



Arizona Hospital and Healthcare Association

*Submitted electronically*

March 18, 2011

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

***Re: Medicaid Program; Payment Adjustment for Provider-Preventable Conditions, Including Health Care-Acquired Conditions; File Code CMS-2400-P (42 CFR, Part 434, 438, 447)***

Dear Dr. Berwick:

On behalf of our over 100 member hospitals, health systems and other healthcare organizations, the Arizona Hospital and Healthcare Association (AzHHA) appreciates the opportunity to respond to the Center for Medicare & Medicaid Services' (CMS') proposed rule implementing provisions in section 2702 of the *Patient Protection and Affordable Care Act* (ACA) related to Medicaid health care-acquired conditions.

Our 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 support the use of this nomenclature for the health care field as a whole. Our detailed comments follow.

**LACK OF CONSISTENCY**

Several of our member hospitals belong to health systems with facilities in multiple states. If states are able to finalize completely different lists of health care-acquired conditions, it would be extremely difficult to implement and manage across a health system. Rather than create additional burden by concentrating in different areas, **we strongly recommend that CMS and states focus on development of 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. 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. **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.**

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 are 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.**

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.

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. AzHHA 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. Where there are no existing guidelines, CMS and states must not finalize conditions. **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.**

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.**

## **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, the AHCCCS Administration and its Medicaid Managed Care plans will need time to train their providers and staff and implement changes. There is not enough time for any of these critical steps. 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.**

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Beyond the financial ramifications created by the timeframes, we are concerned that the tight timeline will force circumvention of the necessary public vetting through state rulemaking processes that must take place for this program to be properly implemented.

Thank you again for the opportunity to comment on the proposed rule. If you have any questions or would like further information regarding our comments, please call me at (602) 445-4303.

Sincerely,

*Tanie*

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Director, Regulatory Advocacy



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