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

Centers for Medicaid and CHIP Services (CMCS)

Mr. Jerry Dubberly, PharmD.
Chief, Medicaid Division
Georgia Department of Community Health
2 Peachtree Street, NW
Atlanta, Georgia 30303

JUN 19 2012

RE: State Plan Amendment (SPA) GA 11-005

Dear Dr. Dubberly:

We have reviewed the proposed amendment to Attachment 4.19-A and 4.19-B of your Medicaid State plan submitted under transmittal number (TN) 11-005. Effective June 30, 2012 this amendment proposes to revise the payment methodology to deny payment for Provider Preventable conditions.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of June 30, 2012. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Stanley Fields at (502) 223-5332.

Sincerely

Cindy Mann
Director, CMCS

RECEIVED
JUN 25 2012
Chief's Office
Medicaid Division

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: 11-005

2. STATE: GEORGIA

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~July 1, 2011~~
JUNE 30, 2012

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:
1902(a)(42)(B)(i)

7. FEDERAL BUDGET IMPACT:
a. FFY 2011 $ 0
FFY 2012 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, pp. 1-5
Attachment 3.1-a, Page 1b-2
ATTACHMENT 4.19A P14, 14b, 14c
ATTACHMENT 4.19A P 4-5
ATTACHMT 4.19B P1.001 1.002

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, pp. 1-5
ATTACHMENT 4.19A P.14
ATTACHMENT 4.19A P.4-5

10. SUBJECT OF AMENDMENT:
Hospital Acquired 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:

12. SIGNATURE OF STATE AGENCY OFFICIAL: [signature]

13. TYPED NAME: JERRY DUBBERLY

14. TITLE: CHIEF, Medicaid Division

15. DATE SUBMITTED: 9/28/11

16. RETURN TO:
Department of Community Health
Medicaid Division
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159

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~~ JUN 30 2012

20. SIGNATURE OF REGIONAL OFFICIAL: [signature]

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, CMCS

23. REMARKS:
Pen & ink changes made to box 8 & 9 and 4 and 19

FORM HCFA-179 (07-92)

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

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

Payment Adjustment for Provider Preventable Conditions (PPC)

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 (OPPC)

The State identifies the following Other Provider-Preventable Conditions for non-payment under Attachment 4.19-B of this State plan.

_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.

On and after May 17, 2012, Medicaid will make zero payments to providers for Other Provider-Preventable Conditions which includes Never Events (NE) as defined by the National Coverage Determination (NCD). The Never Events (NE) as defined in the NCD includes Inpatient Hospitals, Outpatient Hospitals, Ambulatory Surgical Centers (ASC) and practitioners, and these providers regardless of the healthcare setting will be required to report NEs. Reimbursement for conditions described above is defined in Attachment 4.19-B, Page 1.002 of this State Plan.

A. Dates of service beginning on or after May 17, 2012:
   1. The claims identified with provider-preventable conditions through the claims payment system will be reviewed.
   2. When the review of claims indicates an increase of payment to the provider for an identified provider-preventable condition, the amount for the provider-preventable condition will be excluded from the providers' payment.

B. 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.

C. Reductions in provider payment may be limited to the extent that the following apply:
   1. The identified provider-preventable conditions would otherwise result in an increase in payment.
   2. 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. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

D. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

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

Payment Adjustment for Provider Preventable Conditions (PPC)
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 (HAC)
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, for example.

Effective June 30, 2012, Medicaid will make zero payment to providers for services related to Provider Preventable Conditions (PPC) which includes Healthcare Acquired Conditions (HAC). Reimbursement for conditions described above is defined in Attachment 4.19A, Page 14a of this State Plan.

A. Dates of service beginning on or after May 17, 2012:
   1. The claims identified with a Present on Admission (POA) indicator through the claims payment system will be reviewed.
   2. When the review of claims indicates a HAC, the amount for the provider-preventable condition will be excluded from the provider's payment.

B. Reductions in provider payment may be limited to the extent that the following apply:
   1. The identified provider-preventable conditions would otherwise result in an increase in payment.
   2. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for any condition related to HACs and any other provider-preventable conditions.
   3. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

C. Non-payment of HACs or NEs shall not prevent access to services for Medicaid beneficiaries.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES INPATIENT HOSPITAL SERVICES

Payment for Hospital Acquired Conditions:

Effective June 30, 2012 and in accordance with Title XIX of the Social Security Act – Sections 1902, 1903 and 42 CFRs 434, 438, and 447, Medicaid will make no payment to providers for services related to Provider Preventable Conditions (PPC) which includes Healthcare Acquired Condition (HCAC) and Never Events (NE).

In accordance with GA State Plan, Attachment 3.1-A, Page 1, Hospital Services payments are allowed except for the following conditions outlined below.

The above effective date and after, for all Medicaid patients, requests for Diagnosis Related Groups (DRGs) attributable to Present on Admission (POA) conditions will be reimbursed for allowable charges. Peer Review Organization (PRO) review for Present on Admission (POA) is not required.

Provider Preventable Conditions (PPC), which includes Healthcare Acquired Condition (HCAC), with diagnose codes with Y or W, or as defined by CMS, will be considered in the DRG calculation. Conversely, any diagnoses codes with N or U, or as defined by CMS, will not be considered in the DRG calculation. Provider Preventable Conditions (PPC) will not be approved by the Peer Review Organization (PRO). Providers must identify and report PPC occurrences.

Never Events (NE) are defined by the National Coverage Determination (NCD) manual for Inpatient Hospitals and practitioners, and these providers will be required to report NEs. Never Events (NE) for Inpatient Hospital claims will bill separate claims using by Bill Type 110 or as designated by the National Uniform Bill Committee for a non-payment/zero claim. The non-covered Bill Type 110 must have one of the ICD-9 diagnosis codes.

- E876.5 – Performance of wrong operation (procedure) on correct patient
- E876.6 – Performance of operation (procedure) on patient not scheduled for surgery
- E876.7 – Performance of correct operation (procedure) on wrong side/body part

The provider may file a separate claim for the same Medicaid recipient with the same dates of service to include the allowable charges for reimbursement. Providers must identify and report NE occurrences.

Prohibition on payments for PPCs, HCACs and NEs shall not result in a loss of access to care or services for Medicaid beneficiaries. This policy applies to all Medicaid reimbursement provisions, contained in 4.19A, including Medicaid supplemental or enhanced payments and Medicaid disproportionate share hospital payments.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

g. Legal services for an administrative appeal or hearing, or court proceeding involving the provider and the Department or any other state agency when judgment or relief is not granted to the provider. Legal services associated with certificate of need reviews, issuance appeals, disputes or court proceedings are not allowable regardless of outcome. Legal services associated with a provider's initial certificate of need request shall be allowable; and

h. Advertising costs that are (a) for fund-raising purposes, (b) incurred in the sale or lease of a facility or agency or in connection with issuance of the provider's own stock, or the sale of stock held by the provider in another corporation, (c) for the purpose of increasing patient utilization of the provider's facilities, (d) for public image improvement, or (e) related to government relations or lobbying.

i. Hospital Acquired Condition (HAC) Never Events (NE)/Present on Admission (POA)/ Other provider-preventable condition (OPPC)

For dates of service May 17,2012 and after, for all Medicaid patients, requests for Diagnosis Related Groups (DRGs) attributable to Medicare identified hospital acquired conditions and never events will not be approved by the Peer Review Organization (PRO) and are not reimbursable regardless of the setting (all inpatient hospital settings and in all health care settings). PRO review for present on admission is not required. This policy applies to all Medicaid reimbursement provisions, contained in Attachment 4.19-A, including Medicaid supplemental or enhanced payments and Medicaid disproportionate share hospital payments and complies with Medicare Billing Guidelines for Hospital Acquired Conditions, Provider Preventable Conditions, Never Events and Present on Admission.

C. Audits

1. Background - To assure that recognition of reasonable cost is being achieved, a comprehensive hospital audit program has been established. The hospital common audit program has been established to reduce the cost of auditing submitted reports under the above three programs and to avoid duplicate auditing effort. The purpose is to have one audit of a participating hospital which will serve the needs of all participating programs reimbursing the hospital for services rendered.

2. Common Audit Program
The Department has entered into a written agreement with the Georgia based Medicare intermediary for participation in a common audit program of Titles VI, XVIII and XIX. Under this agreement, the intermediary shall provide the result of Department the result desk review and field audits of those hospitals located in Georgia.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

3. Other Hospital Audits
For those hospitals not covered by the common audit agreement with the Medicare intermediary, the Department shall be responsible for the performance of desk reviews and field audits, the Department shall:

a. Determine the scope and format for on-site audits.
b. Contract annually for the performance of desk reviews and audits.
c. Ensure all audits are performed in accordance with generally accepted auditing standards of the AICPA.
d. Ensure that only those expense items that the plan has specified as allowable costs under Section I of this plan have been included by the hospital in the computation of the costs of the various services provided under Title XIX in Georgia;
e. Review to determine the Georgia Medicaid Log is properly maintained and current in those hospitals where its maintenance is required.

4. Retention of Cost Reports
All audited cost reports received from the Medicare intermediary or issued to the Department will be kept for at least 2 years.

5. Overpayments and Underpayments
The Department may adjust the reimbursement of any provider whose rate is established specifically for it on the basis of cost reporting, whenever the Department determines that such adjustment is appropriate. The provider shall be notified in writing of the Department's intention to adjust the rate, either prospectively, retroactively or both. The terms of payment will be in accordance with the Department's policy. All overpayments will be reported by the Department to CMS as required. Information intentionally misrepresented by a hospital in the cost report shall be grounds to suspend the hospital from participation in the Georgia Medicaid Program.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

Payment for Hospital Acquired Conditions:

Effective May 17, 2012 and in accordance with Title XIX of the Social Security Act – Sections 1902, 1903 and 42 CFRs 434, 438, and 447, Medicaid will make no payment to providers for services related to Provider Preventable Conditions (PPCs) which includes Never Events (NE), Other Provider Preventable Conditions (OPPCs) and Additional Other Provider-Preventable Conditions (AOPPCs).

In accordance with GA State Plan, Attachment 3.1-B payments are allowed except for the following conditions outlined below.

Never Events (NE) are defined by the National Coverage Determination (NCD) manual for Outpatient Hospitals, Ambulatory Surgical Centers (ASC) and practitioners, and these providers will be required to report NEs. Outpatient Hospital claims must bill all non-payment/zero services on the same professional 1500 claim as a separate detail line-entry or as designated by the National Uniform Bill Committee for non-payment. All non-payment services found in claims adjudication from NEs, PPCs, and AOPPCs will be subject to post medical records review and recoupment.

The provider may file a professional claim for the same Medicaid recipient with the same dates of service to include the allowable charges for reimbursement. Providers must identify and report NE occurrences. All NEs services will pend for retrospective review.

Prohibition on payments for NE, OPPC, and AOPPC shall not result in a loss of access to care or services for Medicaid beneficiaries. This policy applies to all Medicaid reimbursement provisions contained in 4.19B.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

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

Payment Adjustment for Provider Preventable Conditions (PPC)

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(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.