State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
Director

EDMUND G. BROWN JR.
Governor

DATE: July 21, 2017

DUALS PLAN LETTER 17-002
SUPERSEDES DUALS PLAN LETTER 15-002

TO: CAL MEDICONNECT MEDICARE-MEDICAID PLANS

SUBJECT: REPORTING REQUIREMENTS RELATED TO PROVIDER PREVENTABLE CONDITIONS

PURPOSE:
The purpose of this Duals Plan Letter (DPL) is to notify all Medicare-Medicaid Plans (MMPs) participating in the Duals Demonstration Project (Cal MediConnect) of updated reporting requirements for encounter data resulting from Provider Preventable Conditions (PPCs). This DPL supersedes DPL 15-002.

BACKGROUND:
In January 2012, Governor Brown announced his intent to enhance health outcomes and beneficiary satisfaction for low-income Seniors and Persons with Disabilities by shifting service delivery away from institutional care to home- and community-based settings. To implement that goal, Governor Brown enacted the Coordinated Care Initiative (CCI) by signing Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012), SB 1036 (Chapter 45, Statutes of 2012) and SB 94 (Chapter 37, Statutes of 2013).

One component of CCI is Cal MediConnect. Cal MediConnect is a voluntary program, which serves beneficiaries who are both Medi-Cal and Medicare eligible (dual-eligible beneficiaries) and combines the full continuum of acute, primary, institutional, and home and community-based Medicare and Medi-Cal services into a single benefit package delivered through an organized service delivery system administered by MMPs. Cal MediConnect has been implemented in the counties of Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

Pursuant to Title 42 of the Code of Federal Regulations (CFR), Sections 438.3(g)[1] (requirement previously contained in 42 CFR 438.6(f)(2)(ii)), which was amended to contain specified reporting requirements and re-designated per rulemaking CMS-2390-

[1] 42 CFR 438.3(g) is available online.

F[2] (CMS-2390-F was published May 6, 2016 and the redesignated 438.3(g) was effective 60-days after the publication date) and 447.26[3], and Welfare and Institutions Code (WIC) Section 14131.11[4], states are prohibited from permitting payment to Medicaid providers for treatment of PPCs, including amounts charged for the care and treatment of dual-eligible beneficiaries. PPCs include both "Health Care Acquired Conditions" (HCACs) and "Other Provider Preventable Conditions" (OPPCs) as defined in 42 CFR 447.26(b). The Attachment provided below contains the minimum set of such conditions defined by CMS. CMS further defined OPPCs as conditions that: 1) are identified by the State Plan, 2) are reasonably preventable through the application of procedures supported by evidence-based guidelines, 3) have negative consequence for the beneficiary, 4) are auditable, and 5) include, at a minimum, the procedures listed in the Attachment below. As of July 1, 2012, CMS does not pay for HCACs that occur in an inpatient setting or for OPPCs that occur in any health care setting.

On April 3, 2017, the Department of Health Care Services (DHCS) replaced paper form DHCS 7107 with online reporting of PPCs. As a result, starting May 15, 2017, DHCS no longer accepted paper forms.

REQUIREMENTS:
Title 42, CFR, Section 438.3(g) and the MMP's three-way contract require MMPs to report PPC-related encounters in a form and frequency as specified by the state. Accordingly, MMPs must screen the encounter data, including data received from their network providers, for the presence of PPCs on a monthly basis.

MMPs must use DHCS' secure online reporting portal to report PPCs to DHCS. Please see the instructions about using the portal[5], which include the link to the online portal.[6] Each MMP must report any identified PPCs pursuant to these instructions and in accordance with the steps enumerated below.

MMPs must:

1. Review encounter data submitted by network providers for evidence of PPCs that must be reported via the online reporting portal beginning on the date of the issuance of this DPL.
2. Report each PPC per the instructions for the online reporting portal.

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[2] CMS-2390-F is available online.
[3] 42 CFR 447.26 is available online.
[4] WIC 14131.11 is available online.
[5] Instructions for the online portal is available on the DHCS website.
[6] The online portal can be accessed online.

3. Issue a special notice informing all of their network providers that they must report PPCs to DHCS using the online reporting portal.
4. Require their network providers to also send them a copy of all PPCs submitted to the online portal.
5. Retain copies of all submissions.

DHCS recommends that each MMP designate a staff member to screen and identify PPCs in the MMP's encounter data and ensure that each PPC is reported via the online reporting portal. Each MMP's designated PPC screener can help identify PPCs in encounter data from MMP network providers who are not enrolled as Medi-Cal providers. Medi-Cal enrolled providers have already been informed of these requirements and are likely to be reporting their PPCs via the online portal. However, the designated PPC screener might identify PPCs in encounter data that network providers may have inadvertently overlooked. Therefore, MMPs must screen their encounter data for PPCs and issue a special notice informing all of their network providers of this reporting requirement.

MMPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, and other contract requirements, including applicable APLs and DPLs.

More information about PPC reporting requirements, PPC definitions, and mandatory payment adjustments is available on the Medi-Cal website. MMPs may email questions about the new PPC process to PPCHCAC@dhcs.ca.gov.

If you have any questions regarding this DPL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment: Provider Preventable Conditions[7]

Category 1 – HCACs (For Any Inpatient Hospital Settings in Medicaid)

- Any unintended foreign object retained after surgery
- A clinically significant air embolism
- An incidence of blood incompatibility
- A stage III or stage IV pressure ulcer that developed during the patient's stay in the hospital
- A significant fall or trauma that resulted in fracture, dislocation, intracranial injury, crushing injury, burn, or electric shock
- A catheter-associated urinary tract infection
- Vascular catheter-associated infection
- Any of the following manifestations of poor glycemic control: diabetic ketoacidosis; nonketotic hyperosmolar coma; hypoglycemic coma; secondary diabetes with ketoacidosis; or secondary diabetes with hyperosmolarity
- A surgical site infection following:
    - Coronary artery bypass graft (CABG) - mediastinitis
    - Bariatric surgery; including laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery
    - Orthopedic procedures; including spine, neck, shoulder, elbow
    - Cardiac implantable electronic device procedures
- Deep vein thrombosis/pulmonary embolism following total knee replacement or hip replacement **with pediatric and obstetric exceptions**
- Latrogenic pneumothorax with venous catheterization
- A vascular catheter-associated infection

Category 2 – Other Provider Preventable Conditions (For Any Health Care Setting)

- 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

[7] Adapted from "Medi-Cal Guidance on Reporting Provider-Preventable Conditions," and online portal instructions, available on the DHCS website.