DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SMDL #08-004

July 31, 2008

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) is issuing this State Medicaid Director Letter to provide guidance related to coordination of State Medicaid payment policies with policies recently adopted by the Medicare program. This is needed when hospital providers bill for selected hospital-acquired conditions (HACs), including some conditions on the National Quality Forum's (NQF) list of Serious Reportable Events (commonly referred to as "Never Events"). This letter specifically:

(1) Provides a brief overview of CMS' Medicare payment policy for selected HACs;

(2) Provides a brief overview of policy considerations for State Medicaid programs; and

(3) Provides direction as to how States can implement policies that are aligned with Medicare to prevent payment liability as a secondary payer.

Background

According to a study by the Centers for Disease Control & Prevention (CDC), common medical errors total more than $4.5 billion in additional health spending a year. Other studies have shown that hospitals only bear a small percentage of the total costs associated with preventable medical errors. Prompted by the landmark study by the Institute of Medicine titled "*To Err is Human: Building a Safer Health System*," the NQF created a list of 28 Never Events (Table A enclosed).

The NQF defines Never Events as errors in medical care that are of concern to both the public and health care professionals and providers, clearly identifiable and measurable (and thus feasible to include in a reporting system), and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the health care organization. The Medicare HACs discussed below overlap to some extent with the 28 NQF Never Events, but not all HACs are included in the 28 NQF Never Events.

For the Medicare HAC payment policy, certain conditions have been selected according to the criteria in section 5001(c) of the Deficit Reduction Act (DRA) of 2005. This provision amended Medicare hospital payment provisions at section 1886(d)(4)(D) of the Social Security Act to require the Secretary to select at least two HACs that are: (1) high cost, high volume, or both; (2) identified through ICD-9-CM coding as a complicating condition or major complicating condition that, when present as a secondary diagnosis at discharge, results in payment at a higher Medicare Severity-Diagnosis Related Group (MS-DRG); and (3) reasonably preventable through

application of evidence-based guidelines. CMS required hospitals to begin reporting on claims for discharges, beginning October 1, 2007, whether or not the selected conditions were present on admission. When acquired in a hospital, these selected conditions will no longer lead to higher Medicare payment.

The CMS exercised its authority under section 5001(c) of the DRA by announcing that Medicare will no longer pay the extra cost of treating the following categories of conditions that occur while the patient is in the hospital.

- pressure ulcer stages III and IV;
- falls and trauma;
- surgical site infection after bariatric surgery for obesity, certain orthopedic procedures, and bypass surgery (mediastinitis);
- vascular-catheter associated infection;
- catheter-associated urinary tract infection;
- administration of incompatible blood;
- air embolism; and
- foreign object unintentionally retained after surgery.

Beginning October 1, 2008, Medicare will no longer pay the higher MS-DRG for these conditions. In the 2009 Medicare Inpatient Prospective Payment System Update Regulation (CMS-1390-F), Medicare announced that certain categories of conditions would be covered under the HAC policy effective October 1, 2008. Newly added conditions include deep vein thromboses and pulmonary emboli associated with knee and hip replacements, and certain manifestations of poor glycemic control. In addition, Medicare is announcing it is initiating the National Coverage Determination process to review Medicare coverage of three Never Events (surgery on wrong body part, surgery on wrong patient, and performing the wrong surgery on a patient).

Medicare will no longer pay the higher MS-DRGs arising from these selected conditions if they arose in the course of an admission. Theoretically, for dual eligibles, the hospital could then attempt to bill Medicaid as a secondary payer, and the decision to balance bill would vary by State as to whether a coordinated denial by the State Medicaid program and the Medicare program would occur.

Additional information on the Medicare Payment policy can be found at: www.cms.hhs.gov/HospitalAcqCond.

Medicaid Policy Considerations

Given the large number of dual eligibles, CMS wants to clearly articulate the payment policy for Medicaid as a secondary payer for Medicare non-payment. The intention is to avoid Federal and State fiscal consequences from the provider's improper patient care. Therefore, States are encouraged to implement Medicaid payment policies to coordinate their payment policies with the existing Medicare HAC payment policy and prevent this unintended consequence.

To date, States have adopted varying approaches to address these events in their efforts to align payment and quality. According to responses to CMS queries, nearly 20 States already have, or are considering, methods to eliminate payment for some Never Events. Most of these methods utilize all, or a subset of, the 28 Never Events published by the NQF in 2006. Other States have attempted to use their "medical necessity" process to refuse to pay providers for some Never Events.

A State wishing to avoid Medicaid payment liability for treatment for which Medicare will not pay (on a HAC as defined by Medicare) may do so by including a general statement in its section 4.19A of the Medicaid State plan governing inpatient hospital reimbursement. This section can be amended to indicate that approved inpatient hospital rates are not applicable for HACs that either: (1) are specifically listed in the State Plan; (2) are identified as non-payable by Medicare; or (3) that meet criteria identified in the State Plan Amendment. The State Plan Amendment should further indicate that such policy applies to all Medicaid reimbursement provisions contained in section 4.19A, including Medicaid supplemental or enhanced payments and Medicaid disproportionate share hospital payments. The State would also have to ensure the proper Medicaid claims systems are established to limit payment of such events to prevent any attempt by providers to bill Medicaid as a secondary payer. States that choose to submit such an amendment can avoid or limit additional costs by submitting the required Medicaid State plan amendment to CMS as soon as possible.

States are neither required nor limited to devising Never Event policies that deal with the Medicare-Medicaid payment interaction created by the Medicare HAC Policy. CMS encourages the States to consider the entire Medicaid population (not just dual eligibles) and all of the NQF Never Events in the creation of individual State policies. The guiding principle should be that payment and performance need to be linked.

Please join CMS in this effort to improve the care that Medicare and Medicaid beneficiaries receive. This is an important part of the Secretary's and CMS' Value Driven Health Care initiative to ensure prudent use of resources to enhance quality care.

If you have questions or would like additional information on this guidance, please contact Mr. John M. Young, Division of Quality, Evaluations & Health Outcomes, at (410) 786-0505 or at john.young@cms.hhs.gov. Thank you for your assistance in this important endeavor.

Sincerely,

/s/

Herb B. Kuhn
Deputy Administrator
Acting Director, Center for Medicaid and State Operations

Enclosure

cc:
CMS Regional Administrators

CMS Associate Regional Administrators
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Ann C. Kohler
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Table A

Patient Safety: CMS Initiatives Addressing Never Events

Current NQF Serious Reportable Adverse Events	HHS/CMS Value Driven Health Care Efforts
Surgical Events	
Surgery on wrong body part	National Coverage Determination
Surgery on wrong patient	National Coverage Determination
Wrong surgery on a patient	National Coverage Determination
Foreign object left in patient after surgery	Hospital-Acquired Condition
Post-operative death in normal health patient	
Implantation of wrong egg	
Product or Device Events	
Death/disability associated with use of contaminated drugs	
Death/disability associated with use of device other than as intended	
Death/disability associated with intravascular air embolism	Hospital-Acquired Condition
Patient Protection Events	
Infant discharged to wrong person	
Death/disability due to patient elopement	
Patient suicide or attempted suicide resulting in disability	
Care Management Events	
Death/disability associated with medication error	
Death/disability associated with incompatible blood	Hospital-Acquired Condition
Maternal death/disability with low risk delivery	
Death/disability associated with hypoglycemia	Hospital-Acquired Condition
Death/disability associated with hyperbilirubinemia in neonates	
Stage 3 or 4 pressure ulcers after admission	Hospital-Acquired Condition
Death/disability due to spinal manipulative therapy	
Environment Events	
Death/disability associated with electric shock	Hospital-Acquired Condition
Incident due to wrong oxygen or other gas	
Death/disability associated with a burn incurred within facility	Hospital-Acquired Condition
Death/disability associated with a fall within facility	Hospital-Acquired Condition
Death/disability associated with use of restraints within facility	
Criminal Events	
Impersonating a heath care provider (*i.e.*, physician, nurse)	
Abduction of a patient	
Sexual assault of a patient within or on facility grounds	