

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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

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Office of Inspector General

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Report in Brief

Date: October 2019

Report No. A-06-16-01001

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 treating 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 of States to determine whether the States ensured that their Medicaid managed-care organizations (MCOs) complied with these regulations for inpatient hospital services.

Our objective was to determine whether the Texas Health & Human Services Commission 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 Texas 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 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 code indicating that the condition was not present on admission.

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

What OIG Found

Texas did not ensure that its MCOs complied with Federal and State requirements prohibiting payments to providers for inpatient hospital services related to treating certain PPCs. For our audit period, we identified Medicaid claims totaling \$29.4 million that contained PPCs for five MCOs. Of this amount, we determined that claims totaling \$12.7 million were in compliance with Federal and State regulations regarding nonpayment of PPCs. However, claims totaling \$16.7 million were not in compliance.

Texas' internal controls were not adequate to ensure that its MCOs complied with Federal and State requirements. Specifically, Texas (1) 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 PPCs and (2) did not ensure that the MCOs' payment rates were based only on services that were covered in the State plan.

What OIG Recommends and Texas' Comments

We recommended that Texas work with the five MCOs to determine what portion of the \$16.7 million is unallowable for Federal Medicaid reimbursement and that portion's impact on current- and future-year capitation payment rates. We also made procedural recommendations to Texas that it strengthen its monitoring of all MCOs to ensure compliance with Federal and State requirements and its managed-care contracts relating to the nonpayment of PPCs. The detailed recommendations are in the body of the report.

Texas agreed to implement the first six of our recommendations. Regarding our last recommendation, Texas stated it would review relevant contract provisions to determine whether changes are needed to enforce MCO compliance with Federal PPC claims processing requirements.

TABLE OF CONTENTS

INTRODUCTION	1
Why We Did This Review	1
Objective	1
Background	1
The Medicaid Program.....	1
Medicaid Managed Care and Federal Reimbursement of State Expenditures.....	1
Medicaid Encounter Data for Services Delivered to Medicaid Beneficiaries Enrolled in Managed-Care Plans.....	2
States’ Responsibility for Ensuring Medicaid Managed-Care Organizations’ Compliance With Federal and State Requirements	2
Texas’ Managed-Care Contracts	2
Texas’ Managed-Care Organizations’ Payment Methods for Inpatient Hospital Claims	3
Provider-Preventable Conditions.....	3
Diagnosis Codes and Present-on-Admission Codes.....	4
Prohibition of Payment for Provider-Preventable Conditions	4
The State Agency’s Hospital Incentive Program	5
How We Conducted This Review	5
FINDINGS.....	6
Federal and State Requirements	7
Some of Texas’ Managed-Care Organizations Appropriately Reduced Payments for Claims That Contained Provider-Preventable Conditions	7
Texas’ Managed-Care Organizations Paid Providers for Claims That Contained Provider-Preventable Conditions.....	7
The State Agency’s Policies and Procedures Were Not Adequate	9
Unallowable Payments Made for Claims With Provider-Preventable Conditions May Have Been Included in the Capitation Payment Rates	9
RECOMMENDATIONS	10
STATE AGENCY COMMENTS	10

APPENDICES

A: Audit Scope and Methodology	11
B: Related Office of Inspector General Reports	13
C: State Agency Comments	15

INTRODUCTION

WHY WE DID THIS REVIEW

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

OBJECTIVE

Our objective was to determine whether the Texas Health & Human Services Commission (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.

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

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

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

MCOs are required to maintain records (encounter data) of the services that are delivered to Medicaid beneficiaries enrolled in the MCOs' managed-care plans and the payments the MCOs make to providers for those services (42 CFR § 438.242). The encounter data typically come from the claims that providers submit to the MCOs for payment. These data are required to be transmitted to the State to allow 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 on services that are covered in the State plan (42 CFR § 438.6(c)(4)). Federal reimbursement is available to States only for periods during which the managed-care contract meets Federal regulations (42 CFR § 434.70).

Texas' Managed-Care Contracts

In the managed-care contracts, the State agency requires the MCOs to administer claims payment in accordance with all applicable Federal and State laws, rules, and regulations, including section 2702 of The Patient Protection and Affordable Care Act (ACA),³ entitled "Payment Adjustment for Health Care-Acquired Conditions" (Texas Uniform Managed-Care Contract, Attachment B-1, § 8.1.4.8).⁴

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

³ 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).

⁴ The State agency uses a standard managed-care contract with the same provisions for each MCO.

Texas Managed-Care Organizations' Payment Methods for Inpatient Hospital Claims

Reimbursements for benefits administered by a Texas Medicaid MCO are determined by the MCO. MCOs may reimburse providers using a variety of different payment methodologies. Some of the payment methodologies include All Patient Refined Diagnosis Related Groups (APR-DRG), per diem, percent of billed charges, and ratio of costs to charges.

Provider-Preventable Conditions

PPCs can be identified using certain diagnosis codes on inpatient hospital claims that providers submit to MCOs and in the encounter data that MCOs submit to the States.⁵ Diagnosis codes are used to identify a patient's health conditions.

PPCs include two categories of conditions: healthcare-acquired conditions and other PPCs:

- **Healthcare-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)).⁶ 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)).

⁵ 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 versions of the ICD were the 9th and 10th Revision, *Clinical Modification*.

⁶ With the exception of deep vein thrombosis/pulmonary embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients, these conditions are identified by CMS as Medicare hospital-acquired conditions (42 CFR § 447.26(b)).

Diagnosis Codes and Present-on-Admission Codes

An inpatient hospital claim contains a principal diagnosis code and may contain multiple secondary diagnosis codes.⁷ For each diagnosis code on a claim, inpatient hospitals may report one of four present-on-admission indicator codes (POA codes), described in Table 1 below.

Table 1: 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 ACA and Federal regulations prohibit Federal payments for healthcare-acquired conditions (ACA § 2702 and 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 Texas 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 Texas State Plan Amendment 12-028, Attachment 4.19-A, respectively).

The Texas 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. Furthermore, the *Texas Medicaid Provider Procedures Manual* requires payment to be 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

⁷ 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.

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.

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)). Texas' managed-care contracts require the MCOs to meet the Federal requirements related to nonpayment of PPCs (Texas Uniform Managed-Care Contract, Attachment B-1, § 8.1.4.8.1).

The State Agency's Hospital Incentive Program

In addition to the PPC payment prohibition, the State agency has a quality-based hospital payment program to give providers incentive to decrease rates of PPCs. Hospitals are subject to two tiers of reimbursement reductions if they have high rates of PPCs:

- a 2-percent payment reduction of inpatient claims when PPC rates are 10 percent above the state-wide risk-adjusted average or
- a 2.5-percent payment reduction of inpatient claims when PPC rates are 25 percent above the state-wide, risk-adjusted average.

Reimbursement reductions are applied when setting MCO capitation payment rates.

HOW WE CONDUCTED THIS REVIEW

From January 1, 2014, through December 31, 2015 (audit period),⁹ the State agency contracted with 19 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 5 of the 19 MCOs to identify providers' paid claims that contained at least one secondary diagnosis code¹⁰ for a PPC and that (1) had a POA code indicating that the condition was not present on admission ("N"), (2) had a POA code indicating the documentation in the patient's medical record was insufficient to determine whether the condition was present on admission ("U"), or (3) did not have a POA code.

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

⁹ The audit period encompassed the most current data available at the time we initiated our review.

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

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, 5 MCOs paid providers \$29.4 million for 418 claims that contained PPCs. Of this amount, we determined that 270 claims totaling \$12.7 million were in compliance with Federal and State requirements regarding nonpayment of PPCs. However, 148 claims totaling \$16.7 million¹¹ were not in compliance. This represents the total amount of the claim and not the unallowable portion paid to providers. 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 PPCs, and the State agency did not ensure that the MCOs' payment rates were based only on services that were covered in the Texas State plan. Because the State agency didn't identify non-compliance by the MCOs, it didn't assess liquidated damages as allowed in the contracts with MCOs. Because capitation rate setting is based on prior years' claim payments, unallowable payments for services related to treating PPCs may have been included in the calculation of capitation payment rates for State fiscal years 2016, 2017, and 2018.¹² See Table 2 below for a summary of what we found at each MCO.

Table 2: Summary of Claims by Managed-Care Organization

MCO A	MCO B	MCO C	MCO D	MCO E	TOTAL
Total Claims Identified Containing Provider-Preventable Conditions and Dollar Totals					
146	80	93	57	42	418
\$10,518,972	\$3,473,122	\$3,506,469	\$4,817,204	\$7,152,305	\$29,468,072
Claims Processed With Payment Methodologies That Reduced Payments for Provider-Preventable Conditions and Dollar Totals					
84	71	78	37	0	270
\$4,744,151	\$3,323,194	\$2,804,688	\$1,861,894	\$0	\$12,733,927
Claims Processed With Payment Methodologies That Did Not Reduce Payments for Provider-Preventable Conditions and Dollar Totals					
62	9	15	20	42	148
\$5,774,821	\$149,928	\$701,781	\$2,955,310	\$7,152,305	\$16,734,145

¹¹ The actual number is \$16,734,145.

¹² The Texas State fiscal year runs from September 1 through August 31.

FEDERAL AND STATE REQUIREMENTS

The ACA and Federal regulations prohibit Federal payments for healthcare-acquired conditions (ACA § 2702 and 42 CFR § 447.26, respectively). Federal regulations additionally prohibit Federal payments of other PPCs (42 CFR § 447.26). Federal regulations and the Texas 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 Texas State Plan Amendment 12-028, 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).

In the managed-care contracts, the State agency requires the MCOs to administer claims payment in accordance with all applicable Federal and State laws, rules, and regulations, including section 2702 of the ACA, entitled "Payment Adjustment for Health Care-Acquired Conditions" (Texas Uniform Managed-Care Contract, Attachment B-1, § 8.1.4.8).

In the managed-care contracts, Attachment B-3 lays out remedies under the contract for breach of various provisions. Specifically, item 23 allows the State agency to assess liquidated damages of up to \$5,000 for the first quarter that an MCO fails to comply with the claims processing requirements. The State agency may also assess up to \$25,000 per quarter for each additional quarter that the MCO fails to comply with the claims processing requirements.

SOME OF TEXAS' MANAGED-CARE ORGANIZATIONS APPROPRIATELY REDUCED PAYMENTS FOR CLAIMS THAT CONTAINED PROVIDER-PREVENTABLE CONDITIONS

We identified 270 claims totaling \$12.7 million that were in compliance with Federal and State requirements regarding nonpayment of PPCs. Four of the five MCOs had procedures in place to reduce payment for PPCs when paid to providers using APR-DRG methodology.

TEXAS' 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 \$16.7 million for 148 claims that contained PPCs:

- Of the 148 claims, 124 claims totaling \$14.2 million from all 5 MCOs were for claims that were reimbursed to providers using either per diem, percent of charges, or ratio of cost to charge methodology. Two MCOs stated that they did not have processes in place to

deny payment of healthcare-acquired conditions for claims paid to providers using these methodologies. One MCO stated that it had a process in place, but it was not able to provide us with documentation showing that claim payments were reduced during our audit period. One MCO reduced future payment rates for providers with PPCs instead of prohibiting payment for PPCs. One MCO stated that there was no way for it to systematically reduce payment for PPCs for claims paid using a percent-of-charge methodology.

- Of the 148 claims, 16 claims totaling \$2.5 million were for claims that were reimbursed to providers using APR-DRG methodology. These 16 claims were paid by 1 MCO. Officials from this MCO stated that they did not have processes in place during our audit period to reduce or deny any claims containing healthcare-acquired conditions. During our audit, the MCO worked with an outside vendor to configure the MCO's system to reduce or deny payment for PPCs for providers who are reimbursed with APR-DRG methodology but did not implement a process for providers paid with other payment methodologies. We did not review the change, so we did not determine whether it would be effective in prohibiting payments for inpatient hospital services related to treating certain PPCs.
- Of the 148 claims, 8 claims totaling \$19,550 were for other PPCs related to wrong surgical procedures. These eight claims were paid by two MCOs. One MCO stated that it had an edit in place for when the MCO was the primary insurer but not when the MCO was the secondary insurer. The other MCO stated that it did not have the appropriate edit in place to deny these claims. Both MCOs stated that after we identified the issue, they began working to implement an edit to deny these claims. Since we did not review the edits, we did not determine whether these would be effective in prohibiting payments for inpatient hospital services related to treating certain PPCs.

The MCOs did not determine the unallowable portion of the \$16.7 million that was for services related to treating PPCs and included the unallowable amounts in the encounter data reported to the State agency. See Table 3 on the following page for a summary of claims with PPCs at each MCO.

**Table 3: Summary of Claims Processed in Payment Systems
That Did Not Reduce Payments for Provider-Preventable Conditions**

MCO A	MCO B	MCO C	MCO D	MCO E	TOTAL
All Patient Refined Diagnosis Related Groups Payment Methodology Claim and Dollar Totals					
0	0	0	0	16	16
\$0	\$0	\$0	\$0	\$2,486,226	\$2,486,226
Other Payment Methodologies Claim and Dollar Totals					
57	9	15	17	26	124
\$5,756,674	\$149,928	\$701,781	\$2,953,907	\$4,666,079	\$14,228,369
Other Provider-Preventable Conditions Claim and Dollar Totals					
5	0	0	3	0	8
\$18,147	\$0	\$0	\$1,403	\$0	\$19,550
Totals					
62	9	15	20	42	148
\$5,774,821	\$149,928	\$701,781	\$2,955,310	\$7,152,305	\$16,734,145

THE STATE AGENCY’S POLICIES AND PROCEDURES 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 determine whether its MCOs complied with the requirements or the contract provisions relating to the nonpayment of PPCs. The State agency did not have policies and procedures to ensure that the MCOs’ payment rates were based only on services that were covered in the Texas State plan.

UNALLOWABLE PAYMENTS MADE FOR CLAIMS WITH PROVIDER-PREVENTABLE CONDITIONS MAY HAVE BEEN INCLUDED IN THE CAPITATION PAYMENT RATES

Because the MCOs did not comply with Federal and State requirements prohibiting payment for PPCs and the State agency did not have policies and procedures to identify that its MCOs did not comply with those requirements, the unallowable portion of the \$16.7 million identified for our audit period would have been included¹³ in the calculation of capitation payment rates for State fiscal years 2016, 2017, and 2018.

¹³ If the provider preventable condition caused the claim payment to increase, there would be an unallowable portion included in the capitation payment rate. We were unable to determine if unallowable payments were made.

RECOMMENDATIONS

We recommend that the Texas Health & Human Services Commission:

- work with the five MCOs to determine the portion of the \$16,734,145 that was unallowable for claims containing PPCs and its impact on current- and future-year capitation payment rates,
- require all its MCOs to implement policies and procedures to prohibit payments for inpatient hospital services related to treating PPCs for all provider payment methodologies,
- require all 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 all its MCOs to ensure the MCOs comply with Federal and State requirements and its managed-care contracts relating to the nonpayment of PPCs,
- ensure all MCOs implement edits to appropriately reduce or deny claims for other PPCs,
- consider enforcing the provision in its contracts that allows liquidated damages to be imposed on the five MCOs due to their failure to process claims in accordance with Federal laws and regulations, and
- include specific measures in its contracts that would allow the State agency to recoup funds from all MCOs when contract provisions and Federal and State requirements are not met—a measure that, if incorporated, could result in cost savings for Medicaid.

STATE AGENCY COMMENTS

The State agency agreed to implement our first six recommendations. Regarding our last recommendation, the State agency stated it would review relevant contract provisions to determine whether changes are needed to enforce MCO compliance with Federal PPC claims processing requirements.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From January 1, 2014, through December 31, 2015 (audit period), the State agency contracted with 19 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 5 of the 19 MCOs to identify providers' paid claims that contained at least one secondary diagnosis code¹⁴ 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, the MCOs, or the Medicaid program. Rather, we reviewed only those internal controls related to our objective.

We conducted our audit from September 2016 through August 2018 and performed fieldwork at the selected MCOs' offices.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations, Federal and State guidance, and the Texas State plan,
- obtained information from CMS officials to gain an understanding of the program,
- held discussions with State officials to gain an understanding of 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 PPCs and any action taken by the MCOs to identify and prevent payment of services related to treating PPCs,
- reviewed the State agency and MCOs' internal controls over the processing and reporting of inpatient service expenditures and PPCs,

¹⁴ We reviewed the secondary, not primary, diagnosis codes for PPCs because the ACA's payment prohibition pertains only to secondary diagnosis codes.

- reviewed the MCOs' encounter data to identify inpatient hospital claims that contained healthcare-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,
- obtained documentation to verify whether MCOs had controls in place to reduce payment for claims with healthcare-acquired conditions,
- requested and reviewed, on a test basis, copies of claims to determine the accuracy and reliability of the 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>Pennsylvania Did Not Ensure That Its Managed-Care Organizations Complied With Requirements Prohibiting Medicaid Payments for Services Related to Provider-Preventable Conditions</i>	A-03-16-00205	8/7/2019
<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>	A-02-16-01022	5/30/2019
<i>Massachusetts Did Not Ensure Its Managed-Care Organizations Complied With Requirements Prohibiting Medicaid Payments for Services Related to Provider-Preventable Conditions</i>	A-01-17-00003	5/8/2019
<i>Rhode Island Did Not Ensure Its Managed-Care Organizations Complied With Requirements Prohibiting Medicaid Payments for Services Related to Provider-Preventable Conditions</i>	A-01-17-00004	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>	A-06-16-02003	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>	A-09-15-02039	5/29/2018
<i>Iowa Complied With Most Federal Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions</i>	A-07-17-03221	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>	A-07-16-03216	5/14/2018
<i>Oklahoma Did Not Have Procedures to Identify Provider-Preventable Conditions on Some Inpatient Hospital Claims</i>	A-06-16-08004	3/6/2018
<i>Illinois Claimed Some Improper Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions</i>	A-05-15-00033	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



TEXAS
Health and Human
Services

Dr. Courtney N. Phillips
Executive Commissioner

September 23, 2019

Ms. Patricia Wheeler
Regional Inspector General for Audit Services
Office of Inspector General, Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

Reference Report Number A-06-16-01001

Dear Ms. Wheeler:

The Texas Health and Human Services Commission (HHSC) received a draft audit report entitled "Texas Did Not Ensure That Its Managed-Care Organizations Complied With Requirements Prohibiting Medicaid Payments For Services Related To Provider-Preventable Conditions" from the U.S. Department of Health and Human Services Office of Inspector General. The cover letter, dated August 22, 2019, requested that HHSC provide written comments, including the status of actions taken or planned in response to report recommendations.

I appreciate the opportunity to respond. Please find the attached HHSC management response which (a) includes comments related to the content of the findings and recommendations and (b) detailed actions HHSC has completed or planned.

Please contact Teresa Menchaca, Office of Audit and Compliance Deputy Director, at (512) 707-6139 or Teresa.Menchaca@hhsc.state.tx.us if you need additional information or have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Dr. Courtney N. Phillips".

Dr. Courtney N. Phillips

Texas Health and Human Services Commission
Management Response to the
U.S. Department of Health and Human Services Office of Inspector General Report:
A-06-16-01001
**Texas Did Not Ensure That Its Managed-Care Organizations Complied With
Requirements Prohibiting Medicaid Payments For Services Related To
Provider-Preventable Conditions**

HHSC agrees that during the audit period (January 1, 2014 through December 31, 2015), the five audited MCOs did not accurately process all inpatient claims with provider-preventable conditions. Since the audit period, HHSC identified concerns related to present-on-admission (POA) indicators and required certain MCOs to identify, correct, and resubmit any encounters where a default algorithm was used to populate the POA indicator. These corrections were completed and verified by October 2018. Since October 2018 all MCOs have been required to include POA indicators measurements on their monthly status reports.

Additionally, HHSC's Hospital Quality Program in operation during the audit period has continued. The program features an annual evaluation of the rates of potentially preventable hospital-acquired complications by hospital and managed care organization (MCO). The methodology for identifying provider-preventable conditions relies on the presence and value of the POA indicator; similarly, the provider-preventable conditions logic also relies on the POA indicator. MCO capitation rates are reduced for low performance and, in turn, MCOs recover payments from providers.

HHSC will strengthen its oversight of unallowable payments related to PPCs and will continue to enforce its MCO contracts to ensure all MCOs accurately process claims, up to and including applicable and appropriate contract remedies, as needed.

Recommendation 1: We recommend that the State agency work with the five MCOs to determine the portion of the \$16,734,145 that was unallowable for claims containing PPCs and its impact on current and future year capitation payment rates.

Management Response

Action Plan

HHSC will work with the MCOs to determine the portion of the \$16,734,145 claims total that was unallowable. The total unallowable amount will be lower than the amount identified by DHHS-OIG because \$16,734,145 reflects the total amount of the claims, rather than just the unallowable portion of the claims. In addition, recoupments from hospital providers by MCOs, under HHSC's Hospital Quality Payment program, were not reflected in the total. Both factors will be applied to calculate the total unallowable amount and its potential impact on MCO rates, if any.

Texas Provider-Preventable Conditions (A-06-16-01001)

For MCO capitation rates effective in state fiscal year 2019, HHSC relied on state fiscal year 2017 encounter data for the base period and state fiscal years 2015 through 2018 experience data for trend development. Therefore, unallowable payments from the first eight months of the audit period were not included in the trends for the current (SFY 2019) rates. Considering the size of the managed care programs in Texas and the size of the identified unallowable amounts, the impact to current and future capitation rates may be immaterial. When the payments are evaluated, HHSC will verify whether unallowable payments had a material impact on capitation rates.

HHSC will request and review information from the MCOs identified in this audit for the audit period, January 1, 2014, through December 31, 2015, regarding payments for claims associated with PPCs to calculate the unallowable amount and determine if there is any impact on current or future MCO capitation payment rates.

Responsible Manager

*Deputy Associate Commissioner for Quality and Program Improvement
HHSC Chief Actuary*

Target Implementation Date

December 2020

DHHS - OIG Recommendation 2: We recommend the State agency require all its MCOs to implement policies and procedures to prohibit payments for inpatient hospital services related to treating PPCs for all provider payment methodologies.

Management Response

Action Plan

HHSC will request all MCOs submit their existing policies and procedures prohibiting payments for inpatient hospital services related to treating PPCs as required by the Texas Uniform Managed Care Contract. HHSC will evaluate the policies and procedures to determine if the procedures are adequate and complete.

In cases where the policies and procedures do not meet the requirements, HHSC will follow the corrective action process to determine necessary changes and remedies.

Responsible Manager

Deputy Associate Commissioner for Quality and Program Improvement

Target Implementation Date

April 2020

DHHS - OIG Recommendation 3: We recommend the State require all 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.

Management Response

Action Plan

HHSC will require MCOs to review their inpatient claims data for unallowable claims payments made for PPCs from January 2016 through the most current available data period. MCOs will be directed to adjust claims payments and submit adjusted encounters, as appropriate. Correcting MCO encounter records will remove the unallowable payments from MCOs' experience and from future capitation calculations. HHSC will evaluate corrected encounter records and capitation reductions from its Hospital Quality Program to determine whether inaccurate claims payments had any impact on capitation payments. If necessary, HHSC will determine the most appropriate method to address incorrect capitation payment amounts

Responsible Manager

Deputy Associate Commissioner for Operations
HHSC Chief Actuary

Target Implementation Date

December 2020

DHHS - OIG Recommendation 4: We recommend the State agency strengthen its monitoring of all its MCOs to ensure that the MCOs comply with Federal and State requirements and its managed-care contracts relating to the nonpayment of PPCs.

Management Response

HHSC has robust processes for monitoring MCO contract compliance and encounter data quality including processes to ensure POA indicators are accurate. HHSC agrees that additional monitoring is needed to validate MCOs' compliance regarding nonpayment of PPCs.

Action Plan

HHSC will review current monitoring activities and evaluate if additional monitoring is needed to validate MCOs' compliance regarding nonpayment of PPCs. As stated in the response to Recommendation 2, HHSC will review all MCO policies and procedures to determine whether each MCO is identifying and mitigating unallowable payments due to PPCs. HHSC will continue monitoring POA indicators on encounter records to verify the field is being populated appropriately. Additionally, HHSC will explore adding specific compliance measures into the annual performance audits of each MCO to ensure inpatient hospital claims with PPCs are being properly adjudicated.

Responsible Manager

*Director for Managed Care Compliance and Operations
Deputy Associate Commissioner for Operations
Deputy Associate Commissioner for Quality and Program Improvement*

Target Implementation Date

December 2020

DHHS - OIG Recommendation 5: We recommend the State agency ensure all MCOs implement edits to appropriately reduce or deny claims for other PPCs.

Management Response

Action Plan

Through the review of the MCOs' policies and procedures described in the response to Recommendation 2 and through on-going performance audits described in the response to Recommendation 4, HHSC will ascertain which MCOs have fully implemented the appropriate edits in their claims processing systems. In cases where the edits are insufficient to identify and deny payment, HHSC will use the existing Corrective Action Process to address systems or policy issues.

Responsible Manager

*Deputy Associate Commissioner for Quality and Program Improvement
Director for Managed Care Compliance and Operations*

Target Implementation Date

December 2020

DHHS - OIG Recommendation 6: We recommend the State agency consider enforcing the provision in its contracts that allows liquidated damages to be imposed on the five MCOs due to their failure to process claims in accordance with Federal laws and regulations.

Management Response

HHSC agrees with the importance of enforcing the provision in the MCO contracts allowing liquidated damages to be imposed. HHSC uses a defined, graduated remedies process to enforce its MCO contracts. HHSC reviews all credible allegations of contract violations and, if verified, HHSC applies appropriate contract remedies.

Action Plan

HHSC will review the findings in this audit report and consider the appropriate contract remedies that may apply, in accordance with the formal contract enforcement process. The results of the review HHSC will perform in response to this audit report will also be considered when determining the appropriate remedies.

Responsible Manager

*Director for Managed Care Compliance and Operations
Deputy Associate Commissioner for Quality and Program Improvement*

Target Implementation Date

September 2020

DHHS - OIG Recommendation 7: We recommend the State agency include specific measures in its contracts that would allow the State agency to recoup funds from all MCOs when contract provisions and Federal and State requirements are not met (a measure that, if incorporated, could result in cost savings for Medicaid).

Management Response

The HHSC MCO contracts have comprehensive provisions that provide HHSC a variety of remedy options, and the contracts include a broad liquidated damages matrix. Improved MCO compliance may be achievable without changes to the contract.

Action Plan

HHSC will review relevant contract provisions and available financial remedies in response to Recommendation 6 to determine whether additional or modified contract provisions are needed to enforce MCO compliance with federal PPC claims processing requirements. If changes are indicated, they will be incorporated into the next contract modification cycle, effective September 1, 2020.

Responsible Manager

*Deputy Associate Commissioner for Quality and Program Improvement
Director for Managed Care Compliance and Operations*

Target Implementation Date

September 2020