

ALABAMA MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION OPERATIONAL MANUAL

EFFECTIVE JULY 1, 2012

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**OPERATIONAL MANUAL
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I. OVERVIEW

The Medicaid Emergency Psychiatric Demonstration Operational Manual is provided as a resource tool for participating providers. This is a 3-year Demonstration that will permit Alabama Medicaid to provide payment to private psychiatric hospitals for inpatient emergency psychiatric care in IMDs to recipients age 21 to 64 who have expressed suicidal or homicidal thoughts or gestures or determined to be dangerous to themselves or others.

The goal of the Demonstration is to assess whether this expansion of Medicaid coverage to include services provided in private, free-standing inpatient psychiatric facilities improves access to and quality of medically necessary care and whether this change in reimbursement policy is cost-effective. For any questions or clarification of requirements of the Demonstration, you may contact the Clinics/Mental Health Services Associate Director.

A. Emergency Inpatient Hospital Psychiatric Authority

The Emergency Inpatient Hospital Psychiatric Demonstration project was awarded to Medicaid by CMS. The state has been given statutory waiver authority to allow for payment and Federal matching funds for current IMD exclusion qualifying services.

B. Participating Freestanding Psychiatric Hospitals

The following hospitals will be participating in the demonstration

| Participating Freestanding Psychiatric Hospitals |
|---|
| Mountain View Hospital-Gadsden, AL |
| Baypointe Hospital-Mobile, AL |
| Eastpointe Hospital-Mobile, AL |
| Hill Crest Behavioral Health Services-Birmingham, AL |

C. Recipients to be Served

All participating providers must verify recipient eligibility before services can be billed to Medicaid. Recipients must be between the ages of 21-64, have a psychiatric emergency medical condition of expressing suicidal or homicidal thoughts or gestures, or determined to be dangerous to self or others by means other than suicidal or homicidal thoughts and/or gestures.

These recipients will be allowed to participate and must either have full Medicaid, be Medicaid eligible, or have SOBRA pregnant women coverage on the day of admission. Dual eligible recipients (Medicare/Medicaid) will also be included.

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All enrolled providers must follow non-discriminatory standards of care for all recipients regardless of eligibility category. Ensuring that no person shall, on the grounds of race, color, creed, national origin, age, health status or handicap, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program of services provided by Medicaid.

Compliance with Federal Civil Rights and Rehabilitation Acts is required of providers participating in the Alabama Medicaid Agency.

II. DEFINITIONS

Active treatment

The implementation of a professionally developed, supervised, and individualized plan of care. At least one professional member of the interdisciplinary treatment team must be involved in providing active intervention for an unresolved or active problem as noted on the plan of care. Appropriate members of the treatment team must document active intervention when a patient's placement options are unresolved.

Care Coordinator

A registered nurse working for Medicaid's contractor who will determine the appropriateness of the admission and the required stabilization of the patient.

Clean Claim

A clean claim is one that can be processed without Medicaid obtaining additional information from the provider of service or a third party insurance carrier.

CMS

Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

Continuity of Care

Uninterrupted continual care of the Medicaid recipient that is coordinated to address the health care needs among practitioners and across organizations and time.

Debarment

Debarment is exclusion from participation as a Medicare/Medicaid provider.

Disclosing Entity

The entity is a Medicaid provider or a fiscal agent.

Eligible

A person eligible to receive Medicaid benefits, or certified as eligible to receive Medicaid benefits and who has been issued a Medicaid identification number. For the purposes of this demonstration, eligibility will also be defined as an individual having a psychiatric emergency medical condition of expressing suicidal or homicidal thoughts or gestures, or is determined to be dangerous to self or others by means other than suicidal or homicidal thoughts and/or

gestures.

Eligibility

A process of determination of eligibility for medical assistance performed by Medicaid.

Fiscal Agent

The company designated by Medicaid, through contract, to maintain the Medicaid claims processing system.

Fiscal Year

Defined as October 1 through September 30.

Follow Up Coordinator

May be a non-clinical staff member responsible for updating a tracking log with all post discharge information.

Grievance

A grievance is a written expression of dissatisfaction about any matter.

Healthcare Acquired Conditions

Healthcare Acquired Conditions include Hospital Acquired Conditions (HACs).

Homicidal

Expressing homicidal thoughts or gestures,

Hospital Acquired Condition (HAC)

A condition that is reasonably preventable and not present or identified at the time of admission, but is either present at discharge or documented after admission.

Indicator

An indicator is a measurable dimension of care (e.g., a medical event, diagnosis, or outcome) to reflect aspects of care, the importance of which is gauged by frequency, severity, or cost.

Institution for Mental Disease (IMD)

An inpatient psychiatric facility with 17 or more beds in which more than half of the residents between the ages of 21 through 64 have a primary or secondary mental health diagnosis.

Material Omission

A fact, data or other information excluded from a report, contract, etc., the absence of which could lead to erroneous conclusions following reasonable review of such report, contract, etc.

Medicaid

A Federal/State program authorized by Title XIX of the Social Security Act, as amended, which provides Federal matching funds for a medical assistance program for recipients of federally aided public assistance and SSI benefits and other specified groups. Certain minimal populations and services shall be included.

Medically Necessary

Appropriate and necessary services as determined by health care practitioners according to national or community standards. For the purposes of the demonstration, the primary criteria for determining medical necessity will be that the patient is in an emergency psychiatric condition and has not been stabilized.

Medical Record

The document that records all of the medical treatment and services provided to the Medicaid recipient.

MEPD Eligibility

For purposes of the Medicaid Emergency Psychiatric Demonstration, only those patients who meet the specific criteria as set forth by Section 2707 of the Affordable Care Act of 2010 which states, “in the case of psychiatric emergencies, if an individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others”, would be considered to have an emergency psychiatric condition. If these conditions are not met, the patient does not meet the terms of an admission.

Other Provider Preventable Conditions (OPPCs)

The OPPC’s for consideration should be limited to those that yield a serious adverse result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition.

Per Diem

An all-inclusive daily rate paid to participating providers for inpatient psychiatric services, including physician services.

Performance Measure

A consistent measurement of service, practice, and governance of a health care organization. Measurements shall produce solid, statistically-based measurement of critical processes that in turn shall permit the organization to make solid decisions about improvements.

Present on Admission (POA)

A set of specified conditions that are present at the time the order for inpatient hospital occurs. Conditions that develop during an outpatient encounter, including the emergency room, observation or outpatient surgery are considered POA.

Provider Preventable Conditions (PPCs)

Defines reportable conditions into two separate categories, Healthcare Acquired Conditions and Other Provider Preventable Conditions (OPPCs).

Psychiatric Emergency Medical Condition

A situation in which an individual who expresses suicidal or homicidal thoughts or gestures or is determined to be dangerous to self or others.

Quality Assurance

An objective and systematic process that evaluates the quality and appropriateness of services provided.

Recipients

Medicaid eligibles between the ages of 21 through 64 with an emergency psychiatric condition.

Release of Information Form

Each participating IMD must have a 'release of information form' signed by the recipient or a representative for the recipient in order for the patient information to be shared with Alabama Medicaid.

Remittance Advice

A document that provides a detailed explanation of the transactions that resulted in payment(s) or other financial activity each financial cycle (checkwrite).

SOBRA

SOBRA is an eligibility category for children and pregnant women. SOBRA is further defined as maternity services for a woman who is eligible for pregnancy only related care, postpartum and family planning services. These women are maternity eligible until the end of the month in which the 60th postpartum day falls. After SOBRA ends the women are covered by family planning services. These women are also identified as poverty level women.

Stabilization

A condition in which the emergency medical condition no longer exists with respect to the individual and the individual is no longer dangerous to self or others.

Substance Abuse

Regular use of a substance that results in negative consequences in social, health, or occupational areas.

Suicidal

Expressing suicidal thoughts or gestures.

Third Party Liability (TPL)

Any individual, entity, or program that is or may be liable to pay all or part of the expenditures for covered services furnished to enrollees. The recipient is still restricted to receiving care through the Primary Contractor unless the TPL is a HMO/Managed Care Plan with a restricted provider network, and then a program exemption shall be requested. Primary Contractor is responsible for collecting all third party payments prior to submitting a claim to Medicaid for payment.

Utilization Review

Prospective, concurrent and retrospective review and analysis of data related to utilization of health care resources in terms of cost effectiveness, efficiency, control, quality, and medical necessity.

III. RECIPIENT CHOICE

A. Recipient Choice, Rights and Responsibilities

Recipients must be allowed to select the enrolled inpatient psychiatric hospital of their choice. The enrolled psychiatric hospital must accept all eligible Medicaid recipients between the ages of 21 through 64 with a psychiatric emergency. The following will apply to all recipients served in the Demonstration:

1. Recipients must be provided with all required information regarding rights and responsibilities, grievance process and fair hearing process, and telephone numbers, at the time of enrollment.
2. The hospital must ascertain if a recipient also has third party liability. If TPL is available, obtain the name of the insurance company, the name on the policy (insured), recipient relationship to the insured, address, phone number and policy number. If possible, ascertain from the recipient what type of coverage the policy provides. Verify the information with the insurance company or Medicaid and record all information in the file. Some of this information may be available through the online eligibility systems maintained by Medicaid's Fiscal Agent. **It is vital that this type of information be collected at the beginning of the inpatient stay.**

IV. HOSPITAL ENROLLMENT REQUIREMENTS

A. Hospital Enrollment

The following guidelines apply for Hospital Enrollment in the Demonstration:

1. The hospital must be a private, non-governmental, Institution for Mental Disease (IMD).
2. The hospital must enroll with Medicaid specifically for the Demonstration with a new NPI number
3. Each hospital must sign a 'Memorandum of Understanding' of their responsibilities based on CMS's Terms and Conditions.
4. Each hospital will be assigned by Medicaid a specialty number. This specialty number will allow Medicaid to obtain data related to the Demonstration.

B. Facilities Selected by Medicaid for Demonstration

There are four free-standing, non-governmental, psychiatric inpatient facilities selected by Medicaid for participation in the Demonstration. Each of the facilities has a strong history of providing excellent mental health services in their communities and has worked with both Medicaid and the Alabama Department of Mental Health (ADMH) for a number of years. Since they are located in separate geographic locations within the state, this will enhance recipient access to care.

The following provides additional information about these facilities:

Hill Crest Behavioral Health Services

6869 5th Avenue South, Birmingham, 35212
(205) 833-9000
CEO – Steve McCabe

Hill Crest Behavioral Health Services, an operating unit of parent company Universal Health Services, Inc. (UHS), is a 94-bed facility dedicated to mental health for more than seven decades. Hill Crest is a fully licensed, psychiatric and residential treatment facility which operates out of a three-story, 88,000 square-foot hospital complex. The medical staff manages separate programs in adult, adolescent, and child psychiatry, adolescent residential treatment programs, and intensive adolescent therapeutic group homes located in Jefferson County, Alabama. This facility primarily serves citizens in Jefferson and Shelby Counties, but also covers a wide number of other counties including: Blount, Saint Clair, Walker, Talladega, Cullman, Perry, Tallapoosa, Elmore, Coosa, Marshall, Chilton, Etowah, Bibb, Clay, Dallas, Cherokee,

Calhoun, Tuscaloosa, Winston and DeKalb.

Mountain View Hospital

3001 Scenic Drive
Gadsden, 35902-8406
(256) 546-9265
CEO – Dr. Michael Sheehi
Administrator – Sara Romano

Mountain View Hospital is a 68-bed private freestanding psychiatric hospital located in Gadsden, Alabama. The hospital provides comprehensive inpatient and outpatient psychiatric services for children through adults, along with chemical dependency programs, partial hospitalization, and therapeutic foster care. The hospital serves patients throughout Alabama, primarily serving the northern and central part of the state. This includes Etowah County primarily, as well as the surrounding counties of DeKalb, Marshall, Madison, St. Clair, Calhoun, and Cherokee.

BayPointe Hospital

5750-A Southland Drive, Mobile, Alabama 36693
(251) 661-0153
CEO – Tuerk Schlesinger
Administrator – Angela Ferrara

BayPointe Hospital opened its doors in 2001, currently has a 24 bed capacity to serve adults in psychiatric crisis. Accredited by The Joint Commission, BayPointe presently serves Mobile, Baldwin and Washington Counties as the primary service area and the following counties as secondary service areas: Choctaw, Marengo, Dallas, Wilcox, Clarke, Monroe, Autauga, Lowndes, Montgomery, Macon, Elmore, Lee, Russell, Bullock, Pike, Barbour, Henry, Dale, Houston, Geneva, Coffee, Covington, Crenshaw, Butler, Conecuh, Escambia, and Monroe Counties.

EastPointe Hospital

7400 Roper Lane, Daphne, Alabama 36526
CEO – Tuerk Schlesinger
Administrator – Jarrett Crum

EastPointe Hospital, a 66-bed facility in Daphne, AL., opened in January 2012. It offers inpatient psychiatric services to adults in psychiatric crisis. EastPointe Hospital will serve Mobile, Baldwin and Washington Counties as the primary service area and the following counties as secondary service areas: Choctaw, Marengo, Dallas, Wilcox, Clarke, Monroe, Autauga, Lowndes, Montgomery, Macon, Elmore, Lee, Russell, Bullock, Pike, Barbour, Henry, Dale, Houston, Geneva, Coffee, Covington, Crenshaw, Butler, Conecuh, Escambia, and Monroe Counties.

V. DEMONSTRATION PROCEDURES

A. Staff Designation and Roles for Medicaid Contractor

The Project Coordinator will manage the program to ensure the goals of the project are met, deadlines are adhered to and that CMS is provided the information needed to identify the progress of the Demonstration, to include outcomes data and other information. The Project Coordinator will also be responsible for reviewing/discussing outcomes data with the Alabama Department of Mental Health and CMS.

The Project Coordinator assigned to the emergency psychiatric demonstration for the Alabama Medicaid Agency is Solomon Williams, Associate Director, Clinics/Mental Health Services.

Medicaid will utilize an existing contractual arrangement with a recognized peer review organization to manage concurrent authorization of admission, continued stay and discharge of all recipients upon stabilization, thus meeting the requirements of the demonstration.

A Care Coordinator, who is a registered nurse, will determine the appropriateness of the admission and the continued stay based on the MEPD criteria. It is the responsibility of the Care Coordinator to assure that all emergency psychiatric admissions and continued stays have been reviewed to allow for appropriate billing to Medicaid. For each participating IMD, the designated reviewer will submit the required admission and continued stay review information to the Care Coordinator in order to make a determination. The IMD facility reviewer may be a registered nurse, licensed practical nurse, social worker or have a degree in a related field such as psychology.

A Follow-up Coordinator, who may be non-clinical, will be responsible for updating a tracking log with all post discharge information.

It is the responsibility of both the Care Coordinator and the Follow-up Coordinator to assess whether any of the enrolled inpatient psychiatric hospitals are having difficulty in meeting the Demonstration requirements for stabilizing and transitioning patients based on the data submitted. Both the Care Coordinator and the Follow-up Coordinator (these may or may not be the same person) will report outcomes data received from the participating IMD's on a tracking document to the Program Coordinator on a monthly basis.

B. Admission

A psychiatric emergency medical condition is defined as a situation in which an individual who expresses suicidal or homicidal thoughts or gestures or is determined to be dangerous to self or others. For purposes of the Medicaid Emergency Psych Demonstration, only those patients who meet the specific criteria as set forth by Section 2707 of the Affordable Care Act of 2010 which

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states, “In the case of psychiatric emergencies, if an individual expressing suicidal or homicidal thoughts or gestures, or determined dangerous to self or others”, would be considered to have an emergency psychiatric condition. If these conditions are not met, the patient does not meet the terms of an admission.

Upon admission to an IMD, the attending physician will conduct a thorough mental and physical examination of the patient to determine the admitting diagnosis, any contributing factors and to develop a plan of care that will stabilize the patient and provide for a smooth transition to any post-acute care needed. This information, along with an estimate of the number of days needed for stabilization, will be recorded on the Psychiatric Admission Form and signed by the physician.

The Psychiatric Admission Form must be forwarded to Medicaid’s contracted Medical and Quality Review Contractor (hereafter referred to as “Contractor”) **and** Medicaid’s Fiscal Agent, Hewlett Packard (hereafter referred to as HP) within 24 hours of admission. A correctly completed coversheet must be sent with the record mailed to HP. The coversheet is found on Medicaid’s website at this link,

http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.3_LTC_Services/5.4.3_MEPD_Psych_Cover_Sheet_8-16-12.pdf. The Contractor’s Care Coordinator will then review the admission to ensure it meets the criteria of the demonstration and that a plan for stabilization is established.

Providers must indicate the referral source on the coversheet as accurately as possible. This data will be collected and submitted to CMS.

The Care Coordinator will have one working day to review this information and send approval or denial to HP and the participating IMD. The approval to the participating IMD must indicate the timeframe that is approved based on the estimated time needed to stabilize the patient. This review will ensure the participating provider meets the intent of the Affordable Care Act, and prior to the third day, a process is in place to ensure the patient is stabilized prior to discharge.

The standardized Psychiatric Admission Form (Attachment No. 1) includes, at a minimum, the following information:

1. Events leading to present hospitalization
2. Diagnosis (within the range of 290-316)
3. History and physical, to include any evidence of substance abuse
4. Mental and physical capacity
5. Summary of present medical findings including prognosis

6. Plan for stabilization* to include estimated number of inpatient days needed to stabilize the patient.

**All patients participating in this Demonstration must be involved in active treatment. "Active treatment" is defined as implementation of a professionally developed and supervised individualized plan of care. At least one professional member of the interdisciplinary treatment team must be involved in providing active intervention for an unresolved or active problem as noted on the plan of care. Appropriate members of the treatment team must document active intervention when a patient's placement options are unresolved.*

C. Admission Criteria

The following criteria will be assessed to determine if a patient meets the definition of a psychiatric emergency medical condition:

- (a) Expressing suicidal or homicidal thoughts or gestures, or determined to be dangerous to self or others by means other than suicidal or homicidal thoughts and/or gestures.

D. Continued Stay Review

If the patient requires additional inpatient treatment beyond the original estimated length of stay due to the fact that the patient's condition has not been stabilized, the participating IMD must forward a request for a continued stay. This request must be sent to the Contractor/Care Coordinator via secure e-mail or fax indicating the specified number of additional days on the standardized Continued Stay Form (Attachment No. 2). This must be done 24-hours prior to the end of the original estimated length of stay. The participating IMD must also mail this to HP, with a completed coversheet. The Contractor/Care Coordinator will have one working day to review and approve or deny the continued stay request and notify the participating IMD.

Stabilization is defined as a condition in which the emergency medical condition no longer exists with respect to the individual and the individual is no longer dangerous to self or others.

A continued stay may be granted if the patient is still considered to be in a psychiatric emergency situation as evidenced by:

- (a) Expressing suicidal or homicidal thoughts or gestures, or is determined to be a danger to self or others.

Outliers

An outlier Length of Stay (LOS) is defined as any stay beyond 20 days. In most psychiatric emergencies the average LOS is between 7-10 days. If a patient's LOS exceeds 20 days, the facility must document all steps in the medical record that have been taken to transition the patient to another level of care. In order to qualify for additional days, the patient must continue to meet the criteria for continued stay. Medicaid's Contractor will notify the Agency through the Agency tracking log of all outliers on a monthly basis.

In the case of a commitment to the Department of Mental Health, the patient will be discharged from the MEPD project within 14 days of the commitment date.

E. Discharge

If the physician believes the patient is stabilized, is no longer expressing suicidal or homicidal thoughts or gestures, and no longer considered to be dangerous to self or others, and is ready for discharge, the participating IMD will complete a standardized Discharge Form (Attachment No. 3). The Discharge Form must be signed by the attending physician. The information on this form will provide documentation for a discharge plan of care. Within 3 days after discharge, this form, with a completed coversheet, must be mailed to HP and submitted via secure e-mail or fax, with a completed coversheet, to the Contractor for review by the Follow-up Coordinator.

The Follow-up Coordinator will review the discharge plan to ensure that the patient is appropriately discharged from inpatient care, understands the discharge plan, and intends to follow through with post-acute treatment plan.

F. Care Coordination/Management

The designated IMD reviewer can be a Registered Nurse, Licensed Practical Nurse, Social Worker, or have a degree in a related field such as psychology at the participating IMD will be responsible for the following after the patient is discharged:

- (a) Reporting all information on the Post Discharge Wellness Check Form. (Attachment No. 4)
- (b) All post discharge follow-up forms must be securely e-mailed or faxed to the Contractor within seven working days after the 3 day contact, 21 day contact and 90 day contact. These forms must also be mailed to HP, with a completed coversheet.

The Follow-up Coordinator will be responsible for the following:

- (a) Updating a tracking log with all post discharge information, along with the Care Coordinator
- (b) Forwarding all follow up logs/tracking documents to the Project Coordinator on a monthly basis.

G. Outreach

Notify Providers and other key stakeholders of the purpose of the Demonstration and method for accessing emergency care at one of the participating IMDs.

1. Submit all outreach materials to CMS prior to distribution for approval.
2. Coordination with local community mental health centers, other agencies, and service providers to ensure awareness of the program and to identify other services available to meet the needs of the Medicaid recipient.

H. Participating Provider Education

Medicaid will provide training for each participating IMD which includes, but is not limited to:

1. Program requirements based on CMS's Terms and Conditions
2. Concurrent review procedures
3. Billing procedures
4. Expectations for discharge planning process

I. Billing Inquiries/Claims Resolution

All claims must be filed with HP. A provider representative from HP will assist in resolving claims issues.

Claims will only be accepted for a complete inpatient episode of care. A claim may not be split across two quarters (e.g., a patient starts treatment in one quarter and ends treatment in the next quarter). Hold the claim until the entire episode has been completed and then submit it to Medicaid as it cannot be submitted to CMS otherwise.

All claims that are billed with a patient status that indicates "still a patient" will initiate a review and may be denied.

Participating IMDs shall only refer claim inquiries to Medicaid that require an administrative review and cannot be resolved by HP.

Providers may refer to the Provider Manual Chapter 5 – Filing Claims for information regarding filing claims for all UB-04 claims and to Provider Manual Chapter 44 – Emergency Psychiatric IMD’s (ages 21 -64), for information on policy.

J. Appeals Process

All adverse review decisions made by the Contractor may be subject to an appeal by the requesting provider or recipient (Aggrieved Party). An Aggrieved Party may request an informal review and a fair hearing for denied Medicaid benefits. However, an informal review must be requested and adjudicated before advancing to a fair hearing.

a. Informal Review

An Aggrieved Party may request reconsideration of an adverse decision through the informal review process by filing a written request with Contractor within 30 calendar days of the date of the denial letter. Upon receipt of a reconsideration request, the Contractor’s consulting physician shall review the documentation and render a decision based on Medicaid-approved criteria within five working days of receipt of a complete reconsideration request. Contractor shall mail notice of the reconsideration decision to the Aggrieved Party and enter the decision into the system.

b. Fair Hearing

An Aggrieved Party may request a Fair Hearing by filing a written request with the Medicaid Administrative Hearings Office within 60 calendar days of the date of the reconsideration denial notice by the Contractor. The Contractor’s consulting physician and other appropriate personnel who were involved in the denial shall be available at Medicaid’s request to attend any Fair Hearings and provide justification for the denial.

Refer to Provider Manual Chapter 7, Understanding Your Rights and Responsibilities as a Provider for details on requesting an informal review or a fair hearing.

VI. ADVERSE EVENTS

A. Payment Adjustment for Provider Preventable Conditions (PPCs)

Effective for Dates of Service October 1, 2011, and thereafter; Medicaid is mandated to meet 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 (PPC's).

Provider Preventable Conditions are clearly defined into two separate categories: Healthcare Acquired Conditions and Other Provider Preventable Conditions (OPPC's).

Healthcare Acquired Conditions include Hospital Acquired Conditions (HACs). Other Provider Preventable Conditions refer to OPPCs.

No reduction in payment for a 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.

Reductions in provider payment may be limited to the extent that the identified PPCs would otherwise result in an increase in payment. It is the responsibility of the **provider** to identify and report any PPC and **not seek payment** from Medicaid for any additional expenses incurred as a result from the PPC. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

To be reportable, PPC's must meet the following criteria:

- The PPC must be reasonably preventable as determined by a root cause analysis or some other means.
- The PPC must be within the control of the provider.
- The PPC must be clearly and unambiguously the result of a preventable mistake made and provider procedures not followed, and not an event that could otherwise occur.
- The PPC must result in significant harm. The OPPCs for consideration should be limited to those that yield a serious adverse result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition. A serious disability is defined as a major loss of function that endures for

more than 30 days, is not present at the time services were sought and is not related to the presenting condition.

- Any process for identifying non-payable events must actively incorporate some element of case-by-case review and determination. While the source and cause of some adverse events may be clear, most would require further investigation and internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability.

OPPCs **must be reported to Medicaid** by encrypted emailing of the required information to:

AdverseEvents@medicaid.alabama.gov. Providers that do not currently have a password for the Adverse Event reporting may request one by contacting Solomon Williams at Solomon.Williams@medicaid.alabama.gov or via phone at 334-353-3206.

The following information is required for reporting:

- Recipient first and last name
- Date of birth
- Medicaid number
- Date event occurred
- Event type

A sample form is on the Alabama Medicaid Agency website at www.medicaid.alabama.gov under Programs/Medical Services/Hospital Services. Providers may submit their own form as long as it contains all of the required information.

Inpatient Psychiatric Hospitals are paid based on a daily per diem rate. It is the responsibility of the hospital to identify any Hospital-Acquired Condition (HAC) and not seek payment for any additional days that have lengthened a recipient's stay due to a HAC. These days should be reported on the UB-04 claim with a value code of '81' and an amount greater than '0'.

B. Reporting HACs and Present on Admission (POA) on the UB-04 Claim Form

Inpatient psychiatric hospitals should use the POA indicator on claims for HACs listed below; with the exception of Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients as identified by

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Medicare. If no claim is submitted for the HAC, then the Alabama Medicaid Agency is to be notified via encrypted e-mail at AdverseEvents@medicaid.alabama.gov. (See reporting information above)
Below are HACs with ICD-9 Codes that hospitals are required to report on the UB-04 claim form:

| Selected HAC | CC/MCC (ICD-9-CM Codes) |
|--|--|
| Foreign Object Retained After Surgery | 998.4 (CC) and 998.7 (CC) |
| Air Embolism | 999.1 (MCC) |
| Blood Incompatibility | 999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63 (CC) 999.69 (CC) |
| Pressure Ulcer Stages III & IV | 707.23 (MCC) and 707.24 (MCC) |
| Falls and Trauma: -Fracture -Dislocation -Intracranial Injury -Crushing Injury -Burn -Electric Shock | Codes within these ranges on the CC/MCC list: 800-829.1 830-839.9 850-854.1 925-929.9 940-949.5 991-994.9 |
| Catheter-Associated Urinary Tract Infection (UTI) | 996.64—Also excludes the following from acting as a CC/MCC: 112.2 (CC), 590.10 (CC), 590.11 (MCC), 590.2 (MCC), 590.3 (CC), 590.80 (CC), 590.81 (CC), 595.0 (CC), 597.0 (CC), 599.0 (CC) |
| Vascular Catheter-Associated Infection | 999.31 (CC) |
| Manifestations of poor glycemic control | 250.10-250.13 (MCC), 250.20-250.23 (MCC), 251.0 (CC), 249.10-249.11 (MCC), 249.20-249.21 (MCC) |
| Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG) | 519.2 (MCC) and one of the following procedure codes: 36.10-36.19. |
| Surgical Site Infection Following Certain Orthopedic Procedures | 996.67 (CC) OR 998.59 (CC) and one of the following procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, or 81.85. |

| Selected HAC | CC/MCC (ICD-9-CM Codes) |
|---|--|
| Surgical Site Infection Following Bariatric Surgery for Obesity | Principal Diagnosis code-278.01 OR 998.59 (CC) and one of the following procedure codes: 44.38,44.39, or 44.95 |
| Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED) | 996.61 (CC) or 998.59 (CC) and one of the following procedure codes: 00.50, 00.51, 00.52, 00.53, 00.54, 37.74, 37.75, 37.76, 37.77, 37.79, 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.89, 37.94, 37.96, 37.98 |
| Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures | 415.11 (MCC), 415.19 (MCC), or 453.40-453.42 and one of the following procedure codes: 81.51-81.52, 81.54. |
| Iatrogenic Pneumothorax with Venous Catheterization | 512.1 (CC) and the following procedure code: 38.93 |

The hospital may use documentation from the physician’s qualifying diagnoses to identify POA which must be documented within 72 hours of the occurrence. Medicaid also recommends that the PPC be reported to Medicaid on the claim or via e-mail within 45 days of occurrence.

Medicaid will accept all POA indicators as listed below:

- **Y**-Yes. Diagnosis was present at time of inpatient admission.
- **N**-No. Diagnosis was not present at time of inpatient admission.
- **U**-No information in the record. Documentation insufficient to determine if the condition was present at the time of inpatient admission.
- **W**-Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.

Hospital records will be retroactively reviewed by Medicaid’s contracted Quality Improvement Organization (QIO). If any days are identified that are associated with a lengthened stay due to a PPC; then Medicaid will initiate recoupment for the identified overpayment.

It is the hospital’s responsibility to include all supporting documentation with the chart for a review to be conducted by Medicaid’s contracted Quality Improvement Organization (QIO). Submission of a root cause analysis is not

required but may be submitted as part of the documentation to support billing.

C. Reporting of Serious Adverse Events

Serious Adverse Events occurring during an IMD stay include death, physical injury whether self-induced or accidental, nosocomial infection, or illness and any emergency admission to an acute care hospital for any reason. Adverse Events are to be reported on the IMD Discharge Plan Form which must be signed by the attending physician. Within 3 days after discharge, this information must be reported to the Alabama Medicaid Agency by encrypted emailing of the discharge form to:

AdverseEvents@medicaid.alabama.gov. Providers that do not currently have a password for the Adverse Event reporting may request one by contacting Solomon Williams at Solomon.Williams@medicaid.alabama.gov or via phone at 334-353-3206.

VII. PAYMENT FOR SERVICES

A. Provider Payment

Participating IMDs will submit claims through HP, Medicaid's fiscal agent. Hospitals will be paid a flat per diem rate and will be paid as per the existing Medicaid checkwrite schedules, which usually occur twice a month. This will be a global type fee arrangement. Each hospital will be responsible for negotiating physician payments as part of the global reimbursement. There will be no additional compensation for the inpatient care of these recipients.

B. CMS-State Payment Process

Medicaid has agreed to meet CMS's Terms and Conditions for data submissions and claims submissions. CMS will monitor the Demonstration and requires the following from Medicaid:

1. Medicaid will submit to CMS quarterly, based on the Federal Fiscal year, pertinent data and information for payment and monitoring purposes within 30 days of the end of each payment quarter. The information requirement is in Attachment Number's 5, 6, and 7.
2. CMS will provide Federal matching funds for Medicaid payments made to participating IMDs for inpatient services to Medicaid beneficiaries aged 21 to 64 for services provided to stabilize an emergency psychiatric condition. CMS will provide the Federal matching payment to Medicaid on a quarterly basis at the regular Federal Medical Assistance Percentage (FMAP).
3. CMS or its contractual representative will notify Medicaid if the data are

clean and accepted for payment, or notify the State within 30 days of submission that corrective actions or supplemental data are needed. Medicaid will have up to 10 days to resubmit claims to CMS. Payments will only be issued upon the clearance of submitted data. If CMS determines that data quality is inadequate for the claim payment in the quarter submitted, the claim will be rejected; however, the State may resubmit the claim for payment the next quarter.

4. The monitoring and claims information data provided quarterly by Medicaid will be submitted through encrypted spreadsheets that meet the 256-bit Advanced Encryption Standard (AES). Quarterly claims information will be forwarded to the IMPAQ International at MEPD@impaquint.com. IMPAQ will send the data to the Office of Financial Management (OFM). In order to provide CMS and Medicaid with some indication of the distribution of funding vis-à-vis the funding limit and to provide for a fair and equitable spending target for each State, a mechanism will be implemented to provide a continual estimate of anticipated expenditures for each State and to set and adjust spending limits for each State based on real and anticipated patient admissions and costs. This mechanism will be used to set and adjust spending guides or limits to help to assure that all States are allowed to participate for the full three years of the Demonstration without exceeding the total funding limitation. States will be provided with these readjusted, predicted spending limits on a quarterly basis. In this way, both CMS and the States will be able to assess their cumulative expenditures relative to the total Demonstration funding limitation.
5. All State claims for FMAP subject to the Demonstration spending limit (including all settlements) must be made within 1 year after the calendar quarter in which the State incurred the expenditure. Furthermore, all claims for services rendered during the Demonstration period (including any cost settlements) must be made within 1 year after the conclusion of termination of the Demonstration.
6. Should data be audited by CMS, the State will be held responsible for return of funding for claims submitted that cannot be substantiated.
7. In no case will the aggregate amount of payments made by CMS to all eligible States under the Demonstration exceed the total Federal spending limit for the Demonstration. Medicaid understands that if CMS finds that the volume or cost of services substantially deviates from that agreed upon in the beginning of the Demonstration, it reserves the right to adjust patient census and expenditure estimates, reset State-level spending limits, and reapportion funds at its discretion.
8. Any payments to Alabama Medicaid by CMS made in error or in excess of

state-level spending limits under the Demonstration will be returned to CMS. Medicaid is aware that CMS reserves the right to withhold up to 20 percent of payments in the last payment quarter of the Demonstration in order to offset any funds that would have to be recouped. If no errors or excess spending occurs, withheld payments will be returned to Medicaid.

9. Medicaid agrees that information about services provided under the Demonstration will not be included on the CMS Form 64. Any duplicative Federal matching payment made as a result of any such an inclusion will be recouped by CMS.

VIII. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Medicaid is responsible for developing quality of care measures and reporting treatment outcomes to CMS. Measures that have been identified include but are not limited to the following:

1. Identifying the percentage of Medicaid eligibles who are admitted to participating IMDs compared with admissions to other facilities (i.e. acute care hospitals, state hospitals, etc.).
2. Decrease the number psychiatric boarding patients.
3. Increase continuity of care through discharge planning/follow-up care.
4. Improve patient access to emergency mental health and healthcare services.

Medicaid will measure the outcomes in several ways:

1. By obtaining data from all acute care hospitals at beginning and end of Demonstration to determine number of psychiatric admissions and emergency room visits.
2. By tracking admissions to the state facilities to see if they decrease during the Demonstration.
3. By tracking access to community mental health and/or substance abuse services to determine the impact of a more seamless transition from inpatient to community care.
4. By surveying community providers to gain their perceptions of Demonstration's impact on continuity of care, particularly with respect to patients with co-occurring conditions.

The Care Coordinator/Follow-up Coordinator will assist the Program Coordinator in providing this data to CMS and the Department of Mental Health.

IX. RECORDS AND REPORTS

A. Qualitative Monitoring Report and Data Collection

On a quarterly basis Medicaid will report to CMS any updates or changes in the areas listed below. These changes will be reported for every upcoming quarter on the attached CMS Qualitative Monitoring Report and Data Collection Report. The following are areas that are addressed in this report:

1. Staff Designations and Roles
2. Administration and Management
3. Institutions of Mental Diseases
4. Program Implementation
5. Qualitative Monitoring Report and Data Collection
6. Enrollment and Expenditure Tracking
7. Serious Adverse Events
8. Evaluation Support
5. Other Updates

X. MEDICAID OVERSIGHT

A. General

Medicaid shall monitor all participating IMD's performance through a combination of performance measures, medical record reviews and administrative reviews. The purpose of oversight activities is to ensure that contract requirements are being met; standards of care are being implemented and enforced.