

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEW YORK MAY NOT
HAVE COMPLIED WITH
FEDERAL AND STATE
REQUIREMENTS PROHIBITING
MEDICAID PAYMENTS FOR
INPATIENT HOSPITAL SERVICES
RELATED TO PROVIDER-
PREVENTABLE CONDITIONS**

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Gloria L. Jarmon
Deputy Inspector General
for Audit Services

May 2019
A-02-16-01022

Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

Report in Brief

Date: May 2019

Report No. A-02-16-01022

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



Why OIG Did This Review

Provider-preventable conditions (PPCs) are certain reasonably preventable conditions caused by medical accidents or errors in a health care setting. Federal regulations effective July 1, 2011, prohibit Medicaid payments for services related to PPCs. The Centers for Medicare & Medicaid Services (CMS) delayed its enforcement of the regulations until July 1, 2012, to allow States time to develop and implement new payment policies. This review is one in a series of OIG reviews of States' Medicaid payments for inpatient hospital services related to PPCs.

Our objective was to determine whether New York complied with Federal and State requirements prohibiting Medicaid payments for inpatient hospital services related to treating certain PPCs.

How OIG Did This Review

We reviewed Medicaid paid claim data for July 2013 through June 2016 (audit period) to identify claims that contained at least one secondary diagnosis code for a PPC and those missing a present-on-admission (POA) code or with a POA indicating that the condition was either not present on admission or the documentation in the medical record was insufficient to make a determination.

New York May Not Have Complied With Federal and State Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions

What OIG Found

We were unable to determine whether New York complied with Federal and State requirements prohibiting Medicaid payments for inpatient hospital services related to treating certain PPCs because New York did not provide sufficient evidence that it properly identified claims containing PPCs or determined whether the payments for the related services should have been reduced. Without such evidence, we could not verify whether New York's payments for claims containing PPCs were appropriately reduced.

We identified claims totaling \$90.9 million (\$50.3 million Federal share) that contained a diagnosis code identified as a PPC and certain POA codes, or the claims were missing POA codes. According to New York, based on its own limited review of a subset of claims we identified, its claim processing system ensured that payments for all claims with PPCs were processed accurately. However, New York did not provide sufficient evidence that it prevented or reduced any payments. Therefore, we could not independently verify whether claims were processed correctly. In addition, we requested documentation of the list of PPCs New York said were programmed into its claim payment processing system used to identify PPCs, as well as its policies and procedures to identify and update PPCs. However, New York did not provide the requested documentation. Therefore, we have set aside payments for these services for resolution by CMS and New York.

What OIG Recommends and New York's Comments

We made a series of recommendations to New York, including that it provide CMS with sufficient documentation to determine whether any portion of the \$50.3 million Federal Medicaid reimbursement was unallowable and refund to the Federal Government the unallowable amount.

In written comments on our draft report, New York generally agreed with our recommendations; however, it disagreed with our finding. Although New York asserts that it is appropriately reducing payments in accordance with Federal and State requirements, we maintain that, without sufficient evidence to support its assertion, we cannot objectively determine whether it complied with requirements prohibiting Medicaid payments for inpatient hospital services related to treating certain PPCs. Therefore, we maintain that our finding and related recommendations are valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

Provider-preventable conditions (PPCs) are certain reasonably preventable conditions caused by medical accidents or errors in a health care setting. Federal regulations effective July 1, 2011, prohibit Medicaid payments for services related to PPCs. The Centers for Medicare & Medicaid Services (CMS) delayed its enforcement of the regulations until July 1, 2012, to allow States time to develop and implement new payment policies. We conducted this review to determine whether New York State complied with these regulations for inpatient hospital services. This review is one in a series of Office of Inspector General (OIG) reviews of States' Medicaid payments for inpatient hospital services related to PPCs. (See Appendix B for a list of related OIG reports.)

OBJECTIVE

Our objective was to determine whether the New York State Department of Health (State agency) complied with Federal and State requirements prohibiting Medicaid payments 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. The Federal Government pays its share of a State's medical assistance expenditures under Medicaid according to the Federal medical assistance percentage (FMAP). From July 1, 2013, through June 30, 2016 (audit period), New York's FMAP ranged from 50 percent to 100 percent.

Provider-Preventable Conditions

PPCs can be identified on inpatient hospital claims through certain diagnosis codes.¹ Diagnosis codes are used to identify a patient's health conditions.

¹ 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 and 10th Revision, Clinical Modification.

PPCs include two categories: 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)).² These conditions include, among others, surgical site infections and foreign objects retained after surgery (76 Fed. Reg. 32817 (June 6, 2011)).
- **Other PPCs** are certain conditions occurring in any health care setting that a State identifies in its State plan and must include, at a minimum, the following three specific conditions identified in Federal regulations: 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)).

Diagnosis Codes and Present-on-Admission Codes

An inpatient hospital claim contains a principal diagnosis code and may contain multiple secondary diagnosis codes.³ For each diagnosis code on a claim, inpatient hospitals may report one of five present-on-admission indicator codes (POA codes), described in the table below.

Table: The Five 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.
1 ^a	Exempt from POA reporting.

^a The ICD companion document *ICD-9-CM and ICD-10-CM Official Guidelines for Coding and Reporting* states that “Diagnosis present on admission” for certain diagnosis codes are exempt from POA reporting because they represent circumstances regarding the healthcare encounter or factors influencing health status that do not represent a current disease or injury or are always present on admission. We note that the ICD list of these exempt diagnosis codes do not apply to any PPCs.

² 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)).

³ 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.

The absence of a POA code on a claim does not exempt States from prohibiting payments for services related to PPCs.

Prohibition of Payment for Provider-Preventable Conditions

The Patient Protection and Affordable Care Act (ACA)⁴ 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 be prohibited (42 CFR § 447.26(b)).⁵ Federal regulations 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)). Each State agency must identify for nonpayment the conditions on the list of Medicare hospital-acquired conditions and is required to comply with subsequent updates or revisions to the list (76 Fed. Reg. 32816, 32820 (June 6, 2011)). The list of Medicare hospital-acquired conditions includes 14 categories of conditions, such as falls and trauma. The list provides diagnosis codes and diagnosis code/procedure code combinations that are considered Medicare hospital-acquired conditions. Some categories include a range of diagnosis codes, but only diagnosis codes within the range that are defined as complications or comorbidities (CCs) or major CCs are considered Medicare hospital-acquired conditions (76 Fed. Reg. 25789, 25810 (May 5, 2011)).⁶ States must maintain records to assure that claims for Federal funds meet applicable Federal requirements (42 CFR § 433.32).

The New York Medicaid State plan (State plan) requires the State agency to meet the Federal requirements related to nonpayment of PPCs. The State agency pays Medicaid inpatient hospital claims using one of two payment methods: all-patient refined diagnosis-related groups (APR-DRG)⁷ or per diem. For Medicaid hospital inpatient claims reimbursed by APR-DRG, the Medicaid payment associated with these claims should exclude reimbursement for services not present on admission for any health-care-acquired condition. For per diem payments, according to the State plan, claims containing a diagnosis not present on admission will be subsequently reviewed by clinical review staff to determine whether the diagnosis contributed to a longer length of stay. If the clinical review can reasonably isolate that portion of the actual length of stay that is directly related to the diagnosis not present on admission, payment will be denied for that portion of the stay. The State plan also requires that no payment will be made for inpatient services for other PPCs (State Plan Amendments 11-046-A and 11-82, Attachment 4.19-A).

⁴ 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).

⁵ Prior to the enactment of the ACA and its implementing Federal regulations, PPCs (i.e., health-care-acquired conditions and other PPCs) were referred to as “hospital-acquired conditions” and “adverse events,” respectively.

⁶ Comorbidity means more than one condition is present in the same person at the same time.

⁷ The State agency uses diagnosis-related groupings to classify beneficiaries’ resource intensity, severity of illness, and risk of mortality, which are used to determine reimbursement for their inpatient hospital stays.

HOW WE CONDUCTED THIS REVIEW

For the audit period, the State agency claimed approximately \$12.8 billion (\$7.1 billion Federal share) for inpatient hospital services.^{8, 9} We reviewed the Medicaid paid claim data for the inpatient hospital services and identified claims that contained at least one secondary diagnosis code¹⁰ for a PPC and that (1) had a POA code indicating that the condition was not present on admission (“N”), (2) had a POA code indicating that 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 reported.¹¹

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.

FINDING

We were unable to determine whether the State agency complied with Federal and State requirements prohibiting Medicaid payments for inpatient hospital services related to treating certain PPCs because the State agency did not provide sufficient evidence that it properly identified claims containing PPCs or determined whether the payments for the related services should have been reduced. Without such evidence, we could not verify whether the State agency’s payments totaling \$90,923,002 (\$50,256,025 Federal share) for claims containing PPCs were appropriately reduced. Therefore, we have set aside payments for these services for resolution by CMS and the State agency.

⁸ The audit period encompassed the most current data available at the time we initiated our review.

⁹ We removed “Medicare crossover claims” that contained a PPC from our review. The Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with kidney disease. Medicaid pays part or all of the Medicare deductibles and coinsurance to providers for claims submitted on behalf of some individuals who are entitled to both Medicare and Medicaid benefits. These claims are called Medicare crossover claims.

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

¹¹ We also identified claims that had POA code “1” and included them in the category as not having a POA code, as CMS considers POA code “1” as an equivalent to a blank.

THE STATE AGENCY DID NOT PROVIDE SUFFICIENT EVIDENCE THAT IT COMPLIED WITH FEDERAL AND STATE REQUIREMENTS PROHIBITING MEDICAID PAYMENTS FOR INPATIENT HOSPITAL SERVICES RELATED TO TREATING CERTAIN PROVIDER-PREVENTABLE CONDITIONS

For our audit period, we identified 3,686 claims totaling \$90,923,002 (\$50,256,025 Federal share) that contained a diagnosis code identified as a PPC and (1) a POA code indicating that the condition was not present on admission, (2) a POA code indicating that the documentation in the patient's medical record was insufficient to determine whether the condition was present on admission, or (3) no POA code.

Claims Reimbursed Under the All-Patient Refined Diagnosis-Related Group Payment Methodology

The State agency said that its claim processing system was programmed to prevent or reduce claims that contained PPCs that were reimbursed under the APR-DRG payment methodology during our audit period.¹² However, the State agency did not maintain adequate documentation to demonstrate this. As a result, we could not objectively determine whether the claim processing system had controls in place and was properly designed to prevent or reduce payments for claims that contained PPCs. Therefore, we requested that the State agency review the claims and provide sufficient supporting documentation to demonstrate that the claim system prevented or reduced payments for the claims that contained PPCs we identified (e.g., supporting documentation such as the payment including the PPC(s) compared with the payment excluding the PPC(s)). The State agency provided insufficient documentation to demonstrate that their claim processing system reduced payments for PPCs.

The State agency indicated that the process for verifying the accuracy of the payments associated with the identified claims would involve a complex multistep process that would require a considerable amount of staff time. As an alternative, the State agency offered to verify the payments for 50 APR-DRG claims that contained PPCs. According to the State agency, based on its review of the 50 claims,¹³ its claim processing system ensured that payments for the claims were processed accurately, as were the payments for all claims with PPCs. However, the State agency did not provide sufficient evidence that its claim processing system prevented or reduced any payments. Rather, it provided limited information regarding the tests it

¹² The claim processing system is managed by a State agency contractor (CSRA State and Local Solutions LLC) that serves as the fiscal agent for the operations and enhancement of the State agency's Medicaid Management Information Systems.

¹³ We provided the State agency a judgmental selection of 50 claims that contained PPCs. We selected claims that would test potential outcomes of the State agency's claim processing system. The State agency stated that none of the 50 claims required reductions in payment for PPCs, according to the results of tests conducted by the State agency and its APR-DRG contractor.

conducted.¹⁴ Therefore, we could not independently verify whether the 50 claims were processed correctly and that the State agency's claim processing system prevented or reduced payments for claims containing PPCs.

Claims Reimbursed Under the Per Diem Payment Methodology

The State agency said that, for claims paid on a per diem basis, it prevented or reduced claims that contained PPCs through a manual review of claims because the claim processing system was not programmed to identify and make payment reductions for claims that contained PPCs. However, the State agency did not provide any documentation of claims that had been reduced because of the presence of a PPC nor any evidence that it prevented payments for claims that contained PPCs or that it conducted any manual reviews for these claims.

The State Agency Did Not Provide Evidence It Used the Correct List of Provider-Preventable Conditions in the Claim Payment Processing System

The State agency provided a document from its APR-DRG contractor that included general details about the software used by the contractor. However, the document did not substantiate that the State agency used the correct list of PPCs in the claim payment processing system. The State agency also did not provide evidence that it had any policies and procedures to identify or update PPCs. We requested documentation of the list of PPCs the State agency said were programmed into its claim payment processing system used to identify PPCs, as well as its policies and procedures to identify and update PPCs. However, the State agency did not provide the requested documentation.

RECOMMENDATIONS

We recommend that the State agency:

- provide CMS with sufficient documentation to determine whether any portion of the \$50,256,025 Federal Medicaid reimbursement was unallowable and refund to the Federal Government the unallowable amount,
- review the inpatient hospital claims it processed and paid before and after our audit period and identify for refund to the Federal Government the Federal share of any improper payments related to services for treating PPCs,
- ensure that it has policies and procedures that are fully implemented and effective in prohibiting unallowable payments for services related to PPCs, and

¹⁴ The State agency provided brief conclusions for the 50 claims tested, screenshots of its claim processing system responsible for identifying health-care-acquired conditions, and limited information about its claim processing system.

- work with its contractors to ensure that it maintains evidence to support that payments for claims containing PPCs are being prevented or reduced.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency generally agreed with our recommendations; however, it disagreed with our finding. The State agency stated that it has implemented policies and procedures to comply with Federal and State requirements for the nonpayment of PPCs. Specifically, it cited relevant State plan amendments and projects to update its claim processing system to prevent or reduce payment for APR-DRG claims that contained PPCs. The State agency asserted that to ensure continuous compliance with these requirements, it implemented the following controls: (1) testing of each new version of APR-DRG-related software installed in its claim processing system and (2) utilization review of certain claims with PPCs, including claims paid on a per diem basis.

The State agency reiterated that its process for verifying the accuracy of the payments associated with the 3,686 claims that we identified in our draft report would involve a complex multistep process that would require considerable resources.¹⁵ It also reiterated that none of the 50 claims that we judgmentally selected for review resulted in payment reductions after removing PPCs, according to the results of verification tests conducted by the State agency and its APR-DRG contractor. The State agency contended that we reported that we could not determine whether the State agency complied with Federal and State requirements for the 50 claims because none of them resulted in a different APR-DRG grouping after the verification tests.

Although the State agency asserts that it is appropriately reducing payments in accordance with Federal and State requirements, we maintain that, without sufficient evidence to support its assertion, we cannot objectively determine whether it complied with requirements prohibiting Medicaid payments for inpatient hospital services related to treating certain PPCs. Therefore, we maintain that our finding and related recommendations are valid.

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

¹⁵ We note that, in response to our third and fourth recommendations, the State agency indicated that it will review this process to determine any changes that should be implemented.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From July 1, 2013, through June 30, 2016 (audit period), the State agency claimed \$12,770,520,140 (\$7,104,760,566 Federal share) for Medicaid inpatient hospital services. We reviewed the Medicaid paid claim data for the inpatient hospital services and identified claims that contained at least one secondary diagnosis code 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 that 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 reported. 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 removed Medicare crossover claims that contained a PPC from our review.

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

We conducted our fieldwork at the State agency’s offices in Albany, New York.

METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal and State laws, regulations, and guidance and the State plan;
- held discussions with CMS officials to gain an understanding of how claims for inpatient hospital services are processed and CMS guidance on payments for PPCs;
- held discussions with State agency officials to gain an understanding of how the State agency processes claims for inpatient hospital services, and any action taken by the State agency to identify and prevent payment for PPCs;
- requested a description of the State agency’s internal controls over the accumulation, processing, and reporting of inpatient hospital services expenditures and PPCs;
- obtained a claim database containing inpatient hospital services expenditures from the State agency’s Medicaid Management Information System for claims paid during our audit period;
- reconciled the inpatient hospital services expenditures claimed by the State agency on Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance

Program, with supporting schedules and claim databases for specific quarters within our audit period;

- reviewed the claim database to identify claims with admission dates between July 1, 2013, and June 30, 2016, that contained PPCs and had the POA codes N, U, or 1, or did not have a POA code reported;
- requested the State agency determine whether claims for services related to treating PPCs were paid appropriately; and
- discussed the results of our audit with State agency 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

APPENDIX C: STATE AGENCY COMMENTS



ANDREW M. CUOMO
Governor

Department
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HOWARD A. ZUCKER, M.D., J.D.
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SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

April 25, 2019

Ms. Brenda Tierney
Regional Inspector General for Audit Services
Department of Health and Human Services - Region II
Jacob Javitz Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No: A-02-16-01022

Dear Ms. Tierney:

Enclosed are the New York State Department of Health's comments on the United States Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-16-01022 entitled, "New York May Not Have Complied With Federal and State Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Marybeth Hefner
Donna Frescatore
Dennis Rosen
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**New York State Department of Health
Comments on the Department of Health and Human
Services Office of Inspector General
Draft Audit Report A-02-16-01022 entitled,
“New York May Not Have Complied with Federal and State
Requirements Prohibiting Medicaid Payments for Inpatient Hospital
Services Related to Provider-Preventable Conditions”**

The following are the New York State Department of Health's (Department) comments in response to the Department of Health and Human Services, Office of Inspector General (OIG) Draft Audit Report A-02-16-01022 entitled, "New York May Not Have Complied with Federal and State Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions."

General Comments:

The Department disagrees with the OIG's findings stating that they are unable to determine whether New York complied with Federal and State requirements prohibiting Medicaid payments for inpatient hospital services related to treating certain provider-preventable conditions (PPCs).

Since 2011, the Department has implemented numerous policies and protocols to comply with Federal and State requirements for the non-payment of PPCs. The Department submitted four State Plan Amendments (SPA) 11-46A, 11-82, 13-0041 and 14-0026 to comply with Federal and State requirements for the non-payment of PPCs. At the time of the initial SPA, the Department also had begun implementing a change to the Electronic Medicaid of New York (eMedNY) system to reduce reimbursement for health care acquired conditions (HCACs or PPCs). This project began in 2011 as a Medicaid Redesign Team ("MRT") Phase 1 initiative and was assigned project number 82. This project was successfully completed. In addition to tracking the SPA in the MRT workplan, the MRT project tasks also included a change to the eMedNY payment system ("project #1560") and the delivery of software from 3M that incorporated the Federal Rule changes. The eMedNY project #1560 was established to transition to version 28 of the 3M APR DRG software, effective January 1, 2011, and incorporated the ability for the Present on Admission ("POA") field on the inpatient claim to be used in APR DRG payment. The objective of this project was to bring the Department into compliance with the Federal mandate.

The process of implementing projects in eMedNY requires research, development and testing and, as of January 27, 2011, the Department began passing the POA indicators to the 3M APR DRG software in preparation of the HCAC implementation. The HCAC grouper software was implemented in version 29 of the APR DRG grouper software and utilized by the Department for all discharges on and after January 1, 2012 (eMedNY project #1644). The grouping software identifies the evidence of a HCAC causing the redaction of the codes from the claim prior to assigning an APR DRG.

Two controls have been implemented to verify the continuance of the reduction of claims after the implementation occurred.

1. Testing of the system occurs at the time a new version of the APR DRG and HCAC software are implemented in eMedNY. When a new version of the APR DRG grouper software and HCAC software are implemented in eMedNY, project numbers are assigned for tracking purposes and documentation and testing is completed. To confirm proper implementation of the software, 3M provides test cases to be utilized in testing. These test

cases provide the details that confirm that the software is properly being used in claims processing.

2. The Department contracts for a utilization review (UR) of claims that have been processed and paid by the Department. Part of this review is for cost outlier claims which includes a review for HCACs. As part of the standard cost outlier review, DRG-coding validation is conducted to determine if a HCAC occurred during the hospitalization. In addition, for claims utilizing per diem payments, UR claims containing a diagnosis not present on admission is reviewed by clinical staff to determine if the diagnosis contributed to a longer length of stay. If the clinical review can reasonably isolate the portion of the actual length of stay that is directly related to the diagnosis not present on admission, payment will be denied for the directly related length of stay. Based on the Department's discussion with the contractor, the number of HCAC cases in both cost outlier and retrospective utilization review is not significant. Therefore, it is not expected that a significant number of cases will have an overall payment reduced because of a HCAC, due to the complexity of the patient. However, the contractor has reviewed cases with the potential for HCAC payment reduction, even though limited in number, which also confirms the reduction occurs when appropriate.

OIG identified 3,686 claims that contained a diagnosis code identified as a PPC; however, OIG did not state that the claim was paid inappropriately only that these diagnosis codes were on the claims. The Department has a claims test environment that is managed by its contractor. Since the test environment mimics the actual eMedNY payment system, for these claims to be reviewed, the contractor would have to write programming language to bypass the HCAC module. In addition, each claim would need to be passed through the system three times: (1) to find the claim in eMedNY and submit it to the test environment running it through the HCAC module to confirm the results of the original paid claim equaled the results in the test environment; (2) to run the claim again to void the claim and; (3) to run the claim bypassing the HCAC module. This means that each claim tested has three manual claims submitted. Due to time and financial cost to the Department for the testing of these claims, the Department offered to review 50 claims which was 150 manual claims processing. In addition, the Department offered OIG the option to select the 50 claims from their identified claims. The Department began the claims review process in the test environment once the 50 claims were received.

The grouping of a claim is a complex 18-step process, developed by 3M based on their clinical expertise, and the inclusion or elimination of one or a few codes may not influence the grouping result. According to 3M, severity levels of the codes in question may have little or no impact when present or not on the claim, especially in comparison to how sick the patient and if there are multiple illnesses.

For the 50 claims selected by OIG, after the removal of the HCAC, the grouping result did not change. After the grouping results were determined from the test environment, the contractor confirmed that they were bypassing the HCAC module for the grouper software and provided a screen shot for confirmation. In addition, to further confirm the results, the Department requested the assistance of 3M to review the 50 claims to determine if the results, based on their clinical logic, were appropriate. Per 3M, these claims mainly fell into two categories, except for one case (trauma), and the 50 claims grouped appropriately when the HCAC codes were removed. The two categories are as follows:

1. Claims with HCAC codes that are not used in assigning the APR DRG. Therefore, these HCAC codes had no impact on the grouping whether they were on the claim or not.

2. Claims with HCAC codes that had no impact because there were only codes on the claim at the same level or higher that were used to assign the SOI level.

The OIG reports that they cannot determine if the Department complied with Federal and State requirements due to the 50 cases selected not resulting in a different APR DRG grouping after the HCAC codes were removed. However, based on the MRT process that the Department engaged in when implementing the HCAC module, the testing that continues with the implementation of a new version of the APR DRG grouper software and HCAC module, utilization reviews and the confirmation by 3M for the test results of the 50 claims, the Department is confident that it is appropriately reducing payment based on HCACs in accordance with Federal and State requirements.

Recommendation #1:

Provide CMS with sufficient documentation to determine whether any portion of the \$50,256,025 Federal Medicaid reimbursement was unallowable and refund to the Federal Government the unallowable amount.

Response #1:

The Department will continue to work with the Centers for Medicare and Medicaid Services (CMS) to provide documentation supporting the fact that the Department has not paid Medicaid funds for PPCs and no refund to the Federal Government is required.

Recommendation #2:

Review the inpatient hospital claims it processed and paid before and after our audit period and identify for refund to the Federal Government the Federal share of any improper payments related to services for treating PPCs.

Response #2:

The Department will continue to work with CMS to provide documentation supporting the fact that the Department has not paid Medicaid funds for PPCs and no refund to the Federal Government is required.

Recommendation #3:

Ensure that it has policies and procedures that are fully implemented and effective in prohibiting unallowable payments for services related to PPCs.

Response #3:

The Department will review its current processes to determine any changes that should be implemented in documenting the removal of the PPC in the payment process.

Recommendation #4:

Work with its contractors to ensure that it maintains evidence to support that payments for claims containing PPCs are being prevented or reduced.

Response #4:

The Department will review its current processes to determine any changes that should be implemented in documenting the removal of the PPC in the payment process.