American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

Submitted electronically

March 18, 2011

Donald Berwick, M.D., M.P.P.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: Medicaid Program; Payment Adjustment for Provider-Preventable Conditions Including Health Care-Acquired Conditions

Dear Dr. Berwick:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed regulation on Medicaid health care-acquired conditions.

Hospitals recognize the importance of eliminating health care-acquired conditions, but we have serious reservations about the manner in which CMS has structured this Medicaid payment penalty policy. Among our concerns are the several new concepts CMS attempts to introduce to identify these conditions. Throughout our letter, we simply refer to these as health care-acquired conditions, and we think it would be best for the health care field as a whole if CMS were to also adopt this nomenclature. Our detailed comments follow.

LACK OF CONSISTENCY

Many hospitals belong to health systems that cross several state borders. If states are able to finalize completely different lists of health care-acquired conditions, it would be extremely difficult to manage across a health system. Rather than create additional burden by concentrating in different areas, **we strongly recommend that CMS and states focus on a core set of health care-acquired conditions that are consistent across all states**. Our recommendations on how CMS can ensure consistency are included in the "statutory authority" and "Medicare hospital-acquired conditions" sections below.

STATUTORY AUTHORITY

CMS should first rely on the *Patient Protection and Affordable Care Act* (ACA) to guide states toward establishing a consistent list of Medicaid health-care acquired conditions. Section 2702 of the ACA **limits** CMS' application of payment prohibition for health care-acquired conditions for the Medicaid program in a number of ways. We believe CMS has exceeded its statutory authority in several of the proposals made for this policy. If CMS were to closely follow the Medicare hospital-acquired conditions (HAC) policy, it would achieve a consistent set of Medicaid health care-acquired conditions, which was Congress' intent. **We ask CMS and states to use the current list of Medicare HACs as the sole source from which the Medicaid health care-acquired conditions may be selected from**.

CMS encouraged states to consider a wide variety of sources, including the National Quality Forum's (NQF) list of Serious Reportable Events (SREs), when selecting health care-acquired conditions. However, states are not legally permitted to select from the SRE list. §2702(c) of the ACA states:

> In carrying out this section, the Secretary shall apply to State plans (or waivers) under title XIX of the Social Security Act the regulations promulgated pursuant to section 1886(d)(4)(D) of such Act (42 U.S.C. 1395ww(d)(4)(D)) relating to the prohibition of payments based on the presence of a secondary diagnosis code specified by the Secretary in such regulations.

This statutory criterion restricts selection of health care-acquired conditions to only those that can be coded as a secondary diagnosis and are listed as either a complication or comorbidity (CC) or major complication or comorbidity (MCC) using the ICD-9-CM classification system. Not all of the SREs would trigger a higher payment in Medicare's Inpatient Prospective Payment System (IPPS). The SREs that are already selected under the Medicare HAC program are those that have secondary diagnosis codes that could trigger a higher payment. Further, because the ACA restricts the health care-acquired conditions in this way, CMS should work with several states that have already legislated Medicaid non-payment for the SREs in order to instill consistency between federal and state law.

Section 1886(d)(4)(D) of the *Social Security Act* limits the application of the Medicare HAC policy to subsection (d) hospitals or those hospitals paid under the IPPS. This restriction also applies to the Medicaid health care-acquired conditions policy. However, CMS proposed to identify conditions for "hospital and nonhospital conditions identified by the state for nonpayment." CMS should not ask states to apply the Medicaid policy beyond IPPS hospitals. **We ask that CMS explicitly state that §2702 of the ACA should be applied only to IPPS hospitals.**

MEDICARE HAC POLICY

Given the restrictions included in §2702 of the ACA, we recommend CMS work with states to ensure that the list of health care-acquired conditions does not expand beyond the Medicare HAC list. We further note that §3008 of the ACA asks CMS to carefully study and submit a report to Congress prior to expanding the Medicare HAC policy to other settings of care beyond IPPS hospitals. We believe that Congress' intent behind this cautious process was to minimize unintended consequences that may occur when programs are implemented prior to establishing the necessary evidence to support their existence.

There are several criteria built into the Medicare HAC policy around selection of conditions that should be applied to the Medicaid policy. The Medicare policy requires conditions to:

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

We believe that it was Congress' intent that these criteria be applied to conditions selected for the Medicaid program. **To that extent, we strongly encourage CMS to provide more guidance to states around these selection criteria.**

We urge CMS to work with the states to determine the frequency of HACs in each state Medicaid program. CMS also should use the process it has engaged in with the Research Triangle Institute to study the effects of the Medicare HAC policy for the Medicaid program. It is incumbent on CMS and states to publish **in a transparent manner** the frequency of health care-acquired conditions in the Medicaid program prior to finalizing any payment prohibitions.

The Medicare HAC policy requires that IPPS hospitals be reimbursed a lower DRG when a HAC is not present on admission (POA). We note that several states do not pay for care of Medicaid patients on a DRG methodology, rather they reimburse on a per diem basis. The prohibition of payment for per diem states may prove to be very challenging, and CMS should provide detailed guidance in this area. We note that the Medicare HAC policy allows for IPPS hospitals to be reimbursed a higher DRG for other CCs and MCCs, even when there is a HAC present that is not POA. In the fiscal year 2011 IPPS final rule (75 FR 50091), the Research Triangle Institute found that in 77 percent of discharges, IPPS hospitals still received the higher DRG when a HAC was not POA. Because most cases with a HAC receive a higher DRG payment due to other CCs and MCCs, the Research Triangle Institute estimates that this policy saves approximately $20 million per year. This limit on the savings that can be achieved was built in to ensure that IPPS hospitals still continue to be reimbursed for the care provided to highly complex patients. **CMS and states must ensure that the same type of limit is built into the Medicaid policy.**

One of the most important aspects of the Medicare HAC policy is that the conditions must be reasonably preventable through the application of evidence-based guidelines. This must also be a factor in selecting conditions for the Medicaid policy. The AHA encourages CMS to work extensively with CDC, AHRQ and the public to identify evidence-based guidelines prior to selecting conditions for the Medicaid policy. All of the guidelines that have been identified for the Medicare policy are specific to the Medicare population. As such, they cannot be automatically transferred to the very different Medicaid population. **CMS and states should have an active dialogue with the public on evidence-based guidelines that exist explicitly pertaining to the reasonable prevention of health care-acquired conditions in the Medicaid population**. Where there are no existing guidelines, CMS and states must not finalize conditions.

The Medicare HAC policy is highly dependent on the clinical judgment that providers convey when they report whether the HAC was present on admission. Without this critical piece of information, **Medicaid programs cannot accurately assess whether a service should be reimbursed**. In the proposed regulation, CMS would require states to implement requirements for provider self-reporting of health care-acquired conditions in the Medicaid claims payment process. Although there is a federal POA reporting requirement for IPPS hospitals, there are a limited number of state POA reporting requirements. We are very concerned about states' ability to implement a new data reporting element in the claims process. Not only are we concerned about the financial resources needed to do this, but we are even more concerned with the timeframe for implementing POA reporting.

It took the Medicare program, which has far more resources at its disposal, nearly three years to implement the POA data element. To this extent, we believe that CMS has grossly underestimated the burden associated with implementing a POA data element into the various Medicaid claims processing systems. **We urge CMS to work with states and the Office of the Actuary to more appropriately assess the burden associated with altering the Medicaid claims processing systems.**

IPPS hospitals have been reporting POA on a national level for just over two years, and there are still several problems that need to be resolved. For example, no one has engaged in a national study to test the validity of POA reporting. Various studies done in California, New York and Pennsylvania have indicated there is wide variability in POA accuracy. These results have been validated by Agency for Healthcare Research and Quality (AHRQ).[1] Beyond the burden associated with improving POA accuracy in the Medicare program, hospitals have limited experience with POA reporting in the Medicaid program. CMS was silent on estimating the burden of implementing the Medicaid health care-acquired conditions policy for providers. **CMS should work with states and the Office of the Actuary to more appropriately assess the burden associated with hospital reporting of POA in the Medicaid program.**

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[1] http://www.webmm.ahrq.gov/perspective.aspx?perspectiveID=66

PROCESS AND TIMING

Section 2702 of the ACA requires the Medicaid program to "prohibit payments to states for health care-acquired conditions" by July 1, 2011. We are very concerned about the limited time available to implement this section.

States and CMS are given 90 days to negotiate changes to a State Amendment Plan (SAP) after a regulation is finalized. Given the late nature of this proposed regulation, it is unlikely that SAPs will be modified prior to July 1. In addition to modifications to the SAP, states will need time to implement changes to their systems and educate providers about the changes. Providers also will need to train their staff and implement changes. There is not enough time for any of these critical steps. Our biggest concern with missing the July 1 deadline is the possibility of reprocessing claims. Not only does claims reprocessing place a significant burden upon providers, but it creates additional expenses for the states, whose budgets are already severely stretched. Given these significant milestones that must be achieved prior to the beginning of the policy, **we ask that CMS work with states to establish a responsible delay of the start date for the Medicaid health care-acquired conditions policy**.

Beyond the financial ramifications created by the timeframes, we are concerned that the tight timeline will force circumvention of the necessary public vetting that must take place for this program. In developing the Medicare HAC policy, CMS worked closely with the Centers for Disease Control and Prevention (CDC) and AHRQ. The partnership led to better policy development. We recommend that CMS again partner with CDC and AHRQ when considering the conditions for selection under the Medicaid program. In addition, CMS held several public listening sessions when developing the Medicare HAC policy. We urge CMS to similarly host at least one public listening session prior to completing the final regulation for the Medicaid program.

ADDITIONAL CONCERNS

Although we request that CMS follow the Medicare HAC program closely, the Medicare HAC program is not perfect. There are still several improvements that must be made to the Medicare HAC program that CMS should consider when designing the Medicaid policy. We have always been concerned about the absence of risk adjustment in the Medicare HAC policy. While we recognize that risk adjustment is not an exact science, there is no mechanism in place for hospitals to make the case that they were improperly penalized under the HAC policy. At a minimum, hospitals should be afforded the right to appeal a HAC determination. This has been a limitation of the Medicare HAC program, and **we strongly encourage CMS to work with states to ensure an appeal mechanism is included in the Medicaid health care-acquired conditions program**.

We appreciate the opportunity to comment on the Medicaid health care-acquired conditions policy. If you have any questions, please contact me or Lisa Grabert, senior associate director of policy, at (202) 626-2305 or lgrabert@aha.org.

Sincerely,

Rick Pollack
Executive Vice President