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CMS Imposes Medicaid Payment Restrictions on Provider-Preventable Conditions

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Effective July 1, 2011, states must submit state plan amendments to the U.S. Centers for Medicare & Medicaid Services (CMS) indicating how each state will prohibit Medicaid payments to providers for provider-preventable conditions as required under the Patient Protection and Affordable Care Act. CMS revealed that it will delay compliance action related to the new provisions until July 1, 2012.

On June 6, 2011, the U.S. Centers for Medicare & Medicaid Services (CMS) published its final rule (Final Rule) implementing Section 2702 of the Patient Protection and Affordable Care Act. Section 2702 requires the Secretary of U.S. Department of Health and Human Services to establish rules prohibiting payments to states for provider-preventable conditions (PPCs). The Final Rule defines PPCs as both health-care acquired conditions (HCACs) and other provider-preventable conditions (OPPCs).

As of July 1, 2011, CMS is statutorily required to deny Medicaid reimbursement requests associated with PPCs. Additionally, state Medicaid programs must submit state plan amendments to CMS indicating how the states will deny medical assistance for PPCs (subject to certain limited exceptions). The Final Rule also provides that Medicaid managed care organizations (MCOs) that contract with providers to serve Medicaid beneficiaries must require those providers to report PPCs associated with claims to the MCO. CMS revealed that it expects MCOs to track PPC data and make it available to the state upon request. To accomplish this, the Final Rule requires states that provide medical assistance using MCOs to modify their managed care contracts to reflect the PPCs payment adjustment.

The first category of PPCs, HCACs, are applicable to Medicaid inpatient hospital settings and incorporate Medicare's list of hospital-acquired conditions, exclusive of Deep Vein Thrombosis/Pulmonary Embolism (as these complications are not common in Medicaid-eligible populations). CMS notes in the preamble of the Final Rule that while it is inherently complex to incorporate Medicare's hospital-acquired conditions as a baseline for each state because of population differences across the programs, CMS anticipates that states will be able to appropriately account for such differences.

Notably, all states are required to comply with subsequent updates or revisions to the Medicare hospital-acquired condition list, which is typically published in the IPPS rule issued annually by CMS.

The second category of PPCs, OPPCs, apply broadly to inpatient and outpatient settings and include the three Medicare National Coverage Determinations (*i.e.*, surgery on the wrong patient, wrong surgery on a patient and wrong site surgery). Like HCACs, state plans must provide for nonpayment for care and services related to OPPCs regardless of where the patient received services (*i.e.*, inpatient or outpatient settings).

The Final Rule encourages states to increase the number of PPCs for which Medicaid payments can be denied, provided that a state consider evidence-based guidelines in adopting additional PPCs and obtain CMS approval before adding additional PPCs.

In response to comments related to concerns with implementing the program, CMS indicated that while the Patient Protection and Affordable Care Act requires the Final Rule to be statutorily effective as of July 1, 2011, CMS will delay compliance action related to the new provisions until July 1, 2012.

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