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

Center for Medicaid and CHIP Services (CMCS)

Mr. Gary D. Alexander, Secretary
Commonwealth of Pennsylvania
Department of Public Welfare
Office of Medical Assistance Programs
Bureau of Policy, Budget and Planning
P.O. Box 8046
Harrisburg, PA 17105

JUN 19 2012

RE: State Plan Amendment (SPA) 11-020

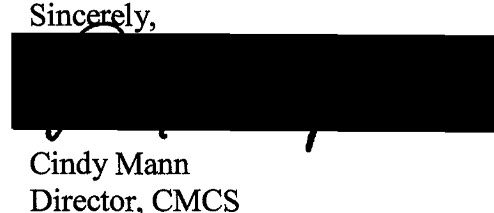
Dear Mr. Alexander:

We have completed our review of State Plan Amendment 11-020. This SPA modifies Attachments 4.19-A, 4.19-B, and 4.19D of Pennsylvania's Title XIX State Plan. Specifically, SPA 11-020 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 11-020, effective July 1, 2011. 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.

Sincerely,



Cindy Mann
Director, CMCS

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 11-020

2. STATE: Pennsylvania

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2011

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 CFR 447.26 Subpart A and
Sections1902(a)(4), 1902(a)(6), & 1903 of the Social Security Act

7. FEDERAL BUDGET IMPACT:

a. FFY	2011	$	0
b. FFY	2012	$	0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Section 4.19, Page 66(c)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

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:
Review and approval authority has been delegated to the Department of Public Welfare

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME: Gary D. Alexander

14. TITLE: Secretary of Public Welfare

15. DATE SUBMITTED: SEP 30 2011

16. RETURN TO:
Commonwealth of Pennsylvania
Department of Public Welfare
Office of Medical Assistance Programs
Bureau of Policy, Budget and Planning
P.O. Box 8046
Harrisburg, Pennsylvania 17105

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: JUN 19 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2011

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: [redacted]

22. TITLE: Deputy Director, CMCS

23. REMARKS:

Citation

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

Payment Adjustment for Provider Preventable Conditions (PPCs)

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 (HCACs)

The Department identifies the following HCACs for non-payment under Section 4.19A.

__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 (OPPCs)

The Department identifies the following OPPCs for non-payment under Section 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.
_______ Additional Other Provider-Preventable Conditions identified below (please indicate the section(s) of the plan and specific service type and provider type to which the provision will be applied).

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

Acute Care General Hospitals Paid Under the Prospective Payment System Methodology

1. Providers are mandatorily required to report HCACs to the Department using the applicable Present on Admission (POA) indicators on claims. Any HCAC diagnosis, as identified with the appropriate POA indicator, will be excluded from grouping of the inpatient claim. This will allow the Department to reasonably isolate costs associated with HCACs and thereby ensure that hospitals receive no payment for services for HCACs.
2. Providers are mandatorily required to report OPPCs to the Department via the OPPC Self Reporting Form as an attachment to hospital claims. The Department will manually review the claim to determine whether the OPPC will result in a higher paying APR-DRG or increased severity level associated with the APR-DRG. If so, the payment will be reduced to the appropriate APR-DRG and severity level and payment will be made to the hospital accordingly.
3. If the hospitalization is solely the result of an OPPC that occurs upon admission, no APR-DRG payment will be made to the hospital.

Hospitals Paid Under the Per Diem Payment System Methodology – Psychiatric Hospitals/Units, Medical Rehabilitation Hospitals/Units and Drug and Alcohol Hospitals/Units

1. Providers are mandatorily required to report HCACs to the Department using applicable Present on Admission (POA) indicators on claims.
2. Providers are mandatorily required to report OPPCs to the Department as an attachment to hospital claims.
3. The Department's will identify PPCs, i.e., HCACS and OPPCs through the Department's Concurrent Utilization Review process and deny days of care for the same. Hospital claims must reflect the number of Department approved days and denied days as identified through the Concurrent Utilization Review process. The Department's payment to hospitals will only reflect payment for approved days; no payment will be made for denied days for HCACs or OPPCs.

In accordance with 42 CFR 447.26(c):

(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:
   a. The identified PPC will otherwise result in an increase in payment.
   b. The Department can reasonably isolate for nonpayment the portion of the payment directly related to treatment for and related to the PPC.
(3) The Department assures the Centers for Medicare and Medicaid Services that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

Methods and Standards for Governing Payment for Nursing Facility Services

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 (OPPCs)

The Department identifies the following OPPCs for non-payment under Section(s) 4.19 D.

_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 (please indicate the section(s) of the plan and specific service type and provider type to which the provision will be applies.

Payments for OPPCs will be adjusted in the following manner:

(1) Providers are mandatorily required to report OPPCs to the Department using modifiers PA (surgical or other invasive procedure on wrong body part), PB (surgical or other invasive procedure on wrong patient), PC (surgical or other invasive procedure on patient) on their claims.
(2) No payment will be made for services for OPPCs.

In accordance with 42 CFR 447.26(c):

(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:
    a. The identified PPC will otherwise result in an increase in payment.
    b. The Department can reasonably isolate for nonpayment the portion of the payment directly related to treatment for and related to the PPC.
(3) The Department assures the Centers for Medicare and Medicaid Services that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

Methods and Standards for Reasonable Cost-Related Reimbursement for Intermediate Care Facilities for the Mentally Retarded and Persons with Other Related 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.

Other Provider Preventable Conditions (OPPCs)

The Department identifies the following OPPCs for non-payment under Section(s) 4.19 D.

_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 (please indicate the section(s) of the plan and specific service type and provider type to which the provision will be applies.

Payments for OPPCs will be adjusted in the following manner:

(1) Providers are mandatorily required to report OPPCs to the Department using modifiers PA (surgical or other invasive procedure on wrong body part), PB (surgical or other invasive procedure on wrong patient), PC (surgical or other invasive procedure on patient) on their claims.
(2) No payment will be made for services for OPPCs.

In accordance with 42 CFR 447.26(c):

(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:
    a. The identified PPC will otherwise result in an increase in payment.
    b. The Department can reasonably isolate for nonpayment the portion of the payment directly related to treatment for and related to the PPC.
(3) The Department assures the Centers for Medicare and Medicaid Services that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

METHODS AND STANDARDS OF RESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Citation

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

Payment Adjustment for Provider Preventable Conditions (OPPCs)

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 Department identifies the following OPPCs 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.
______ Additional Other Provider-Preventable Conditions identified below (please indicate the section(s) of the plan and specific service type and provider type to which the provision will be applies.

Payments for OPPCs will be adjusted in the following manner:

(1) Providers are mandatorily required to report OPPCs to the Department using modifiers PA (surgical or other invasive procedure on wrong body part), PB (surgical or other invasive procedure on wrong patient), PC (surgical or other invasive procedure on patient) on their claims.
(2) No payment will be made for services for OPPCs.

In accordance with 42 CFR 447.26(c):

(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:
    a. The identified PPC will otherwise result in an increase in payment.
    b. The Department can reasonably isolate for nonpayment the portion of the payment directly related to treatment for and related to the PPC.
(3) The Department assures the Centers for Medicare and Medicaid Services that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

Methods and Standards for Governing Payment for County Nursing Facility Services

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 (OPPCs)

The Department identifies the following OPPCs for non-payment under Section(s) 4.19 D.

_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 (please indicate the section(s) of the plan and specific service type and provider type to which the provision will be applies.

Payments for OPPCs will be adjusted in the following manner:

(1) Providers are mandatorily required to report OPPCs to the Department using modifiers PA (surgical or other invasive procedure on wrong body part), PB (surgical or other invasive procedure on wrong patient), PC (surgical or other invasive procedure on patient) on their claims.
(2) No payment will be made for services for OPPCs.

In accordance with 42 CFR 447.26(c):

(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:
    a. The identified PPC will otherwise result in an increase in payment.
    b. The Department can reasonably isolate for nonpayment the portion of the payment directly related to treatment for and related to the PPC.
(3) The Department assures the Centers for Medicare and Medicaid Services that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

Methods and Standards for Reasonable Cost-Related Reimbursement for State Operated Nursing Facilities

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 (OPPCs)

The Department identifies the following OPPCs for non-payment under Section(s) 4.19 D.

_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 (please indicate the section(s) of the plan and specific service type and provider type to which the provision will be applies.

Payments for other provider-preventable conditions OPPCs will be adjusted in the following manner:

(1) Providers are mandatorily required to report OPPCs to the Department using modifiers PA (surgical or other invasive procedure on wrong body part), PB (surgical or other invasive procedure on wrong patient), PC (surgical or other invasive procedure on patient) on their claims.
(2) No payments will be made for services for OPPCs.

In accordance with 42 CFR 447.26(c):

(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.
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    b. The Department can reasonably isolate for nonpayment the portion of the payment directly related to treatment for and related to the PPC.
(3) The Department assures the Centers for Medicare and Medicaid Services that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.