Arnall Golden Gregory LLP

Client Alert

Contact Attorney Regarding This Matter:

Neil W. Hoffman, Ph.D.
404.873.8594 - direct
404.873.8595 - fax
neil.hoffman@agg.com

CMS Final Rule will Prohibit Medicaid Payments for Preventable Healthcare-Acquired Conditions

On June 1, 2011, the Centers for Medicare & Medicaid Services (CMS) issued a final rule prohibiting states from paying providers under Medicaid for healthcare-acquired conditions. This final rule implements Section 2702 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148; the Affordable Care Act), which requires that regulations be issued effective as of July 1, 2011, to prohibit federal payment to states under Section 1903 of the Social Security Act for any amounts expended in providing medical assistance for certain healthcare-acquired conditions. This new rule, in effect, prohibits states from paying providers under Medicaid for certain, reasonably preventable conditions. The regulations set forth under this final rule represent the latest in efforts to improve quality of care for federal health program beneficiaries. The following provides a brief description of two earlier regulatory initiatives, both of which are discussed in the preamble to the final rule.

Federal Medicare Reimbursement Policies

Among other things, the Deficit Reduction Act of 2005 (Pub. L. 109-171) amended the Social Security Act to provide for payment adjustments to hospitals for certain hospital-acquired conditions (HACs). These are conditions that share the following characteristics:

a) they involve high cost, high volume, or both;
b) they result in the assignment of a case to a MS-DRG that increases payment when presented as a secondary diagnosis; and
c) they are reasonably preventable through evidence-based guidelines.

Under these amended provisions, when an HAC is not present on admission (POA), but is reported as a secondary diagnosis associated with hospitalization, the hospital's Medicare (IPPS) payment is subject to adjustment, reflecting that the condition was acquired in the hospital. Under such circumstances, the hospital discharge cannot be assigned to a higher payment MS-DRG if the HAC diagnosis is the only reason for doing so. Since October 1, 2007, hospitals subject to Medicare's IPPS have been required to submit information on their Medicare claims to inform whether the diagnoses are POA. Note that the June 1 final rule includes the list of Medicare HACs for fiscal year 2011.

Arnall Golden Gregory LLP
Attorneys at Law
171 17th Street NW
Suite 2100
Atlanta, GA 30363-1031
404.873.8500
www.agg.com

Earlier, in 2002, the National Quality Forum (NQF) published "Serious Reportable Events in Healthcare: A Consensus Report." This report listed 27 adverse events that were considered serious, largely preventable, and of concern to the public and to healthcare providers. This list, which has undergone subsequent revisions, is comprised of what are now known as "never events." NQF's Consensus Standards Maintenance Committee on Serious Reportable Events maintains and updates this list, which currently contains 29 items. Pursuant to three national coverage determinations (NCDs), CMS does not cover a particular surgical or other invasive procedure where the practitioner erroneously performs 1) the wrong procedure; 2) the correct procedure but on the wrong body party; or 3) the correct procedure but on the wrong patient. Hospitalizations and other services related to the non-covered procedures are likewise not covered under Medicare.

State Medicaid Reimbursement Policies

The Deficit Reduction Act only addressed IPPS payments under Medicare. With respect to Medicaid, CMS issued State Medicaid Director Letter (SMDL) #08-004 on July 31, 2008, to encourage states to adopt policies against reimbursing providers for HACs and Never Events in coordination with Medicare. The July 31, 2008, SMDL indicated three options for states to follow. Those states that wanted to implement HAC nonpayment policies could do so by amending their Medicaid State plans to specify the extent to which they would deny payments for HACs. Those states that only wanted to avoid secondary liability for Medicare denials of HACs and NCDs could do so by amending their Medicaid State Plans accordingly. States were also permitted to adopt broader payment prohibitions through the process of amending their State Medicaid Plans.

The Affordable Care Act of 2010

The Affordable Care Act takes this a step farther. Section 2702 of this Act requires the Secretary of Health and Human Services to implement Medicaid payment adjustment for healthcare-acquired conditions (HCACs), defined as "a medical condition for which an individual was diagnosed that could be identified by a secondary diagnostic code described in section 1886(d)(4)(D)(iv) of the [Social Security] Act." This final rule issued on June 1 of this year uses Medicare's list of preventable conditions in inpatient hospital settings as the base set and allows states to identify additional preventable conditions and settings for denying Medicaid payment to providers.

The final rule is effective July 1, 2011, but states have the option to implement it between its effective date and July 1, 2012. The final rule is available by clicking here.[1]

1 http://www.ofr.gov/OFRUpload/OFRData/2011-13819_PI.pdf