

In this month's issue

- CMS Issues Proposed Rule Requiring States to Implement Policies for Payment Adjustments for Provider Preventable Conditions
- What Healthcare Practices Need to Know about the New Tax Relief Act of 2010

CMS Issues Proposed Rule Requiring States to Implement Policies for Payment Adjustments for Provider Preventable Conditions*By Conrad Meyer, JD/MHA*

On February 17, 2011, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that would implement Section 2702 of the Patient Protection and Affordable Care Act (PPACA) requiring states to implement policies under their Medicaid programs prohibiting federal payments to states for providing medical assistance for healthcare-acquired conditions. The proposed rule would require the states Medicare programs to implement these policies by July 1, 2011.

Background

In 2002, the Medicare Program addressed certain “never events” through national coverage determinations (NCDs) in response to a report from the National Quality Forum listing 27 adverse events that were “serious, largely preventable and of concern to both the public and health care providers.” The thought was that Medicare patients might experience serious injuries if they undergo erroneous surgical or other invasive procedures that may require additional healthcare to correct adverse outcomes resulting from errors. Based on the report regarding the “never events,” Medicare issued three NCDs. Under these NCDs, Medicare specified that it does not cover a particular surgical or other invasive procedure to treat a particular medical condition when a practitioner erroneously performs: (1) a different procedure altogether; (2) the correct procedure but on the wrong body part; or (3) the correct procedure but on the wrong patient.

In 2005, the Deficit Reduction Act (DRA) was enacted prohibiting payment to hospitals for certain preventable hospital-acquired conditions (HACs) identified by the Secretary of Health and Human Services (Secretary). According to the DRA, these conditions were required to have the following characteristics:

- (a) High cost or high volume, or both;
- (b) Result in the assignment of the case to a diagnosis-related group (MS-DRG) and has a higher payment when present as a secondary diagnosis; and
- (c) Could reasonably have been prevented through the application of evidence-based guidelines.

The DRA required the Secretary to revise the list of HACs from time to time as long as it contained at least two of the three conditions listed above. The DRA further required that when an HAC is not present on admission (POA), but is reported as a secondary diagnosis associated with the hospitalization, the Medicare payment under the in-patient prospective payment system (IPPS) to the hospital may be reduced to reflect that the condition was hospital-acquired. In addition to the reduction in reimbursement for HACs, since October 1, 2007, hospitals subject to IPPS have been required to submit information to CMS on Medicare claims specifying whether diagnosis were POA in order to determine if a patient suffered an HAC.



As an example, a few of the Medicare HACs are listed below:

- ♦ foreign object retained after surgery
- ♦ embolism
- ♦ blood incapability
- ♦ stage 3 and stage 4 pressure ulcers
- ♦ falls and trauma
- ♦ manifestations of poor glyceemic control
- ♦ catheter-associated urinary tract infection (UTI)
- ♦ vascular catheter-associated infection
- ♦ surgical site infections following certain surgical procedures
- ♦ deep vein thrombosis/pulmonary embolism

The current list of Medicare HACs can be found at 75 FR 50084 through 50085.

On March 23, 2010, with the enactment of PPACA, the Secretary is now required to implement Medicaid payment adjustments for healthcare-acquired conditions (HCACs), formally known as HACs. Specifically, Section 2702 of PPACA sets out a general framework for application of the Medicare prohibitions on payment for HACs that would be applicable to the Medicaid Program. The general framework for establishing Medicaid policies on HCACs requires the Secretary implement the current regulations already contained in the DRA regarding reduction of payment for HACs. However according to the proposed rule, CMS wishes to codify provisions in the final rule that would allow states flexibility in identifying provider preventable conditions (PPCs) that include, at a minimum, the HACs identified by Medicare. The rationale behind state identification of PPCs is to expand the scope of non-payment provisions to service settings outside that of inpatient hospitals. Most importantly, states would be required to implement these policies effective July 1, 2011. CMS advises that for states to be in compliance with the July 1, 2011 effective date, the last day for states to submit to CMS their state plan amendment (SPA) would be September 30, 2011, which is the last day of the quarter in which the amendment would be effective. Further, PPACA requires that in establishing state Medicaid policies for prohibition or payment for HCACs, such policies should not result in loss of access to care or services for Medicaid beneficiaries.

Provisions of the Proposed Rule

CMS broke PPCs down into two categories: 1) HCAC and 2) other provider-preventable conditions (OPPC). As stated above, the proposed rule would require states to adopt, at a minimum, the same HACs Medicare currently identifies for non-payment and to comply with future updates to the Medicare HAC list. Despite this requirement, the rule would allow states, when implementing these policies, the flexibility to identify conditions for non-payment, as approved by CMS, that the states determined meet the criteria set forth in the DRA outlined above. According to CMS, states not only must identify HCACs, but also identify OPPCs that occur outside of the inpatient hospital setting including, nursing facilities, ambulatory surgery centers (ASCs), and other provider settings. The difference between HCACs and OPPCs is that the OPPCs are conditions that occur outside of the inpatient hospital setting. CMS defines OPPCs to include, at a minimum the following:

- (a) Wrong surgical or other invasive procedure performed on a patient.
- (b) A surgical or other invasive procedure performed on the wrong body part.
- (c) A surgical or other invasive procedure performed on the wrong patient.

According to the proposed rule, states would be required to implement, at a minimum, federally identified OPPCs, while expanding the list of OPPCs that states could apply non-payment provisions. CMS provided criteria for states to consider when identifying additional OPPCs including:

- (a) A condition or event identified by a state for inclusion under this provision must be a discrete, auditable, quantifiable, and clearly defined occurrence;
- (b) A condition or event must be clearly adverse, resulting in a negative consequence of care that results in unintended injury or illness; and
- (c) A condition or event identified must be reasonably preventable, meaning an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure.

Both HCACs and OPPCs identified by states would receive the same treatment, meaning non-payment for care related to those specific conditions. To assist the states in identifying conditions for non-payment, CMS suggests states use conditions that “could” be identified in the Medicare Program by a secondary ICD-9-CM or ICD-10-CM code as an HAC. Lastly, the proposed rule would also require states to implement requirements for provider self-reporting of all HCACs in the Medicaid claims payment process.

Pursuant to the provisions of the PPACA, states will now be required to implement policies for non-payment of HCACs and OPPCs for their individual Medicaid programs. By implementing these policies, states’ Medicaid programs would deny federal financial participation for Medicaid expenditures made for PPCs, including HCACs and OPPCs identified in the state’s Medicaid plan, while ensuring that related payment adjustments do not limit the beneficiaries access to care. This proposed rule would not only affect hospitals but also numerous other healthcare settings including nursing facilities, ASCs, and other healthcare facilities that participate in the Medicaid program. Even though the final rule has yet to be published, healthcare providers who participate in the Medicaid program should carefully review both their policies governing quality control and the upcoming final rule regarding CMS’ mandate to states to implement these non-payment provisions to assure that they are in compliance in order to avoid what could be substantial revenue loss if a patient succumbs to a HCAC or OPPC at their facility.

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What Healthcare Practices Need to Know About the New Tax Relief Act of 2010

By: Robert Bowsher and Lance Kinchen

In 2010, President Obama signed into law the Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 (Act). The Act temporarily extends tax cuts that were set to expire at the end of 2010 and adds new tax incentives for businesses to acquire additional equipment and property. The following is a summary of some of the Act’s main provisions that may be relevant to your healthcare practice.

Individual Income Tax Rates: One of the biggest benefits resulting from the new Act is that the individual income tax rates or brackets will remain unchanged through the end of 2012. Prior to the new Act, the 25%, 28%, 33% and 35% individual income tax brackets were set to expire at the end of 2010. Without the Act, the individual income tax brackets would have been 28%, 31%, 36% and 39.6% in 2011. The Act extends the 25%, 28%, 33% and 35% individual income tax brackets for an additional two years, through 2012. The Act also maintains the 10% bracket for low income taxpayers for an additional two years, through 2012.

Capital Gains and Dividend: The Act extends for those taxpayers in the 25% individual income tax bracket and above, the long-term capital gains and dividend tax rates at 15%. Without the new Act, the rates for long-term capital gains would have increased to a maximum of 20% and dividends would have been subject to the ordinary income tax rates. The new Act also retains the long-term capital gains and dividend rates for taxpayers below the 25% bracket at 0 percent.

Itemized Deduction Limitation: For the past several years, the amount of itemized deductions that a taxpayer may claim has been reduced to the extent that the taxpayer’s adjusted gross income is above a certain amount. The first year in which there were no limitations on itemized deduction is in 2010. The Act extends the repeal of the itemized deduction limitation for an additional two years, through 2012.

AMT Relief: The Act increases the AMT exemption amount for 2010 from \$33,750 to \$47,450 for non-married individuals and from \$45,000 to \$72,450 for married individuals filing jointly. The Act increases the AMT exemption amount for 2011 to \$48,450 for non-married individuals and \$74,450 for married individuals filing jointly.

Temporary Extension of Estate Tax Relief: After December 31, 2010, the Bush era estate tax reduction was scheduled to expire and return to the exemption amounts and the rates in effect in 2001. This result was apparently not acceptable to anyone and the resulting Tax Relief Act makes significant changes to the estate tax provisions of the Internal Revenue Code, which will now be in effect until January 1, 2013.

- (a) The applicable credit amount, which is the amount an individual can pass free of estate tax to his heirs, was scheduled to be \$1.0 million in 2011 with a maximum tax rate of 55% was changed for decedents dying after December 31, 2009 to be \$5.0 million with a maximum tax rate of 35%.
- (b) After December 31, 2010, the gift tax exclusion amount for an individual's lifetime gifts will be raised from \$1.0 million to \$5.0 million. Additionally, the applicable credit for estate tax purposes and the exclusion amount for gift tax purposes will again become a unified credit for taxable transfers both during an individual's lifetime and also at death.
- (c) The Act did away with, in general, the carryover basis for heirs of decedent's dying in 2010, providing a return to a step up in basis to the fair market value of the decedent's property at the date of death.
- (d) For decedents dying in 2010, the executor of such estates may elect out of the new estate tax and stepped up basis provisions and have the old provisions apply. For estates having net assets in excess of \$5.0 million, the executor may want to elect out of the new tax provisions to avoid paying estate taxes but then the assets of the estate will have a carryover basis to the heirs, not a stepped up basis. Under rules to be issued by the Treasury, the executors of such estates will have nine months from enactment of the Act to elect out.
- (e) The Act introduces a new benefit for married decedents dying after December 31, 2010. In situations where the first spouse to die does not use all of the deceased spouse's applicable credit amount of \$5 million, the unused portion is available for use by the surviving spouse as an addition to such surviving spouse's own applicable exclusion amount of \$5 million. For example, if the first spouse to die only has a taxable estate of \$3 million, the surviving spouse may use the predeceased spouse's carryover amount of \$2 million with such surviving spouse's own \$5 million exclusion for taxable transfers of \$7 million made during life or at death.

These provisions are only a temporary fix to the estate and gift tax issues and all of these provisions sunset after December 31, 2012, when the old law of 2001 once again is scheduled to come back into effect at an applicable credit amount of \$1 million and a maximum tax rate of 55%.

Payroll Tax Cut: The Act reduces only the **employee portion** of the social security tax from 6.2% to 4.2% for 2011. Under current law, employees pay 6.2% in social security tax in all wages earned up to \$106,800 (in 2011). Self-employed individuals pay 12.4% social security self-employment taxes on all of their self-employment income up to the same threshold. The Act provides that self-employed individuals will only pay 10.4% on self-employed income up to the threshold amount for 2011.

100% Bonus Depreciation: Businesses are allowed to recover the cost of capital expenditures over time according to a depreciation schedule. Congress allowed businesses, beginning January 1, 2008 through December 31, 2009, to take an additional depreciation deduction allowance equal to 50% of the cost of the depreciable property placed in service in those years. Under the Small Business Jobs Act of 2010, this temporary increase in the depreciation deduction allowance was extended through December 31, 2010. The Act now extends and temporarily increases this bonus depreciation provision for investments in new business equipment. For qualified property acquired after September 8, 2010 and before January 1, 2012, and which is placed in service by the taxpayer before January 1, 2012 (before January 1, 2013 for certain longer-lived and transportation property), the Act provides for 100% bonus depreciation. For qualified property placed in service after December 31, 2011 and through December 31, 2012 (before January 1, 2013 for certain longer-lived and transportation property), the Act provides for 50% bonus depreciation.

Section 179 Deduction: Under current law, a taxpayer may elect to deduct the cost of certain property placed in service for the year rather than depreciate those costs over time. The 2003 tax cuts temporarily increased the maximum dollar amount that may be deducted from \$25,000 to \$100,000. The tax cuts also increased the phase-out amount from \$200,000 to \$400,000. In 2007, the tax cuts temporarily increased these thresholds to \$125,000 and \$500,000, respectively, indexed for inflation. These amounts have been further increased and extended several times on a temporary basis, including most recently as part of the Small Business Jobs Act, which increased the thresholds to \$500,000, with the \$500,000 amount reduced by the amount by which the cost of the qualifying property placed into service in that year exceeds \$2 million for the taxable years beginning in 2010 and 2011. The Act extends the 2007 maximum amount for taxable years beginning in 2012, to \$125,000 and phase-out thresholds to \$500,000, respectively, indexed for inflation.

Gulf Opportunity Zone Extensions:

- (a) The Act extends for two years an additional depreciation deduction equal to 50% of the cost of new property investments made in the Gulf Opportunity Zone. The Act makes qualifying expenditures in 2011 eligible provided the property is placed in service by December 31, 2011.
- (b) The Act extends for an additional two years the increased rehabilitation credit for qualified expenditures in the Gulf Opportunity Zone. The Gulf Opportunity Zone Act of 2005 increased the rehabilitation credit from 10% to 13% of qualified expenditures for any qualified rehabilitated building other than a certified historic structure, and from 20% to 26% of qualified expenditures for any certified historic structure located in the Gulf Opportunity Zone. The extension applies to qualified rehabilitation expenditures with respect to such buildings or structures incurred before January 1, 2012.
- (c) The Gulf Opportunity Zone Act of 2005 provided an additional allocation of low-income housing tax credits to the Gulf Opportunity Zone in an amount equal to the product of \$18.00 multiplied by the portion of the state population that is in the Gulf Opportunity Zone. The additional allocations were made in calendar years 2006, 2007 and 2008, and required that the properties be placed in service before January 1, 2011. The Act extends that placed-in-service deadline for one year to December 31, 2011.
- (d) Under previous law, Gulf Opportunity Zone bonds were authorized to help rebuild areas devastated by Hurricane Katrina and must be issued by December 31, 2010. The Act provides one additional year to issue Gulf Opportunity Zone bonds, through December 31, 2011.

Conclusion: The Act contains numerous other provisions that may apply to your specific situation. We recommend that you consult your individual tax advisor to determine what provisions of the Act may affect your individual or business tax returns. Pursuant to IRS Circular 230 and IRS regulations, we inform you that, unless specifically indicated otherwise, any tax advice contained in this communication, including attachments, was not intended or written to be used, and cannot be used, for the purpose of (i) avoiding tax-related penalties under the Internal Revenue Code, or (ii) promoting, marketing or recommending to another party any tax-related matter addressed herein.

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