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.

See Attached Conditions

Other Provider-Preventable Conditions

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

_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.

See Attached Conditions

_X_ Additional Other Provider-Preventable Conditions identified below

---

(1) No reduction in payment for a provider preventable condition 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.

(2) Reductions in provider payment may be limited to the extent that the following apply:

(i) The identified provider-preventable conditions would otherwise result in an increase in payment.
(ii) The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

(3) A State plan must ensure that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

Effective July 1st, 2011, Potentially Preventable Complications are identified based on the present on admission (POA) information on hospital discharge abstract data set submitted to HSCRC. MHAC scaling is determined by two components: a. incidence of complications b. amount of additional charges for each PPC. The incidence of complications is the count of each PPC included in the MHAC program adjusted for the patient mix using APR-DRG and SOI categories. This method calculates hospital's expected incidence of complications given the severity of its patients mix based on the defined performance criteria (state average in the previous year) and compares expected values to the observed incidence to scale the hospital's overall performance. The amounts of additional charges for each PPC are estimated using a state-wide regression analysis of standardized charges in the previous year, which controls for the admission APR-DRGs and SOIs. For each PPC, the overall impact is calculated as follows:

PPCi=Each of the PPCs included in MHAC
A=hospital's actual number of PPC
E=hospital's expected rate of PPC
RA=estimated additional charge of PPC based on state-wide regression estimate

IMPACTi=(APPCi-EPPCi)*RAPPCi

The sum of each individual PPC impact yields an overall additional resource use due to excess/low complication rates for each hospital. The MHAC hospital index is calculated as the overall additional resource use as a percentage of hospital revenue from cases that were included in the PPC determination.

Table 1: PPC Regression

	Based on HSCRC FY 2011 Case Mix Data		
PPC #	PPC Description	Case #	CMS Corresponding HAC
1	Stroke & Intracranial Hemorrhage	1,005	
2	Extreme CNS Complications	542	
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	5,824	
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	949	
5	Pneumonia & Other Lung Infections	4,470	**Surgical Site Infections, Mediastinitis following CABG is a subset of PPC #5**
6	Aspiration Pneumonia	1,853	
7	Pulmonary Embolism	623	Deep Vein Thrombosis and **Pulmonary Embolism Following Certain Orthopedic Procedures is a subset of PPC 7**
8	Other Pulmonary Complications	4,669	
9	Shock	2,010	
10	Congestive Heart Failure	2,071	
11	Acute Myocardial Infarction	1,280	
12	Cardiac Arrythmias & Conduction Disturbances	1,119	
13	Other Cardiac Complications	316	
14	Ventricular Fibrillation/Cardiac Arrest	747	
15	Peripheral Vascular Complications Except Venous Thrombosis	266	
16	Venous Thrombosis	1,576	**Deep Vein Thrombosis** and Pulmonary Embolism **Following Certain Orthopedic Procedures is a Subset of PPC 16**
17	Major Gastrointestinal Complications without Transfusion or Significant Bleeding	786	
18	Major Gastrointestinal Complications with Transfusion or Significant Bleeding	298	
19	Major Liver Complications	431	
20	Other Gastrointestinal Complications without Transfusion or Significant Bleeding	458	
22	Urinary Tract Infection	5,665	**Catheter-Associated Urinary Tract Infection is a subset of PPC 22**
23	GU Complications Except UTI	496	
24	Renal Failure without Dialysis	8,069	
25	Renal Failure with Dialysis	215	
26	Diabetic Ketoacidosis & Coma	53	
27	Post-Hemorrhagic & Other Acute Anemia with Transfusion	1,191	
28	In-Hospital Trauma and Fractures	148	**Falls and Trauma (see also PPC**
29	Poisonings Except from Anesthesia	181	
30	Poisonings due to Anesthesia	1	
31	Decubitus Ulcer	1,063	**Pressure Ulcer Stages III & IV is a subset of PPC 31**

TN # 11-15 Approval Date APR - 3 2012 Effective Date JUL - 1 2011
Supersedes TN # NEW

Table 1: PPC Regression

PPC #	PPC Description	Case #	CMS Corresponding HAC
32	Transfusion Incompatibility Reaction	4	**Blood Incompatibility**
33	Cellulitis	1,194	
34	Moderate Infectious	1,085	
35	Septicemia & Severe Infections	2,789	
36	Acute Mental Health Changes	766	
37	Post-Operative Infection & Deep Wound Disruption Without Procedure	1,246	
38	Post-Operative Wound Infection & Deep Wound Disruption with Procedure	92	**Surgical Site Infection Following Certain Orthopedic Procedures is a subset of PPC 38 Surgical Site Infection Following Bariatric Surgery for Obesity is a subset of PPC 38**
39	Reopening Surgical Site	160	
40	Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure (	3,267	
41	Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I	198	
42	Accidental Puncture/Laceration During Invasive Procedure	1,463	
43	Accidental Cut or Hemorrhage During Other Medical Care	112	
44	Other Surgical Complication - Mod	445	
45	Post-procedure Foreign Bodies	30	
46	Post-Operative Substance Reaction & Non-O.R. Procedure for Foreign Body	2	
47	Encephalopathy	1,480	
48	Other Complications of Medical Care	755	**Air Embolism is a subset of PPC 48**
49	Iatrogenic Pneumothrax	963	
50	Mechanical Complication of Device, Implant & Graft	552	
51	Gastrointestinal Ostomy Complications	350	
52	Inflammation & Other Complications of Devices, Implants or Grafts Except Vascula	1,163	
53	Infection, Inflammation & Clotting Complications of Peripheral Vascular Catheters &	382	
54	Infections due to Central Venous Catheters	495	**Vascular Catheter-Associated Infection is a subset of PPC 54**
56	Obstetrical Hemorrhage wtih Transfusion	508	
57	Obstetric Lacerations & Other Trauma Without Instrumentation	1,219	
58	Obstetric Lacerations & Other Trauma With Instrumentation	484	
59	Medical & Anesthesia Obstetric Complications	865	
60	Major Puerperal Infection and Other Major Obstetric Complications	289	
61	Other Complications of Obstetrical Surgical & Perineal Wounds	182	
62	Delivery with Placental Complications	248	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of Maryland

Introduction

Reimbursement and payment criteria will be established which are designed to enlist participation of a sufficient number of providers of services in the Program so that eligible persons can receive the medical care and services included in the Plan at least to the extent these are available to the general population.

Payments for care or service will not exceed the amounts indicated in the following section below and participation in the program will be limited to providers of service who accept as payment in full the amounts so paid.

The Single State Agency will take whatever measures are necessary to assure appropriate audit of records wherever reimbursement is based on cost of providing care or service, or fee plus cost of materials.

Reimbursement Limitations:

A. The Department may not reimburse the claims received by the Program for payment more than 12 months after the date of services.

B. Medicare Claims. For any claim initially submitted to Medicare and for which services have been:

(1) Approved, requests for reimbursement shall be submitted and received by the Program within 12 months of the date of service or 120 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and

(2) Denied, requests for reimbursement shall be submitted and received by the Program within 12 months of the date of service or 120 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.

C. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 12 months of the earliest date of service.

D. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 12 months period, or within 60 days of rejection, whichever is later.

E. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 12 months of the date on which eligibility was determined.

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.

Other Provider-Preventable Conditions

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

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.

___ Additional Other Provider-Preventable Conditions identified below

MD Does not pay for OPPC when they occur in settings under Attachment 4.19-B.

---

(1) No reduction in payment for a provider preventable condition 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.

(2) Reductions in provider payment may be limited to the extent that the following apply:

(i) The identified provider-preventable conditions would otherwise result in an increase in payment.
(ii) The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

(3) A State plan must ensure that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

OS Notification

State/Title/Plan Number:	**Maryland 11-015**
Type of Action:	**SPA Approval**
Required Date for State Notification:	**May 13, 2012**
Fiscal Impact in Millions:	**FY 2011 $0** **FY 2012 $0**

Number of Potential Newly Eligible People: 0
Eligibility Simplification: No
Provider Payment Increase: No
Delivery System Innovation: No
Number of People Losing Medicaid Eligibility: 0
Reduces Benefits: No

Detail: **Effective July 1, 2011, MD SPA 11-015 updates the Maryland Medicaid State Plan to incorporate language related to ACA Section 2702, prohibiting payments to states for costs associated with Healthcare Acquired and Provider-Preventable Conditions. The submission also attests to Maryland's compliance with Health Care Acquired Conditions in 42 CFR 447.26(b). With 11-015, MD proposes to adjust payments through MD Health Services Cost Review commission (HSCRC) rate setting under Maryland's Medicare Waiver approved in 1997. All Maryland payers reimburse hospital services at prospective rates reviewed and approved by the HSCRC. This all payer system is codified in the SSA in Section 1841(b).**

MD will identify PPC based on the POA indicator on discharge data submitted to the Maryland Health Services Cost Review Commission (HSCRC). All incidents of PPC are tracked by the HSCRC. Under Maryland's policy, payment adjustments will occur in rate setting based on a hospital's expected incidence of complication given the severity of the hospitals patient mix. HSCRC then compares the expected values to the observed incidence to scale the overall performance.

Scaling is determined using the incidence of complications and the amount of additional charges for each PPC, along with a regression analysis of standardized charges from the previous year. For each PPC, the overall impact is calculated as follows:

> **IMPACTi=(APPCi-EPPCi)*RAPPCi, where PPCi represents each of the PPCs, A is a hospital's actual number of PPCs, E is the hospital's expected number of PPCs, and RA is the estimated additional charge based on the statewide regression.**

The base rate before the formulary adjustment assumes some "non-payment" for HAC. MD implemented HAC using SFY 2009 data as a baseline to gauge FY 2010 performance. Hospitals were scaled on that performance and a performance adjustment was applied to 2011 rates. If a hospital performs better than expected and EPPCi is greater than APPCi, their payment rate increases.

There is no fiscal impact anticipated. Maryland already had HAC policy in place.

Other Considerations:

The State's only Urban Indian Organization was consulted on this SPA, and responded without reservations.

This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

This OSN has been reviewed in the context of the ARRA and the approval of the SPA is not in violation of ARRA provisions.

CMS Contact: **Gary Knight (304) 347-5723**
National Institutional Reimbursement Team