

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**RHODE ISLAND DID NOT ENSURE ITS
MANAGED-CARE ORGANIZATIONS
COMPLIED WITH REQUIREMENTS
PROHIBITING MEDICAID
PAYMENTS FOR SERVICES RELATED TO
PROVIDER-PREVENTABLE CONDITIONS**

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Gloria L. Jarmon
Deputy Inspector General
for Audit Services

January 2019
A-01-17-00004

Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

Date: January 2019

Report No. A-01-17-00004

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

Federal regulations effective July 1, 2011, prohibit Medicaid payments for services related to provider-preventable conditions (PPCs). The Centers for Medicare & Medicaid Services delayed its enforcement of the regulations until July 1, 2012, to allow States time to develop and implement new payment policies. This review is part of a series of reviews to determine whether the States ensured that their Medicaid managed-care organizations (MCOs) complied with these regulations for inpatient services.

Our objective was to determine whether Rhode Island ensured that its MCOs complied with Federal and State requirements prohibiting payments to providers for inpatient hospital services related to treating certain PPCs.

How OIG Did This Review

We obtained an understanding of the monitoring activities the State agency performed to ensure that the MCOs complied with Federal and State requirements and their managed-care contracts relating to the nonpayment of PPCs. From July 2012 to June 2015, the State agency contracted with two MCOs to provide services to Medicaid beneficiaries. We reviewed Medicaid encounter data from the two MCOs to identify providers' paid claims that contained at least one secondary diagnosis code for a PPC and that had a present on admission (POA) code indicating that the condition was not present on admission or did not have a POA code.

Rhode Island Did Not Ensure Its Managed-Care Organizations Complied With Requirements Prohibiting Medicaid Payments for Services Related to Provider-Preventable Conditions

What OIG Found

Rhode Island did not ensure its MCOs complied with Federal and State requirements prohibiting Medicaid payments to providers for inpatient hospital services related to treating certain PPCs. PPCs are certain reasonably preventable conditions caused by medical accidents or errors in a health care setting. For our audit period, we identified that MCOs paid providers approximately \$3,968,040 for 241 claims that contained PPCs. Rhode Island's internal controls were not adequate to ensure that its MCOs complied with Federal and State requirements. For instance, the State agency did not follow up with the MCOs to determine why POA codes were missing or whether the payments made for the related claims complied with Federal and State requirements. In addition, the MCOs did not have policies or procedures to identify PPCs on claims for inpatient hospital services or determine whether payments for claims containing PPCs should have been reduced.

As a result, the unallowable portion of the \$4 million identified for our audit period was included in the capitation payment rates for State fiscal years 2017 and 2018.

What OIG Recommends and State Agency Comments

We made several recommendations to the State agency, including (1) work with the MCOs to determine the portion of the \$4 million that was unallowable for claims containing PPCs and its impact on current and future capitation payment rates; (2) include a clause in its managed-care contracts with the MCOs that would allow the State agency to recoup funds from the MCOs when contract provisions and Federal and State requirements are not met, thereby resulting in potential cost savings; and (3) require the MCOs to implement internal controls to prohibit payments for inpatient hospital services related to treating PPCs, and other procedural recommendations.

In written comments to our draft, the State agency concurred with four of our six recommendations and described the actions that it planned to take to address them. Although the State agency did not concur with two of our recommendations, it did describe how it plans to take action related to them.

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INTRODUCTION

WHY WE DID THIS REVIEW

Provider-preventable conditions (PPCs) are certain reasonably preventable conditions caused by medical accidents or errors in a health care setting. Federal regulations effective July 1, 2011, prohibit Medicaid payments for services related to PPCs. The Centers for Medicare & Medicaid Services (CMS) delayed its enforcement of the regulations until July 1, 2012, to allow States time to develop and implement new payment policies. We previously reviewed selected States' compliance with these regulations for inpatient hospital services paid under Medicaid fee-for-service. This review is part of a series of reviews of States to determine whether the States ensured that their Medicaid managed-care organizations (MCOs) complied with these regulations for inpatient hospital services. (See Appendix B for a list of our related Medicaid fee-for-service reports.)

OBJECTIVE

Our objective was to determine whether the Rhode Island Executive Office of Health & Human Services (State agency) ensured that its MCOs complied with Federal and State requirements prohibiting payments to providers for inpatient hospital services related to treating certain PPCs.

BACKGROUND

The Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Medicaid Managed-Care and Federal Reimbursement of State Expenditures

States use two primary models to pay for Medicaid services: fee-for-service and managed-care. In the managed-care model, States contract with MCOs to make services available to enrolled Medicaid beneficiaries, usually in return for a predetermined periodic payment, known as a capitation payment. States make capitation payments to MCOs for each covered individual regardless of whether the enrollee receives services during the relevant time period (42 CFR § 438.2). MCOs use the capitation payments to pay claims for these services, including inpatient hospital services.

States seeking Federal reimbursement for the capitated payments paid to MCOs must receive prior approval from CMS for their contracts with MCOs (managed-care contracts) (42 CFR § 438.806). To claim Federal reimbursement, States report capitation payments made to MCOs as MCO expenditures on Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program.

Medicaid Encounter Data for Services Delivered to Medicaid Beneficiaries Enrolled in Managed-Care Plans

MCOs are required to maintain records (encounter data) of the services that are delivered to Medicaid beneficiaries enrolled in their managed-care plans and the payments the MCOs make to providers for those services (42 CFR § 438.242). The encounter data typically comes from the claims that providers submit to the MCOs for payment. This data is required to be transmitted to the State to allow the States to track the services received by members enrolled in Medicaid managed-care plans (42 CFR § 438.604). States, in turn, are required to use the encounter data when setting capitation payment rates for MCOs (42 CFR § 438.6(c)).¹

States' Responsibility for Ensuring Medicaid Managed-Care Organizations' Compliance With Federal and State Requirements

Under the managed-care model, States are responsible for ensuring their contracted MCOs comply with Federal and State requirements and the provisions of their managed-care contracts (42 CFR §§ 438.602 and 438.608). Federal regulations also require States to document that all payment rates in managed-care contracts are based upon services that are covered in the State plan (42 CFR § 438.6(c)(4)). Federal reimbursement is available to States only for periods during which the managed-care contract meets Federal regulations (42 CFR § 434.70).

Rhode Island's Managed-Care Contracts

In the managed-care contracts, the State agency requires the MCOs to provide covered services in accordance with all applicable Federal and State laws, regulations, and policies (Rhode Island Executive Office of Health and Human Services Contract § 3.01.01).² The contracts further require that the MCOs have a compliance program that includes policies and procedures for complying with all applicable Federal and State rules, regulations, guidelines, and standards (Rhode Island Executive Office of Health and Human Services Contract § 2.19.01).

¹ Effective July 5, 2016, States are required to use encounter data for at least the 3 most recent years when developing the capitation payment rates for MCOs (42 CFR § 438.5(c)(1)).

² The State agency uses a standard managed-care contract with the same provisions for each MCO.

Provider-Preventable Conditions

PPCs can be identified on inpatient hospital claims that providers submit to MCOs and in the encounter data that MCOs submit to the States through certain diagnosis codes.³ Diagnosis codes are used to identify a patient's health conditions.

PPCs include two categories of conditions: health-care-acquired conditions and other PPCs.

- **Health-care-acquired conditions** are conditions acquired in any inpatient hospital setting that (1) are considered to have a high cost or occur in high volume or both, (2) result in increased payments for services, and (3) could have been reasonably prevented (the Social Security Act § 1886(d)(4)(D)(iv)).⁴ These conditions include, among others, surgical site infections and foreign objects retained after surgery (76 Fed. Reg. 32817 (June 6, 2011)).
- **Other PPCs** are certain conditions occurring in any health care setting that a State identifies in its State plan and must include, at a minimum, the following three specific conditions identified in Federal regulations: (1) a wrong surgical or other invasive procedure performed on a patient, (2) a surgical or other invasive procedure performed on the wrong body part, and (3) a surgical or other invasive procedure performed on the wrong patient (42 CFR § 447.26(b)).

Diagnosis Codes and Present-on-Admission Codes

An inpatient hospital claim contains a principal diagnosis code and may contain multiple secondary diagnosis codes.⁵ For each diagnosis code on a claim, inpatient hospitals may report one of four present-on-admission indicator codes (POA codes), described in the table on the next page.

³ Diagnosis codes are listed in the *International Classification of Diseases* (ICD), which is the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. CMS and the National Center for Health Statistics provide guidelines for reporting ICD diagnosis codes. During our audit period, the applicable version of the ICD was the 9th Revision, Clinical Modification.

⁴ These conditions are identified by CMS as Medicare hospital-acquired conditions, other than deep vein thrombosis/pulmonary embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients (42 CFR § 447.26(b)).

⁵ The principal diagnosis is the condition established after study to be chiefly responsible for the admission, and secondary diagnosis codes describe any additional conditions that coexist at the time of service.

Table: The Four Present-on-Admission Indicator Codes

| POA Code | Definition |
|-----------------|--|
| Y | Condition was present at the time of inpatient admission. |
| N | Condition was not present at the time of inpatient admission. |
| U | Documentation is insufficient to determine whether condition was present on admission. |
| W | Provider is unable to clinically determine whether condition was present on admission. |

The absence of POA codes on claims does not exempt MCOs from prohibiting payments to providers for services related to PPCs.

Prohibition of Payment for Provider-Preventable Conditions

The Patient Protection and Affordable Care Act (ACA)⁶ and Federal regulations prohibit Federal payments for health-care-acquired conditions (42 CFR § 447.26). Federal regulations authorize States to identify other PPCs for which Medicaid payments will also be prohibited (42 CFR § 447.26(b)).⁷ Both Federal regulations and the Rhode Island State plan (State plan) require that payment for a claim be reduced by the amount attributable to the PPC that causes an increase in payment and that can be reasonably isolated (42 CFR § 447.26(c)(3) and State Plan Amendment (SPA) 12-005, attachment 4.19-A, respectively).

The State plan requires the State agency to meet the Federal requirements related to nonpayment of PPCs and prohibits the State agency from paying for the portion of a claim that is attributable to a PPC. Payment is prohibited for claims for inpatient services that contain PPCs for which a POA code (1) indicates the condition was not present at the time of inpatient admission, (2) indicates the documentation in the patient’s medical record was insufficient to determine whether the condition was present on admission, or (3) is missing. Payments are not reduced for conditions that were present before admission or that the provider was clinically unable to determine were present before admission.

Federal regulations require managed-care contracts to comply with the Federal and State requirements prohibiting payment for PPCs (42 CFR § 438.6(f)). The managed-care contracts also require the MCOs to meet the Federal requirements related to nonpayment of PPCs (Rhode Island Executive Office of Health and Human Services Contract § 2.16.02.13).

⁶ P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010).

⁷ Before enactment of the ACA and its implementing Federal regulations, PPCs (i.e., health-care-acquired conditions and other PPCs) were referred to as “hospital-acquired conditions” and “adverse events,” respectively.

The State agency uses its Medicaid Management Information System (MMIS) to collect and store encounter data from its MCOs. As of July 1, 2013, the State agency implemented an edit within the MMIS that could reject claims missing the required POA codes but was set to an “information-only” status⁸ to ensure that all claims were included in the capitation payment rates.

HOW WE CONDUCTED THIS REVIEW

From July 1, 2012, through June 30, 2015 (audit period),⁹ the State agency contracted with two MCOs to provide services to Medicaid beneficiaries. We obtained an understanding of the monitoring activities the State agency performed to ensure that the MCOs complied with Federal and State requirements and their managed-care contracts relating to the nonpayment of PPCs. We also reviewed Medicaid encounter data from the two MCOs to identify providers’ paid claims that contained at least one secondary diagnosis code¹⁰ for a PPC and that (1) had a POA code indicating that the condition was not present on admission (“N”), (2) had a POA code indicating the documentation in the patient’s medical record was insufficient to determine whether the condition was present on admission (“U”), or (3) did not have a POA code.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A describes our audit scope and methodology.

FINDINGS

The State agency did not ensure that its MCOs complied with Federal and State requirements prohibiting Medicaid payments to providers for inpatient hospital services related to treating certain PPCs. For our audit period, we identified that MCOs paid providers \$3,968,040 for 241 claims that contained PPCs. The State agency’s internal controls were not adequate to ensure that its MCOs complied with Federal and State requirements. Specifically, the State agency did not have policies and procedures to determine whether its MCOs complied with Federal and State requirements and provisions of the managed-care contract relating to the nonpayment of

⁸ “Information-only” means the edit would not reject claims, but would allow the State agency to identify claims missing POA codes.

⁹ The audit period encompassed the most current data available at the time we initiated our review and provided an adequate picture of the States controls.

¹⁰ We reviewed the secondary, not primary, diagnosis codes for PPCs because the ACA’s payment prohibition pertains only to secondary diagnosis codes.

PPCs and did not ensure that the MCOs' payment rates were based only upon services that were covered in the State plan. As a result, unallowable payments for services related to treating PPCs were included in the calculation of capitation payment rates for State fiscal years 2017 and 2018.

FEDERAL AND STATE REQUIREMENTS

The ACA and Federal regulations prohibit Federal payments for health-care-acquired conditions (ACA § 2702 and 42 CFR § 447.26, respectively). Federal regulations and the State plan do not deny payment for an entire claim that contains a PPC. Instead, the requirements limit the reduction of the payment to the amount attributable to the PPC that causes an increase in payment and that can be reasonably isolated (42 CFR § 447.26(c)(3) and SPA 12-005, attachment 4.19-A, respectively).

Federal regulations require that the managed-care contracts contain a provision for MCOs to comply with all Federal regulations, including the regulations prohibiting payments for PPCs (42 CFR § 438.6(f)). The State agency is responsible for monitoring each MCO's operations and must have in effect procedures to ensure MCOs are not violating conditions for Federal reimbursement or provisions of the managed-care contracts (42 CFR § 438.66).

RHODE ISLAND'S MANAGED-CARE ORGANIZATIONS PAID PROVIDERS FOR CLAIMS THAT CONTAINED PROVIDER-PREVENTABLE CONDITIONS

Although Federal and State requirements and the managed-care contracts prohibited the MCOs from paying for services related to PPCs, the MCOs paid providers for claims that contained PPCs. We identified that MCOs paid providers \$3,968,040 for 241 claims that contained PPCs consisting of:

- 31 claims that (1) had a POA code indicating that either the condition was not present at the time of inpatient admission or the documentation in the patient's medical record was not sufficient to determine whether the condition was present on admission or (2) were missing at least 1, but not all, POA codes and
- 210 claims that did not have a POA code for any of the diagnoses identified on the claim.

Although required by the contract, the MCOs did not determine the unallowable portion of the \$3,968,040 that was for services related to treating PPCs and included the unallowable amounts in the encounter data reported to the State agency.

For our audit period, neither MCO reduced payments to providers for any claims that contained PPCs. The MCOs did not have policies or procedures to identify PPCs on claims for inpatient hospital services or determine whether payments for claims containing PPCs should have been reduced. During our audit period, one MCO created an edit within its claims processing system

to reject claims that were missing POA codes; however, implementation of the reject capability was delayed. In May 2018, the MCO implemented an edit to identify claims with PPCs so they could be reviewed and payments reduced. However, because this edit was not implemented until after the completion of our fieldwork, we did not determine whether it would be effective in prohibiting payments for inpatient hospital services related to treating certain PPCs. In addition, officials from the same MCO stated they were planning to review claims paid since August 2016 to identify claims with PPCs and determine if payments for the claims should be reduced. As of May 2018, officials from the second MCO stated that they were exploring ways to meet the PPC requirements but did not plan to review claims that were previously paid.

THE STATE AGENCY'S INTERNAL CONTROLS WERE NOT ADEQUATE

Although Federal regulations require the State agency to monitor its MCOs' operations and ensure its MCOs comply with Federal and State requirements and provisions of its managed-care contract, the State agency did not have policies and procedures to determine whether its MCOs complied with the requirements or the contract provisions relating to the nonpayment of PPCs. In addition, although the State agency identified claims within the encounter data that were missing POA codes, the State agency did not follow up with the MCOs to determine why the POA codes were missing or whether the payments made for the related claims complied with Federal and State requirements.

PAYMENTS MADE FOR CLAIMS WITH PROVIDER-PREVENTABLE CONDITIONS WERE INCLUDED IN THE CAPITATION PAYMENT RATES

Because the MCOs did not comply with Federal and State requirements prohibiting payment for PPCs and the State agency's internal controls were not adequate to identify that its MCOs did not comply with those requirements, the unallowable portion of the \$3,968,040 identified for our audit period was included in the calculation of capitation payment rates for State fiscal years 2017 and 2018.

RECOMMENDATIONS

We recommend that the State agency:

- work with the MCOs to determine the portion of the \$3,968,040 that was unallowable for claims containing PPCs and its impact on current and future year capitation payment rates;
- include a clause in its managed-care contracts with the MCOs that would allow the State agency to recoup funds from the MCOs when contract provisions and Federal and State requirements are not met—a measure that, if incorporated, could result in cost savings for the Medicaid program;

- require the MCOs to implement internal controls to prohibit payments for inpatient hospital services related to treating PPCs;
- require its MCOs to review all claims for inpatient hospital services that were paid after our audit period to determine whether any payments for services related to treating PPCs were unallowable and adjust future capitation payment rates for any unallowable payments identified;
- strengthen its monitoring of its MCOs to ensure the MCOs comply with Federal and State requirements and its managed-care contracts relating to the nonpayment of PPCs; and
- ensure that claims identified by the MMIS information-only edit are referred back to the MCOs for appropriate correction and inclusion of missing POA codes.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency concurred with our first, fourth, fifth, and sixth recommendations. The State agency did not concur with our second and third recommendations. The State agency's comments are included in their entirety as Appendix C.

Regarding the second recommendation, according to the State agency's response, managed care contracts already include language that would allow the State agency to recoup funds from the MCOs when contract provisions and Federal and State requirements are not met. While we agree that the contract allows for sanctions if the MCO fails to comply with contract requirements, we recommend including specific provisions allowing the State agency to recoup the amount of unallowable claims that were attributable to PPCs.

Regarding our third recommendation, the State agency said it does not believe additional requirements for MCOs to implement internal controls is necessary. The State agency said it believes sufficient requirements are already in place in the managed care contracts. However, the State agency said it will monitor adherence to the managed care contracts more closely and will draft related policies and procedures. We acknowledge these efforts to improve compliance with the PPC requirement.

Finally, the State agency asserted that the \$3,968,040 reported in our first recommendation could be construed as representing the amount attributable to the PPCs. We disagree because the recommendation is clear that the overpayment related to the PPCs is an undetermined portion of the \$3,968,040. The amount is undeterminable because of the MCOs' lack of compliance with Federal and State regulations and a lack of State oversight. The State agency also asserted that some of the claims were validly paid; we acknowledge the MCOs' efforts to further review the claims and suggest that the State agency use these results in their compliance efforts going forward.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From July 1, 2012, to June 30, 2015 (audit period), the State agency contracted with two MCOs to provide services to Medicaid beneficiaries. We obtained an understanding of the monitoring activities the State agency performed to ensure that the MCOs complied with Federal and State requirements and their managed-care contracts relating to the nonpayment of PPCs. We also reviewed Medicaid encounter data from both of the MCOs to identify providers' paid claims that contained at least one secondary diagnosis code¹¹ for a PPC and that (1) had a POA code indicating that the condition was not present on admission ("N"), (2) had a POA code indicating the documentation in the patient's medical record was insufficient to determine whether the condition was present on admission ("U"), or (3) did not have a POA code. We did not determine whether the hospitals (1) reported all PPCs, (2) assigned correct diagnosis codes or POA codes, or (3) claimed services that were properly supported.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only those internal controls related to our objective.

We conducted our audit from April 2017 through January 2018 and performed fieldwork at the State agency's office in Cranston, Rhode Island.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations, Federal and State guidance, and the State plan;
- held discussions with CMS officials to gain an understanding of the program and obtain State plan amendments;
- held discussions with State officials to gain an understanding of inpatient services and PPCs and monitoring activities the State agency performed to ensure that the MCOs complied with Federal and State requirements and their managed-care contracts relating to the nonpayment of PPCs;
- held discussions with MCO officials to gain an understanding of inpatient services and PPCs and any action taken (or planned) by the MCOs to identify and prevent payment of services related to treating PPCs;

¹¹ We reviewed the secondary, not primary, diagnosis codes for PPCs because the ACA's payment prohibition pertains only to secondary diagnosis codes.

- reviewed the State agency and MCOs' internal controls over the accumulation, processing, and reporting of inpatient service expenditures and PPCs;
- reviewed the MCOs' encounter data to identify inpatient hospital claims that contained health-care-acquired conditions and had the POA codes "N" or "U" or did not have a POA code reported;
- reviewed the MCOs' encounter data to identify whether any inpatient hospital claims contained other PPCs;
- requested and reviewed line item detail from the MCOs for selected claims and resolved discrepancies within the encounter data; and
- discussed the results of our audit with State and MCO officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

| Report Title | Report Number | Date Issued |
|---|--------------------------------------|--------------------|
| <i>Nevada Did Not Comply With Federal and State Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions</i> | <u>A-09-15-02039</u> | 5/29/2018 |
| <i>Iowa Complied With Most Federal Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions</i> | <u>A-07-17-03221</u> | 5/14/2018 |
| <i>Missouri Did Not Comply With Federal and State Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions</i> | <u>A-07-16-03216</u> | 5/14/2018 |
| <i>Oklahoma Did Not Have Procedures to Identify Provider-Preventable Conditions on Some Inpatient Hospital Claims</i> | <u>A-06-16-08004</u> | 3/6/2018 |
| <i>Illinois Claimed Some Improper Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions</i> | <u>A-05-15-00033</u> | 9/20/2016 |
| <i>Washington State Claimed Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions</i> | <u>A-09-14-02012</u> | 9/15/2016 |
| <i>Idaho Claimed Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions</i> | <u>A-09-15-02013</u> | 9/15/2016 |

APPENDIX C: STATE AGENCY COMMENTS



3 West Road | Virks Building | Cranston, RI 02920

Report Number: A-01-17-00004

Mr. David Lamir
Regional Inspector General for Audit Services
Office of Audit Services Region I
JFK Federal Building
15 New Sudbury Street, Room 2425
Boston, MA 02203

Dear Mr. Lamir:

Thank you for your September 28, 2018 letter and draft report A-01-17-00004, *Rhode Island Did Not Ensure Its Managed-Care Organizations Complied With Requirements Prohibiting Medicaid Payments for Services Related to Provider-Preventable Conditions*. Rhode Island appreciates the opportunity to review and comment on the findings and recommendations included in the draft report.

EOHHS believes the report gives the misleading impression that Rhode Island's Medicaid managed care plans inappropriately paid \$3,968,040 in claims related to provider-preventable conditions (PPCs). The total dollar amount reported by the OIG includes the entire claim, rather than just the costs applicable to the portion of the claim associated with the PPC. Thus, the nearly \$4 million amount being reported is significantly overstated.

EOHHS also does not agree that all the claims identified by the OIG include unallowable costs. In some instances, claims that the OIG identified were paid in error were, upon further review, found to be validly paid claims. Rhode Island's Medicaid managed care plans are conducting a detailed review of the claims to determine which ones were validly paid and which ones need to be reduced to account for the presence of a PPC.

As requested in your letter dated September 28, 2018, EOHHS is providing a statement of concurrence or non-concurrence for each of the recommendations contained in the draft report.

OIG Recommendation 1: *Work with the MCOs to determine the portion of the \$3,968,040 that was unallowable for claims containing the PPCs and its impact on current and future year capitation payment rates.*

We concur with this recommendation. EOHHS has already begun working with the MCOs to review the claims included in the audit. One plan has completed their initial review of its claims, and the other plan has reviewed 80 percent of sampled claims attributed to it. EOHHS will continue working with the MCOs to identify the total amount paid in error for PPCs, and have been asked to complete this work by January 31, 2019.

OIG Recommendation 2: *Include a clause in its managed care contract with the MCOs that would allow the State agency to recoup funds from the MCOs when contract provisions and Federal and State requirements are not met – a measure that, if incorporated, could result in cost savings for the Medicaid program.*

We do not concur with the assertion in this recommendation that EOHHS does not have a way to recoup funds from MCOs for violation of contract provisions. EOHHS' managed care contracts already include language that would allow for this. Article II: Health Program Standards lays out the requirements that MCOs must meet, which includes the requirement around PPCs. Section 3.07.01 requires MCOs to meet the requirements in Article II and stipulates that failure to comply may subject the MCO to intermediate sanctions. Section 3.07.04.01 then outlines the penalties or damages that EOHHS may levy for an MCOs failure to meet performance standards. The relevant sections of the contract are included below for reference.

2.15.01.16 Payment Adjustment for Provider Preventable Conditions

The contractor shall meet the requirements of 42 CFR 447.26i, Subpart A, and sections 1902(a)(4), 1092(a)(6), and 1903, with respect to non-payment for provider preventable conditions for Health Care-Acquired Conditions and Other Provider-Preventable Conditions. Specifically, this includes the development of the capacity for claims systems to recognize and reject/deny procedures coded with the modifiers PA (surgical or other invasive procedure performed on the wrong body part), PB (surgical or other invasive procedure performed on the wrong patient), and PC (wrong surgical or invasive procedure performed on a patient). The disallowance of reimbursement for OPPCs applies to freestanding and hospital-based clinics, freestanding and hospital-based ambulatory surgery services, office-based settings and emergency departments that submit claims to the Contractor.

3.07.01 Performance Standards for Medicaid Managed Care

The performance standards for Health Plans shall be defined as substantial compliance with the program requirements specified in ARTICLE II: HEALTH PLAN PROGRAM STANDARDS and the Attachments of this Agreement. Contractor agrees to cooperate fully with the State in its efforts to monitor and assess compliance with these performance standards. Contractor will cooperate fully with the State or its designees in efforts to validate performance measures.

Failure to comply with the provisions of this section may subject Contractor to intermediate sanctions including: (1) civil monetary penalties, as described in Section 3.07.04; (2) Appointment of temporary management of the Health Plan, as provided for in 42 CFR 438.706; (3) granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll; (4) suspension of new enrollment including automatic assignment after the effective date of the sanction; and/or (5) suspension of payment for members enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

3.07.04.01 Non-Compliance with Program Standards

Contractor shall ensure that performance standards as described in Section 3.07.01 are met in full. The size of the damages associated with failure to meet performance standards will vary depending on the nature of the deficiency. Therefore, in the event of any breach of the terms of this Agreement with respect to performance standards, unless otherwise specified below, damages shall be assessed against Contractor in an amount equal to the costs incurred by the State to ensure adequate service delivery to the affected members. When the non-compliance results in transfer of members to another Health Plan, the damages shall include a maximum amount equal to the difference in the capitation rates paid to the Contractor and the rates paid to the replacement Health Plan. Damages shall not be imposed until such time that the State has notified Contractor in writing of a deficiency and has allowed a reasonable period of time for resolution.

OIG Recommendation 3: *Require the MCOs to implement internal controls to prohibit payments for inpatient hospital services related to treating PPCs.*

EOHHS does not concur that additional requirements to prohibit payments for inpatient hospital services related to treating PPCs is necessary. These requirements are already in place in Section

2.15.01.16 of the managed care contract, the text of which is provided below. Nonetheless, EOHHS will monitor adherence to this contract provision more closely, and will draft a policy and procedure for conducting this oversight within the next 60 days.

2.15.01.16 Payment Adjustment for Provider Preventable Conditions

The contractor shall meet the requirements of 42 CFR 447.26i, Subpart A, and sections 1902(a)(4), 1092(a)(6), and 1903, with respect to non-payment for provider preventable conditions for Health Care-Acquired Conditions and Other Provider-Preventable Conditions. Specifically, this includes the development of the capacity for claims systems to recognize and reject/deny procedures coded with the modifiers PA (surgical or other invasive procedure performed on the wrong body part), PB (surgical or other invasive procedure performed on the wrong patient), and PC (wrong surgical or invasive procedure performed on a patient). The disallowance of reimbursement for OPPCs applies to freestanding and hospital-based clinics, freestanding and hospital-based ambulatory surgery services, office-based settings and emergency departments that submit claims to the Contractor.

OIG Recommendation 4: *Require its MCOs to review all claims for inpatient hospital serviced that were paid after our audit period to determine whether any payments for services related to treating PPCs were unallowable and adjust future capitation payment rates for any unallowable payments identified.*

EOHHS concurs with this recommendation and, in a notification sent on October 16, 2018, has already required the MCOs to review all claims for inpatient hospitals services for dates of service July 1, 2015 to present to determine whether any payments for services related to treating PPCs were unallowable. To ease the administrative burden on the MCOs, EOHHS is running a report using encounter data to help MCOs identify claims that need further review. We will work with the MCOs to establish a due date for completing the review based on the number of claims identified. EOHHS has also advised MCOs that future capitation rates for any unallowable payments identified will be adjusted based on the review's findings.

OIG Recommendation 5: *Strengthen its monitoring of its MCOs to ensure the MCOs comply with Federal and State requirements and its managed care contracts relating to the nonpayment of PPCs.*

EOHHS concurs with this recommendation and will develop and implement a policy and procedure within the next 60 days to strengthen oversight of MCOs' adherence to contract provisions related to the non-payment of PPCs.

OIG Recommendation 6: *Ensure that claims identified by the MMIS informational-only edit are referred back to the MCOs for appropriate correction and inclusion of missing POA codes.*

We concur with this recommendation. As outlined in our response to Recommendation 4, EOHHS is analyzing encounter data to identify claims with PPC indicators that require further research, review, and if appropriate, correction.

Should you have any questions or concerns, please contact Meghan Ruane, by telephone at (401) 462-3497 or via email at meghan.ruane@ohhs.ri.gov.

Sincerely,

Patrick Tighe
Medicaid Program Director

cc: January Angeles, Deputy Medicaid Director for Managed Care and Oversight
Katie Alijewicz, Deputy Medicaid Director for Budget and Finance
Meghan Ruane, Medicaid Managed Care Compliance Manager
Kristin Sousa, Medicaid Managed Care Director