Memorandum

Date JUL 18 2000

From for June Gibbs Brown
Inspector General

Subject Review of HMO Payments - Beneficiaries on Dialysis (A-14-98-00211)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached is our final report entitled, "Review of HMO Payments - Beneficiaries on Dialysis." This review is an addendum to two previous Office of Inspector General audits on the end stage renal disease (ESRD) classification of Medicare beneficiaries enrolled in risk-based managed care organizations (MCO) [see our reports, *"Review of Medicare Payments to Health Maintenance Organizations for End Stage Renal Disease Beneficiaries" (A-04-94-01090)* issued February 1996, and *"Systems and Overpayment Issues: End Stage Renal Disease Payments to Health Maintenance Organizations" (A-14-96-00203)* issued June 1997]. As part of our overall plan to evaluate MCO activities, we performed a limited review of the Health Care Financing Administration's (HCFA) tracking of the health status of the MCO population of beneficiaries classified as having ESRD. Specifically, we reviewed the effectiveness of HCFA's corrective plan to prevent erroneous classifications of the ESRD status of beneficiaries enrolled in MCOs.

Starting January 1, 2000, the Balanced Budget Act (BBA) of 1997 modified the payment methodology for MCOs. The BBA of 1997 required HCFA to implement a risk-adjusted payment methodology that accounts for the variations in per capita cost based on health status for all Medicare beneficiaries enrolled in MCOs. For Calendar Year 2000, the risk adjustment will be based on diagnostic data related to the inpatient hospital stays of Medicare MCO members. Additional data related to other medical services will be included as soon as HCFA finalizes and implements collection methods.

Prior to BBA of 1997, HCFA adjusted the monthly payments to MCOs by a set of risk factors such as age and gender. The rate was then increased for certain high-cost categories of beneficiaries. Medicare beneficiaries who are classified as having ESRD are included in these special status categories. A person is classified as having ESRD when that person is medically determined to have a kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. Monthly payment rates for ESRD classified beneficiaries are approximately seven times greater than the regular non-ESRD payment rate.

Our review showed that HCFA's systems improvements which were implemented to facilitate investigation and termination of ESRD eligibility, that will be a risk adjustment factor, are not thorough. Based on our analysis of a limited number of beneficiary medical records and information obtained from HCFA's Renal Beneficiary and Utilization System (REBUS), we found that 14 of the 76 (18 percent) beneficiaries we reviewed were misclassified ESRD during 1997 resulting in $112,486 in gross payment errors. We found that 9 of the 76 beneficiaries' ESRD status was terminated prematurely and 5 of the 76 beneficiaries had no signs of renal failure.

We also found that census data which was supposed to be received by HCFA from the ESRD Networks was not completely recorded semiannually on the REBUS system. The data was recorded on the REBUS system semiannually for some beneficiaries and not at all for other beneficiaries we reviewed. In addition, we found that in certain cases, the census data received by HCFA was wrong. For instance, one beneficiary had recovered function and was no longer undergoing dialysis, however, the census data reported on the REBUS system showed the beneficiary still undergoing dialysis treatment.

The limited work we have performed to date raises concerns of the potential problems that may face HCFA as it transitions to risk adjustments for all MCO payments. As previously stated, BBA of 1997 requires Medicare to "risk adjust" payments to MCOs by basing the Medicare capitation amount on the health status of the MCO enrollees. About 6 million of Medicare's 40 million beneficiaries have chosen to enroll in MCOs. Risk adjustments will increase payments to plans for their sickest patients, and thus curtail the disincentive for plans to enroll these beneficiaries. It also will lower payments to plans for their healthier patients. We are concerned that since our work indicated there are still problems ensuring that payments are correct for the relatively small ESRD population, then conceivably problems may arise with the accuracy of payments when the health status of all beneficiaries enrolled in an MCO are used to calculate the Medicare payments.

We recommended that HCFA make procedural and systems changes to prevent further erroneous misclassifications of ESRD status and instruct all ESRD Networks to verify the status of beneficiaries and submit census data on a timely basis. Under separate cover, we provided HCFA the details on the 14 beneficiaries involved with erroneous payments so that corrective action could be taken.

In response to our draft report, HCFA agreed with all of our recommendations. Currently, HCFA has ESRD information management projects underway which are focused on improved business processes within the ESRD program and better data management. The HCFA is working with the ESRD networks in designing a new information system which will both standardize processes across the Networks and link the Networks electronically to HCFA systems. Also, HCFA is working with the ESRD Networks to ensure that census data is received and posted timely. The HCFA has resolved the erroneous payment

problems associated with 13 of the 14 beneficiaries outlined in the report and is currently working to resolve issues associated with the 14th beneficiary.

We believe that HCFA's procedural and systems improvements will help prevent further erroneous misclassifications of ESRD status. We look forward to working with HCFA in further analysis of managed care issues, particularly to ensure that the overall risk factors required by the BBA of 1997 are effectively implemented. This final report has been revised to reflect HCFA's technical comments.

Please advise us within 60 days on the status of any further action taken or planned on our recommendations. If you have any questions or need clarification on the report, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-14-98-00211 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HMO PAYMENTS - BENEFICIARIES ON DIALYSIS

JUNE GIBBS BROWN
Inspector General

JULY 2000
A-14-98-00211

Memorandum

Date JUL 18 2000

From Michael Mangano for June Gibbs Brown
Inspector General

Subject Review of HMO Payments - Beneficiaries on Dialysis (A-14-98-00211)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This final report provides you with the results of our continuing review of Medicare payments made to risk-based managed care organizations (MCO) on behalf of beneficiaries classified as having end stage renal disease (ESRD). The Health Care Financing Administration (HCFA) authorizes fixed monthly payments to MCOs for the services provided to enrolled Medicare beneficiaries. The payments are adjusted by a set of risk factors such as age and gender. The rate is then increased for certain high-cost categories of beneficiaries. Medicare beneficiaries who are classified as having ESRD are included in these special status categories. Monthly payment rates for ESRD classified beneficiaries are approximately seven times greater than the regular non-ESRD payment rate. The Balanced Budget Act (BBA) of 1997 requires Medicare to expand these "risk adjusted" type of payments to MCOs starting January 1, 2000. The limited review we performed on the ESRD payment adjustments raises concerns as to the potential problems that may arise as all MCO payments are subjected to risk adjustments.

OBJECTIVE

This review is an addendum to two previous Office of Inspector General audits on the ESRD classification of Medicare beneficiaries enrolled in risk-based MCOs (see our reports, *"Review of Medicare Payments to Health Maintenance Organizations for End Stage Renal Disease Beneficiaries" (A-04-94-01090)* issued February 1996, and *"Systems and Overpayment Issues: End Stage Renal Disease Payments to Health Maintenance Organizations" (A-14-96-00203)* issued June 1997). The objective of this limited review was to evaluate the effectiveness of HCFA's corrective plan to prevent erroneous classifications of the ESRD status of beneficiaries enrolled in MCOs.

SUMMARY OF FINDINGS

Our review showed that HCFA's systems improvements which were implemented to facilitate investigation and termination of ESRD eligibility, that will be a risk adjustment factor when the BBA of 1997 risk adjustment is implemented, are not thorough. Based on our analysis of a limited number of beneficiary medical records and

information obtained from HCFA's Renal Beneficiary and Utilization System (REBUS), we found that 14 of the 76 (18 percent) beneficiaries reviewed were ESRD misclassified during 1997 resulting in payment errors of $112,486:

- 9 of the 14 beneficiaries' ESRD status was terminated prematurely resulting in underpayments of $57,497, and
- 5 of the 14 beneficiaries had no signs of renal failure resulting in overpayments of $54,989.

We also found that census data which was supposed to be received by HCFA from the ESRD Networks was not completely recorded semiannually on the REBUS system as planned. We determined that the misclassifications of Medicare ESRD beneficiaries in our review were part of a HCFA systems problem. The HCFA's systems improvements which were implemented to facilitate investigation and termination of ESRD eligibility were not thorough.

The limited work we have performed to date raised concerns of the potential problems that HCFA may face as it transitions to risk adjustments for MCO payments. As previously stated, the BBA of 1997 requires Medicare to "risk adjust" payments to MCOs, starting January 1, 2000. That means payments to MCOs will be based on the health status of their enrollees. About 6 million of Medicare's 40 million beneficiaries have chosen to enroll in MCOs. Risk adjustments will increase payments to plans for their sickest patients, and thus curtail the disincentive for plans to enroll these beneficiaries. It also will lower payments to plans for their healthier patients. We are concerned that since our work indicated there are still problems ensuring that the payments are correct for the relatively small ESRD population, then conceivably problems may arise with accuracy of payments when the health status of all beneficiaries enrolled in an MCO are used to calculate the Medicare payments.

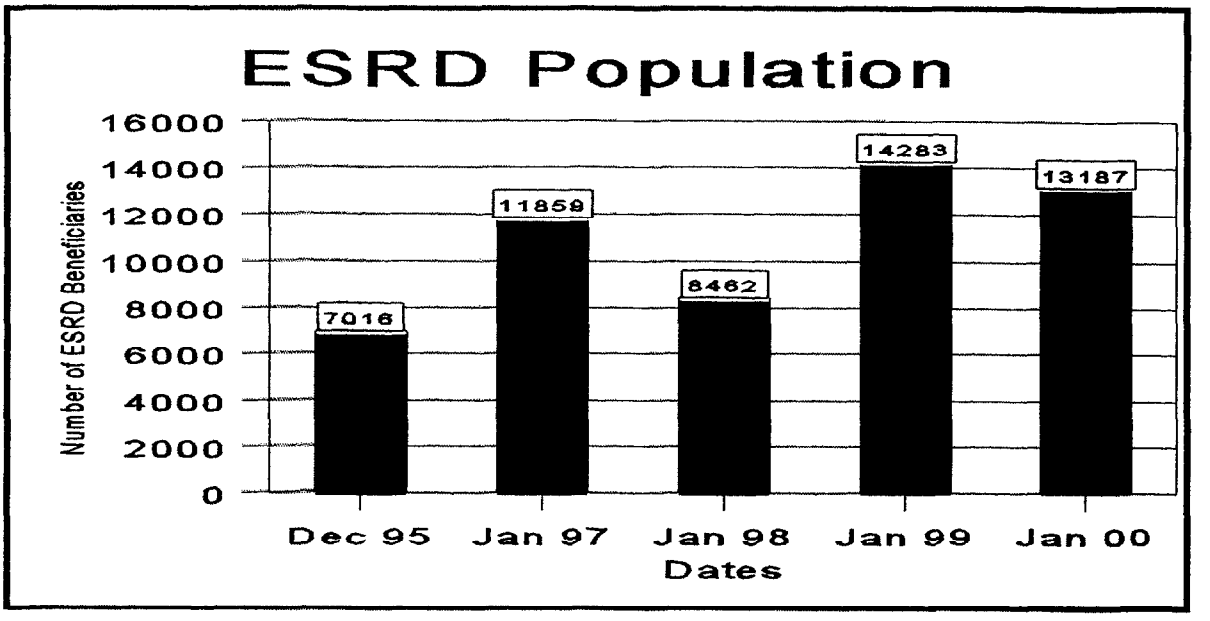
We recommended that HCFA make procedural and systems changes to prevent further erroneous misclassifications of ESRD status and instruct all ESRD Networks to verify the status of beneficiaries and submit census data on a timely basis. Under separate cover, we provided HCFA the details on the 14 beneficiaries involved with erroneous payments so that corrective action could be taken.

BACKGROUND

Under the Medicare managed care risk program, HCFA contracts with MCOs to provide comprehensive health services on a prepayment capitated basis to enrolled beneficiaries. For each enrolled beneficiary, HCFA authorizes a fixed monthly payment which is adjusted by a set of risk factors such as the beneficiary's age and gender. An enhanced payment rate is made for certain high-cost categories of beneficiaries, such as those having ESRD. A monthly capitation rate is established for Part A and Part B on a county by county level except for the ESRD rate

which is established on a State level. Each month, HCFA provides MCOs with a special status report which identifies beneficiaries for whom the MCO received an enhanced ESRD payment amount.

The graph below shows MCO ESRD population trends of the past 4 years[1].



Monthly payment rates for ESRD classified beneficiaries are approximately seven times greater than the regular non-ESRD payment rate. For instance, during 1999, HCFA's capitation rate for regular Medicare beneficiaries averaged approximately $460 per month. However, for ESRD beneficiaries, HCFA's capitation rate averaged approximately $3,393 per month. The ESRD enhanced payment rate results in an additional payment of approximately $2,933 above the payment rate for regular non-ESRD Medicare beneficiaries. In January 1999, there were 14,283 Medicare beneficiaries classified as ESRD. With an average enhanced payment of $3,393 per beneficiary, total capitation payments for ESRD beneficiaries were approximately $48.5 million. Of this $48.5 million in capitation payments, $41.9 million accounts for the additional payment for ESRD beneficiaries.

The following table details the trend of monthly average capitation payments[2] and additional payments for ESRD beneficiaries.

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[1]Beneficiaries identified with an ESRD indicator in the GHP system.

[2]Average monthly capitation payments based on 95 percent of United States per capita costs (USPCC's).

Month/Year	ESRD Beneficiaries	Average Monthly Non-ESRD Capitation Rate	Average Monthly ESRD Capitation Rate	Average Incremental Increase for ESRD	Approximate Annualized[3] Additional ESRD Payments
December 1995	7,016	$380	$3,491	$3,111	$262 million
January 1997	11,859	$444	$3,668	$3,224	$459 million
January 1998	8,462	$449	$3,072	$2,623	$266 million
January 1999	14,283	$460	$3,393	$2,933	$503 million
January 2000	13,187	$480	$3,676	$3,196	$506 million

A person is classified as having ESRD when that person is medically determined to have a kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. Federal regulations prohibit Medicare beneficiaries who have been medically diagnosed as having ESRD from enrolling in MCOs. However, beneficiaries who develop ESRD after enrollment may remain enrolled.

In February 1996, the Office of Inspector General issued a report *"Review of Medicare Payments to Health Maintenance Organizations for End Stage Renal Disease Beneficiaries"(A-04-94-01090)*. In that review we found a weakness in HCFA's systems which caused the system not to recognize ESRD termination dates for beneficiaries enrolled in MCOs. As a result, the system triggered the higher ESRD capitation rate to plans rather than the regular capitation rate even if the beneficiary was no longer diagnosed as having ESRD. In this review, we found that risk-based plans received approximately $35.7 million in improper payments on behalf of beneficiaries who were erroneously classified as having ESRD. We recommended that HCFA make procedural and systems changes to prevent further erroneous classifications of ESRD status and overpayments due to such misclassifications. The HCFA concurred with our recommendation and as part of their corrective action plan, proposed procedural and system changes to prevent further erroneous classifications of ESRD status and overpayments.

[3]Based on these beneficiaries remaining in the MCO, and no payment changes for age.

In June 1997, we issued a report *"Systems and Overpayment Issues: End Stage Renal Disease Payments to Health Maintenance Organizations" (A-14-96-00203).* In that review we found that HCFA's systems had been modified to maintain a more complete history of ESRD information and, effective October 1996, HCFA implemented systems changes to adjust payments to MCOs when a beneficiary's ESRD entitlement ends.

As part of a systems modification project, HCFA enhanced it's Program Management and Medical Information System (PMMIS). The PMMIS is used as a centralized source for identifying periods of ESRD entitlement and for posting the entitlement periods to the Enrollment Database.

The HCFA implemented the REBUS which is an automated interactive database of ESRD patient and provider information. It is used by HCFA and the renal community to perform the duties and responsibilities of monitoring the Medicare status, transplant activities, dialysis activities, and Medicare utilization of ESRD patients and their Medicare providers. The REBUS was developed to provide a centralized database for HCFA ESRD data and to facilitate generating reports and editing this data. The REBUS serves as the primary access mechanism for the PMMIS.

In addition, a process was created to enhance HCFA's ability to know who in the Medicare ESRD population is no longer eligible for Medicare based on the ESRD coverage provisions. Each month, a report is produced and forwarded to each ESRD Network which identifies every Medicare beneficiary with a potential ESRD coverage termination 4 months in the future based on the lack of information about chronic dialysis service. The ESRD Networks have agreed to investigate the current status of everyone HCFA identifies as close to ESRD coverage termination. On a semiannual basis, census data containing current status information on the beneficiary is sent by the ESRD Networks to HCFA.

SCOPE

The objective of our review was to determine the effectiveness of HCFA's corrective actions to prevent MCOs being paid incorrectly because of erroneously identified ESRD classified beneficiaries.

From HCFA's Group Health Plan System (GHP) which records managed care information for Medicare beneficiaries, we identified those beneficiaries classified as ESRD[4] from January 1997 to February 1998. We only included in our universe those beneficiaries who were still enrolled in a risk-based MCO (from January 1997 to February 1998) and did not receive a kidney transplant during 1997 (ESRD is a lifetime condition unless a beneficiary receives a kidney transplant). Since we wanted to determine the effectiveness of the ESRD data gathering process for MCO beneficiaries, we concentrated our review on those

[4]Beneficiaries identified with an ESRD indicator in the GHP system.

beneficiaries from January 1997 who were no longer classified as having ESRD in February 1998. We determined that 4,385 beneficiaries were no longer classified with ESRD.

From the population of 4,385, we removed 212 beneficiaries who had died. We then used HCFA's GHP system to determine which of the remaining 4,173 beneficiaries were currently enrolled in an MCO. We determined that 1,340 beneficiaries were no longer enrolled in an MCO and the remaining 2,833 beneficiaries were still enrolled in an MCO. We only included in our universe those beneficiaries who were enrolled in a risk-based MCO.

From the 2,833, we removed all records of those ESRD classified beneficiaries who had a transplant. We determined that 776 of the beneficiaries classified with ESRD received a transplant.

Using HCFA's McCoy system, we reviewed the records of the remaining 2,057 beneficiaries identified as having ESRD. We obtained the beneficiaries' history from the McCoy system to determine periods of ESRD classification, managed care plan enrollment data, as well as demographic information, such as the beneficiary's gender and date of birth.

We then utilized HCFA's REBUS system to verify periods of ESRD classification and determine the transplant and dialysis status of each beneficiary. To test the reliability of the REBUS information, we performed a review of ESRD eligibility at four MCOs throughout the country. We reviewed all associated cases at the four MCOs which related to the criteria above. We reviewed the MCO's records of the primary care physician, nephrologist, and dialysis center to verify ESRD status for 76 beneficiaries in our universe who were enrolled in these MCOs. We were unable to review eight beneficiaries' medical records because the MCO was unable to provide them to us.

Our audit was made in accordance with generally accepted government auditing standards. Our work was done at United Healthcare in Baltimore, Maryland; Humana of South Florida in Miramar, Florida; Pacificare of Arizona in Phoenix, Arizona; Aetna USHealthcare in Blue Bell, Pennsylvania; and at HCFA headquarters in Baltimore, Maryland.

DETAILED FINDINGS

Our limited scope review showed that HCFA's system improvements which were implemented to facilitate investigation and termination of ESRD eligibility, that will be a risk adjustment factor when BBA of 1997 is fully implemented, are not thorough. Based on our analysis of a limited number of beneficiary medical records and information obtained from HCFA's REBUS and McCoy systems, we found that 14 of the 76 (18 percent) beneficiaries were misclassified ESRD during 1997 resulting in payment

errors of $112,486. We found that 9 of the 76 beneficiaries' ESRD status was terminated prematurely and 5 of the 76 beneficiaries had no signs of renal failure.

CRITERIA - MEDICARE REGULATIONS

A person who has ESRD is entitled to Medicare benefits pursuant to section 226A of the Social Security Act. Federal regulations found at 42 CFR 406.13 define ESRD and specify when Medicare entitlement based on ESRD ends. The regulations define ESRD as the stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. The regulations state that entitlement ends with the end of the:

(1) 12th month after the month in which a course of dialysis ends, unless the individual receives a kidney transplant during that period or begins another regular course of dialysis: or;

(2) 36th month after the month in which the individual has received a kidney transplant, unless the individual receives another transplant or begins a regular course of dialysis during that period.

Once the entitlement ends, a beneficiary is no longer classified as having ESRD. When a beneficiary is no longer classified as having ESRD, the enhanced ESRD payment to the MCO on behalf of that beneficiary is no longer payable.

Regulations at 42 CFR 417.423(a) prohibit Medicare beneficiaries who have been medically diagnosed as having ESRD from enrolling in a MCO. An exception [42 CFR 417.432(e)(2)] exists for individuals who have ESRD and are commercial members of the MCO immediately prior to Medicare enrollment in the same plan. These ESRD individuals may remain in the MCO when they become eligible for Medicare. Medicare beneficiaries who develop ESRD after enrollment in the MCO may also remain enrolled.

CONDITION - MISCLASSIFIED ESRD BENEFICIARIES

Our review at Aetna USHealthcare, Humana, PacifiCare, and United Healthcare identified 14 beneficiaries who were misclassified ESRD. We determined that nine beneficiaries had their ESRD status terminated prematurely and five beneficiaries classified as ESRD showed no signs of renal failure.

After reviewing the information contained on REBUS and comparing this information to the medical records provided by the MCOs, we determined that, for 14 of the beneficiaries, the information did not match. The ESRD status for nine of these beneficiaries was terminated

even though medical records reviewed showed that these beneficiaries were still under the care of a nephrologist and were undergoing renal dialysis. During 1997, Medicare underpaid the MCOs $57,497 for these nine beneficiaries.

Medical records for the other five beneficiaries classified as ESRD showed they had not received any treatment for renal failure and should not have the ESRD classification. We determined that one of these five beneficiaries had their status incorrectly recorded as that of their spouse who was classified with ESRD. During 1997, Medicare overpaid the MCOs $54,989 for these five beneficiaries.

We also found that census data which is supposed to be received and recorded by HCFA on a semiannual basis was not recorded on REBUS for all beneficiaries. In addition, we found that in certain cases, the census data received and recorded by HCFA was incorrect. For example, one beneficiary had recovered kidney function and was no longer receiving renal dialysis according to their medical records. However, the census data reported in REBUS showed the beneficiary still undergoing hemodialysis.

CAUSE - SYSTEM IMPROVEMENTS NOT THOROUGH

We determined that the misclassifications of Medicare ESRD beneficiaries in our review were part of a HCFA systems problem. We found that HCFA's systems improvements which were implemented to facilitate investigation and termination of ESRD eligibility were not thorough.

EFFECT - INCORRECT INFORMATION IN HCFA'S REBUS SYSTEM

Due to the incomplete improvements of HCFA's systems, information contained in HCFA's REBUS system was incorrect.

This incorrect information can have an effect on the status of a Medicare beneficiary as well as the amount of the capitation payment that an MCO receives per month for the beneficiary. For instance, a Medicare beneficiary who is enrolled in a MCO and is incorrectly classified with ESRD status will be receiving an enhanced payment from HCFA on a monthly basis. This results in an overpayment to the MCO by HCFA. If the beneficiary has ESRD, but is not classified within HCFA's system as ESRD, the MCO will not receive the enhanced payment for the beneficiary and, therefore, will be underpaid by HCFA.

Implementing the BBA of 1997 requirement to risk adjust payments to MCOs starting January 1, 2000 will require HCFA to correctly record and manipulate large volumes of data, such as the ESRD designation, for all MCO enrolled beneficiaries. We are concerned that

our limited review highlights the potential problems that HCFA may face in transitioning to overall risk adjustments. We welcome the opportunity to work with HCFA to ensure the overall risk adjustment factors required by the BBA of 1997 are effectively implemented.

RECOMMENDATIONS

We recommended that HCFA:

- make procedural and systems changes to prevent further erroneous misclassifications of ESRD status,
- instruct all ESRD Networks to verify status of beneficiaries and to submit the census data on a timely basis, and
- take corrective payment action for the 14 beneficiaries we identified who were part of erroneous payments.

HCFA COMMENTS

The HCFA agreed with all of our recommendations. Currently, HCFA has ESRD information management projects underway which are focused on improved business processes within the ESRD program and better data management. The HCFA is working with the ESRD networks to design a new information system which would both standardize processes across the Networks and link the Networks electronically to HCFA systems. Also, HCFA is working with the ESRD Networks to ensure that census data is received and posted timely. The HCFA resolved the erroneous payment problems associated with 13 of the 14 beneficiaries outlined in the report and is currently working to resolve issues associated with the 14th beneficiary. The complete text of HCFA comments are included as an appendix to this report.

OIG RESPONSE

We believe that HCFA's procedural and systems improvements will help prevent further erroneous misclassifications of ESRD status. We look forward to working with HCFA in further analysis of managed care issues, particularly to ensure that the overall risk factors required by the BBA of 1997 are effectively implemented. This final report has been revised to reflect HCFA's technical comments.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Administrator
Washington, D.C. 20201

DATE: JUN - 9

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of HMO Payments - Beneficiaries on Dialysis" (A-14-98-00211)

Thank you for the opportunity to review the above-referenced report. The objective of the audit was to examine the appropriateness of Medicare payments made to risk-based managed care organizations for end-stage renal disease (ESRD) beneficiaries.

Since 1993, the Clinton Administration has done more than any previous administration to fight, waste, fraud, and abuse of the Medicare program. The result is a record series of successful investigations into fraud, as well as the creation of new management tools to identify improper payments to health care providers. Last year, the federal government recovered nearly $500 million as a result of health care prosecutions. Medicare has also reduced its improper payment rate sharply from 14 percent four years ago to less than 8 percent last year, and HCFA is committed to achieving further reductions in the future.

With the enactment of section 2991 of Public Law 92-603 (1972 Amendments to the Social Security Act), full Medicare coverage was extended to persons with ESRD, effective July 1, 1973. To be eligible for Medicare benefits, the patient must be currently or fully insured, or be eligible for social security benefits, or be the spouse or dependent child of such a person. Additionally, a physician must certify that the individual requires chronic dialysis or a kidney transplant to maintain life.

The Health Care Financing Administration (HCFA) is charged with the effective administration of Medicare benefits to eligible persons with end stage renal disease. Integral to the effective management of the ESRD program is the operation of a comprehensive database covering medical and demographic information for the Medicare ESRD population. This database, along with other ESRD program-related data, is contained within the ESRD Program Management and Medical Information System (PMMIS). This system, required by law, is designed to serve the needs of the Department of Health and Human Services in support of program analysis, policy development, and epidemiological research. The ESRD PMMIS includes information both on

Medicare and non-Medicare ESRD beneficiaries and on Medicare-approved ESRD hospitals and dialysis facilities.

The principal sources of beneficiary-specific information are ESRD Network Organizations, billing records and incidence-specific medical information forms that report onset of ESRD, characteristics and status of kidney transplant and dialysis, and cause of death for an ESRD beneficiary. The principle sources of hospital and facility information are Medicare certification approval notices and annual survey of these organizations.

Beyond your specific concerns regarding ESRD, your report raised concerns about potential problems that HCFA may encounter as it transitions to a risk-adjusted approach to payment for MCOs. We take our responsibility for collecting and verifying data (as part of the risk-adjusted initiative) very seriously, and have imposed a number of safeguards to ensure complete and accurate data, including the following:

1. HCFA monitors the volume of encounter data submitted by each M+C organization. Plans are provided with periodic updates that reflect the number of enrollees for that organization, as well as the number of discharges (unduplicated) that have been submitted for that plan. Plans that have a low volume of discharges are contacted concerning their data problems and approaches to address specific issues are discussed. HCFA staff also visits a small number of plans that submit a low volume of encounter data. The staff provides technical assistance to the plan in approaches for improving encounter data submissions.

2. Plans are required to attest to the validity and accuracy of encounter data. This requires that plans attest to the validity, accuracy, and completeness of the data used for payments. In addition, plans must attest that providers have submitted valid encounter data. This attestation is required on a yearly basis.

3. A reconciliation of payments to M+C organizations is conducted annually. The reconciliation helps to ensure that risk adjusted payments are based on the most accurate demographic data and encounter data. The reconciliation occurs approximately 6 months after the payment year is over. In conducting the reconciliation, encounter data submitted after the deadline for the previous year are gathered, and changes in beneficiary demographics (e.g., age, gender, Medicaid eligibility) are collected. Then, the risk adjustment factor for each person is recalculated and compared to the risk factor applied during the payment year. Payments are then reconciled (either upward or downward) for each person.

4. Encounter data are validated against medical records. The audit focuses on the accuracy and validity of the encounter data submitted by a plan. Medical records are obtained from hospitals; then, diagnostic and procedural coding information is compared to the content of the encounters submitted to HCFA. Early next year, we will begin to audit about 30,000 medical records based on encounters submitted for the 2000-payment year. We expect to audit encounter data on a yearly basis.

The Health Care Financing Administration (HCFA) concurs with OIG recommendations. Our specific comments are as follows:

OIG Recommendation
HCFA should make procedural and systems changes to prevent further erroneous misclassification of ESRD status.

HCFA Response
We concur. HCFA is aware of the misclassification errors, outlined in the report, and we have initiated significant efforts to address both the process and systems issues. Currently, HCFA has three ESRD information management projects underway which are focused on improved business processes within the ESRD program and better data management. They are as follows:

The Renal Management Information System (REMIS)/PMMIS will replace the existing Renal Beneficiary and Utilization System (REBUS) Program Management and Medical Information System (PMMIS). The new REMIS/PMMIS will incorporate the majority of the capabilities, interfaces and processes of the current REBUS/PMMIS; and will address the procedural and systems changes, identified in the OIG audit report. REMIS/PMMIS will not only correct functional deficiencies in REBUS, but also incorporate significant information technology improvements. It will improve data reporting, reliability, and validity among ESRD providers/facilities, Networks and HCFA.

The Standard Information Management System (SIMS) project will provide for improved electronic communication capabilities, data standardization and reporting contractual requirements to HCFA. Using SIMS the ESRD Networks will be able to send daily updates to HCFA as opposed to the current 30-day submission in REBUS. Through SIMS the Network will be able to maintain a system to track receipt of ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration, HCFA-2728 and the ESRD Death Notification, HCFA-2746 forms from the providers facilities. This will ensure timelier posting of ESRD data.

In addition, the Vital Information System to Improve Outcomes in Nephrology (VISION) project will require electronic reporting from all dialysis facilities. This will expedite the transmission of ESRD data from the Network to HCFA.

OIG Recommendation
HCFA should instruct all ESRD Networks to verify the status of the beneficiary and to submit the census data on a timely basis.

HCFA Response
We concur. It appears that some census and patient status data are not being reported to HCFA in a timely manner. This has caused the renal coverage of some beneficiaries to terminate prematurely and others to be incorrectly classified as ESRD. HCFA is working with the ESRD

Networks to ensure that census data is received and posted timely. HCFA has also worked with ESRD Networks to design a new information system that would both standardize processes across the Networks and link the Networks electronically to HCFA systems.

OIG Recommendation

HCFA should take corrective payment action for the 14 beneficiaries identified who were part of erroneous payment.

HCFA Response

We concur. HCFA has already resolved the erroneous payment problems associated with 13 out of the 14 beneficiaries outlined in the report. HCFA is currently working to resolve issues regarding the 14th beneficiary.

Attachment

The OIG provided a list of 14 beneficiaries who were identified by name, social security number, and date of birth. To preserve the privacy of these patients, we have listed them as beneficiary #1, #2, etc.

Beneficiary #1

Finding: The patient's ESRD coverage was terminated prematurely. HCFA's REBUS system shows that the beneficiary's coverage was terminated on December 31, 1997. Information found in the beneficiary's medical records shows that the beneficiary was still undergoing treatment for kidney failure in 1998.

Corrective Action: The last patient census data received from the ESRD Network on February 19, 1997, confirmed that the beneficiary's renal status as active through December 31, 1997. His Medicare renal coverage period terminated because of no indication of chronic dialysis for 12 months. The ESRD Network was contacted and confirmed the beneficiary's current renal status. Our records have been updated accordingly.

Beneficiary #2

Finding: The patient did not have renal failure. According to a letter from her physician, there is no history of any renal failure or kidney transplant. It was determined that her husband's medical records and hers were mixed up; her husband has ESRD.

Corrective Action: The Enrollment Data Base (EDB) synch/refresh process created a system's problem which caused a transposition of the husband's/wife's records. We have corrected and updated both records to reflect this change

Beneficiary #3

Finding: The patient showed no signs of renal failure. The patient was diagnosed with a tumor of the kidney but no renal failure.

Corrective Action: At present, we are unable to reconcile this beneficiary's records. Due to are multiple data discrepancies in the REBUS, EDB, and SSA records. We are investigating and will make the necessary corrections.

Beneficiary #4

Finding: The patient showed no signs of renal failure.

Corrective Action: The Enrollment Data Base (EDB) synch/refresh process created a system problem which caused a transposition of two beneficiaries' REBUS records. We have corrected and updated both records to reflect this change.

Beneficiary #5

Finding: The patient showed no signs of renal failure.

Corrective Action: The Enrollment Data Base (EDB) synch/refresh process created a system problem which caused a transposition of two beneficiaries' REBUS records. We have corrected and updated both records to reflect this change.

Beneficiary #6

Finding: The patient's coverage was terminated prematurely. According to her medical records, the patient was undergoing dialysis in December 1997. HCFA's REBUS shows that the patient's ESRD status was ended in December 1997.

Corrective Action: A gap in the patient status record caused her renal coverage periods to terminate erroneously Her records have been updated to reflect her current renal status.

Beneficiary #7

Finding: The patient did not have kidney failure. There were no medical records to support that the beneficiary was diagnosed with kidney failure.

Corrective Action: According to the ESRD Network, this beneficiary discontinued dialysis on February 7, 1996. His Medicare renal coverage period terminated on December 31, 1996 based on the last patient census data from the ESRD Network on December 31, 1995. Our records show that the beneficiary died on June 22, 1999. We have updated our records accordingly.

Beneficiary #8

Finding: The patient was still undergoing dialysis treatment three times per week until his death in August 1998. According to HCFA's REBUS system, the beneficiary's ESRD coverage was ended in June 1997. Her medical records indicate that she was still on dialysis at this time receiving treatment for kidney failure.

Corrective Action: A gap in the beneficiary's status record caused his renal coverage periods to terminate erroneously. Our records show that he died on August 15, 1998. We have updated our records accordingly.

Beneficiary #9

Finding: The patient is still undergoing dialysis treatment three times per week for kidney failure as of November 1997 and his ESRD status was terminated prematurely. According to HCFA's REBUS system, the beneficiary's ESRD coverage was ended December 31, 1997.

Corrective Action: A gap in the patient status record caused his renal coverage period to terminate erroneously. Our records show that the beneficiary died on September 29, 1998. We have updated our records accordingly.

Beneficiary #10

Finding: The patient was still undergoing dialysis treatments three times per week for kidney failure as of August 1997. According to HCFA's REBUS system, the beneficiary's ESRD coverage was terminated in December 1997. We determined that the beneficiary's ESRD coverage was terminated prematurely by HCFA.

Corrective Action: A gap in the patient status record caused his renal coverage period to terminate erroneously. Our records show that the beneficiary died on March 11, 1999. We have updated our records accordingly

Beneficiary #11

Finding: The patient's ESRD coverage was terminated prematurely. According to medical records, the patient was still undergoing dialysis treatment in December 1997. HCFA's REBUS system shows that the beneficiary's ESRD status was ended on December 31, 1997.

Corrective Action: A gap in the patient status record caused his renal coverage period to terminate erroneously. Our records show that the beneficiary died on August 7, 1999. We have updated our records accordingly.

Beneficiary #12

Finding: The patient's ESRD coverage was terminated prematurely. According to medical records, the beneficiary was still undergoing dialysis treatment for kidney failure until her death in May 1998. HCFA's REBUS system shows that the beneficiary's ESRD coverage was ended in June 1997.

Corrective Action: A gap in the patient status record caused her renal coverage period to terminate erroneously. According to the ESRD Network, she discontinued dialysis of May 8, 1998 and died on March 31, 1998. Our records have been updated accordingly.

Beneficiary #13

Finding: The patient's ESRD coverage was terminated prematurely. According to HCFA's REBUS system, the beneficiary's ESRD coverage ended on December 31, 1997. According to medical records and HMO authorization forms, the patient was still on dialysis in February 1998. The beneficiary was looking into receiving a kidney transplant.

Corrective Action: A gap in the beneficiary's patient status record caused his renal coverage period to terminate erroneously. The ESRD Network has confirmed the beneficiary's current renal status and we have updated our records accordingly.

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Beneficiary #14

Finding: The patient's ESRD coverage was terminated prematurely. According to HCFA's REBUS system, the beneficiary's ESRD coverage was ended on June 30, 1997. According to medical records reviewed, the patient is still undergoing dialysis treatment for his kidney failure as of September 1998.

Corrective Action: A gap in the beneficiary's patient status record caused his renal coverage period to terminated erroneously. The ESRD Network has confirmed his current renal status. He died on January 13, 1999. We have updated our records accordingly,