ACADEMIC MEDICAL PROFESSIONALS
INSURANCE EXCHANGE RISK RETENTION GROUP
1250 Broadway, Suite 3401
New York, NY 10001

www.academicins.com

AHPIA Solutions, Inc.
Attorney-in-Fact

Tel: 646 808 0600
Fax: 646 808 0601

CMS Issues Proposed Rule Requiring States to Implement Policies for Payment Adjustments for Provider Preventable Conditions

By Conrad Meyer, Chaffe McCall, L.L.P., New Orleans, LA

On February 17, 2011, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule1 that would implement Section 2702 of the Patient Protection and Affordable Care Act (PPACA)2 requiring states to implement policies under their Medicaid programs prohibiting federal payments to states for providing medical assistance for healthcare-acquired conditions. The proposed rule would require the states Medicaid programs to implement these policies by July 1, 2011.

Background

In 2002, the Medicare Program addressed certain "never events" through national coverage determinations (NCDs) in response to a report from the National Quality Forum listing 27 adverse events that were "serious, largely preventable and of concern to both the public and health care providers."3 The thought was that Medicare patients might experience serious injuries if they undergo erroneous surgical or other invasive procedures that may require additional healthcare to correct adverse outcomes resulting from errors. Based on the report regarding the "never events," Medicare issued three NCDs. Under these NCDs, Medicare specified that it does not cover a particular surgical or other invasive procedure to treat a particular medical condition when a practitioner erroneously performs: (1) a different procedure altogether; (2) the correct procedure but on the wrong body part; or (3) the correct procedure but on the wrong patient.4

In 2005, the Deficit Reduction Act (DRA) was enacted prohibiting payment to hospitals for certain preventable-hospital acquired conditions (HACs) identified by the Secretary of Health and Human Resources (Secretary).5 According to the DRA, these conditions were required to have the following characteristics:

- High cost or high volume, or both;
- Result in the assignment of the case to a diagnosis-related group (MS-DRG) and has a higher payment when present as a secondary diagnosis; and
- Could reasonably have been prevented through the application of evidence-based guidelines.

The DRA required the Secretary to revise the list of HACs from time to time as long as it contained at least two of the three conditions listed above. The DRA further required that when an HAC is not present on admission (POA), but is reported as a secondary diagnosis associated with the hospitalization, the Medicare payment under the in-patient prospective payment system (IPPS) to the hospital may be reduced to reflect that the condition was hospital-acquired.6 In addition to the reduction in reimbursement for HACs, since October 1, 2007, hospitals subject to IPPS have been required to submit information to CMS on Medicare claims specifying whether diagnoses were POA in order to determine if a patient suffered an HAC.7 As an example, a few of the Medicare HACs are listed below:

- foreign object retained after surgery
- embolism
- blood incapability
- stage 3 and stage 4 pressure ulcers
- falls and trauma
- manifestations of poor glycemic control
- catheter-associated urinary tract infection (UTI)
- vascular catheter-associated infection
- surgical site infections following certain surgical procedures
- deep vein thrombosis/pulmonary embolism8

On March 23, 2010, with the enactment of PPACA, the Secretary is now required to implement Medicaid payment adjustments for healthcare-acquired conditions (HCACs). Specifically, Section 2702 of PPACA sets out a general framework for application of the Medicare prohibitions on payment for HACs that would be applicable to the Medicaid Program. The general framework for establishing Medicaid policies on HCACs requires the Secretary to implement the current regulations already contained in the DRA regarding reduction of payment for HACs. However according to the proposed rule, CMS wishes to codify provisions in the final rule that would allow states flexibility in identifying provider preventable conditions (PPCs) that include, at a minimum, the HACs identified by Medicare. The rationale behind state-identification of PPCs is to expand the scope of non-payment provisions to service settings outside that of inpatient hospitals. Most importantly, states would be required to implement these policies effective July 1, 2011. CMS states that for states to be in compliance with the July 1, 2011, effective date, the last day for states to submit to CMS their state plan amendment (SPA) would be September 30, 2011, which is the last day of the quarter in which the amendment would be effective. Further, PPACA required that in establishing state Medicaid policies for prohibition or payment for HCACs, such policies should not result in loss of access to care or services for Medicaid beneficiaries.

Provisions of the proposed rule

CMS broke PPCs down into two categories: 1) HCAC and 2) other provider-preventable conditions (OPPC). As stated above, the proposed rule would require states to adopt, at a minimum, the same HACs Medicare currently identifies for non-payment and to comply with future updates to the Medicare HAC list. Despite this requirement, the rule would allow states, when implementing these policies, the flexibility to identify conditions for non-payment, as approved by CMS, that the states determined meet the criteria set forth in the DRA outlined above. According to CMS, states not only must identify HCACs, but also identify OPPCs that occur outside of the inpatient hospital setting including, nursing facilities, ambulatory surgery centers (ASCs), and other provider settings. The difference between HCACs and OPPCs is that OPPCs are conditions that occur outside of the inpatient hospital setting. CMS defines OPPCs to include, at a minimum the following:

- Wrong surgical or other invasive procedure performed on a patient.
- A surgical or other invasive procedure performed on the wrong body part.
- A surgical or other invasive procedure performed on the wrong patient.

According to the proposed rule, states would be required to implement, at a minimum, federally identified OPPCs, while expanding the list of OPPCs that states could apply non-payment provisions. CMS provided criteria for states to consider when identifying additional OPPCs including:

- A condition or event identified by a State for inclusion under this provision must be a discrete, auditable, quantifiable, and clearly defined occurrence.
- A condition or event must be clearly adverse, resulting in a negative consequence of care that results in unintended injury or illness.
- A condition or event identified must be reasonably preventable, meaning an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure.9

Both HCACs and OPPCs identified by states would receive the same treatment, meaning non-payment for care related to those specific conditions. To assist the states in identifying conditions for non-payment, CMS suggests states use conditions that "could" be identified in the Medicare Program by a secondary ICD-9-CM or ICD-10-CM code as an HAC.10 Lastly, the proposed rule would also require states to implement requirements for provider self-reporting of all HCACs in the Medicaid claims payment process.11

Conclusion

Pursuant to the provisions of the PPACA, States will now be required to implement policies for non-payment of HCACs and OPPCs for their individual Medicaid programs. By implementing these policies, states' Medicaid programs would deny federal financial participation for Medicaid expenditures made for PPCs, including HCACs and OPPCs identified in the state's Medicaid plan, while ensuring that related payment adjustments do not limit the beneficiaries access to care. This proposed rule would not only affect hospitals but also numerous other healthcare settings including nursing facilities, ASCs, and other healthcare facilities who participate in the Medicaid program. Even though the final rule has yet to be published, healthcare providers who participate in the Medicaid program should carefully review both their policies governing quality control and the upcoming final rule regarding CMS' mandate to states to implement these non-payment provisions to assure that they are in compliance in order to avoid what could be substantial revenue loss if a patient succumbs to a HCAC or OPPC at their facility.

***

176 Fed. Reg. 92832Act Sec. 2702 of the Patient Protection and Affordable Care Act (P.L. 111-148).376 Fed. Reg. 92864Medicare NCDs related to "never events" can be found at Medicare National Coverage Determinations Manual Ch.1, part 2, Section 140.6, 140.7, and 140.8 at http://www.cms.gov/Manuals/IOM/list.asp.5Section 5001(c) of the Deficit Reduction Act of 2005 (DRA). Modifying Section 1886(d)(4) of the Social Security Act at https://www.cms.gov/HospitalAcqCond/Downloads/DeficitReductionAct2005.pdf6Id. at Footnote 5. see Section 5001 of DRA modifying Section 1886(d)(4)(D)(ii) of the Social Security Act.7Id. at Footnote 5 see Section 5001 of DRA modifying Section 1886(d)(4)(D)(iii) of the Social Security Act.8The current list of Medicare HACs that can be found at 75 FR 50084 through 50085.976 Fed. Reg. 92901076 Fed. Reg. 92891176 Fed. Reg. 9290