

June 23, 2011

## MEDICAID NON-PAYMENT FOR HEALTHCARE- ASSOCIATED CONDITIONS: FINAL RULE

### **The Issue:**

On June 6, the Centers for Medicare & Medicaid Services (CMS) issued a final rule outlining its planned implementation of non-payment for Medicaid healthcare-associated conditions (HCAC). 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. 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.

A detailed summary of the final rule is attached. The summary was prepared for the AHA by Health Policy Alternatives, Inc.

### **Our Take:**

The ACA extended the Medicare hospital-acquired conditions provision to Medicaid programs and to providers other than hospitals and allows states to implement non-payment policies for other conditions. The AHA remains concerned that the final rule gives states very little federal guidance on how to select conditions for inclusion in their policies and on how to identify the costs associated with the selected conditions. Hospitals will want to pay attention to plans their states have for implementing the program and provide comment and input to the state regulatory process when possible.

### **What You Can Do:**

Please share this advisory with your senior management, risk management and quality improvement teams.

### **Further Questions:**

Please contact Beth Feldpush, senior associate director of policy, at (202) 626-2963 or [bfeldpush@aha.org](mailto:bfeldpush@aha.org).

## **Medicaid Program: Payment Adjustment for Provider-Preventable Conditions Including Health Care-Acquired Conditions Summary of Final Rule**

On June 6, 2011 the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* a final rule for the Medicaid program implementing section 2702 of the Patient Protection and Affordable Care Act (Pub. Law 111-148). The law as amended is referred to by HHS as the Affordable Care Act (ACA). Section 2702 prohibits federal payments to States for Medicaid expenditures on health care-acquired conditions.

The final rule makes some changes to the regulations as proposed in the notice of proposed rulemaking published for public comment on February 17, 2011. The effective date of the final rule is July 1, 2011 as required by the statute, but CMS states that it will not enforce compliance with the rule until July 1, 2012, effectively giving states another year to put their plans in place.

### **Background**

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.

Prior to enactment of this provision, the Medicaid program did not have any statutory provision relating to HCACs, but on July 31, 2008 CMS issued guidance to States through a State Medicaid Director Letter encouraging them to adopt payment prohibitions to coordinate with the Medicare HAC provision. In the guidance, CMS indicated that States could amend their Medicaid State plans with a specific policy for nonpayment of HACs, or they could amend their plan to indicate that Medicaid payment would not be available for the Medicare HACs or for erroneous procedures as identified by Medicare under three national coverage determinations (NCDs) that deny Medicare coverage when a practitioner performs the wrong procedure, the correct procedure on the wrong body part or the correct procedure on the wrong

patient. CMS indicates that 13 States submitted State Plan Amendments (SPAs) to include nonpayment provisions; other States implemented nonpayment policies through other State laws or administrative authority.

Review of State Practices Prohibiting Payment for HCACs. CMS summarizes its review of State practices relating to nonpayment for HCACs. The review included Medicaid SPAs that were originally submitted by the States in response to the 2008 CMS guidance, State policies outside Medicaid involving quality assurance, pay-for-performance, reporting requirements and payment systems, and other sources. CMS found that 21 States have HCAC-related nonpayment policies, most of which identify at least the Medicare HACs for nonpayment in hospitals. All of these include provisions that deny payment for claims previously denied by Medicare with respect to services provided to dual Medicare-Medicaid eligible beneficiaries. Half exceeded the Medicare policies in terms of the conditions, systems used to indicate the conditions, or the settings to which the nonpayment policies apply; and at least 7 States were found to apply the policies beyond the inpatient hospital setting to include physicians and ambulatory surgery centers.

### **Provisions of the Final Rule**

The rule prohibits Medicaid payments by States for services related to provider-preventable conditions. The term “provider-preventable condition (PPC), is defined to encompass two categories: (1) HCACs and (2) other provider-preventable conditions (OPPCs). HCACs apply to any inpatient hospital setting and are defined as the full list of Medicare HACs, with the exception of Deep Vein Thrombosis/Pulmonary Embolism following total knee or hip replacement in pediatric and obstetric patients (see the attachment for the list of Medicare HACs). OPPCs are defined as conditions that apply in any healthcare service setting, and must include the three specified Medicare nonpayment NCDs for erroneous procedures.

States are not required to identify and deny payment for any additional OPPCs under the regulation, but States may do so, with CMS approval. Other conditions identified by the State as OPPCs must 1) have been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through application of procedures supported by evidence-based guidelines, 2) have a negative consequence for the beneficiary, and 3) be auditable.

While the ACA provision refers only to HCACs, CMS cites existing authority in Title XIX in providing for the use of the PPC umbrella term, and believes that the broader implementation of the Medicaid nonpayment policy allows for appropriate incorporation of existing State practices. CMS believes this is necessary because HCAC is a narrowly defined term in the statute and does not allow for the inclusion of additional conditions that are already applicable in some States or the three specified Medicare NCDs regarding erroneous procedures.

CMS notes that States have considerable flexibility in setting provider payment rates and methodologies, and the final rule provides that States will determine how to implement nonpayment for PPCs. States must be able to reasonably isolate for nonpayment the portion of payment directly related to treatment for and related to the PPC, and reductions in provider payment may be limited to the extent that the PPC would otherwise result in an increase in payment. As part of the SPA process (discussed below), States will set forth their mechanism to comply with the requirement for nonpayment of PPCs. CMS notes that not all States use grouper systems to reimburse providers, and CMS intends that the regulations provide flexibility so that these States can design methodologies different from the one Medicare uses in the context of the MS-DRG system for inpatient hospital payment in order to isolate payment amounts associated with HCACs. CMS also intends to work with each State to develop implementation strategies that make sense within its payment methodologies.

Within that flexibility, the regulations do impose certain requirements with respect to the payment adjustments associated with PPCs, however. First, the final rule limits any reduction in payment to the amounts directly identifiable as related to the PPC and resulting treatment. CMS sees this provision as meeting the requirement of section 2702 that adjustments to payment rates do not result in a loss of access to care by Medicaid beneficiaries. In addition, the rule requires that no payment reduction for a PPC may be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to initiation of treatment for that patient by that provider.

The final rule also revises the regulatory text to clarify that no federal matching funds are available for a Medicaid claim that has been denied by Medicare because of the presence of an HAC. CMS indicates that States may work with their Medicare Fiscal Intermediary to identify codes related to the treatment of dually eligible individuals. In addition, CMS, involving the Federal Coordinated Health Care Office, will provide guidance to States on this issue.

States must implement provider self-reporting of PPCs through their claims systems. Providers must report PPCs in instances when there is no associated bill. States have flexibility to determine how to implement these requirements. Once data are collected at the State level, States will submit the data to CMS as part of the standard process of reporting Medicaid provider claims data through the Medicaid Management Information Systems.

State contracts with managed care organizations (MCOs) must require compliance with requirements for provider identification of PPCs as a condition of payment and the prohibition of payment for PPCs. CMS anticipates that savings earned from the application of PPC policies to managed care plans will be factored into the individual contract rates established with those plans. CMS intends that MCO contracts with providers will require providers to report PPCs to the MCO, and that MCOs will report

PPC data to the State upon request. The final rule modifies the regulatory text to clarify these requirements.

States must revise their State Medicaid plans through the SPA process to comply with the requirements of the final rule. In general, SPAs must be submitted no later than the last day of the quarter in which the amendment would take effect. CMS has developed a State plan “preprint” that outlines the minimum provisions of the final rule and allows States the flexibility to identify additional OPPCs for nonpayment. States will define the related payment methodologies within the appropriate sections of their Medicaid State plan. The SPA process requires public notice and opportunity for comment. CMS plans to issue subregulatory guidance to States regarding the necessary changes to Medicaid managed care contracts under the regulations.

The requirements will be effective July 1, 2011 as required under the statute, but CMS intends to delay compliance action on the provisions until July 1, 2012.

## ATTACHMENT

The following is a list of the current Medicare HACs.

- Foreign object retained after surgery.
- Air embolism.
- Blood incompatibility.
- Stage III and IV pressure ulcers.
- Falls and trauma.
  - Fractures.
  - Dislocations.
  - Intracranial injuries.
  - Crushing injuries
  - Burns.
  - Electric shock.
- Manifestations of poor glycemic control.
  - Diabetic ketoacidosis.
  - Nonketotic hyperosmolar coma.
  - Hypoglycemic coma.
  - Secondary diabetes with ketoacidosis
  - Secondary diabetes with hyperosmolarity.
- Catheter-associated urinary tract infection (UTI)
- Vascular catheter-associated infection.
- Surgical site infection following:
  - Coronary artery bypass graft (CABG) – Mediastinitis.
  - Bariatric Surgery.
    - Laparoscopic gastric bypass.
    - Gastroenterostomy.
    - Laparoscopic gastric restrictive surgery.
  - Orthopedic Procedures.
    - Spine.
    - Neck.
    - Shoulder.
    - Elbow.
- Deep vein thrombosis (DVT)/pulmonary embolism (PE)
  - Total knee replacement.
  - Hip replacement.