DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

FINAL

ORDER

Medicaid Nonpayment and Reporting Requirements For Provider Preventable Conditions

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend existing rules in the Title XIX Medicaid State Plan regarding *Medicaid nonpayment and reporting requirements for provider preventable conditions*. The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the September 2011 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by September 30, 2011 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

The proposed provides notice to the public that the Division of Medicaid and Medical Assistance (DMMA) intends to amend the Title XIX Medicaid State Plan regarding *Medicaid nonpayment and reporting requirements for provider preventable conditions*.

Statutory Authority

- Patient Protection and Affordable Care Act (Pub. L. No. 111-148 as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152)), together known as the Affordable Care Act;
- 42 CFR §434.6, *General requirements for all contracts and subcontracts;*
- 42 CFR §438.6, *Contract requirements;*
- 42 CFR §447.26, *Prohibition on payment for provider-preventable conditions.*

Background

On June 6, 2011, the Centers for Medicare and Medicaid Services (CMS) issued a final rule outlining its planned implementation of non-payment for Medicaid healthcare-associated conditions (HCACs). The final rule is available at http://www.gpo.gov/fdsys/pkg/FR-2011-06-06/pdf/2011-13819.pdf. The rule implements Section 2702 of the Patient Protection and Affordable Care Act (ACA) of 2010, which prohibits federal payments to state Medicaid programs for the costs associated with HCACs.

In addition, the law allows states to identify other conditions for which they may deny provider payments. States must ensure that any non-payment rules they put into effect do not result in a loss of access to care or services for Medicaid beneficiaries. The rule requires providers to self-report the occurrence of HCACs through their existing claims systems.

Section 2702 of the ACA requires the Secretary to identify current State practices that prohibit Medicaid payment for health care-acquired conditions (HCACs), determine which practices are appropriate for the Medicaid program, and apply them to the Medicaid program through regulations to be effective July 1, 2011. The regulations are to prohibit federal payment for specified HCACs and ensure that the prohibition will not result in loss of access to care for Medicaid beneficiaries. For this purpose, HCACs are defined as medical conditions for which an individual was diagnosed that could be identified by a secondary diagnostic code described in the Medicare requirements at section 1886(d)(4)(D)(iv) of the Social Security Act. (In the Medicare program, this section applies to prohibition of certain inpatient hospital payments, and the identified conditions are referred to as Hospital Acquired Conditions, or HACs.) In implementing the Medicaid payment prohibition, the Secretary must apply, as appropriate, the Medicare inpatient hospital payment regulations promulgated under section 1886(d)(4)(D). In doing so, the Secretary may exclude certain Medicare HACs if they are inapplicable to Medicaid beneficiaries.

While the rule's requirements will take effect July 1, 2011, as required by the statute, CMS intends to delay compliance action on the provision until July 1, 2012.

Summary of Proposal

In response to the requirements outlined in Section 2702 of the Affordable Care Act (ACA), the Delaware Medical Assistance Program (DMAP) is implementing new policy that prohibits Medicaid payment for services related to Provider

Preventable Conditions (PPCs). In addition, DMAP will require that providers self-report the occurrence of a PPC. DMAP will implement Section 2702 and prohibit Medicaid payments for care associated with PPCs. The new policy is effective for dates of service on and after July 1, 2011.

Specifically, upon receipt of CMS-approved state plan amendment preprint templates, the Medicaid state plan will be amended at Attachment 3.1-A and Attachment 4.19-B to allow enforcement of payment prohibitions for services related to provider preventable conditions. The DMAP will update its payments systems to improve enforcement and, consistent with Section 2702 of the ACA, which takes effect July 1, 2011, implement policies to prohibit Medicaid payment for provider preventable conditions. DMAP provider manual(s) will also be updated, as appropriate.

The provision of this state plan amendments are subject to approval by the Centers for Medicare and Medicaid Services (CMS).

Fiscal Impact

It is anticipated that there will be minimal fiscal impact to the General Fund as these Provider Preventable Conditions are generally not billed to the Medicaid program.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE

The Governor's Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities (SCPD) offered the following observations summarized below. The Division of Medicaid and Medicaid Assistance (DMMA) has considered each comment and responds as follows.

As background, CMS issued a final regulation in June 2011 implementing Section 2702 of the federal Patient Protection and Affordable Care Act. The CMS regulation bars Medicaid payments to hospitals for services rendered related to provider-preventable conditions. Such conditions include foreign objects retained after surgery, blood transfusions with incompatible blood, falls and trauma occurring in the hospital, etc. The bar on payment does not apply to services related to pre-existing conditions, i.e., "present on admission" ("POA"). Id. Moreover, covered hospitals must report all provider preventable conditions. Finally, States have some discretion to apply the regulation to non-hospital providers. At 32823. DMMA is now proposing to implement the new CMS regulation through a Medicaid State Plan amendment. The brief amendment essentially adopts the CMS requirements. Hospitals will be required to report provider preventable conditions to DMMA and be barred from submitting claims for services related to such conditions. GACEC and SCPD have the following observations on the proposed DMMA Plan Amendment.

First, the CMS regulation [§447.26(c)(5), reproduced at 76 Fed. Reg. 32837], contains the following provision:

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

One concern addressed by this provision is that hospitals anticipating Medicaid non-payment to remediate a provider-preventable condition may opt to decline to treat the condition. This could be very harmful to Medicaid beneficiaries who have developed a provider-preventable condition. A related concern would be imposing the costs of treatment of the provider-preventable condition on the Medicaid beneficiary through direct billing. It would be preferable for DMMA to include the following clarification in the regulation:

> Providers identifying a provider-preventable condition whose costs of treatment are barred under this section shall not deny medically necessary treatment to the affected patient nor attempt to impose financial liability on the affected patient.

Agency Response: As referenced in the regulation's "Summary of Proposal", CMS has issued a State plan amendment preprint template. The template language captures the assurance that the State is in compliance with 42 CFR 447, Subpart A. Specifically, 42 CFR §447.26(c)(4) addresses the clarification requested. A copy of the template can be provided upon request.

Regarding billing Medicaid beneficiaries, DMAP provider manuals already have in place specific policies that protect Medicaid beneficiaries. See, for example, General Policy Manual, 1.16, *Billing DMAP Clients* on the DMAP website at:

http://www.dmap.state.de.us/downloads/manuals.html.

Second, CMS expects states to include "provider-preventable condition" payment and reporting standards in MCO contracts. At 32828-32829. DMMA may wish to review the DSHP and DSHP Plus proposed contract provisions to ensure incorporation of the reporting and billing standards.

Agency Response: DMMA will comply with all CMS requirements related to payment and reporting standards.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the September 2011 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Title XIX Medicaid State Plan regarding *Medicaid nonpayment and reporting requirements for provider preventable conditions* is adopted and shall be final effective November 10, 2011.

Rita M. Landgraf, Secretary, DHSS

DMMA FINAL ORDER REGULATION #11-50b
REVISION:

Delaware Medical Assistance Program Provider Specific Policy Manual

(Policy Number Undetermined) Provider Preventable Conditions

The following applies to any healthcare service provided to Medicaid recipients and dual eligible beneficiaries:

(1) In accordance with 76 FR 32837, which is incorporated by reference, the Delaware Medical Assistance Program (DMAP) will not reimburse providers or contractors for provider preventable conditions (PPCs) as defined in this Centers for Medicare and Medicaid Services (CMS) rule. Providers and contractors are prohibited from submitting claims for payment of these conditions except as permitted in 76 FR 32837 when the provider preventable condition existed prior to the initiation of treatment by the provider.

(2) Medicaid providers who treat Medicaid eligible patients must report all provider preventable conditions whether or not reimbursement for the services is sought.

(3) Providers must report the occurrence of a PPC through the appropriate claim(s) type submission process.

(4) DMAP will not accept Medicare primary, Medicaid secondary professional, or institutional crossover claims resulting in zero liability.

(5) DMAP will align with Medicare's policy and billing guidelines for all providers impacted by this policy, and adopt CMS' changes.

15 DE Reg. 664 (11/01/11) (Final)