

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

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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.

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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.