2012	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Penny Thompson	22. TITLE: Deputy Director, CMCS
23. REMARKS:	

State/Territory: District of Columbia

Citation	Payment Adjustment for Provider Preventable Conditions
42 CFR 447,434 438, and 1902(a)(4), 1902(a)(6), and 1903 conditions.	The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19(A)

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19 A____

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

TN No. _____ Approval Date JUL 26 2012 Effective Date JUL 1 - 2012

Supersedes

TN No. NEW

Citation

42 CFR 447,434
438, and 1902(a)(4),
1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19(A)

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider Preventable Conditions

The State identifies the following Other Provider preventable Conditions for non-payment under Section(s) 4.19 A____

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Payments for provider preventable conditions (PPCs) will be adjusted in the following manner:

Hospitals paid under the diagnosis-related group (DRG) basis

1. Providers are mandatorily required to report HCACs to the Agency using the applicable Present on Admission (POA) indicators on claims.

2. The Agency's claims processing system will identify HCACs from the diagnosis, procedure and POA information on the claim and disregard the HCAC in assigning the AP-DRG. Payment for the stay would only be affected if the presence of the HCAC would otherwise have pushed the stay into a higher-paying AP-DRG.

3. DRG claims will continue to be priced by the DRG, with a reduction in payment if removing the HCAC condition results in a DRG with a lower relative weight.

Hospitals paid under the non-diagnosis-related group (non-DRG) basis or the Per Diem Payment System Methodology

1. Non-DRG hospital claims will price according to existing payment methodologies for the provider (e.g. per diem).

2. Non-DRG claims will go through the HAC logic of the AP-DRG grouper software in order to determine whether the HCAC affects payments and to calculate the proper payment adjustment, if applicable.

3. This process will function in the same manner as for DRG claims. Therefore, if removing the HCAC condition results in a DRG with a lower relative weight, only then will the payment be affected and adjusted by a percentage based on the difference in the DRG weights.

Citation
42 CFR 447.26 (c)

Provider Guidelines relating to Provider Reimbursement

i. No reduction in payment for a provider preventable condition (PPC) will be imposed on a provider when the condition, defined as a PPC for a particular patient, existed prior to the initiation of treatment for that patient by that provider.

ii. Reductions in a provider payment may be limited to the extent that the following apply:
   a. The identified provider preventable condition would otherwise result in an increase in payment; and
   b. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable condition.

iii. The Agency assures the Centers for Medicare and Medicaid Services (CMS) that non-payment for provider preventable conditions does not prevent access to services for Medicaid beneficiaries.

Citation

42 CFR 447,434
Part 438, and 1902(a)(4),
1903 1902(a)(6), and 1903
conditions.

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and with respect to non-payment for provider preventable

Other Provider Preventable Conditions

The State identifies the following Other Provider Preventable Conditions for non-payment under Section(s) 4.19 B.

X_ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Payments for other provider preventable conditions (OPPCs) will be adjusted accordingly:

1. Providers are mandatorily required to report OPPCs to the Agency by using diagnosis codes in the corresponding fields provided for event codes on the claims.
2. Providers are mandatorily required to also report OPPCs using corresponding CPT/HCPCS modifiers associated with the surgical procedures on all claims.
3. Claims indicating any one of the three erroneous surgeries or procedures will be reviewed and denied if appropriate.

Citation

42 CFR 447.26 (c)

Provider Guidelines relating to Provider Reimbursement

i. The Agency assures the Centers for Medicare and Medicaid Services (CMS) that non-payment for OPPCs does not prevent access to services for Medicaid beneficiaries.