

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CMS COULD TAKE ACTIONS TO HELP
STATES COMPLY WITH FEDERAL
REQUIREMENTS PROHIBITING
MEDICAID PAYMENTS FOR INPATIENT
HOSPITAL SERVICES RELATED TO
PROVIDER-PREVENTABLE CONDITIONS**

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Office of Inspector General

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Report in Brief

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



Why OIG Did This Audit

Provider-preventable conditions (PPCs) are certain reasonably preventable conditions caused by medical accidents or errors in a healthcare setting. In 2011, the Centers for Medicare & Medicaid Services (CMS) issued Federal regulations prohibiting Federal Medicaid payments for services related to PPCs. The goal of the regulations is to improve quality of care by prohibiting payments for medical errors. Prior OIG audits of nine States found that none of them fully complied with Federal requirements. Based on the information we compiled during those audits, we conducted this audit to identify actions that CMS could take to help States' compliance and to augment States' efforts to improve the quality of care provided to Medicaid beneficiaries.

Our objective was to identify actions that CMS could take to help States comply with Federal requirements prohibiting Medicaid payments for inpatient hospital services related to treating PPCs.

How OIG Did This Audit

We compiled and analyzed the results of our nine prior audits and reviewed the State plans for each of the nine States. We also interviewed CMS officials and obtained from CMS documentation related to its (1) development and implementation of the Federal regulations related to PPCs and (2) review and approval of State plan amendments incorporating those regulations.

CMS Could Take Actions To Help States Comply With Federal Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions

What OIG Found

CMS could take actions to (1) verify that all State plans fully comply with Federal requirements prohibiting Medicaid payments for inpatient hospital services related to treating PPCs and (2) issue clarifying guidance to address specific areas in which States did not comply with those requirements. None of the nine States we previously audited had State plans that included all of the Federal requirements, and one State did not amend its State plan to incorporate the Federal requirements. In addition, five of the nine States did not identify PPCs on inpatient claims from all inpatient hospitals, four States did not correctly use the Medicare list of hospital-acquired conditions to identify all PPCs, four States did not identify PPCs on Medicare crossover claims for individuals dually eligible for Medicare and Medicaid, and one State did not use all of the diagnosis codes reported by inpatient hospitals to identify PPCs.

Although CMS previously issued instructions and guidance on the implementation of the Federal requirements, the results of our audits of the nine States suggest that CMS needs to do more to help States comply with those requirements and to achieve the overall goal of improved quality of care for Medicaid beneficiaries. If CMS does not verify that State plans fully comply with Federal requirements and provide clear guidance on these requirements, States may continue to struggle to prevent unallowable payments for PPCs and may not take measures to improve the quality of inpatient hospital services through the prevention of medical errors.

What OIG Recommends and CMS Comments

We recommend that CMS verify that all State plans comply with Federal requirements prohibiting payments for PPCs and issue clarifying guidance to States in specific areas (e.g., to help ensure that States identify PPCs on inpatient claims from all inpatient hospitals). We also make other procedural recommendations. The report lists all of our recommendations.

CMS concurred with our recommendations and described actions that it had taken or planned to take to address the recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

Provider-preventable conditions (PPCs) are certain reasonably preventable conditions caused by medical accidents or errors in a healthcare setting. In 2011, the Centers for Medicare & Medicaid Services (CMS) issued Federal regulations prohibiting Federal Medicaid payments for services related to PPCs. The goal of the regulations is to improve Medicaid beneficiaries' quality of care by prohibiting payments for medical errors.

Prior Office of Inspector General (OIG) audits of nine States found that none of them fully complied with Federal requirements because the States had not implemented adequate internal controls to ensure that their Medicaid fee-for-service payments for claims that contained PPCs were reduced. (See Appendix B for a list of the related OIG reports.¹) Based on the information we compiled during those audits, we conducted this audit to identify actions that CMS could take to help States comply with the Federal requirements and to augment the States' efforts to improve the quality of care provided to Medicaid beneficiaries.

OBJECTIVE

Our objective was to identify actions that CMS could take to help States comply with Federal requirements prohibiting Medicaid payments for inpatient hospital services related to treating 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.² Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements, assuring that care and services are provided in the best interests of beneficiaries.

¹ In addition to our audits of nine States' fee-for-service payments, we audited four States' Medicaid managed-care organizations' payments for PPCs. This report includes the results of our audits for only the States' fee-for-service payments.

² A State may update its State plan by submitting a State plan amendment (SPA) to CMS for review and approval.

Provider-Preventable Conditions

PPCs include two categories: healthcare-acquired conditions and other PPCs.³ Healthcare-acquired conditions are conditions acquired in any inpatient hospital setting (42 CFR § 447.26(b)).⁴ These conditions include, among others, surgical site infections and foreign objects left inside the body after surgery (76 Fed. Reg. 32816, 32817 (June 6, 2011)). Other PPCs are 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: a wrong surgical or other invasive procedure performed on a patient, a surgical or other invasive procedure performed on the wrong body part, and a surgical or other invasive procedure performed on the wrong patient (42 CFR § 447.26(b)).

PPCs can be identified on inpatient hospital claims through certain diagnosis codes.⁵ For each diagnosis code on a claim, a hospital is required to document whether a patient's condition was present on admission to the hospital (POA status).⁶ A State is not exempt from prohibiting payment for services related to a PPC if a hospital failed to document a condition's POA status.

Federal Law and Regulations Prohibiting Federal Medicaid Payments for PPCs

The Patient Protection and Affordable Care Act (ACA) required CMS to identify and incorporate into new Medicaid PPC regulations any suitable existing State practices prohibiting payment for healthcare-acquired conditions (ACA § 2702 (a)).⁷ The ACA also required CMS to identify and

³ Under Medicare, healthcare-acquired conditions and other PPCs are referred to as "hospital-acquired conditions" (HACs) and "adverse events," respectively.

⁴ These conditions (1) are considered to have a high cost or to occur in high volume or both, (2) result in increased payments for services, and (3) could have been reasonably prevented. CMS identifies these conditions as Medicare HACs, other than deep vein thrombosis/pulmonary embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients (Social Security Act § 1886(d)(4)(D)(iv) and 42 CFR § 447.26(b)).

⁵ Diagnosis codes are used to identify a patient's health conditions. The 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 audits, the applicable versions of the ICD were the 9th and 10th Revisions, Clinical Modification (ICD-9 and ICD-10).

⁶ An inpatient hospital claim contains a principal diagnosis code and may contain multiple secondary diagnosis codes. The principal diagnosis code describes the condition established after study to be chiefly responsible for the hospital admission, and secondary diagnosis codes describe any additional conditions that coexist at the time of service. The PPC regulations pertain only to secondary diagnosis codes. Hospitals may report POA status using present-on-admission indicator codes (POA codes) on inpatient hospital claims.

⁷ The ACA, 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), prohibited Medicaid payment for healthcare-acquired conditions.

incorporate, as appropriate for the Medicaid program, the Medicare requirements prohibiting payments for HACs (ACA § 2702 (c)).

Federal regulations implemented July 1, 2011, prohibit Medicaid payment for all PPCs, including Medicaid payments made on behalf of individuals who are dually eligible for both Medicare and Medicaid (42 CFR § 447.26 (c)(1)).⁸ Payment for services related to treating a PPC must 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)). Payment will not be reduced for a PPC that existed before treatment was started (i.e., a condition that was present on admission) (42 CFR § 447.26(c)(2)). Any reduction in payment may be limited to the extent that a State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the PPC (42 CFR § 447.26(c)(3)(ii)).

CMS's Development and Implementation of the Federal Regulations Related to PPCs

Before enactment of the ACA in 2010, CMS had encouraged States to develop Medicaid policies prohibiting payment for HACs similar to the policies that had been previously implemented under Medicare.^{9, 10} In 2011, to create the Federal regulations for nonpayment of PPCs, CMS used the Medicare HAC requirements as a baseline to promote uniformity across the two programs. CMS designed the regulations to provide healthcare providers with a strong incentive to limit preventable medical errors, to develop quality practices, and to promote quality improvements for the healthcare industry (76 Fed. Reg. 32816, 32821, and 32836 (June 6, 2011)).

To develop the regulations, CMS reviewed State plans and State policies not reflected in the State plans. CMS also surveyed States to identify existing practices prohibiting payment for HACs. After gathering and analyzing the information, CMS issued a proposed rule for public comment. CMS reviewed and analyzed the comments it received and issued a final rule containing the regulations as well as guidance and specific requirements on how States were to implement the regulations.

⁸ Medicaid pays to providers part or all of the Medicare deductibles and coinsurance for claims submitted on behalf of some individuals who are entitled to both Medicare and Medicaid benefits. These claims are called Medicare crossover claims.

⁹ After enactment of the Deficit Reduction Act of 2005 (P.L. No. 109-171, Feb. 8, 2006), CMS developed the list of Medicare HACs (Medicare HAC list) and prohibited Medicare reimbursement for cases in which a HAC occurred and was not present on admission. The Medicare requirements were applicable to only those hospitals reimbursed under the inpatient prospective payment system (IPPS) and were effective for all discharges occurring on or after October 1, 2008.

¹⁰ In 2008, CMS sent a letter to States encouraging them to implement Medicaid requirements that aligned with Medicare's requirements prohibiting payments for HACs (State Medicaid Director Letter #08-004, dated July 31, 2008).

CMS required States to amend the appropriate sections of their State plans by incorporating into them specific requirements that CMS identified in the final rule (76 Fed. Reg. 32816, 32819 (June 6, 2011)). In addition, CMS developed a template (State plan preprint) that States were required to use to amend their State plans¹¹ and a document containing answers to frequently asked questions (FAQs). To give States time to develop and implement new payment policies in accordance with the regulations, CMS delayed enforcing compliance with the regulations until July 1, 2012.

Prior Office of Inspector General Audits of Nine States' Compliance With Federal Requirements Related to PPCs

We conducted audits of nine States' Medicaid payments for inpatient hospital services to determine whether each State complied with Federal requirements prohibiting Medicaid payments for services related to treating PPCs. We found that six of the nine States paid a total of \$173.8 million (\$102.3 million Federal share)¹² for claims that contained at least one PPC and (1) a POA code that indicated the condition was not present at the time of inpatient admission, (2) a POA code that indicated the documentation in the patient's medical record was insufficient to determine whether the condition was present on admission, or (3) no POA code. For the remaining three States, one State refunded the unallowable portion of the claims identified in our audit before we completed our audit, and two States had paid claim data that could not be used to determine whether claims contained PPCs.

All nine States did not have adequate internal controls (e.g., missing or unimplemented policies and procedures) to ensure that payments for claims that contained PPCs were reduced. As a result, for the six States that were paid \$173.8 million (\$102.3 million Federal share), five did not determine the unallowable portion that was for services related to treating PPCs and so should not have been claimed for Federal Medicaid reimbursement. In addition, one State did not provide sufficient documentation that it had determined whether any portion was unallowable.¹³

HOW WE CONDUCTED THIS AUDIT

We compiled and analyzed the results of our prior audits of nine States' compliance with Federal requirements prohibiting Medicaid payments for services related to treating PPCs. (The States audited were Idaho, Illinois, Iowa, Louisiana, Missouri, Nevada, New York, Oklahoma,

¹¹ CMS officials stated that the State plan preprint was designed to outline the minimum requirements that States were to include in their State plans.

¹² The payment amount was \$173,848,959 (\$102,322,504 Federal share).

¹³ This State said that its claims were processed accurately, but it could not provide sufficient evidence that it prevented or reduced any payments for PPCs. Therefore, we could not independently verify whether claims were processed correctly and recommended that the State provide CMS with sufficient documentation to determine whether any portion was unallowable.

and Washington State.) We reviewed the State plans for each of these States to determine whether the State plans complied with Federal requirements. We interviewed CMS officials to gain an understanding of CMS's (1) development and implementation of the Federal regulations related to PPCs and (2) review and approval of SPAs incorporating those regulations. We also obtained documentation from CMS related to its interaction with all States and internal communications related to its implementation and oversight of the Federal requirements.

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

CMS could take the following actions to help States comply with Federal requirements prohibiting Medicaid payments for inpatient hospital services related to treating PPCs: (1) verify that all State plans fully comply with Federal requirements and (2) issue clarifying guidance to address specific areas in which States did not comply with those requirements.

We found that none of the nine States we previously audited had State plans that included all of the Federal requirements. This noncompliance may have occurred because the State plan preprint did not contain all of the provisions identified in Federal requirements and CMS did not verify that State plans fully complied with those requirements. In addition, one State did not amend its State plan to incorporate the Federal requirements.

We also found that:

- five States did not identify PPCs on inpatient claims from all inpatient hospitals,
- four States did not correctly use the Medicare HAC list to identify all PPCs,
- four States did not identify PPCs on Medicare crossover claims, and
- one State did not use all of the diagnosis codes reported by inpatient hospitals to identify PPCs.

The lack of CMS guidance on certain issues or the existence of unclear guidance may have contributed to these four deficiencies.

Although CMS provided to all of the States the State plan preprint and guidance on the implementation of the Federal requirements, the results of our audits of the nine States suggest that CMS needs to do more to help States comply with those requirements and to achieve the overall goal of improved quality of care for Medicaid beneficiaries. If CMS does not verify that State plans fully comply with Federal requirements and provide clear guidance on these requirements, States may continue to struggle to prevent unallowable payments for PPCs and may not take measures to improve the quality of inpatient hospital services through the prevention of medical errors.

CMS COULD TAKE ACTION TO VERIFY THAT ALL STATE PLANS FULLY COMPLY WITH FEDERAL REQUIREMENTS RELATED TO PAYMENTS FOR PPCs

We found that none of the nine States had State plans that included all of the Federal requirements related to payments for PPCs. This noncompliance may have occurred because the State plan preprint did not contain all of the provisions identified in Federal requirements and CMS did not verify that State plans fully complied with those requirements. In addition, one State did not amend its State plan as required to incorporate the Federal requirements.

Federal Requirements

States with PPC payment policies that did not comply with Federal requirements and those without such policies were required to amend their State plans by incorporating the requirements related to nonpayment for PPCs (42 CFR § 447.26(c)(1); 76 Fed. Reg. 32816, 32824 (June 6, 2011)). Each State was required to submit to CMS for approval a SPA incorporating the State's payment provisions related to the nonpayment of PPCs, including its payment methodologies and related methodologies for isolating amounts for nonpayment (76 Fed. Reg. 32816, 32830 (June 6, 2011)). In addition, the State plan was required to contain the following provisions:

- Medicaid will not pay for services related to treating PPCs, including services provided to individuals who are dually eligible for both Medicare and Medicaid (42 CFR § 447.26(c)(1)).
- Nonpayment for services related to treating PPCs does not prevent access to services for Medicaid beneficiaries (42 CFR § 447.26(c)(5)).
- Providers must identify and report through existing claim systems PPCs that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available (42 CFR § 447.26(d) and 76 Fed. Reg. 32816, 32819 (June 6, 2011)).

In the final rule, CMS states that it will review States' SPAs and supplementary information to determine the final action on State PPC policies (76 Fed. Reg. 32816, 32830 (June 6, 2011)).

None of the Nine States Had State Plans That Included All of the Federal Requirements Related to Payment for PPCs

None of the nine States we audited had State plans that included all of the required provisions identified in Federal requirements.¹⁴ Specifically, the State plans did not:

- define all of the States' payment methodologies and their related methodologies to isolate amounts for nonpayment (three States);
- prohibit payment for the treatment of PPCs for individuals dually eligible for Medicare and Medicaid, i.e., payment for Medicare crossover claims (nine States);
- ensure that nonpayment for PPCs did not prevent access to services for Medicaid beneficiaries (four States); and
- require providers to self-report PPCs through their claims systems (nine States).

To incorporate the required provisions into their State plans, States were required to use the State plan preprint.¹⁵ However, the preprint did not contain the provisions listed above. CMS officials stated that they were not sure why certain provisions were not included in the preprint but that they should have been included. CMS officials also stated that CMS approved the SPAs without all of the required provisions because they relied on the statement of assurance that was included in the State plan preprint. This statement, which States were required to incorporate into their SPAs, said that the State meets the Federal requirements for nonpayment of PPCs.

One State Did Not Amend Its State Plan To Incorporate the Federal Requirements

Of the nine States that did not have State plans that fully complied with Federal requirements, one State did not submit a SPA to amend its State plan as required. The State had previously submitted a SPA to amend its State plan in 2010 to prohibit payment for services related to adverse events and HACs that were identified as nonpayable by Medicare. However, because the State's 2010 policies did not comply with Federal requirements for the nonpayment of PPCs, the State was required to submit to CMS a SPA that incorporated the requirements.

According to CMS, it tracked which States had submitted SPAs and which States had not. CMS officials stated that they were responsible for following up with the States that had not submitted SPAs or had not had their SPAs approved by CMS. However, they stated that they did not realize that one State had not submitted a SPA to amend its State plan.

¹⁴ Eight of the nine States submitted SPAs to amend their State plans as required, but the remaining State did not. (See the following section.)

¹⁵ The eight States that submitted SPAs used CMS's State plan preprint.

CMS COULD TAKE ACTION TO ISSUE CLARIFYING GUIDANCE TO ADDRESS SPECIFIC AREAS IN WHICH STATES DID NOT COMPLY WITH FEDERAL REQUIREMENTS

We found that five of the nine States did not identify PPCs on inpatient claims from all inpatient hospitals, four States did not correctly use the Medicare HAC list to identify all PPCs, four States did not identify PPCs on Medicare crossover claims, and one State did not use all of the diagnosis codes reported to it by inpatient hospitals to identify PPCs. The lack of CMS guidance on certain issues or the existence of unclear guidance may have contributed to these deficiencies.

Five States Did Not Identify PPCs on Inpatient Claims From All Inpatient Hospitals

Federal regulations prohibit Medicaid payments for services related to treating PPCs in any inpatient hospital setting (42 CFR §§ 447.26(a) and (b)). CMS states in the preamble to the final rule that it does not have the authority to exempt any inpatient hospital providers from these requirements (76 Fed. Reg. 32816, 32822 (June 6, 2011)).

Five of the nine States we audited did not identify PPCs on inpatient claims from all inpatient hospitals. Specifically, these States incorrectly excluded claims from certain types of inpatient hospitals (e.g., critical-access hospitals, children's inpatient facilities, and cancer hospitals) from their PPC payment reduction policies. The States said that they did not subject Medicaid claims from these hospitals to these policies because they believed that claims from hospitals exempted from the HAC payment provision and POA code reporting requirements under Medicare¹⁶ were also exempted under Medicaid.

Four States Did Not Correctly Use the Medicare Hospital-Acquired Conditions List To Identify All PPCs

States are required to identify for nonpayment under Medicaid the conditions on the Medicare HAC list and to use any subsequent updates or revisions to the list (42 CFR § 447.26(b); 76 Fed. Reg. 32816, 32820 (June 6, 2011)). The list includes 14 categories of conditions, such as falls and trauma, and provides diagnosis codes and diagnosis code/procedure code combinations that are considered Medicare HACs.

Four of the nine States we audited did not correctly use the Medicare HAC list to identify all PPCs. Specifically, when identifying PPCs, States (1) incorrectly excluded diagnosis codes that were on the list, (2) incorrectly included diagnosis codes that were not on the list, or (3) did not apply the correct list of HACs in effect to the applicable year.

¹⁶ Since October 1, 2007, hospitals that are reimbursed under Medicare's IPPS have been required to submit, for each diagnosis identified on a claim, a POA code specifying whether the diagnosis was present on admission. Under Medicare, the HAC payment provision and POA code reporting requirements apply to hospitals paid under the IPPS but do not apply to hospitals exempt from the IPPS.

In addition, as of October 1, 2015, States were required to use the HAC list that was based on ICD-10 codes and was effective for fiscal year (FY) 2016. On the FY 2016 HAC list, we identified that 24 of the procedure codes were not valid.¹⁷ Because of these errors, States that relied on the FY 2016 HAC list may not have identified all PPCs.

In February 2017, we notified CMS of the errors that we found on the FY 2016 HAC list. As of October 2019, CMS had not provided States with a corrected list. CMS officials stated that the person responsible for updating the list had retired and the position had not been filled.

Four States Did Not Identify PPCs on Medicare Crossover Claims

Federal regulations prohibit Medicaid payments for services related to treating PPCs for individuals dually eligible for both Medicare and Medicaid (42 CFR §§ 447.26(b) and (c)(1)).¹⁸ CMS states in the preamble to the final rule that when information needed to determine the appropriate Medicaid payment is missing from a claim (e.g., diagnosis and POA codes), a State may determine that Medicare has reduced payment by working with the MAC to identify the appropriate codes related to the treatment provided to a dually eligible individual (76 Fed. Reg. 32816, 32828 (June 6, 2011)).

Four of the nine States we audited did not identify PPCs on Medicare crossover claims related to dually eligible beneficiaries.¹⁹ The States did not review these claims for a variety of reasons. For example, one State told us it believed that if Medicare reduced its payment for a PPC, no further reduction to the payment was required under the Medicaid policy; another State told us it did not believe that the Medicaid portion of an unallowable payment for a PPC could be reasonably isolated from the coinsurance or deductible amount that Medicaid was responsible for paying.

CMS states in the preamble to the final rule that the intent of the rule as it relates to Medicare crossover claims is that no payment will be available under either Medicare's IPPS or Medicaid for an identified HAC. Further, in the FAQs, CMS states that the absence of POA codes on Medicare crossover claims does not exempt States from the requirement to apply PPC payment reductions for Medicaid beneficiaries or beneficiaries who are dually eligible for both Medicare and Medicaid when the provider has not documented a condition that was present on admission. CMS goes on to say that when a provider claims a Medicaid payment, the provider

¹⁷ ICD-10 procedure codes have seven alphanumeric characters. The 24 invalid codes contained only 6 alphanumeric characters.

¹⁸ Inpatient hospitals submit claims for beneficiaries who are dually eligible for Medicare and Medicaid to a designated Medicare administrative contractor (MAC) because Medicare is the primary payer for those claims. The MAC processes the claims to determine Medicare's portion of the payment and then submits the claims to the State agency to pay the Medicaid portion of the beneficiary's coinsurance or deductible. When these claims are submitted to the State agency for Medicaid payment, they become known as Medicare crossover claims.

¹⁹ The remaining five States did not identify PPCs on any claims or did not provide data that were sufficient to determine whether PPCs were identified on crossover claims.

should include the POA status when documenting the claim, and States should work with all affected provider types to ensure that claims are properly documented. However, CMS officials stated that when the Federal requirements were being developed, CMS did not consider how a provider should quantify a PPC payment adjustment for a crossover claim.

In addition, CMS officials informed us that they did not intend the “reasonably isolate” language in the regulations to limit a State’s responsibility for identifying a payment reduction on a claim that did not contain POA codes. (This language states that any reduction in payment may be limited to the extent that a State can reasonably isolate for nonpayment the portion of the payment directly related to treating a PPC.) Instead, they intended the language to limit a State’s responsibility for identifying a payment reduction when it would be difficult for the State to isolate the service to which a PPC was attributed.

One State Did Not Use All of the Diagnosis Codes Reported by Inpatient Hospitals To Identify PPCs

States are required to have claim processing systems capable of identifying, by recipient, screening and related diagnosis and treatment services (CMS’s *State Medicaid Manual*, Pub. No. 45, § 11325). In the preamble to the final rule, CMS conveys the importance of the States’ and CMS’s ability to capture data related to the occurrences of PPCs and mandates that each State require providers to self-report PPCs through the State’s claim systems, regardless of the provider’s intention to bill. CMS requires the reporting of PPCs through a State’s Medicaid Management Information System (MMIS) because it is an existing resource that is “routinely and regularly” modified to accept State payment adjustments (76 Fed. Reg. 32816, 32828 (June 6, 2011)).

One of the nine States we audited did not use all of the diagnosis codes that inpatient hospitals reported to it to identify PPCs.²⁰ Specifically, the State reviewed only four secondary diagnosis codes to determine whether it paid for services related to treating PPCs. The State did not use all of the reported diagnosis codes because it did not upload all of the codes to the MMIS.

CMS officials informed us that they did not require States to use a minimum number of diagnosis codes to identify PPCs, but a State should use all of the claim data that it has available (i.e., the diagnosis and POA codes) to determine the existence of PPCs and reduce payments for services related to treating those PPCs. CMS officials added that if a State does not have all of the available claim data in its MMIS, it must make an effort to review the actual claim that was submitted by the hospital to make the adjustment and reasonably isolate the payment associated with the PPC.

²⁰ The electronic claim form used by hospitals includes fields for 1 primary and up to 24 secondary diagnosis and POA codes.

CONCLUSION

States have not been prohibiting Medicaid payments for all services related to treating PPCs. CMS states in the preamble to the final rule that the overall goal of the Federal regulations related to PPCs, although directed at Medicaid payments, is to improve the quality of care provided to Medicaid beneficiaries. States that have not implemented adequate controls to prohibit Medicaid payments for services related to treating PPCs are not preventing unnecessary Medicaid spending and may be missing opportunities to evaluate and improve the quality of the care provided to beneficiaries. CMS has previously issued instructions and guidance on the implementation of the Federal requirements prohibiting Medicaid payment for PPCs.

However, the results of our audits show that States need additional assistance to comply with the requirements and to achieve the overall goal of improved quality of care for Medicaid beneficiaries. If CMS does not verify that State plans fully comply with those requirements and does not provide clarifying guidance on the specific areas highlighted in this report, States may continue to struggle to prevent unallowable payments for PPCs and may not take measures to improve the quality of inpatient hospital services through the prevention of medical errors.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- verify that all State plans comply with Federal requirements prohibiting payments for PPCs by reviewing all existing State plans to ensure that States' policies related to PPCs are defined;
- issue a revised State plan preprint that contains all of the provisions identified in Federal requirements, if CMS continues to require States to use the preprint;
- issue clarifying guidance to States to help ensure that they:
 - identify PPCs on inpatient claims from all inpatient hospitals,
 - correctly use the Medicare HAC list to identify PPCs,
 - acquire from all inpatient hospital providers the information necessary to determine whether Medicare crossover claims contain PPCs and fully understand how to determine whether a crossover claim containing a PPC requires a payment adjustment,
 - understand how and when to apply the "reasonably isolate" language in 42 CFR § 447.26(c)(3)(ii) as it relates to the limitation of reduction in payment for PPCs, and

- use all of the diagnosis codes that inpatient hospitals report to them to identify PPCs;
- make the necessary corrections to the FY 2016 Medicare HAC list; and
- work with States to ensure that their systems and processes for identifying PPCs use all diagnosis codes reported by inpatient hospitals.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendations and described actions that it had taken or planned to take to address the recommendations. CMS's comments are included in their entirety as Appendix C.

CMS's comments on our recommendations are summarized below:

- Regarding our first recommendation, CMS stated that it will review State plans to ensure they are in compliance with Federal requirements and will determine an appropriate timeframe to conduct this work.
- Regarding our second recommendation, CMS stated it will revise the State plan preprint to contain all Federal requirements and will work with States to comply.
- Regarding our third recommendation, CMS had the following comments:
 - Regarding issuing clarifying guidance to help States ensure that they (1) identify PPCs on inpatient claims from all inpatient hospitals, (2) correctly use the Medicare HAC list to identify PPCs, (3) understand how and when to apply the "reasonably isolate" language in Federal regulations, and (4) use all of the diagnosis codes that inpatient hospitals report to them to identify PPCs, CMS stated that it will consider the best way to communicate with States on these issues and is in the process of determining an appropriate timeframe to conduct this work.
 - Regarding issuing clarifying guidance to help States ensure that they acquire from all inpatient hospital providers the information necessary to determine whether Medicare crossover claims contain PPCs, CMS stated that it generally concurred with our recommendation. CMS noted that States have raised concerns with barriers to receiving this information from providers and that Medicare's HAC policy applies only to hospitals that are subject to the IPPS, while the Medicaid PPC policy applies to all inpatient hospitals. CMS stated that it recognizes that further clarification is needed and will consider the best way to communicate with States on this issue in light of the States' concerns.

- Regarding our fourth recommendation, CMS stated that it has made the necessary corrections to the FY 2016 Medicare HAC list.
- Regarding our fifth recommendation, CMS stated that it will work with States to help them identify PPCs using all diagnosis codes reported by inpatient hospitals and is in the process of determining an appropriate timeframe to conduct this work.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

To identify actions that CMS could take to help States comply with Federal requirements prohibiting Medicaid payments for inpatient hospital services related to treating PPCs, we (1) compiled and analyzed the results of our prior audits of nine States' compliance with the requirements, (2) reviewed the State plans for each of the nine States to determine whether they complied with requirements, and (3) reviewed CMS's activities related to implementation and oversight of the requirements.

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

We conducted our audit from July 2018 through January 2020 and performed fieldwork at CMS's office in Baltimore, Maryland.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed CMS's State plan preprint for incorporation of the provisions identified in Federal requirements;
- reviewed the State plans of the nine States to determine whether the State plans complied with Federal requirements;
- compiled and analyzed the results of our nine prior audits;
- interviewed CMS officials to gain an understanding of CMS's (1) development and implementation of the Federal regulations related to PPCs and (2) review and approval of SPAs incorporating those regulations;
- obtained documentation from CMS related to its interaction with all States and internal communications on its implementation and oversight of the Federal requirements; and
- discussed the results of our audit with CMS 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>New York May Not Have Complied With Federal and State Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions</i>	<u>A-02-16-01022</u>	5/30/2019
<i>Louisiana Did Not Comply With Federal and State Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions</i>	<u>A-06-16-02003</u>	12/17/2018
<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>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>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>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: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: February 19, 2020

TO: Amy Frontz
Deputy Inspector General for Audit Services

FROM: Seema Verma
Administrator 

SUBJECT: Office of Inspector General (OIG) Draft Report: CMS Could Take Actions to Help States Comply with Federal Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions (A-09-18-02004)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to making sure that Medicaid payments are made appropriately and accurately.

On June 30, 2011, CMS published a final rule requiring that states implement non-payment policies for provider preventable conditions (PPCs).¹ PPCs consist of health care-acquired conditions, which are conditions acquired in any inpatient hospital setting, and other PPCs, which are conditions occurring in any healthcare setting that a state identifies in its state plan. CMS reviews state plans upon submission to ensure they have included, at a minimum, three specific conditions as other PPCs in their state plans: a wrong surgical or other invasive procedure performed on a patient; a surgical or other invasive procedure performed on the wrong body part; and a surgical or other invasive procedure performed on the wrong patient. If CMS were aware of a state not being in compliance with the regulation, we would work with them to address any issues.

To further assist states implement this regulation, CMS has issued guidance to states, including a frequently asked questions document and a state plan preprint.² States can use the preprint to more easily incorporate federal requirements into their state plans. CMS also provides technical assistance on this issue at a state's request.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

Verify that all State plans comply with Federal requirements prohibiting payments for PPCs by reviewing all existing State plans to ensure that States' policies related to PPCs are defined.

¹ Federal Register; Vol. 76, No. 108, Part III; Medicaid Program; Payment Adjustment for Provider-Preventable Conditions Including Health Care-Acquired Conditions; Final Rule; <https://www.govinfo.gov/content/pkg/FR-2011-06-06/pdf/2011-13819.pdf>.

² "Provider Preventable Conditions"; <https://www.medicaid.gov/medicaid/finance/provider-preventable-conditions/index.html>.

CMS Response

CMS concurs with OIG’s recommendation. CMS will determine an appropriate timeframe to conduct this work. CMS will review state plans to ensure they are in compliance with federal requirements and conduct this work over time.

OIG Recommendation

Issue a revised State plan preprint that contains all of the provisions identified in Federal requirements if CMS continues to require States to use the preprint.

CMS Response

CMS concurs with OIG’s recommendation; however, there are Paperwork Reduction Act (PRA) requirements for revising the pre-print, so CMS will need to work through proper channels to make sure any changes and the administrative burden for the states and CMS are properly documented. CMS will revise the state plan preprint to contain all federal requirements as part of our PRA renewal process and will work with states to comply on a reasonable and prospective basis.

OIG Recommendation

Issue clarifying guidance to States to help ensure that they identify PPCs on inpatient claims from all inpatient hospitals.

CMS Response

CMS concurs with OIG’s recommendation. CMS will consider the best way to communicate with states on this issue. CMS is in the process of determining an appropriate timeframe to conduct this work.

OIG Recommendation

Issue clarifying guidance to States to help ensure that they correctly use the Medicare HAC list to identify PPCs.

CMS Response

CMS concurs with OIG’s recommendation. CMS will consider the best way to communicate with states on this issue. CMS is in the process of determining an appropriate timeframe to conduct this work.

OIG Recommendation

Issue clarifying guidance to States to help ensure that they acquire from all inpatient hospital providers the information necessary to determine whether Medicare crossover claims contain PPCs and fully understand how to determine whether a crossover claim containing a PPC requires payment adjustment.

CMS Response

CMS generally concurs with OIG’s recommendation as we note that states have raised significant barriers to receiving this information from providers, thereby inhibiting states’ ability to determine the effectiveness of their approach to PPCs. Concerns have been raised that Medicare’s Hospital Acquired Conditions (HAC) policy only applies to hospitals that are subject to the inpatient prospective payment system payment while the Medicaid PPC policy applies to all inpatient hospitals and the incongruity of the two policies creates implementation difficulties that are different for each state. While this issue was discussed in the Frequently Asked Questions (FAQ)

listed on Medicaid.gov, we recognize that further clarification is needed. CMS will consider the best way to communicate with states on this issue in light of states' concerns.

OIG Recommendation

Issue clarifying guidance to States to help ensure that they understand how and when to apply the “reasonably isolate” language in 42 CFR § 447.26(c)(3)(ii) as it relates to the limitation of reduction in payment for PPCs.

CMS Response

CMS concurs with OIG’s recommendation. CMS will consider the best way to communicate with states on this issue. CMS is in the process of determining an appropriate timeframe to conduct this work. Some of this guidance has been provided to states through the FAQs posted on Medicaid.gov. As such, we would have to take the necessary time to determine how best to approach this clarification with states.

OIG Recommendation

Issue clarifying guidance to States to help ensure that they use all of the diagnosis codes that inpatient hospitals report to them to identify PPCs.

CMS Response

CMS concurs with OIG’s recommendation. CMS will consider the best way to communicate with states on this issue. CMS is in the process of determining an appropriate timeframe to conduct this work.

OIG Recommendation

Make the necessary corrections to the FY 2016 Medicare HAC list.

CMS Response

CMS concurs with OIG’s recommendation. CMS has made the necessary corrections to the HAC lists on our website.

OIG Recommendation

Work with States to ensure that their systems and processes for identifying PPCs use all diagnosis codes reported by inpatient hospitals.

CMS Response

CMS concurs with OIG’s recommendation. CMS will work with states to help them identify PPCs using all diagnosis codes reported by inpatient hospitals. CMS is in the process of determining an appropriate timeframe to conduct this work.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.