



MEDICAID NEWS

FOR IMMEDIATE RELEASE
June 1, 2011

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Affordable Care Act Gives States Tools to Improve Quality of Care in Medicaid, Save Taxpayer Dollars

New rule will reduce payments for preventable healthcare acquired conditions

WASHINGTON, D.C. – The Centers for Medicare & Medicaid Services (CMS) today issued a final Affordable Care Act rule that will reduce or prohibit payments to doctors, hospitals and other health care providers for services that result from certain preventable healthcare acquired illnesses or injuries. This rule will help reward providers who provide high quality care to people in Medicaid leading to better care for patients and lower costs.

This final rule builds on States' successes and Medicare policies, which already reduce or prohibit hospital payments for preventable conditions. The new rule would better align Medicare and Medicaid payment policy, while giving States the flexibility to expand the list of preventable conditions the program would no longer pay for. In recent years, many States have been at the forefront of these improvements.

"Today, we are partnering with States to give them the tools to improve the quality of care for patients and lower costs for taxpayers," said CMS Administrator Donald M. Berwick, M.D. "These steps will encourage health professionals and hospitals to reduce preventable infections, and eliminate serious medical errors. As we reduce the frequency of these conditions, we will improve care for patients and bring down costs at the same time."

This step is part of CMS' ongoing efforts to improve the quality of care that patients receive and reduce overall health care costs. These efforts include tying payment to quality standards, investing in patient safety initiatives to reduce preventable hospitalizations such as the Partnership for Patients, and implementing broad reform of our health care delivery system.

The new rule prohibits States from making payments to providers under the Medicaid program for conditions that are reasonably preventable. It uses Medicare's list of preventable conditions in inpatient hospital settings as the base (adjusted for the differences in the Medicare and Medicaid populations) and provides States the flexibility to identify additional preventable conditions and settings for which Medicaid payment will be denied.

The final rule is effective July 1, 2011 but gives States the option to implement between its effective date and July 1, 2012.

To learn more, please visit:

- Final rule at the *Federal Register*: Payment Adjustment for Provider-Preventable Conditions Including Health Care-Acquired Conditions

http://www.ofr.gov/OFRUpload/OFRData/2011-13819_PI.pdf

- AHRQ Patient Fact Sheet: [20 Tips to Help Prevent Medical Errors](#)

APPENDIX

List of Provider-Preventable Conditions (PPCs)

PPCs are divided into two categories: HCACs and OPPCs (Other Provider-Preventable Conditions). HCACs will apply to all inpatient hospitals under Medicaid and are defined as:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
 - Fractures
 - Dislocations
 - Intracranial Injuries
 - Crushing Injuries
 - Burns
 - Electric Shock
- Catheter-Associated Urinary Tract Infection (UTI)

- Vascular Catheter-Associated Infection

- Manifestations of Poor Glycemic Control
 - Diabetic Ketoacidosis
 - Nonketotic Hyperosmolar Coma
 - Hypoglycemic Coma
 - Secondary Diabetes with Ketoacidosis
 - Secondary Diabetes with Hyperosmolarity
- Surgical Site Infection Following:
 - Coronary Artery Bypass Graft (CABG) - Mediastinitis

- Bariatric Surgery
 - Laparoscopic Gastric Bypass
 - Gastroenterostomy
 - Laparoscopic Gastric Restrictive Surgery
- Orthopedic Procedures
 - Spine
 - Neck
 - Shoulder
 - Elbow
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Total Knee Replacement or Hip Replacement – *with pediatric and obstetric exceptions*

OPPCs are defined to identify as a baseline, the three Medicare National Coverage Determinations (surgery on the wrong patient, wrong surgery on a patient, and wrong site surgery). States may identify others with CMS approval through the State plan amendment process.