

## CMS FINAL RULE TO ADJUST MEDICAID PAYMENT FOR PROVIDER-PREVENTABLE CONDITIONS INCLUDING HEALTH CARE-ACQUIRED CONDITIONS

*This installment of Hall Render's Health Law Broadcast series on health care reform is designed to provide you with the insight, analysis, and practical suggestions with respect to the various reform initiatives that will affect your organization.*

### EXECUTIVE SUMMARY

Effective July 1, 2011, the Centers for Medicare and Medicaid Services ("CMS") will prohibit Medicaid payments for medical treatment associated with Provider-Preventable Conditions ("PPCs"). This final rule aligns Medicaid with similar Medicare regulations that have been in place for a few years.

### BACKGROUND

On June 1, 2011, CMS released a final rule to adjust Medicaid payments to States by prohibiting payment of any amounts expended in providing medical assistance related to PPCs, including Health Care-Acquired Conditions ("HCACs"), as required by section 2702 of the Patient Protection and Affordable Care Act ("PPACA"). While the final rule requires States to submit their State Medicaid Plan demonstrating compliance with the rule by September 30, 2011, compliance action on the approved State amendments relative to PPC nonpayment policies will be delayed until July 1, 2012.

The purpose of the Medicaid PPC nonpayment rule is to drive quality care and promote the long-term benefit of the Medicaid program, Medicaid beneficiaries, and the health care industry as a whole. The rule prohibits Medicaid payments under section 1903 of the Social Security Act expended for medical assistance related to PPCs, provided that the regulation does not result in loss of access to care or services for Medicaid beneficiaries. Additionally, the rule applies to individuals dually eligible for both Medicare and Medicaid programs.

### DEFINITION OF PROVIDER-PREVENTABLE CONDITIONS

The final rule establishes the umbrella term Provider-Preventable Conditions to incorporate two distinct sub-categories: Health Care-Acquired Conditions ("HCACs") and Other Provider-Preventable Conditions ("OPPCs").

HCACs apply to all Medicaid **inpatient** hospital settings. HCACs are defined as the entire list of Medicare's Health-Acquired Conditions ("HACs"), excluding Deep Vein Thrombosis/Pulmonary Embolism ("DVT/PE") in the following circumstances: following either a total knee or hip replacement, for pediatric populations, and for obstetric populations.

The following is a list of the Medicare HACs for FY 2011 included in this rule's definition of Medicaid HCAC:

- Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III or 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
- Vascular Catheter-Associated Infection
- Surgical Site Infection Following:
  - Coronary Artery Bypass Graft Mediastinitis

- Surgery (Laparoscopic Gastric Bypass, Gastroenterostomy, Laparoscopic Gastric Restrictive Surgery)
- Orthopedic Surgeries (Spine, Neck, Shoulder, Elbow)

OPPCs apply to both Medicaid **inpatient** and **outpatient** health care settings. The final rule establishes a floor in defining OPPCs as including, at a minimum, the three Medicare National Coverage Determinations: wrong surgical or other invasive procedure on a patient, surgical or other invasive procedure performed on the wrong body part, and surgical or other invasive procedure performed on the wrong patient. Subject to CMS approval, States are allowed to expand two areas within this OPPC subcategory. First, States can expand the application of OPPCs to other health care settings through identification of specific preventable events that occur in those health care settings. Second, the final rule allows States to identify additional conditions to include in the State's definition of OPPCs beyond the minimum three Medicare National Coverage Determinations described above.

## **PPC REPORTING REQUIREMENTS**

The final rule requires providers to self-report PPCs through the claims submission process regardless of the provider's intention to bill. The final rule does not require use of any specific coding system (i.e., POA, Global Trigger Tool, ICD-9-CM, or ICD-10-CM) to determine application of the PPC nonpayment policy. However, CMS will require providers to carefully document the physical status of patients on admission and self-report any PPCs during claim submission. The health plan or State can evaluate and make a payment correction if appropriate. The provider will still receive payment for the billed treatment but will not receive payment for services provided related to identified PPCs. The information transmitted through the claims system to State Medicaid programs will then be transmitted to CMS, and the two entities will jointly use this data to strengthen informed policy-making.

## **APPLICATION TO MANAGED CARE ORGANIZATION CONTRACTS**

Although the final rule does not apply to Managed Care Organizations ("MCOs") on its own, 42 C.F.R. § 438.6(f)(2) has been amended to mandate MCO contract compliance with provider identification of PPCs as a condition for payment, including prohibition against payment for PPCs as set by the final rule. CMS intends for MCOs to self-report PPCs during claim submission. Furthermore, CMS expects MCOs to record and track PPC data and make this information available to the State upon request.

## **PROTECTION OF MEDICAID BENEFICIARY ACCESS**

The final rule protects Medicaid beneficiary access by restricting a State's ability to adversely or unduly impact providers for the occurrence of identified PPCs. Specifically, there will be no reduction in payment imposed on a provider for PPCs that existed prior to the initiation of treatment by that provider. Furthermore, the rule limits imposing reductions in payments to the provider to the extent that the identified PPCs would otherwise result in an increase in payment. Also, the final rule limits reductions in payments to providers to the extent that the State can reasonably isolate for nonpayment the portion of the payment directly associated with treatment for, and related to, the PPCs.

## **STATE MEDICAID PLAN AMENDMENTS**

States without existing policies are required to develop and submit State Plan Amendments (SPAs) to comply with this final rule. Additionally, all States with existing policies that do not meet the minimum provisions of this final rule are required to revise State Medicaid plans to comply with this provision. In order to be in compliance with the new Rule, CMS will require the new SPAs to be submitted for review by September 30, 2011.

Upon submitting SPAs for approval, CMS will evaluate whether any additional health care settings or OPPCs proposed by the State are appropriate for the purposes of this rule. To support the Medicaid SPAs, States must supply findings that the proposed expansion of PPCs be reasonably preventable through application of evidence-based guidelines. The State's finding must be based on medical literature by qualified representatives. Ultimately, CMS will review SPAs and supplementary information to determine final action on proposed State PPC policies.

## **APPEALS PROCESS**

Existing appeal processes within a State may be available for a provider to contest whether a State has improperly identified an occurrence of a PPC. In order to prevail, providers will need to prove that the State improperly identified the PPC and that the identified PPC occurred despite all proper precaution.

Should you have any questions, please do not hesitate to contact Maureen Griffin at 317.977.1429  or [mgriffin@hallrender.com](mailto:mgriffin@hallrender.com), Liz 

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