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Submitted via e-mail to [www.regulations.gov](http://www.regulations.gov)

**Re: CMS-2400-P; Medicaid; Proposed Regulation on Payment Adjustment for Provider-Preventable Conditions including Health Care-Acquired Conditions; 76 Fed. Reg. 9283 (February 17, 2011)**

The Medical Society of New Jersey (MSNJ) is a non-profit membership association representing approximately 8,000 physicians in the state of New Jersey. We appreciate the opportunity to comment on the Department of Health & Senior Services' (HHS) proposed rule prohibiting payment for "provider preventable conditions," including "healthcare acquired conditions," to state Medicaid programs.

We appreciate the Federal Government's need to provide consistency between the Medicare and Medicaid programs and the responsibility to implement the new healthcare reform laws. We note that the hospital-based systems in place to avoid hospital-acquired conditions (HACs) may have already benefited both patient populations. In fact, in-patients are treated the same regardless of their insurance status. However, we have grave concerns about flaws in the current Medicare HAC nonpayment policy and its application to the state's Medicaid programs without evidence that these rules will 1) result in overall cost savings to the Medicare program; and, 2) not cause further access to care issues in the Medicaid program.

The proposed rules go far beyond an attempt to square Medicare nonpayment policies with those of the Medicaid program as required by healthcare reform law. The proposed rules likely go beyond the scope of the enabling legislation. **We are concerned that the proposed rules will have a significant negative impact on access to care for Medicaid recipients in New Jersey if adopted as currently drafted.**

**The proposed rules would allow expansion of current Medicare HAC nonpayment policy in a number of significant ways without actual evidence that the current nonpayment rules reduce overall costs to the Medicare program.** First, the proposed rules vastly expand the number of conditions for which there will be no payment. Second, they expand the application of the nonpayment rules beyond hospitals

to virtually any other healthcare settings. Third, they expand the nonpayment rules to physicians. And finally, they may expand nonpayment rules to subsequent providers who treat for conditions that occurred totally outside of their control. All of this is without actual evidence that the current Medicare HAC nonpayment rules reduce overall costs to the Medicare program.

### **Expansion of Hospital-Acquired Conditions:**

The proposed rule vastly expands Medicare's hospital-acquired conditions (HACs) by creating a new "catch all" concept "Provider Preventable Conditions" (PPCs). Provider Preventable Conditions would then include two new categories: Healthcare Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs). *The proposal recognizes the need for new terminology to reach settings outside of the hospital setting because the pertinent new statutory definition of HCACs only applies to the inpatient hospital setting.*

The proposal seeks comments on expansion beyond the conditions listed as Medicare HACs. It recognizes that many states have already developed nonpayment policies to include more conditions than the Medicare HACs. **The federal enabling statute requires only that Medicaid recognize Medicare's current list of HACs.** The states are not constrained from expanding the list of HACs if they wish to do so. **MSNJ strongly urges HHS to adopt only the current list of HACs and make it applicable to Medicaid.** States have the flexibility to adopt more conditions for nonpayment without the sanction of the Federal Government.

In addition, the current HAC policy is flawed. There is strong disagreement in the medical community with CMS about whether many of the in-patient HACs are reasonably preventable. Certain high-risk patients may develop conditions on the HAC list regardless of the preventive measures taken. Any nonpayment policy should use evidence-based guidelines, developed by appropriate medical specialty organizations, based on non-biased, well-designed, prospective, randomized studies. Current in-patient HACs do not meet this criteria which was required by the Deficit Reduction Act.

**MSNJ urges HHS not to expand the list of HACs because there is disagreement over whether the current list includes conditions that are not reasonably preventable and there is no evidence that the nonpayment policy has resulted in actual cost savings to the federal program.**

### **Expansion beyond the Hospital Setting:**

HHS acknowledges that it could have limited the proposal to hospital settings, but noted that some states have implemented nonpayment policies for Medicaid outside of the hospital setting, so it crafted the proposed rule to "provide States full flexibility to

protect beneficiaries and the program.” MSNJ believes that states already have this flexibility, have exercised it, and that this federal sanction is simply not necessary.

**Moreover, expansion beyond the hospital setting is simply premature.** Section 3008 of the Affordable Care Act (ACA) requires the Secretary of HHS to conduct a study on expanding the HAC policy to other settings, including inpatient rehabilitation facilities, long-term care hospitals, hospital outpatient departments, and other hospitals excluded from the inpatient prospective payment system, skilled nursing facilities, ambulatory surgical centers, and health clinics. The mandated study is required to include an analysis of how policies applied to **other institutional settings** could impact quality of patient care, patient safety, and Medicare spending. It is due to Congress by January 1, 2012. Instead of waiting to consider the study of other institutional settings required by the ACA, this proposal extends the nonpayment policy beyond even these institutional settings **to any healthcare setting**.

The root of the HAC rules is to address hospital acquired conditions. Simply, they address conditions that are systems based. To the extent that the conditions may occur in other institutional or hospital-like facilities, states have an interest in addressing these issues, specifically targeting situations to protect their Medicaid beneficiaries and funds. While the proposal’s preamble mentions nursing homes, there is nothing in the proposed regulatory language to limit the settings to which nonpayment policies would apply. Instead, the proposed regulatory language—*any healthcare setting*—could apply virtually anywhere. **MSNJ objects strongly to the possibility that the proposal could be construed to apply to a physician practice and urges HHS to limit the rule to the current hospital based setting.** Extension to any facility type should be based on the results and analysis of the mandated study.

#### **Expansion to Physicians:**

The New Jersey Legislature passed a law, effective in 2009, which prohibits payments to hospitals for “never events” (essentially the same as Medicare’s LCD never events) and certain hospital-acquired conditions. N.J.S.A. 26:2H-12.25. The New Jersey law is applicable to all payers. While the legislature considered applying the law to physicians as well as hospitals, it was persuaded that the conditions to which nonpayment should attach were “systems based” and not conditions that allowed assignment of culpability to an individual physician. The legislature heard testimony and was persuaded that the law must be limited to general hospitals where systems based conditions can be addressed, rather than to penalize physicians who should not be held accountable for conditions outside of their immediate control.

**Aside from the culpability and control issue, there is a significant administrative issue in that the office visit payment approach is completely different from that in the hospital setting.** For example, in a physician’s office, there is no clear way to determine some portion of a physician’s payment that would be denied due to presumed mismanagement of a reasonably preventable condition. Because the presence

and severity of additional conditions present during the visit will vary greatly among patients, and because each patient might receive care from multiple physicians, identifying and valuing the work attributable to a preventable condition managed by any particular physician at any particular visit would be very difficult.

For these reasons, **MSNJ urges HHS not to expand the nonpayment rules to individual physicians.**

#### **Penalizing Subsequent Providers:**

The proposed rule establishes a standard for nonpayment of provider preventable conditions that far exceeds a penalty for the offending entity and acquired condition. The new general rule would allow non-payment for provider preventable conditions (PPC) if two conditions are met: the PPC results in an increased payment; and, the state can “reasonably isolate for nonpayment the portion of the payment *directly related to treatment for, and related to, the provider preventable conditions.*” This definition does not confine nonpayment to the entity in which the PPC occurred. (Even current Medicare payment policy attempts to address conditions “present on admission” excluding conditions present before admission and allowing payment for those conditions.) In other words, downstream providers may be penalized for treatment of PPCs for which they had absolutely no causation, control, or responsibility.

Clearly, subsequent treating physicians or entities should not be penalized for a “preexisting” PPC. The possibility of physicians not being paid for treating a possible preexisting PPC is a significant deterrent to physicians to treat Medicaid patients. It is ironic that insurers have been allowed to exclude coverage for preexisting conditions, yet physician may now become uncompensated for treating preexisting PPC.

#### **Access to Care:**

Section 2701 of the ACA requires that the proposed rules on HCACs not result in a loss of access to care or services for Medicaid beneficiaries. **MSNJ implores HHS to carefully consider the negative impact this proposal will have on access to care for the Medicaid population in New Jersey.**

**New Jersey already has a Medicaid access issue.** This is in the face of increasing numbers of individuals becoming Medicaid eligible under healthcare reform and being forced into Medicaid because of the overall state of the economy. At best, any enhanced federal Medicaid funding will be temporary.

While practice costs in New Jersey are among the highest in the nation the Medicaid payment rate is the lowest. Most physicians simply cannot afford to treat Medicaid patients. Those who do treat Medicaid patients are doing so below their practice costs. A recent survey of our membership indicated that 98% of the surveyed physicians do not treat Medicaid patients because of the low fees. Physicians do not

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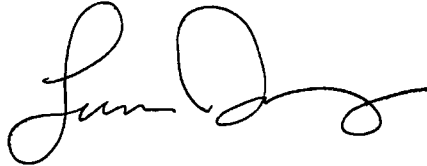
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Donald Berwick, MD, Administrator-Centers for Medicare & Medicaid Services & DHSS

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accept Medicaid patients not only because they are not fairly compensated, but also because they cannot assume the administrative burden. **Quite simply, more complicated rules, and more downside financial risk for situations outside of the control of individual physicians, will result in even fewer physicians treating Medicaid patients in New Jersey.**

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Lawrence Downs". The signature is fluid and cursive, with a large initial "L" and "D".

Lawrence Downs, Esq  
General Counsel  
Medical Society of New Jersey