Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

WASHINGTON STATE CLAIMED FEDERAL MEDICAID REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES RELATED TO TREATING PROVIDER-PREVENTABLE CONDITIONS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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Office of Inspector General

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EXECUTIVE SUMMARY

Washington State claimed $10.8 million in Federal Medicaid reimbursement over an 18-month period for inpatient hospital services related to certain provider-preventable conditions, some portion of which was unallowable.

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. We conducted this review to determine whether Washington was in compliance with the new regulations for inpatient hospital services. This review is one in a series of Office of Inspector General reviews of States' Medicaid payments for inpatient hospital services related to PPCs.

Our objective was to determine whether the Washington State Health Care Authority (State agency) claimed Federal Medicaid reimbursement for inpatient hospital services related to treating certain PPCs.

BACKGROUND

PPCs can be identified on inpatient hospital claims through certain diagnosis codes. 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 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. These conditions include, among others, surgical site infections and foreign objects retained after surgery. Other PPCs are certain conditions identified in a State plan and must include, at a minimum, three specific conditions identified in Federal regulations.

For each diagnosis code on a claim, an inpatient hospital reports one of four present-on-admission indicator codes (POA codes). The POA code indicates that the condition was either present or not present when the patient was admitted as an inpatient to the hospital, the documentation in the patient's medical record was insufficient to determine whether the condition was present on admission, or the provider could not clinically determine whether the condition was present on admission.

The Patient Protection and Affordable Care Act (ACA) and Federal regulations prohibit Federal payments for health-care-acquired conditions. Federal regulations implementing the ACA authorize States to identify other PPCs for which Medicaid payments will also be prohibited. Both Federal and State 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. State regulations prohibit payment for the portion of a claim related to a PPC 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.

The Washington State plan prohibits payment for claims for inpatient hospital services with dates of admission on or after January 1, 2010, that contain PPCs and have POA codes indicating that (1) the condition was not present on admission or (2) the documentation in the patient's medical record was insufficient to determine whether the condition was present on admission.

From July 1, 2012, through December 31, 2013 (audit period), the State agency claimed $935.6 million ($468.5 million Federal share) for inpatient hospital services.

WHAT WE FOUND

The State agency claimed Federal Medicaid reimbursement for inpatient hospital services related to treating certain PPCs. For our audit period, we identified 463 claims totaling $18,269,139 ($10,842,919 Federal share) that contained PPCs 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.

Although Federal and State regulations prohibited the State agency from paying for services related to PPCs, and the State agency would no longer pay for inpatient hospital services related to PPCs as of January 1, 2010, under its State plan, the State agency did not have policies and procedures to determine whether payments should have been adjusted for claims containing PPCs that had certain POA codes or were missing POA codes. As a result, the State agency did not determine the unallowable portion of the $18,269,139 ($10,842,919 Federal share) that was for services related to treating PPCs and should not have been claimed for Federal Medicaid reimbursement. Therefore, we have set aside this amount for resolution by the Centers for Medicare & Medicaid Services (CMS) and the State agency.

During our audit, the State agency developed a written policy to conduct a retrospective clinical review of the care and treatment related to conditions that are deemed preventable and not present on admission. The State agency also developed a written procedure to analyze hospitals' paid claim data quarterly to determine whether PPCs affect payment and to select claims for clinical review. Both the policy and procedure had a retroactive effective date of July 1, 2013. Because they were in draft form during our audit and the State agency had not completed its initial retrospective clinical review, we did not analyze the policy and procedure to determine whether they were effective in prohibiting unallowable payments for inpatient hospital services related to PPCs.

WHAT WE RECOMMEND

We recommend that the State agency:

- work with CMS to determine what portion of the $10,842,919 Federal share claimed was unallowable for Federal Medicaid reimbursement and refund to the Federal Government the unallowable amount;

- review all paid claims before our audit period for inpatient hospital services with dates of admission from January 1, 2010, through June 30, 2012, to determine whether payments should be adjusted for any claims that contained PPCs and:

    - a POA code indicating that the condition was not present on admission,

    - 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

    - no POA code;

- refund to the Federal Government its share of any unallowable amounts for those paid claims reviewed; and

- ensure that its policy and procedure requiring a retrospective clinical review are fully implemented and effective in prohibiting unallowable payments for inpatient hospital services related to PPCs.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency said that it disagreed with the title of the report and our conclusion that it inappropriately paid $18,269,139 for treating PPCs. It stated that the portion of a claim not related to a PPC is allowable and that we identified and reported costs of the entire claim, not the costs applicable directly to the PPC. The State agency concurred that all the claims we identified had a PPC code but did not concur that all of the claims potentially included unallowable costs.

The State agency concurred with our first recommendation, stating that unallowable costs should be refunded to the Federal Government and that it would work with CMS to identify and refund those costs. The State agency did not concur with our second recommendation because of concerns about applying rules retroactively. The State agency concurred with our third and fourth recommendations and described corrective actions that it had taken to address our recommendations.

After reviewing the State agency's comments, we revised the title of the report and the summary at the beginning of the report to clarify that only a portion of the $10.8 million that the State agency claimed in Federal reimbursement would be unallowable. Because the State agency had not implemented policies and procedures to identify the unallowable portion of a claim containing services related to treating PPCs, we set aside the entire claim amount to allow CMS and the State agency to determine what portion of the amount is attributable to PPCs and therefore unallowable. We maintain that our finding and 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.[1] We conducted this review to determine whether Washington was in compliance with the new regulations for inpatient hospital services. This review is one in a series of Office of Inspector General reviews of States' Medicaid payments for inpatient hospital services related to PPCs.

OBJECTIVE

Our objective was to determine whether the Washington State Health Care Authority (State agency) claimed Federal Medicaid reimbursement 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). During our audit period, Washington State's FMAP ranged from 50 percent to 65 percent.

Provider-Preventable Conditions

PPCs can be identified on inpatient hospital claims through certain diagnosis codes.[2] 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 a health care 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

[1] 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.

[2] 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 (ICD-9-CM).

§ 1886(d)(4)(D)(iv)). These conditions include, among others, surgical site infections and foreign objects retained after surgery. Other PPCs are certain conditions identified in a 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 report one of four present-on-admission indicator codes (POA codes), described in the table below.

Table: The Four Present-on-Admission Indicator Codes

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

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. Federal regulations authorize States to identify other PPCs for which Medicaid payments will also be prohibited. Both Federal and State 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. State regulations prohibit payment for the portion of a claim attributable to a PPC 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.

The Washington State plan prohibits payment for claims for inpatient hospital services with dates of admission on and after January 1, 2010, that contain PPCs[5] and have POA codes

[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.

[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] Before 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.

indicating that (1) the condition was not present on admission or (2) the documentation in the patient's medical record was insufficient to determine whether the condition was present on admission.

HOW WE CONDUCTED THIS REVIEW

From July 1, 2012, through December 31, 2013 (audit period), the State agency claimed $935,592,715 ($468,548,459 Federal share) for inpatient hospital services. We reviewed the Medicaid paid claim data for these services to identify claims that contained at least one secondary diagnosis code[6] 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.

FINDING

The State agency claimed Federal Medicaid reimbursement for inpatient hospital services related to treating certain PPCs. For our audit period, we identified 463 claims totaling $18,269,139 ($10,842,919 Federal share) that contained PPCs 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.

The State agency did not have policies and procedures to determine whether payments should have been adjusted for claims containing PPCs that had certain POA codes or were missing POA codes. As a result, the State agency did not determine the unallowable portion of the $18,269,139 ($10,842,919 Federal share) that was for services related to treating PPCs and should not have been claimed for Federal Medicaid reimbursement. Therefore, we have set aside this amount for resolution by CMS and the State agency.

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 and State regulations do not deny payment for an entire claim that contains a PPC but instead limit the reduction of the payment to the amount attributable to the PPC that causes an increase in payment and that can be reasonably

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

isolated (42 CFR § 447.26(c)(3) and Washington Administrative Code (WAC) § 182-502-0022(8)(b), respectively). Further, State regulations provide that payments made to inpatient hospitals for care related to the treatment of the consequences of a health-care-acquired condition or other PPC will be denied or recovered (WAC §§ 182-502-0022(4) and (5)).

Hospitals are required to report PPCs using the appropriately designated POA codes (WAC §§ 182-502-0022(6)(a) and (c)). A reduction in payment will occur for health care services attributable to a PPC that is coded with the POA codes "N" or "U" (WAC § 182-502-0022(8)(c)). Failure to report a POA code for any diagnosis (i.e., leaving the POA code field blank) will result in the loss or denial of payment (WAC § 182-502-0022(6)(f)).

Portions of the claim for inpatient hospital services that contain hospital-acquired conditions or adverse events (i.e., PPCs) with dates of admission on or after January 1, 2010, are not eligible for Medicaid reimbursement under the Washington State plan. Specifically, the State agency does not make additional payments for hospital-acquired conditions (i.e., health-care-acquired conditions) and does not make payments for adverse events (i.e., other PPCs) that are coded with POA codes "N" or "U" (State Plan Amendment 10-005, Attachment 4.19-A, § C, and WAC § 182-502-0022(8)(c))).

THE STATE AGENCY CLAIMED FEDERAL MEDICAID REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES RELATED TO TREATING CERTAIN PROVIDER-PREVENTABLE CONDITIONS

The State agency claimed $18,269,139 ($10,842,919 Federal share) for Medicaid inpatient hospital services related to treating certain PPCs. The claimed amount represented 463 claims that contained PPCs, consisting of:

- 291 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

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

Although Federal and State regulations prohibited the State agency from paying for services related to PPCs, and the State agency would no longer pay for inpatient hospital services related to PPCs as of January 1, 2010, under its State plan, the State agency did not have policies and procedures to determine whether payments should have been adjusted for claims containing PPCs that had certain POA codes or were missing POA codes. As a result, the State agency did not determine the unallowable portion of the $18,269,139 ($10,842,919 Federal share) that was for services related to treating PPCs and should not have been claimed for Federal Medicaid reimbursement. Therefore, we have set aside this amount for resolution by CMS and the State agency.

During our audit, the State agency developed a written policy to conduct a retrospective clinical review of the care and treatment related to conditions that are deemed preventable and not

present on admission. The State agency also developed a written procedure to analyze hospitals' paid claim data quarterly to determine whether PPCs affect payment and to select claims for clinical review. Both the policy and procedure had a retroactive effective date of July 1, 2013. Because they were in draft form during our audit and the State agency had not completed its initial retrospective clinical review, we did not analyze the policy and procedure to determine whether they were effective in prohibiting unallowable payments for inpatient hospital services related to PPCs.

RECOMMENDATIONS

We recommend that the State agency:

- work with CMS to determine what portion of the $10,842,919 Federal share claimed was unallowable for Federal Medicaid reimbursement and refund to the Federal Government the unallowable amount;

- review all paid claims before our audit period for inpatient hospital services with dates of admission from January 1, 2010, through June 30, 2012, to determine whether payments should be adjusted for any claims that contained PPCs and:

    - a POA code indicating that the condition was not present on admission,

    - 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

    - no POA code;

- refund to the Federal Government its share of any unallowable amounts for those paid claims reviewed; and

- ensure that its policy and procedure requiring a retrospective clinical review are fully implemented and effective in prohibiting unallowable payments for inpatient hospital services related to PPCs.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency said that it disagreed with the title of the report and our conclusion that it inappropriately paid $18,269,139 for treating PPCs. It stated that the portion of a claim not related to a PPC is allowable and that we identified and reported costs of the entire claim, not the costs applicable directly to the PPC.

The State agency concurred that all the claims we identified had a PPC code but did not concur that all of the claims potentially included unallowable costs. It identified three categories of claims that it stated "have no indicators of unallowable costs":

- The State agency identified 170 claims totaling $8,723,348 that were for services provided at hospitals that it stated were exempt from POA coding requirements according to CMS guidelines.

- The State agency identified and provided us with additional documentation for 151 claims totaling $438,205 that were paid on behalf of dual-eligible clients for which Medicaid pays only the copay. Referring to State and Federal rules, the State agency commented that because the cost of the PPC cannot be reasonably isolated from the copay, "it is not feasible to deny those copay claims."

- The State agency identified and provided us with additional documentation for 103 claims totaling $2,144,473 for which the State agency indicated the diagnosis-related group (DRG) was unrelated to a health-care-acquired condition. It stated that the DRG was not a complication or comorbidity or a major complication or comorbidity, thus indicating that the health-care-acquired condition did not result in increased costs.

The State agency concurred with our first recommendation, stating that unallowable costs should be refunded to the Federal Government and that it would work with CMS to identify and refund those costs.

Regarding our second recommendation, the State agency commented that this recommendation applied to $7,565,543 paid for services provided before July 1, 2012, "when the new law took effect." It did not concur with our recommendation because of concerns about applying rules retroactively. The State agency said that before July 1, 2012, it complied with State regulations to identify potential PPCs.

The State agency concurred with our third and fourth recommendations and described corrective actions that it had taken to address our recommendations.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we revised the title of the report and the summary at the beginning of the report to clarify that only a portion of the $10.8 million that the State agency claimed in Federal reimbursement would be unallowable. Because the State agency had not implemented policies and procedures to identify the unallowable portion of a claim containing services related to treating PPCs, we set aside the entire claim amount to allow CMS and the State agency to determine what portion of the amount is attributable to PPCs and therefore unallowable. We maintain that our finding and recommendations are valid:

- Regarding the 170 claims for services the State agency claimed were provided at exempt hospitals, the State agency referenced a CMS Medicare Learning Network guidance document that is not applicable to Medicaid. A Federal regulation specifies that a health-care-acquired condition means a condition occurring in *any inpatient hospital* setting (emphasis added) (42 CFR § 447.26(b)). Moreover, CMS stated in its Final Rule

implementing 42 CFR § 447.26 that the ACA requires that hospital-acquired conditions identified under the Medicare inpatient prospective payment system are "applicable to all entities that operate as Medicaid inpatient hospitals." The Final Rule further stated: "We do not have the authority to exempt any Medicaid inpatient hospital providers from these requirements" (76 Fed. Reg. 32815, 32822 (June 6, 2011)).

- Regarding the 151 claims paid on behalf of dual-eligible beneficiaries, CMS specifically addressed its intent regarding dual-eligible beneficiaries, stating that no payment would be available under Medicaid for an identified hospital-acquired condition (76 Fed. Reg. 32815, 32826 (June 6, 2011)). CMS revised the final regulation to reflect that no Federal reimbursement is available for a Medicare-denied claim on the basis of the presence of a hospital-acquired condition. Thus, 42 CFR § 447.26(c)(1) specifies: "A State plan must provide that no medical assistance will be paid for [PPCs] as defined in this section; and as applicable for individuals dually eligible for both the Medicare and Medicaid programs." For claims denied under Medicare that are related to hospital-acquired conditions for dual-eligible beneficiaries, the State plan specifies that the State does not pay the claim, any Medicare deductible, or any coinsurance related to the inpatient hospital services (State Plan Amendment 10-005, Attachment 4.19-A, § C).

- Regarding the 103 claims that the State agency indicated were unrelated to a health-care-acquired condition, CMS regulations prohibit the portion of payment attributable to a hospital-acquired condition (42 CFR 447.26(c). This prohibition includes hospital-acquired conditions that cause assignment to a higher paying DRG, not just DRGs with a complication or comorbidity. Specifically, CMS stated that for a condition to be a hospital-acquired condition, the condition is required to result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis (76 Fed. Reg. 32815, 32817 (June 6, 2011)). Additionally, the State agency subsequently said that it had not reprocessed the 103 claims to determine whether the services related to treating the PPCs increased costs.

Regarding our second recommendation, the State agency electively entered into an agreement with CMS through submission and approval of State Plan Amendment 10-005, Attachment 4.19-A, § C, effective January 1, 2010, to prohibit payment for inpatient hospital services related to hospital-acquired conditions or adverse events (i.e., PPCs) with dates of admission on or after January 1, 2010. Therefore, we continue to recommend that the State agency review all paid claims before our audit period for inpatient hospital services with dates of admission from January 1, 2010, through June 30, 2012, to determine whether payments should be adjusted.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From July 1, 2012, through December 31, 2013, the State agency claimed $935,592,715 ($468,548,459 Federal share) for inpatient hospital services. We reviewed the Medicaid paid claim data for these services to identify 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 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 (i.e., the POA code was missing). 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 or the Medicaid program. Rather, we reviewed only those internal controls related to our objective.

We conducted our audit from February 2014 through November 2015 and performed fieldwork at the State agency's office in Olympia, Washington.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance and the State plan;
- held discussions with CMS officials to gain an understanding of (1) inpatient hospital services and the processing of inpatient hospital claims and (2) CMS guidance furnished to the State agency concerning payments for PPCs;
- held discussions with State agency officials to gain an understanding of inpatient hospital services and PPCs and any action taken (or planned) by the State agency to identify and prevent payment of services related to treating PPCs;
- reviewed the State agency's internal controls over the accumulation, processing, and reporting of inpatient hospital service expenditures and PPCs;
- obtained a claim database containing inpatient hospital service expenditures from the State agency's Medicaid Management Information System for claims paid during the audit period;
- reconciled the inpatient hospital service expenditures claimed by the State agency on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64) with supporting schedules and the claim database;

- reviewed the claim data to identify claims that contained PPCs and had the POA codes "N" or "U" or did not have a POA code reported; 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: STATE AGENCY COMMENTS

STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

May 10, 2016

Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Audit Services, Region X
Office of Inspector General
Department of Health and Human Services
90 7th Street, Suite 3-650
San Francisco, CA 94103

Dear Ms. Ahlstrand:

SUBJECT: Report Number: A-09-14-02012

The Washington State Health Care Authority (HCA) welcomes the opportunity to provide comments on the recommendations contained in draft report A-09-14-02102 entitled *Washington State Claimed Millions in Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions*. We appreciate the work of the Office of Inspector General (OIG) on this matter.

HCA does not agree with the report title or with the conclusion that HCA inappropriately paid $18,269,139 for treating provider-preventable conditions (PPCs). The premise of this statement is that all costs of a claim with a PPC code are unallowable. However, as stated in the report itself, "State regulations prohibit payment for *the portion of a claim related to a PPC* . . ." (emphasis added). The portion of the claim not related to a PPC is allowable. If, for example, a patient slips and falls while in a hospital recovering from surgery, costs related to the surgery are fully reimbursable; only costs directly attributable to the fall are not reimbursable. The OIG has identified and reported costs of the entire claim, not the costs applicable directly to the PPC, thus leading to the misleading title that Washington State inappropriately claimed millions in reimbursement for PPCs.

HCA concurs that all the claims identified by the OIG have a PPC code, but does not concur that all the claims potentially include unallowable costs. HCA has reviewed the claims data and identified three categories of claims which have no indicators of unallowable costs:

- Washington Administrative Code 182-502-0022(4)(b) states, "The POA [present-on-admission] indicator is to be used according to the official coding guidelines for coding and reporting *and the CMS guidelines*." (emphasis added). CMS guidelines allow for certain instances when a POA indicator is not necessary; in particular, for services provided at hospitals which are exempt. See 42 CFR 412 and *Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision* fact sheet at https://www.cms.gov/Outreach-and-Education/Medicare-

Learning-Network-MLN/MLNProducts/downloads/wPOAFactSheet.pdf. One hundred seventy claims totaling $8,723,348 that are included in this report were for services provided at hospitals exempt from the POA coding requirements and not required to have POA codes.

- Both state and federal rule require payment denial only when costs directly related to the PPC can be reasonably isolated. One hundred fifty-one claims totaling $438,205 were paid on behalf of dual-eligible clients. In those instances, Medicaid pays only the copay. Since the cost of the PPC cannot be reasonably isolated from the copay, it is not feasible to deny those copay claims.

- One hundred three claims totaling $2,144,473 were for claims where the Diagnosis Related Grouping (DRG) was unrelated to health care acquired condition (HCAC) and the DRG is not a complication or comorbidity or a major complication or comorbidity, thus indicating that the HCAC did not result in increased costs.

As requested in your letter dated March 23, 2016, HCA is providing a statement of concurrence or non-concurrence for each of the recommendations contained in the draft report.

Recommendation 1: *Work with CMS to determine what portion of the $10,842,919 federal share claimed was unallowable for federal Medicaid reimbursement and refund to the Federal Government the unallowable amount.*

HCA concurs that unallowable costs should be refunded to the Federal Government and will work with CMS to identify and refund unallowable costs.

Recommendation 2: *Review all paid claims before our audit period for inpatient hospital services with dates of admission from January 1, 2011, through June 30,2102, to determine whether payments should be adjusted for any claims that contained PPC's and (a) a POA code indicating that the condition was not present on admission, (b) 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 (c) no POA code.*

This recommendation applies to $7,565,543 paid for services provided prior to July 1, 2012, when the new law took effect. HCA does not concur with this recommendation due to concerns about applying rules retroactively.

Prior to July 1, 2012, Washington Administrative Code 182-502-0022 (7) stated the agency may identify PPCs:

- Through the department of health (DOH); or
- Through the agency's program integrity efforts, including:
  - The agency's claims payment system;
  - Retrospective hospital utilization review process;
  - The agency's provider payment review process
  - The agency's provider audit process; and
  - A provider or client complaint.

HCA complied with these state regulations to identify potential PPCs.

Recommendation 3: *Refund to the Federal Government its share of any unallowable amounts for those paid claims reviewed.*

HCA concurs that unallowable costs should be refunded to the Federal Government and is investigating claims identified through algorithms which have indicators of cost possibly attributable to PPCs. To date, HCA has recouped $90,902 and refunded the appropriate share to the Federal Government.

Recommendation 4: *Ensure that its policy and procedure requiring a retrospective clinical review are fully implemented and effective in prohibiting unallowable payments for services related to PPCs.*

HCA concurs with this recommendation. Since January 2014 HCA has fully implemented automated algorithms to identify and recoup unallowable payments.

HCA would like to point out that providers are required to report PPC regardless of whether the PPC resulted in additional costs to the claim. The fact that so many claims include PPC codes when there are no related costs speaks to the effectiveness of the reporting structure in Washington State.

Should you have any questions or concerns, please contact Kathy E. Smith, Audit and Accountability Manager, by telephone at 360-725-0937 or via email at kathy.smith2@hca.wa.gov.

Sincerely,

/Dorothy Teeter/

Dorothy F. Teeter, MHA
Director

/MaryAnne Lindeblad/

MaryAnne Lindeblad, BSN, MPH
Medicaid Director

By certified mail
By email

cc: Kathy E. Smith, Audit and Accountability Manager, EXO, HCA
Lisa DeLaVergne, Section of Program Integrity Manager, MPOI, HCA