



HOSPITAL-ACQUIRED CONDITIONS

The Affordable Care Act (ACA) mandated several programs that penalize hospitals repeatedly for the same issue—hospital-acquired conditions (HACs). Specifically, the ACA mandated a Medicaid HAC proposal and two separate Medicare HAC policies, one as a stand-alone program and another as part of value-based purchasing (VBP). Taken together, they create a double jeopardy situation for hospitals.

The ACA HAC Policies

By July 1, 2011, the ACA mandates that the Secretary of Health and Human Services (HHS) issue regulations prohibiting Federal Medicaid matching funds to states for payments attributed to care provided for HACs. From the Federal perspective, the purpose of this policy is to ensure that hospitals do not receive additional payment for any services provided in treating patients who have acquired particular conditions during their hospital stay. New York has had a similar policy for several years, although the conditions subject to that policy do not overlap perfectly with the Centers for Medicare & Medicaid (CMS) conditions. It is expected that New York will be fully compliant with the HHS regulations by the July 1 deadline.

On the Medicare front, the ACA mandates that hospitals in the worst quartile of risk-adjusted HAC rates will lose 1% of their Medicare acute inpatient payments, *including* indirect medical education (IME), disproportionate share hospital (DSH), and outlier payments. GNYHA expects that when the penalties begin in Federal fiscal year (FY) 2015, they will be based on FY 2013 cases. A second and separate Medicare ACA policy again penalizes hospitals for HACs through the VBP program. Hospitals that fail to meet certain performance benchmarks or significantly improve their year-over-year performance will see up to 2% of their payments reduced.

Flawed Penalty Design

Because the HACs stand-alone penalty program is not based on actual or improved performance but rather on relative performance, one-quarter of the nation's hospitals are always fated to lose 1% of their acute inpatient payments, and may lack resources for sustained quality improvement efforts. In other words, the construct of the stand-alone penalty program is inherently flawed because regardless of how much hospitals improve, there will always be a bottom 25% that will incur heavy penalties. Additionally, Congress inappropriately failed to carve out special policy payments (e.g., GME, IME, DSH, and outliers) in constructing the penalty formula. In other ACA penalty programs, these policy payments are appropriately carved out to avoid piling on penalties to hospitals that train residents or serve low-income communities. While it would take an act of Congress to achieve, a more appropriate approach would be to eliminate the stand-alone HAC policy altogether, and penalize hospitals for HACs only within the construct of the VBP program, which appropriately carves out IME and DSH.

GNYHA POSITION

Congress should pass legislation fixing the HAC double jeopardy issue by eliminating the stand-alone HAC policy and addressing HACs only through VBP. Regardless, CMS should carve out special policy payments when calculating penalties.