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State Name: District of Columbia

State Plan Amendment (SPA)#: 14-014

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Financial Management Group

APR 08 2015

Claudia Schlosberg, J.D.
Interim State Medicaid Director
Department of Health Care Finance
441 4th St. N.W., Suite 900 South
Washington, DC 20001

RE: State Plan Amendment 14-014

Dear Ms. Schlosberg:

We have completed our review of State Plan Amendment (SPA) 14-014. This SPA modifies Attachment 4.19-A of the District's Title XIX State Plan. Specifically, the SPA restructures and relocates language outlining provider preventable conditions.

We conducted our review of this SPA 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 (the Act) and the regulations at 42 CFR 447 Subpart C. We are approving state plan amendment 14-014 effective October 1, 2014. We are enclosing the HCFA-179 and the amended plan pages.

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

Sincerely,

/S/

Timothy Hill
Director

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: 14-014	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 October 1, 2014	

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 42 C.F.R. Part 447, Subpart C 1923 of the Act	7. FEDERAL BUDGET IMPACT a. FFY 15 $ 0 b. FFY 16 $ 0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19A, Part IV, pp. 35-37	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)* ~~Attachment 4.19A, Part IV, pp. 26-27~~ NEW

10. SUBJECT OF AMENDMENT:
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: PL20-377

/S/	16. RETURN TO Claudia Schlosberg, J.D. Interim State Medicaid Director Department of Health Care Finance 441 4th St. N.W., Suite 900 South Washington, DC 20001
13. TYPED NAME Claudia Schlosberg, JD	
14. TITLE Interim State Medicaid Director	
15. DATE SUBMITTED October 10, 2014	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED	18. DATE APPROVED APR 08 2015
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL OCT 01 2014	20. SIGNATURE OF REGIONAL OFFICIAL /S/
21. TYPED NAME Kristin FAN	22. TITLE Deputy Director, FMG

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT METHODS AND STANDARDS FOR ESTABLISHING PAYMENTS RATES:
HOSPITAL CARE

PART IV. PAYMENT ADJUSTMENT FOR PROVIDER PREVENTABLE CONDITIONS

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT METHODS AND STANDARDS FOR ESTABLISHING PAYMENTS RATES:
HOSPITAL CARE

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.

3. 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.

4. 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT METHODS AND STANDARDS FOR ESTABLISHING PAYMENTS RATES:
HOSPITAL CARE

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.