Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

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Office of Inspector General

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Report in Brief
Date: August 2019
Report No. A-03-16-00205

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 Pennsylvania 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 Pennsylvania performed to ensure that the MCOs complied with Federal and State requirements and their managed-care contracts relating to the nonpayment of PPCs. From October 1, 2013, through September 30, 2015 (audit period), Pennsylvania contracted with 10 MCOs for physical health services and with 32 county governments and 2 private-sector behavioral health MCOs for behavioral health services. We reviewed the 10 physical health and the 2 private-sector MCOs. We reviewed Medicaid encounter data from this time period from the 12 MCOs to identify providers' paid claims that either contained at least one secondary diagnosis code for a PPC and that had a present on admission code (POA) indicating that the condition was not present on admission or did not have a POA code.

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

What OIG Found

Pennsylvania 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. 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 $43.5 million for 576 claims that contained PPCs. Pennsylvania's policies and procedures were not adequate to ensure its MCOs complied with Federal and State requirements. As a result, unallowable payments for services related to treating PPCs might have been included in the calculation of capitation payment rates.

What OIG Recommends and State Agency Comments

We made several recommendations to Pennsylvania, including (1) work with the MCOs to determine the portion of the $43.5 million that was unallowable for claims containing PPCs and its impact on current- and future-year capitation payment rates, (2) include a clause in its managed-care agreements with the MCOs that would allow Pennsylvania 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 Medicaid, and (3) enforce the provisions in its managed-care agreements that allow sanctions or penalties to be imposed for noncompliance with or failure to meet performance and program standards indicated in the contract and subsequent related contracts.

In written comments to our draft report, Pennsylvania concurred with all seven of our recommendations and described the actions that it has taken and plans to take to address them. However, in addressing our first recommendation, Pennsylvania stated that it appeared that physical health MCOs were not paying for PPCs based on its survey of those MCOs although we found 576 claims paid by physical health MCOs that contained PPCs. We continue to maintain that our findings and recommendations are correct.

The full report can be found at https://oig.hhs.gov/oas/reports/region3/31600205.asp.

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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 healthcare setting. Federal regulations effective July 1, 2011, prohibit Medicaid payments for services related to treating 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 related OIG reports.)

OBJECTIVE

Our objective was to determine whether the Pennsylvania Department of 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).[1] MCOs use the capitation payments to pay claims for these services, including inpatient hospital services.

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[1] After our audit period, the managed-care regulations at 42 CFR part 438 were updated. We cite to the regulations that were applicable during our audit period.

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 the MCOs' managed-care plans and the payments the MCOs make to providers for those services (42 CFR § 438.242). The encounter data typically come from the claims that providers submit to the MCOs for payment. These data are required to be transmitted to the State to allow 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)).[2]

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 on 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).

Pennsylvania's Managed-Care Agreements

Pennsylvania's Medicaid managed-care program (HealthChoices) has two components: physical health and behavioral health. The State agency contracts directly with 10 MCOs for physical health services, such as hospital and physician services. For behavioral health services, such as mental health services or drug and alcohol abuse services, the State agency contracts with 34 risk-bearing entities:[3] 32 county governments[4] and 2 private-sector behavioral health MCOs. The county governments perform the same functions as MCOs and subcontract with private

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

[3] A risk-bearing entity assumes financial responsibility for claim payments while accepting a per-member per-month capitation payment.

[4] Pennsylvania has 67 counties. Some counties grouped together and entered into joint agreements with the State agency.

sector behavioral health organizations to provide eligible beneficiaries with behavioral health services.

In its agreements with both physical health and behavioral health MCOs, the State agency requires the MCOs to provide covered services in accordance with all applicable Federal and State laws, regulations, and policies.[5] Under the agreements, the State agency may impose sanctions upon the MCOs if they fail to comply with the requirements under the agreement, specific Social Security Act sections, and CMS regulation sections.

The agreements further require that MCOs have a compliance program that includes policies and procedures for complying with all applicable Federal and State rules, regulations, guidelines, and standards.[6]

Provider-Preventable Conditions

PPCs can be identified using certain diagnosis codes on inpatient hospital claims that providers submit to MCOs and in the encounter data that MCOs submit to the States.[7] Diagnosis codes are used to identify a patient's health conditions.

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

(1) **Health-care-acquired conditions** are conditions acquired in any inpatient setting that 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)).[8] These conditions include, among others,

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[5] For each physical health MCO, the State agency uses a standard managed-care agreement with the same provisions. Similarly, for each behavioral health MCO, the State agency uses a standard managed-care agreement with the same provisions. The applicable agreement section for physical health MCOs are found in section IV: "Applicable Laws and Regulations—B: Specific to MA Program." The applicable agreement section for behavioral health MCOs are found in "Applicable Laws and Regulations and Department Obligations—Section 3.3 General Laws and Regulations."

[6] The applicable agreement section for physical health MCOs are found in the section IV: "Applicable Laws and Regulations Section V: Program Requirements – O(6) Fraud and Abuse." The applicable agreement for behavioral health MCOs are found in "Applicable Laws and Regulations and Department Obligations – Section 3.3 General Laws and Regulations."

[7] 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*.

[8] With the exception of deep vein thrombosis/pulmonary embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients, these conditions are identified by CMS as Medicare hospital-acquired conditions (42 CFR § 447.26(b)).

surgical site infections and foreign objects retained after surgery (76 Fed. Reg. 32817 (June 6, 2011)).

- **Other PPCs** are certain conditions occurring in any healthcare 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.[9] 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 below.

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)[10] 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)).[11] Both Federal regulations and the Pennsylvania State plan (State plan) require

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[9] 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.

[10] 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).

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

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) 11-020, 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)).

HOW WE CONDUCTED THIS REVIEW

From October 1, 2013, through September 30, 2015 (audit period),[12] the State agency contracted with 10 MCOs for physical health services. They also contracted with 32 county governments and 2 private-sector behavioral health MCOs for behavioral health services. We reviewed the 10 physical health MCOs and the 2 private-sector behavioral health MCOs. 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 12 MCOs to identify providers' paid claims that contained at least one secondary diagnosis code[13] 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.

During our fieldwork, we determined that the encounter data from the two behavioral health MCOs was not complete because the data did not contain all diagnosis codes that were reported on the actual claims[14] and POA codes were not always reported by the providers. As a result, it could not be used to determine how many claims contained a PPC or would have been subject to a payment reduction.

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[12] The audit period encompassed the most current data available at the time we initiated our review.

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

[14] The MCO database of claims did not contain enough fields to include all diagnosis codes.

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, MCOs paid providers $43.5 million[15] for 576 claims that contained PPCs. This represents the total amount of the claim and not the unallowable portion paid to providers. As a result, any unallowable payments for services related to treating PPCs might have been included in the calculation of capitation payment rates for calendar years 2016, 2017, and 2018 because capitation rate setting is based on claim payments 3 years before the rate setting year. 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 did not ensure that the MCOs' payment rates were based only on services that were covered in the State plan.

In addition to the 576 claims that contained PPCs, the MCOs might have paid providers for additional services related to treating PPCs. However, the encounter data from the State agency's behavioral health MCOs was not complete and could not be used to determine whether the MCOs paid providers for additional inpatient hospital services related to treating PPCs.[16] As a result, we were not able to determine whether there were other behavioral health claims that contained a PPC or would have been subject to a payment reduction.

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 regulations 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 11-020, attachment 4.19-A, respectively).

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[15] Rounded from $43,524,609.

[16] From the paid claims data for these MCOs, we were able to identify payments of $19,282 for 7 claims that contained PPCs.

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).

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

Contrary to Federal and State requirements that 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 $43.5 million for 576 claims that contained PPCs. These were:

- 540 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

- 36 claims that did not have a POA code for any of the diagnoses identified on the claim.

The MCOs did not determine the unallowable portion of the $43.5 million for services related to treating PPCs and included the unallowable amounts in the encounter data reported to the State agency.

During our audit period, the MCOs did not reduce 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.

THE STATE AGENCY'S MONITORING WAS NOT ADEQUATE

Although Federal regulations require the State agency to include a provision in its agreements that require the MCOs to meet the Federal requirements related to nonpayment of PPCs, the State agency did not include such a provision[17] in its physical health managed-care agreements and did not ensure that all inpatient hospitals submitted POA codes as required by the State plan. In addition, 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 agreement. However, the State agency's monitoring was not adequate to ensure that the MCOs complied with the requirements related to the nonpayment of PPCs. Because the State agency did not include such a provision in its physical health managed-care agreements, nor had the proper program oversight, it could not impose sanctions on the MCOs

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[17] The State agency modified its contract with the physical health MCOs in January 2016 to include the required provision.

for failure to comply with the requirements. The State agency could have imposed sanctions under the behavioral health managed-care agreements for failure to comply with requirements related to nonpayment of PPCs but did not do so.

PAYMENTS MADE FOR CLAIMS WITH PROVIDER-PREVENTABLE CONDITIONS MIGHT HAVE BEEN 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 $43.5 million identified for our audit period might have been included in the calculation of capitation payment rates for calendar years 2016, 2017, and 2018.

In addition to the 576 claims totaling $43.5 million that contained PPCs, the behavioral health MCOs might have paid providers for additional services related to treating PPCs. However, the encounter data from the State agency's behavioral health MCOs were not complete and could not be used to determine whether the MCOs paid providers for additional inpatient hospital services related to treating PPCs. Specifically, the encounter data did not contain all of the diagnosis codes that were reported on the actual claims submitted by providers and the State agency did not require behavioral health providers to report POA codes on claims for reimbursement. As a result, we were not able to determine whether there were additional behavioral health claims in our audit period that contained a PPC or would have been subject to a payment reduction.

RECOMMENDATIONS

We recommend that the Pennsylvania Department of Human Services:

- work with the MCOs to determine the portion of the $43,524,609 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 agreements 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 Medicaid;

- enforce the provisions in its managed-care agreements that allow sanctions or penalties to be imposed for noncompliance with or failure to meet performance and program standards indicated in the contract and subsequent related agreements;

- require the MCOs to:
  - implement policies and procedures to prohibit payments for inpatient hospital services related to treating PPCs;
  - 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;
- require its behavioral health MCOs to review all claims paid after our audit period for PPCs using all of the diagnosis codes submitted by the provider and determine whether any payments for services related to treating PPCs were unallowable and adjust future capitation payment rates for any unallowable payments identified;
- take steps to ensure that the MCOs comply with Federal and State requirements and its managed-care contracts relating to the nonpayment of PPCs; and
- ensure all inpatient hospitals submit POA codes as required in the State plan.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments to our draft report, the State agency concurred with all seven of our recommendations and described the actions that it has taken and plans to take to address them. However, in addressing our first recommendation, the State agency stated that it appeared that physical health MCOs were not paying for PPCs based on its survey of those MCOs although we found 576 claims paid by physical health MCOs that contained PPCs. We continue to maintain that our findings and recommendations are correct. The State agency's comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From October 1, 2013, through September 30, 2015 (audit period), the State agency contracted with 10 MCOs for physical health services. They also contracted with 32 county governments and 2 private-sector behavioral health MCOs for behavioral health services. We reviewed the 10 physical health MCOs and the 2 private-sector behavioral health MCOs. 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 12 MCOs to identify providers' paid claims that contained at least 1 secondary diagnosis code[18] 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.

During our fieldwork, we determined that the encounter data from the two behavioral health MCOs were not complete because they did not contain all diagnosis codes that were reported on the actual claims and POA codes were not always reported by the providers. As a result, the data could not have been used to determine how many claims contained a PPC or should have had a payment reduction.

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

We conducted our audit from December 2016 through May 2018 at the State agency's office in Harrisburg, Pennsylvania, and at 10 MCO offices throughout Pennsylvania.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations, Federal and State guidance, and the State plan;

- 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

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

complied with Federal and State requirements and their managed-care agreements 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;

- reviewed agreements between the State agency and the MCOs to verify that those agreements complied with Federal regulations;

- reviewed the State agency 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;

- obtained POA codes for inpatient encounter data that were not included in the State agency's database;

- reviewed the MCOs' encounter data to identify whether any inpatient hospital claims contained other PPCs;

- obtained screen shots for selected claims to determine the accuracy of the POA codes in the encounter data; and

- discussed the results of our audit with State 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
New York My Not Have Complied With Federal and State Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions	A-02-16-01022	5/30/2019
Massachusetts Did Not Ensure Its Managed-Care Organizations Complied With Requirements Prohibiting Medicaid Payments for Services Related to Provider-Preventable Conditions	A-01-17-00003	5/8/2019
Rhode Island Did Not Ensure Its Managed Care Organizations Complied With Requirements Prohibiting Medicaid Payments for Services Related to Provider-Preventable Conditions	A-01-17-00004	1/4/2019
Louisiana Did Not Comply With Federal and State Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions	A-06-16-02003	12/17/2018
Nevada Did Not Comply With Federal and State Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions	A-09-15-02039	5/29/2018
Iowa Complied With Most Federal Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions	A-07-17-03221	5/14/2018
Missouri Did Not Comply With Federal and State Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions	A-07-16-03216	5/14/2018
Oklahoma Did Not Have Procedures to Identify Provider-Preventable Conditions on Some Inpatient Hospital Claims	A-06-16-08004	3/6/2018
Illinois Claimed Some Improper Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions	A-05-15-00033	9/20/2016
Washington State Claimed Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions	A-09-14-02012	9/15/2016
Idaho Claimed Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions	A-09-15-02013	9/15/2016

APPENDIX C: STATE AGENCY COMMENTS

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

JUL 19 2019

Ms. Nicole Freda
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region III
Strawbridge Building
801 Market Street, Suite 8500
Philadelphia, Pennsylvania 19107

Dear Ms. Freda:

The Department of Human Services (DHS) has received the draft report number A-03-16-00205 titled "Pennsylvania Did Not Ensure Its Managed-Care Organizations Complied With Requirements Prohibiting Medicaid Payments For Services Related To Provider-Preventable Conditions." The objective of this audit was to determine whether the Pennsylvania Department of 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.

Office of Inspector General (OIG) Recommendation 1: We recommend that the State agency work with the MCOs to determine the portion of the $43,524,609 that was unallowable for claims containing PPCs and its impact on current- and future-year capitation payment rates.

Department of Human Services (DHS) Response: DHS concurs with this recommendation. It is important to note, as documented in the draft OIG report, it was not conclusive that the Physical Health MCO (PH-MCO) capitation payments include payment for PPCs. The $43.5 million identified represents the total amount of the claim and not the unallowable portion paid to providers. Furthermore, in response to the OIG audit recommendation of working with the MCOs to determine the portion that was unallowable (first mentioned during the closeout conference between OIG and DHS in March 2019), DHS conducted a survey of the PH-MCOs during April and May of 2019 to better understand each of the PH-MCO's PPC policies and reimbursement related to claims containing PPCs. This survey addressed PH-MCO policies and procedures related to PPCs from calendar year 2013 through the present, the PH-MCO departmental staff involved in the process, criteria triggering a PPC review, frequency of PPC reviews, payment/adjustment processes and how the final payments are accounted for in the PH-MCO claims and financial data. Based on a review of the survey results, all of the PH-MCOs have had PPC policies in place since 2013, and it appears that the PH-MCOs are not paying for PPCs. Therefore, without performing a full PH-MCO claims audit, our understanding is that the $43.5 million identified in the OIG audit represents the PH-MCO payment post-PPC adjustments and unallowable expenditures related to PPCs

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were/are not included in the claims and financial data used in developing the current and future capitation rates. Additionally, it should be noted that while the PH-MCO agreements did not include language related to PPCs during the audit period, it is our understanding that the PH-MCOs were following the PPC policies as outlined in the June 15, 2012 Medical Assistance Bulletin, effective July 1, 2012. DHS and its actuary will continue to monitor unallowable costs related to PPCs for the purposes of capitation rate development.

OIG Recommendation 2: We recommend that the State agency include a clause in its managed-care agreements 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 Medicaid.

DHS Response: DHS concurs with this recommendation. We added the following language to the 2016 HealthChoices PH-MCO agreements within Exhibit E (1): "The PH-MCO will report all identified provider-preventable conditions in a form or frequency, which may be specified by the State (42 CFR 438.6(f)(2)(ii)). The PH-MCO is prohibited from making payment to a provider for provider-preventable conditions that meet the following criteria: 42 CFR 438.6(f)(2)(i), 42 CFR 434.6(a)(12)(i), and 42 CFR 447.26(b): (i) Is identified in the State Plan, (ii) Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by the evidence-based guidelines, (iii) Has a negative consequence for the beneficiary, (iv) Is auditable, and (v) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient. The PH-MCO must require all providers to report provider-preventable conditions associated with claims for payments or enrollee treatments for which payment would otherwise be made (42 CFR 438.6(f)(2)(ii) and 42 CFR 434.6(a)(12)(ii))." The language added in 2016 prohibits PH-MCOs from making payments for PPCs. The agreements contain general authority to sanction PH-MCOs for non-compliance with agreement provisions. DHS is planning to add more explicit language concerning the PPCs and DHS' authority to recover funds that were inappropriately reimbursed from the PH-MCOs.

In 2019, DHS added HealthChoices Operations Report Number 23, "Health-care Acquired Conditions and Provider Preventable Conditions Identified for Non-Payment". The PH-MCOs must submit this report on a semi-annual basis. DHS contract monitoring staff will review these submissions as part of the PH-MCO oversight and compliance enforcement process.

Additionally, for the Behavioral Health MCOs (BH-MCOs), the agreements include the following: PS&R Section II-2.E - The primary contractor and/or its BH-MCO must comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 CFR §438.3(g) and §447.26. The primary contractor and its BH-MCO must report all identified provider-preventable conditions in a form and frequency as specified by the Department. Section II-5.D-7(b) - No payments will be made by the primary contractor and/or its BH-MCO for provider-preventable conditions, as identified in the State Plan and will require that all providers agree to comply with reporting requirements in 42 CFR §447.26(d) as a condition of payment from the primary contractor. The primary contractor and/or its BH-MCO will comply with such reporting requirements to the extent the primary

contractor and/or its BH-MCO directly furnishes services. PS&R Section II-2.H.2 - Sanctions and Penalties - The Department may impose sanctions or penalties for non-compliance with, or failure to meet performance and program standards indicated in the agreement and/or subsequent related contracts. Sanctions and penalties may be imposed by the Department in a variety of ways to include but not be limited to: a) Requiring the primary contractor to submit a corrective action plan, b) Imposing monetary penalties, including suspension or denial of payments, and/or c) Terminating the agreement.

OIG Recommendation 3: We recommend that the State agency enforce the provisions in its managed-care agreements that allow sanctions or penalties to be imposed for noncompliance with or failure to meet performance and program standards indicated in the contract and subsequent related contracts.

DHS Response: DHS concurs with this recommendation; however, we do enforce the sanctions and penalties as described above, as deemed necessary.

OIG Recommendation 4: We recommend that the State agency require the MCOs to implement policies and procedures to prohibit payments for inpatient hospital services related to treating PPCs and 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.

DHS Response: DHS concurs with this recommendation. We will require the PH-MCOs to develop (if necessary) and submit all formal policies and procedures for compliance with the previously discussed elements. DHS contract management teams will review the submissions, determine compliance with all of the requirements and approve them for use by the PH-MCOs. This policy/procedure requirement will also be added to the contract management team's agreement tracking system as a mandatory review item for a minimum of an annual review. Please see the response to Recommendation 1, above, regarding the claims paid after the audit period.

OIG Recommendation 5: We recommend that the State agency require its behavioral health MCOs to review all claims paid after our audit period for PPCs using all of the diagnosis codes submitted by the provider and determine whether any payments for services related to treating PPCs were unallowable and adjust future capitation payment rates for any unallowable payments identified.

DHS Response: DHS concurs with this recommendation. For the BH-MCOs, in 2017 DHS initiated an Encounter Data Validation (EDV) process that involves a monthly review of the encounter submissions by all BH-MCOs. As part of this process, DHS requires that all diagnoses of the individual are included in the claim that the BH-MCO included in the encounter and submits to the state. DHS conducts at least quarterly conference calls with each BH-MCO regarding the results of their reports. One outcome of this process is that BH-MCOs are submitting all of the diagnosis codes included on the claim and working with their providers to ensure the claims include all relevant diagnoses of the individual. The financial impact to the BH-MCO rates for this has been determined to be immaterial and the claim for such instances would typically be handled by the PH-MCOs.

OIG Recommendation 6: We recommend that the State agency take steps to ensure that the MCOs comply with Federal and State requirements and its managed-care contracts relating to the nonpayment of PPCs.

DHS Response: DHS concurs with this recommendation. Please see the responses above, and additionally, DHS provides updates to PPC through MA Bulletins to Hospitals and MCOs. A compliance standard will be added to the DHS tracking system for monitoring PH-MCO agreements and provisions.

OIG Recommendation 7: We recommend that the State agency ensure all inpatient hospitals submit POA codes as required in the State plan.

DHS Response: DHS concurs with this recommendation. The Provider Reimbursement and Operations Management Information System (PROMISe), DHS' MMIS system, requires that the POA field is completed for all inpatient encounters. A problem with service location codes during the audit period caused encounters to have a wrong code, which bypassed the POA edit. DHS has been working closely with the PH-MCOs to address the issue of incorrect service locations reported in encounter data. Many PH-MCOs had system limitations to accurately identify provider service locations on encounters, and the encounters were submitted to MMIS with non-inpatient acute care service locations of hospital providers. When the service locations were not inpatient acute care, the MMIS does not capture POA codes even when the PH-MCOs submitted the codes. The DHS continues to work with the PH-MCOs to correct the issue so the MMIS will capture submitted POA codes.

Thank you for the opportunity to respond to this draft audit report. If you have any questions or concerns regarding this response, please contact Mr. David R. Bryan, Bureau of Financial Operations, Audit Resolution Section, at (717) 783-7217 or via email at davbryan@pa.gov.

Sincerely,

Carolyn K. Ellison

Carolyn K. Ellison
Deputy Secretary for Administration
Shared Services for Health and Human Services

c: Mr. Robert Baiocco, Audit Manager
Mr. David R. Bryan