



The Commonwealth of Massachusetts
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March 18, 2011

Donald Berwick, M.D., Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2400-P
P.O. Box 8016
Baltimore, MD 21244-1850

Dear Dr. Berwick:

Massachusetts is pleased to offer comments on the proposed rule, Medicaid Program; Payment Adjustment for Provider-Preventable Conditions Including Health Care Acquired Conditions (HCAC). Massachusetts strongly agrees that payment adjustment for HCACs and other provider-preventable conditions is an important strategy to improving health outcomes. We respectfully submit the following comments on the proposed rule.

Application of Non-Payment Policy to Capitated Payments

- Please provide guidance for states on how to apply the non-payment requirement for HCACs to capitation payments, specifically including capitation payments made on a per member per month basis under 42 CFR 438.6, where the cost of discrete services are not segregated.
- Specifically, please provide options for how the states may identify or estimate the cost of services on a systematic basis without a case by case review.

Application of Non-Payment Policy to Bundled Payments

- Please provide guidance for states on how to apply the non-payment requirement for HCACs to other types of bundled or global payments that are determined prospectively, where the cost of discrete services are not segregated.
- Specifically, please provide options for how the states may identify or estimate the cost of services on a systematic basis without a case by case review.

State Flexibility in Determining Payment Reductions

- Please clarify whether states that pay for hospital admissions using a federally-approved bundled payment method have the flexibility to implement a non-payment policy for an entire admission during which an HCAC occurs.

The proposed rule at 42 CFR 447.26(c) appears to offer states flexibility in attributing some or all of a payment involving a PPC to the PPC. The proposed rule states that “reductions in provider payment *may* be limited to the extent that the ... identified provider preventable conditions would otherwise result in an increase in payment” or when “the State *can reasonably* isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.” Proposed 42 CFR 447.26(c)(2)(i) and (ii) (emphasis added). However, in several places in its comments, CMS appears to indicate that, regardless of the payment system employed in a given state, it proposes “that *any* reduction in payment would be *limited to* the amounts *directly identifiable* as related to the PPC and the resulting treatment.” 76 Fed. Reg. 9690 (2011) (emphasis added).

We believe that with certain bundled rate methodologies, costs of particular services are not readily ascertainable, so it would not be feasible to attempt to assign a portion of a payment to a particular set of services. For example, Massachusetts’ longstanding federally-approved acute inpatient hospital Standard Payment Amount per Discharge (SPAD) methodology is prospective, casemix-adjusted, hospital-specific payment that is based on prior period costs, and covers all hospital services provided during the first 20 days of an inpatient admission. Since this methodology applies the same hospital-specific rate to all admissions regardless of specific services provided, there is no increase in payment related to a provider preventable condition.

Massachusetts does currently have a federally-approved non-payment policy for the NQF list of 28 Serious Reportable Events (SREs.) Under the Massachusetts policy, if one of these events occurs, the hospital does not receive the SPAD payment for that acute inpatient stay. SREs have represented very few hospital admissions and this policy has not adversely affected access to acute hospital services.

Scope of Non-Payment Rule

- Please clarify whether, apart from denial of payment to the provider that caused a PPC, other providers who subsequently treat a beneficiary with an acquired condition would be entitled to payment.

Implementation Date

- Please consider providing states additional time to implement the HCAC policy. In particular, states that have already implemented their own health care-acquired conditions policies require additional time to align their policies and systems with the parameters of the proposed rule. Accordingly, we are requesting that states be given until at least January 1, 2012 to implement policy and systems changes necessary to comply with the proposed rule.

Thank you for the opportunity to comment. Massachusetts looks forward to continuing to work with CMS to strengthen and improve the Medicaid program.

Sincerely,

A handwritten signature in cursive script that reads "Terence G. Dougherty".

Terence G. Dougherty
Medicaid Director