

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MASSACHUSETTS DID NOT ENSURE 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: May 2019

Report No. A-01-17-00003

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 Massachusetts ensured that its MCOs complied with Federal and State requirements prohibiting payments to providers for inpatient hospital services related to treating certain PPCs.

How OIG Did This Review

We obtained an understanding of the monitoring activities the State agency performed to ensure that the MCOs complied with Federal and State requirements and their managed-care contracts relating to the nonpayment of PPCs. From July 2012 to June 2014, the State agency contracted with five MCOs to provide services to Medicaid beneficiaries. We reviewed Medicaid encounter data from this time period from three of the five MCOs to identify providers' paid claims that contained at least one secondary diagnosis code for a PPC and that had a present on admission (POA) code indicating that the condition was not present on admission or did not have a POA code.

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

What OIG Found

Massachusetts did not ensure its MCOs complied with Federal and State requirements prohibiting Medicaid payments to providers for inpatient hospital services related to treating certain PPCs. PPCs are certain reasonably preventable conditions caused by medical accidents or errors in a healthcare setting. For our audit period, we identified that MCOs paid providers approximately \$10 million for 533 claims that contained PPCs. Massachusetts' internal controls were not adequate to ensure that its MCOs complied with Federal and State requirements. For example, the State did not follow up adequately with the MCOs to determine why POA codes were missing or whether the payments made for the related claims complied with Federal and State requirements. In addition, the MCOs did not have policies or procedures to identify PPCs on claims for inpatient hospital services or determine whether payments for claims containing PPCs should have been reduced.

As a result, the unallowable portion of the \$10 million identified for our audit period was included in the calculation of capitation payment rates for State fiscal years 2015 and 2016.

What OIG Recommends

We made several recommendations to Massachusetts, including (1) work with the MCOs to determine the portion of the \$10 million that was unallowable for claims containing PPCs and its impact on current and future capitation payment rates; (2) enforce the requirement in its managed-care contracts that makes MCO compliance with the PPC provisions a condition of their payment and includes the specific means to recoup funds from the MCOs when such contract provisions and Federal and State requirements are not met, thereby resulting in potential cost savings; (3) enforce the requirement in its managed-care contracts that allows intermediate sanctions to be imposed upon the MCO for failure to comply with applicable Federal or State statutory or regulatory requirements; and (4) require the MCOs to implement internal controls, and other procedural recommendations.

In written comments on our draft report, Massachusetts said it will work with the MCOs to further review the 533 claims and to improve its MCOs' data, reporting, and related processes. The State did not address four of our recommendations and disagreed with the amount of our finding and its impact on future capitation rates.

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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 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 Massachusetts Executive Office of Health & Human Services (State agency) ensured that its MCOs complied with Federal and State requirements prohibiting payments to providers for inpatient hospital services related to treating certain PPCs.

BACKGROUND

The Medicaid Program

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

Medicaid Managed-Care and Federal Reimbursement of State Expenditures

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

(42 CFR § 438.2).¹ MCOs use the capitation payments to pay claims for these services, including inpatient hospital services.

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

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

MCOs are required to maintain records (encounter data) of the services that are delivered to Medicaid beneficiaries enrolled in their managed-care plans and the payments the MCOs make to providers for those services (42 CFR § 438.242). The encounter data typically comes from the claims that providers submit to the MCOs for payment. This data is required to be transmitted to the State to allow the States to track the services received by members enrolled in Medicaid managed-care plans (42 CFR § 438.604). States, in turn, are required to use the encounter data when setting capitation payment rates for MCOs (42 CFR § 438.6(c)).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 upon services that are covered in the State plan (42 CFR § 438.6(c)(4)). Federal reimbursement is available to States only for periods during which the managed-care contract meets Federal regulations (42 CFR § 434.70).

Massachusetts Managed-Care Contracts

In the managed-care contracts, the State agency requires the MCOs to provide covered services in accordance with all applicable Federal and State laws, regulations, and policies (Massachusetts Executive Office of Health and Human Services Contract § 2.6 and Appendix C).³ The contracts further require that the MCOs have a compliance program that includes policies

¹ Subsequent to 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.

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

³ The State agency uses a standard managed-care contract with the same provisions for each MCO.

and procedures for complying with all applicable Federal and State rules, regulations, guidelines, and standards (Massachusetts Executive Office of Health and Human Services Contract § 2.1.A and B). In addition, all payments to the MCO are conditioned on the MCO's compliance with all provisions related to PPCs in the contract (Massachusetts Executive Office of Health and Human Services Contract § 4.2.H).

Provider-Preventable Conditions

PPCs can be identified on inpatient hospital claims that providers submit to MCOs and in the encounter data that MCOs submit to the States through certain diagnosis codes.⁴ Diagnosis codes are used to identify a patient's health conditions.

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

- **Health-care-acquired conditions** are conditions acquired in any inpatient hospital setting that (1) are considered to have a high cost or occur in high volume or both, (2) result in increased payments for services, and (3) could have been reasonably prevented (the Social Security Act § 1886(d)(4)(D)(iv)).⁵ These conditions include, among others, surgical site infections and foreign objects retained after surgery (76 Fed. Reg. 32817 (June 6, 2011)).
- **Other PPCs** are certain conditions occurring in any 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.⁶ For each diagnosis code on a claim, inpatient hospitals may report one of four present-on-admission indicator codes (POA codes), described in the table on the next page.

⁴ 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.

⁵ These conditions are identified by CMS as Medicare hospital-acquired conditions, other than deep vein thrombosis/pulmonary embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients (42 CFR § 447.26(b)).

⁶ The principal diagnosis is the condition established after study to be chiefly responsible for the admission, and secondary diagnosis codes describe any additional conditions that coexist at the time of service.

Table: The Four Present-on-Admission Indicator Codes

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

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

Prohibition of Payment for Provider-Preventable Conditions

The Patient Protection and Affordable Care Act (ACA)⁷ 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)).⁸ Both Federal regulations and the Massachusetts State plan (State plan) require that payment for a claim be reduced by the amount attributable to the PPC that causes an increase in payment and that can be reasonably isolated (42 CFR § 447.26(c)(3) and State Plan Amendment (SPA) 11-012, attachment 4.19-A, respectively).

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

Federal regulations require managed-care contracts to comply with the Federal and State requirements prohibiting payment for PPCs (42 CFR § 438.6(f)). The managed-care contracts also require the MCOs to meet the Federal requirements related to nonpayment of PPCs (Massachusetts Executive Office of Health and Human Services Contract § 2.7 A. 23).

⁷ 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).

⁸ 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.

The State agency uses its Medicaid Management Information System (MMIS) to collect and store encounter data from its MCOs. The State agency implemented an edit within the MMIS that could reject claims missing the required POA codes.⁹ However, the State agency subsequently accepted the claims so the payments would be included in the calculation of the capitation payment rates.

HOW WE CONDUCTED THIS REVIEW

From July 1, 2012, through June 30, 2014 (audit period),¹⁰ the State agency contracted with five MCOs to provide services to Medicaid beneficiaries. We obtained an understanding of the monitoring activities the State agency performed to ensure that the MCOs complied with Federal and State requirements and their managed-care contracts relating to the nonpayment of PPCs. We also reviewed Medicaid encounter data from three of the five MCOs to identify providers' paid claims that contained at least one secondary diagnosis code¹¹ for a PPC and that (1) had a POA code indicating that the condition was not present on admission ("N"), (2) had a POA code indicating the documentation in the patient's medical record was insufficient to determine whether the condition was present on admission ("U"), or (3) did not have a POA code.

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

Appendix A describes our audit scope and methodology.

FINDINGS

The State agency did not ensure that its MCOs complied with Federal and State requirements prohibiting Medicaid payments to providers for inpatient hospital services related to treating certain PPCs. For our audit period, we identified that MCOs paid providers \$9,971,471 for 533 claims that contained PPCs. The State agency's internal controls were not adequate to ensure that its MCOs complied with Federal and State requirements. Specifically, the State agency did not have policies and procedures to determine whether its MCOs complied with Federal and State requirements and provisions of the managed-care contract relating to the nonpayment of

⁹ The edit would prevent the claims from being included in the State agency's encounter data.

¹⁰ The audit period encompassed the most current data available at the time we initiated our review and provided an adequate picture of the States controls.

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

PPCs and did not ensure that the MCOs' payment rates were based only upon services that were covered in the State plan. As a result, unallowable payments for services related to treating PPCs were included in the calculation of capitation payment rates for State fiscal years 2015 and 2016.

FEDERAL AND STATE REQUIREMENTS

The ACA and Federal regulations prohibit Federal payments for health-care-acquired conditions (ACA § 2702 and 42 CFR § 447.26, respectively). Federal regulations and the State plan do not deny payment for an entire claim that contains a PPC; instead, the requirements limit the reduction of the payment to the amount attributable to the PPC that causes an increase in payment and that can be reasonably isolated (42 CFR § 447.26(c)(3) and SPA 11-012, attachment 4.19-A, respectively).

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

MASSACHUSETTS MANAGED-CARE ORGANIZATIONS PAID PROVIDERS FOR CLAIMS THAT CONTAINED PROVIDER-PREVENTABLE CONDITIONS

Although Federal and State requirements and the managed-care contracts prohibited the MCOs from paying for services related to PPCs, the MCOs paid providers for claims that contained PPCs. We identified that MCOs paid providers \$9,971,471 for 533 claims that contained PPCs consisting of:

- 60 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
- 473 claims that did not have a POA code for any of the diagnoses identified on the claim.

Although required by the contract, the MCOs did not determine the unallowable portion of the \$9,971,471 that was for services related to treating PPCs and included the unallowable amounts in the encounter data reported to the State agency (Massachusetts Executive Office of Health and Human Services Contract § 2.7 A. 23).

For our audit period, the three 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. In addition, the MCOs did not have edits that would reject claims missing POA codes or to identify claims that contained PPCs not present on admission. Of the three MCOs we reviewed, two MCOs continue to participate in the Medicaid program and have since implemented these types of edits. The third MCO we reviewed withdrew from participation in the program. However, because these edits were implemented after our audit period, we did not determine whether they were effective in prohibiting payments for inpatient hospital services related to treating certain PPCs.

THE STATE AGENCY'S INTERNAL CONTROLS WERE NOT ADEQUATE

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

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

Because the MCOs did not comply with Federal and State requirements prohibiting payment for PPCs and the State agency's internal controls were not adequate to identify that its MCOs did not comply with those requirements, the unallowable portion of the \$9,971,471 identified for our audit period was included in the calculation of capitation payment rates for State fiscal years 2015 and 2016.

RECOMMENDATIONS

We recommend that the State agency:

- work with the MCOs to determine the portion of the \$9,971,471 that was unallowable for claims containing PPCs and its impact on current and future year capitation payment rates;
- enforce the requirement in its managed-care contracts that makes MCO compliance with the PPC provisions a condition of their payment and includes the specific means to recoup funds from the MCOs when such contract provisions and Federal and State requirements are not met—a measure that, if incorporated, could result in cost savings for the Medicaid program;

- enforce the requirement in its managed-care contracts that allows intermediate sanctions to be imposed upon the MCO for failure to comply with applicable Federal or State statutory or regulatory requirements;
- require the MCOs to implement internal controls to prohibit payments for inpatient hospital services related to treating PPCs and ensure edits implemented after our audit period are effective;
- require its MCOs to review all claims for inpatient hospital services that were paid after our audit period to determine whether any payments for services related to treating PPCs were unallowable and adjust future capitation payment rates for any unallowable payments identified;
- strengthen its monitoring of MCOs to ensure that they comply with Federal and State requirements and the State’s managed-care contracts relating to the nonpayment of PPCs; and
- ensure that claims identified by the MMIS edit are referred back to the MCOs for appropriate correction and inclusion of missing POA codes.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency addressed our first, fourth, and sixth recommendations and did not address the second, third, fifth, and seventh recommendations. The State agency said that it did not believe our overall finding was accurate. The State agency said it anticipates the unallowable portion of the finding, if any, to be much less than \$9,971,471. The State agency said that during the audit period the MCOs structured payments to hospitals in a manner that likely resulted in the MCOs appropriately paying claims that may have contained PPCs. Specifically, the State agency said the MCOs “generally paid a fixed payment or per diem payment to hospitals, the amount of which was not a function of a patient’s diagnosis. Therefore, in accordance with 42 CFR 447.26(c)(3), because the PPC would not have resulted in a higher payment from the MCO to the provider, a payment reduction would not have been appropriate if high quality care unrelated to PPCs was also delivered.”

Furthermore, the State agency said that it is confident that our finding would not have impacted the capitation rates it paid its MCOs for fiscal years 2015 and 2016. The State agency said that even assuming the entire \$9,971,471 should not have been paid by the MCOs, this total payment amount represents a fraction of 1 percent of the base data of \$4 billion and, therefore, would not have been material to the capitation rate development. It further stated that its capitation rate development process applies an adjustment that removes from the base data admissions in which a PPC is reported. Therefore, the State agency said it “is confident that the abovementioned payments from MCOs to providers did not result in higher capitation payments from [the State agency] to MCOs.”

The State agency said it will work with its MCOs to continue evaluating the 533 claims that we identified and take appropriate action as needed, and the State agency said it will continue its efforts to work with the MCOs on improving the MCOs' data, reporting, and related processes.

The State agency's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

Regarding the State agency's assertion that our finding is not accurate, we suggest in our first recommendation that the State agency work with the MCOs to determine the portion of the \$9,971,471 that was unallowable for claims containing PPCs. We note that the unallowable portion of the \$9,971,471 must be determined because the MCOs did not comply with Federal and State regulations prohibiting payment for PPCs and the State did not provide the required program oversight.

Regarding the State agency's general comment that a PPC would not have resulted in a higher payment to providers, we note that States are required to update their State plans to reflect changes in Federal laws and regulations and must submit these changes promptly so that CMS can determine whether the plans continue to satisfy the requirements for approval and ensure the availability of FFP payments (42 CFR § 430.12(c)). Furthermore, CMS's regulations for implementing the PPC rule (42 CFR § 447.26(c)) specifically require States to amend their State plans to provide that no medical assistance will be paid for PPCs, and the State plan must require that providers identify PPCs associated with claims for Medicaid payment.

In the Final Rule published in the Federal Register, CMS clarifies that it allowed States flexibility in how they could implement the PPC rule; however, States must "submit for approval Medicaid State plan amendments that would implement PPC nonpayment policies." Furthermore, the Final Rule says, "The SPA review process will give CMS and providers the opportunity to consider State policy before it is implemented and to provide guidance and input based on our knowledge of the issues" (76 Fed. Reg. 32824 (June 6, 2011)). In its CMS-approved State plan amendment, the State agency specified that it will not pay for services which the hospital indicates are PPC-related and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC (Attachment 4.19-A). We note that the State agency's oversight activities were not adequate to support compliance with the CMS approved SPA and Federal law.

In response to the State agency's assertion that it has a capitation rate development process that applies an adjustment that removes admissions in which a PPC is reported, we note that neither the State agency nor the MCOs had adequate policies, procedures, or edits to identify claims with POA codes that were not present on admission. Therefore, we believe the impact on the capitation rates could not be accurately determined.

We acknowledge the State agency's efforts to work with the MCOs to further review the 533 claims and its efforts to improve its MCOs' data, reporting, and related processes.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From July 1, 2012, through June 30, 2014 (audit period), the State agency contracted with five MCOs to provide services to Medicaid beneficiaries. We obtained an understanding of the monitoring activities the State agency performed to ensure that the MCOs complied with Federal and State requirements and their managed-care contracts relating to the nonpayment of PPCs. We also reviewed Medicaid encounter data from three of the five MCOs to identify providers' paid claims that contained at least one secondary diagnosis code¹² for a PPC and that (1) had a POA code indicating that the condition was not present on admission ("N"), (2) had a POA code indicating the documentation in the patient's medical record was insufficient to determine whether the condition was present on admission ("U"), or (3) did not have a POA code. We did not determine whether the hospitals (1) reported all PPCs, (2) assigned correct diagnosis codes or POA codes, or (3) claimed services that were properly supported.

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

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

METHODOLOGY

To accomplish our objective, we:

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

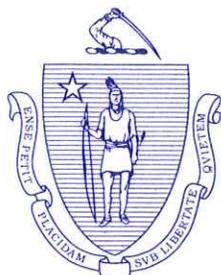
¹² We reviewed the secondary, not primary, diagnosis codes for PPCs because the ACA's payment prohibition pertains only to secondary diagnosis codes.

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

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

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Rhode Island Did Not Ensure Its Managed Care Organizations Complied With Requirements Prohibiting Medicaid Payments for Services Related to Provider-Preventable Conditions</i>	<u>A-01-17-00004</u>	1/4/2019
<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>Iowa Complied With Most Federal Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions</i>	<u>A-07-17-03221</u>	5/14/2018
<i>Missouri Did Not Comply With Federal and State Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions</i>	<u>A-07-16-03216</u>	5/14/2018
<i>Oklahoma Did Not Have Procedures to Identify Provider-Preventable Conditions on Some Inpatient Hospital Claims</i>	<u>A-06-16-08004</u>	3/6/2018
<i>Illinois Claimed Some Improper Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions</i>	<u>A-05-15-00033</u>	9/20/2016
<i>Washington State Claimed Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions</i>	<u>A-09-14-02012</u>	9/15/2016
<i>Idaho Claimed Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions</i>	<u>A-09-15-02013</u>	9/15/2016



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March 8, 2019

Mr. David Lamir
Regional Inspector General for Audit Services
Office of Audit Services, Region 1
JKF Federal Building
15 New Sudbury Street, Room 2425
Boston, MA 02203

RE: Massachusetts Executive Office of Health and Human Services Response to U.S. Department of Health and Human Services, Office of the Inspector General Draft Report No: A-01-17-003

Dear Mr. Lamir:

The Massachusetts Executive Office of Health and Human Services ("EOHHS") is writing to respond to the draft copy of the U.S. Department of Health and Human Services, Office of the Inspector General's ("OIG") draft report titled Massachusetts Did Not Ensure Its Managed-Care Organizations Complied With Requirements Prohibiting Medicaid Payments for Services Related to Provider-Preventable Conditions (No. A-01-17-003; dated January 2019) ("the Report"). Thank you for allowing EOHHS to provide comments on the Report. EOHHS also appreciates the opportunity to have met with the OIG to discuss EOHHS' work in this area.

EOHHS understands the OIG reviewed all paid claims, which met specific criteria, from three of the five EOHHS contracted managed care organizations ("MCOs") to providers during the audit period of July 1, 2012 through June 30, 2014. During that two year period, a total of 533 claims contained Provider Preventable Conditions ("PPCs") as determined by the OIG. The total payment from MCOs to those providers through those 533 claims for all services – unrelated and related to OIG-determined PPCs – equaled \$9,971,471.00. EOHHS further understands that the OIG determined that an unspecified portion of that \$9,971,471.00 – or the portion that was specifically for the services related to the OIG-determined PPCs – is the amount the OIG finds to be unallowable. As set forth below, EOHHS believes the OIG's finding is not accurate and, in any event, anticipates the unallowable portion, if any, to be much less than \$9,971,471.00.



First, during the audit period, MCOs and many other Massachusetts payers (such as EOHHS) structured their payments to hospitals such that payment to hospitals would have been the same regardless of the occurrence of a PPC in most cases. A hospital must be paid for the provision of high quality care it delivers during a hospitalization in which a PPC occurred (see, Federal Register, Vol. 76 Issue 108, June 6, 2011). Similarly, payment reductions should be made only to the extent that the PPC would otherwise result in higher payment, and only to the extent that the portion of a payment directly related to the PPC can reasonably be isolated (see, 42 CFR 447.26(c)(3)). Therefore, depending on the circumstances, certain payment structures such as per diem, bundled, or other all-inclusive payments could require no payment reduction even assuming the existence of a PPC. MCOs structured payments to hospitals during the audit period in a manner that likely resulted in the MCOs appropriately paying claims that may have contained PPCs. Specifically, during the audit period, MCOs generally paid a fixed payment or per diem payment to hospitals, the amount of which was not a function of a patient's diagnosis. Therefore, in accordance with 42 CFR 447.26(c)(3), because the PPC would not have resulted in a higher payment from the MCO to the provider, a payment reduction would not have been appropriate if high quality care unrelated to PPCs was also delivered.

Further, EOHHS questions whether the 533 claims identified by the OIG from its review of the secondary data (namely, the MCOs' encounter data) actually contained PPCs that would have resulted in the MCOs needing to assess whether payment was appropriate. For example, the OIG identifies 473 of the 533 claims as missing Present-On-Admission (POA) codes. While EOHHS recognizes that improvements are needed with respect to the MCOs' data, reporting, and related processes, and EOHHS has been making significant efforts over the past several years in working with its MCOs on improving the quality of such encounter data, EOHHS does not believe that a data or reporting error necessarily leads to a finding that the MCOs inappropriately paid for PPCs. Further, as EOHHS has been reviewing these claims with MCOs, MCOs have expressed the concern that not all 533 claims identified by the OIG were PPCs from a clinical perspective.

Additionally, EOHHS is confident that the OIG's finding would not have impacted the capitation rates EOHHS paid its MCOs in Massachusetts fiscal years 2015 and 2016. The base data used to develop the capitation rates for such years totaled approximately \$4 billion. Even assuming the entire \$9,971,471.00 should not have been paid by the MCOs, which EOHHS does not believe is the case for the reasons mentioned above, such amount represents a fraction of one percent of that base data (again, the \$4 billion) and therefore would not have been material to the capitation rate development. In addition, EOHHS' capitation rate development process applies an adjustment that removes from the base data admissions in which a PPC is reported. Therefore, EOHHS is confident that the abovementioned payments from MCOs to providers did not result in higher capitation payments from EOHHS to those MCOs.

Sudders - OIG – March 8, 2019

Finally, EOHHS appreciates the OIG's recommendations with respect to working with the MCOs on PPCs. EOHHS will work with its MCOs to continue evaluating the 533 claims identified by the OIG and, upon completing such a review, take appropriate action as needed. Such actions could include reviewing EOHHS requirements related to MCOs' internal controls regarding PPCs, improving monitoring and management efforts between EOHHS and its MCOs, and working with MCOs to improve MCO PPC policies and procedures, such as strengthening applicable employee training, internal reporting, claim edit mechanisms, or other appropriate measures. EOHHS will also continue its efforts to work with the MCOs to improve the MCOs' data, reporting, and related processes.

Thank you for your consideration of EOHHS' comments.

Sincerely,


Marylou Sudders