OMB No.: 0938 – 1136
CMS Form: CMS-10364

ATTACHMENT 4.19-A
ADDENDUM

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **Delaware**

Payment Adjustment for Provider Preventable Conditions

With the implementation of the HIPAA 5010 version of the 837 institutional claim, inpatient hospital claims that meet the criteria for an outlier payment AND that contain either of the following data elements on the claim will be suspended for manual review by Delaware Medicaid:

1) A Present on Admission indicator of "N", "U" or "1"

AND

A Medicare-defined Hospital Acquired Condition procedure or diagnosis code, except for deep vein thrombosis/pulmonary embolism following total knee replacement or hip replacement in pediatric and obstetric patients.

2) A diagnosis code of E8765, E8766 or E8767

For general acute care hospitals, if the portion of payment to the hospital directly related to treatment for and related to the Hospital Acquired Condition can be isolated, the payment for the outlier will be reduced by that amount and the hospital discharge payment and any remaining payable outlier amount will be paid on the claim. The discharge payment will not be reduced, as this part of the hospital payment would not have been increased as a result of the PPC. For hospitals that are paid a per diem rate, the number of covered days shall be reduced by the number of days associated with diagnoses not present on admission for any HAC. The number of reduced days shall be based on the average length of stay (ALOS) for the specific type of hospital from claims paid in the prior state fiscal year.

In compliance with 42 CFR 447.26(c), Delaware Medicaid provides:

1) That 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) That 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) Assurance that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

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ATTACHMENT 4.19-B
Introduction

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF DELAWARE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

OTHER TYPES OF CARE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **Delaware**

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) 4.19 (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 provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services)* of the plan:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **Delaware**

Payment Adjustment for Provider Preventable Conditions

Claims for non-institutional services described in Attachment 4.19-B that includes a diagnosis code of E8765, E8766 or E8767 will be denied by Delaware Medicaid.

In compliance with 42 CFR 447.26(c), Delaware Medicaid provides:

1) That 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) That 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) Assurance that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

OMB No.: 0938 – 1136
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ATTACHMENT 4.19-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Delaware

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.

____ 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 provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services)* of the plan:

TN No. SPA #11-005 **Supersedes** **TN No. NEW** **CMS ID: 7982E**	**Approval Date** DEC – 2 2011 **Effective Date July 1, 2011**

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1136. The time required to complete this information collection is estimated to average 7 hours per response, including the time to complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

OS Notification

State/Title/Plan Number:	Delaware 11-005
Type of Action:	SPA Approval
Required Date for State Notification:	December 8, 2011
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 21, 2011, DE SPA 11-005 adds the CMS pre-prints for provider preventable conditions (PPC) to attachments 4.19A and 4.19B. With 11-005, DE proposes to adjust payments through MMIS for inpatient hospitals by first determining if the claim has any select present on admission (POA) indicator AND if it falls in the Medicare defined HAC (with the exception of those deep vein thrombosis/pulmonary embolism), or if the claim is wrong surgery, wrong patient, wrong body part. For any claims with these characteristics that are also outliers, Delaware will: 1) suspend and manually review the claim; 2) attempt to identify the portion of the charges related to the PPC; 3) subtract any identified and isolated PPC amount from the total charges; and 4) compute any remaining outlier payment using Delaware's approved outlier methodology. Delaware's payment methodology for general hospitals is a flat discharge payment plus an outlier payment if the total claim amount exceeds a specified threshold. For claims that exceed the outlier threshold, the state pays a fixed percent of the outlier amount. Payment will equal the facility's flat discharge payment plus any remaining outlier (after the PPC amount is removed).

For hospital inpatient claims where a PPC is indicated but there is no outlier payment (meaning the claim only qualifies for the discharge payment) and therefore no increase in what the payment would have been absent the PPC, there is no adjustment in the discharge payment to the hospital.
For hospitals that are paid a per diem rate, the number of covered days is reduced by the number of days associated with diagnoses not POA for any HAC. The number of reduced days is based on the average length of stay for the specific type of hospital from claims paid in the prior state fiscal year.
For all other non-institutional settings Delaware will deny payment for any claims indicating wrong site, wrong surgery, or wrong patient.

There is no fiscal impact anticipated due to the flat rate discharge per facility. Notice was published at delawareonline and in The NewsJournal on 7/20/2011.

Other Considerations:

This issue does not appear to have generated significant outside interest and we do not recommend the Secretary contact the governor.

Delaware does not have any federally recognized Indian tribes or UIOs, therefore the Tribal Consultation requirements do not apply.

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National Institutional Reimbursement Team