DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

May 3, 2007

Report Number: A-06-06-00104

Mr. Rem Beitel
Vice President, General Counsel
CommunityCare Oklahoma
218 W. 6th Street
Tulsa, OK 74119

Dear Mr. Beitel:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services' (OAS) report entitled "Encounter Data Submitted by CommunityCare Oklahoma for 2003 Monthly Capitation Payments." A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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If you have any questions or comments about this report, please do not hesitate to call me or Cheryl Blackmon, Audit Manager at (214) 767-9205 or through e-mail at cheryl.blackmon@oig.hhs.gov. To facilitate identification, please refer to report number A-06-06-00104 in all correspondence.

Sincerely,

Gordon L. Sato
Regional Inspector General
For Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Dr. James R. Farris
Regional Administrator, Region VI
Centers for Medicare & Medicaid Services
1301 Young Street, Suite 714
Dallas, Texas 75202

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ENCOUNTER DATA SUBMITTED BY COMMUNITYCARE OKLAHOMA FOR 2003 MONTHLY CAPITATION PAYMENTS

Daniel R. Levinson
Inspector General

May 2007
A-06-06-00104

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

The designation of financial management practices as questionable as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS operating division.

EXECUTIVE SUMMARY

BACKGROUND

The Balanced Budget Act of 1997 mandated the implementation of a risk adjustment methodology for Medicare+Choice (M+C) payments that accounted for varied per capita costs based on the health status of beneficiaries. The Centers for Medicare & Medicaid Services (CMS) selected the Principal Inpatient Diagnostic Cost Group (PIP-DCG) model as an interim approach to address this requirement prior to the calendar year 2004 implementation of a more comprehensive risk adjustment methodology, the CMS Hierarchical Condition Category model.

The PIP-DCG model was a prospective payment model that used information (referred to as "encounter data") collected on beneficiaries in a base year to predict payment for the following year. CMS used diagnostic information (principal discharge diagnoses and some secondary diagnoses) collected by providers during hospital inpatient stays to assign beneficiaries to disease groups and provide them with a PIP-DCG risk factor. CMS based the total risk adjustment factors and the payments on the single, most costly disease group assigned to the individual and on demographic factors.

From 2000 until 2007, CMS phased in the risk-based portion of each payment. The remainder of each payment was based on the demographic-only method that was in place prior to the implementation of a risk adjustment methodology. During our audit period, 10 percent of each payment was based on risk. As of 2007, 100 percent of payments are risk-based.

The accuracy and completeness of diagnostic information was critical to correctly calculating payments made on behalf of M+C beneficiaries under the PIP-DCG model, and remains critical under the comprehensive risk adjustment methodology implemented in 2004.

CommunityCare HMO (CommunityCare) is a health maintenance organization licensed in Oklahoma. CommunityCare administered an M+C plan during our audit period. According to a CommunityCare official, CommunityCare received approximately $123.6 million in Medicare premiums from CMS during 2003.

OBJECTIVES

Our objectives were to determine whether the encounter data CMS used as the basis for the 2003 monthly capitation payments made on behalf of beneficiaries enrolled in CommunityCare's Senior Health Plan were valid and accurate. Specifically, we determined whether:

- the encounter data met the definition of "valid encounter data" that we developed from CMS guidance,

- CMS used the correct diagnoses when assigning beneficiaries' risk factors, and

- medical records supported the encounter data.

SUMMARY OF FINDINGS

All of the encounter data supporting inpatient claims for beneficiaries in our sample met our definition of "valid encounter data." Our definition of valid encounter data was developed from CMS guidance, which states that encounter data are (1) based on principal discharge diagnoses as coded by the providers, (2) based on inpatient encounters exceeding one day, and (3) generated in facilities covered under the PIP-DCG model. Furthermore, in accordance with chapter 7 of the CMS "Managed Care Manual" and the CMS "Risk Adjustment Training Manual," CMS appropriately used the diagnoses provided by CommunityCare to assign risk factors to beneficiaries in our sample. However, medical records did not always substantiate the encounter data used to determine beneficiaries' risk factors.

Chapter 7 of the CMS "Managed Care Manual" requires that medical records substantiate all diagnostic information provided to CMS. For the beneficiaries associated with the 100 sampled beneficiary enrollment months, the principal diagnoses used to determine the risk factors could not be substantiated by the medical records for 14 beneficiaries.

In our opinion, the unsubstantiated encounter data occurred because CommunityCare's internal controls were not sufficient to:

- prevent the loss of at least one medical record,
- prevent coding errors at the provider level, and
- detect incorrectly coded diagnoses before they were submitted to CMS.

Based on our sample, we estimated that payments to CommunityCare would have been reduced by approximately $50,000 during calendar year 2003 if CommunityCare would have submitted accurate and supportable encounter data to CMS. The payment differential was based on the 10 percent phase-in of the PIP-DCG model. The payment difference would have been 10 times higher if risk adjustment had been fully implemented.

RECOMMENDATIONS

With respect to encounter data that was not substantiated by medical record documentation, we recommend that CommunityCare:

- strengthen internal controls to ensure that providers maintain medical records;

- insert into provider contracts provisions that promote the accurate recording of encounter data; and

- train providers to code diagnoses accurately.

COMMUNITYCARE'S COMMENTS AND OFFICE OF INSPECTOR GENERAL'S RESPONSE

CommunityCare did not take exception to most of our findings. However, CommunityCare partly disagreed with our finding that medical records did not always support encounter data. In addition, CommunityCare expressed concerns with our recommendations on how to prevent unsubstantiated encounter data. We continue to believe that our recommendations are valid, but agree with some of CommunityCare's comments regarding our recommendations and have made appropriate changes. The full text of CommunityCare's written comments is included as an Appendix.

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INTRODUCTION

BACKGROUND

The Balanced Budget Act of 1997 mandated the implementation of a risk adjustment methodology for Medicare+Choice (M+C) payments that accounted for varied per capita costs based on the health status of beneficiaries. The Centers for Medicare & Medicaid Services (CMS) selected the Principal Inpatient Diagnostic Cost Group (PIP-DCG) model as an interim approach to address this requirement prior to the calendar year 2004 implementation of a more comprehensive risk adjustment methodology.[1]

The PIP-DCG model was a prospective payment model that used information (referred to as "encounter data") collected on beneficiaries in a base year to predict payment for the following year. CMS used diagnostic information (principal discharge diagnoses and some secondary diagnoses) collected by providers during hospital inpatient stays to assign beneficiaries to disease groups and provide them with a PIP-DCG risk factor. CMS based the total risk adjustment factors and the payments on the single, most costly disease group assigned to the individual and on demographic factors.

From 2000 until 2007, CMS phased in the risk-based portion of each payment. The remainder of each payment was based on the demographic-only method that was in place prior to the implementation of a risk adjustment methodology. During our audit period, 10 percent of each payment was based on risk. As of 2007, 100 percent of payments are risk-based.

The accuracy and completeness of diagnostic information was critical to correctly calculating payments made on behalf of M+C beneficiaries under the PIP-DCG model, and remains critical under the comprehensive risk adjustment methodology implemented in 2004.

CommunityCare HMO (CommunityCare) is a health maintenance organization licensed in Oklahoma. CommunityCare administered an M+C plan during our audit period. According to a CommunityCare official, CommunityCare received approximately $123.6 million in Medicare premiums from CMS during 2003.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether the encounter data CMS used as the basis for the 2003 monthly capitation payments made on behalf of beneficiaries enrolled in CommunityCare's Senior Health Plan (the plan) were valid and accurate. Specifically, we determined whether:

[1]The risk adjustment methodology implemented in 2004 is called the Centers for Medicare & Medicaid Services Hierarchical Condition Category model.

- the encounter data met the definition of "valid encounter data" that we developed from CMS guidance,

- CMS used the correct diagnoses when assigning beneficiaries' risk factors, and

- medical records supported the encounter data.

Scope

We focused our review on the encounter data that CommunityCare submitted to CMS for patients discharged between July 1, 2001, and June 30, 2002 (the data collection period). CMS used the encounter data to determine the plan's payments during calendar year 2003 (the payment period).

Our audit universe consisted of enrollment months associated with beneficiaries who were enrolled in the plan during both the data collection period and the payment period. We reviewed the encounter data submitted on behalf of beneficiaries whose enrollment months we selected for our statistical sample of 100 beneficiary enrollment months.

We did not review the overall internal control structures of CommunityCare and its providers, or of CMS and its M+C contracted partners. We limited our internal control review to CommunityCare's controls over the accuracy of the encounter data it submitted to CMS.

Methodology

We statistically selected 100 beneficiary enrollment months, identified the relevant inpatient hospital stays that occurred during the data collection period, and obtained the medical records associated with those stays. Next, we identified the inpatient stay that led to the risk factor assigned to each beneficiary represented in our sample. We then submitted the corresponding medical records and diagnostic data to a Quality Improvement Organization (QIO), the Oklahoma Foundation for Medical Quality (OFMQ), to review the accuracy of coded diagnoses. Where the QIO identified a miscoded principal diagnosis that would have resulted in a lower risk factor than the one CMS assigned to the beneficiary, we determined whether the beneficiary had a second inpatient stay requiring medical review. We then submitted the medical records for the additional inpatient stays to the QIO to review.

We analyzed the encounter data associated with the inpatient stays we submitted for review to determine whether the data were valid and whether CMS correctly used it when assigning the beneficiaries' risk factors. Upon receipt of the QIO's final results, we identified where the QIO found discrepancies between the medical records and the coded diagnoses. We determined the effect of the discrepancies on the beneficiaries' risk factors and calculated overpayments and underpayments for the impacted beneficiary months. Finally, using the unrestricted variable appraisal module in the Office of Audit

Services's statistical software, we estimated the amount of erroneous payments in the audit universe.

We performed our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

All of the encounter data supporting inpatient claims for beneficiaries in our sample met our definition of "valid encounter data."[2] Furthermore, in accordance with chapter 7 of the CMS "Managed Care Manual" and the CMS "Risk Adjustment Training Manual," CMS appropriately used the diagnoses provided to assign risk factors to beneficiaries in our sample. However, medical records did not always substantiate the encounter data used to determine beneficiaries' risk factors.

UNSUBSTANTIATED ENCOUNTER DATA

Centers for Medicare & Medicaid Services Requirements

Chapter 7 of the CMS "Managed Care Manual" requires that medical records substantiate all diagnostic information provided to CMS.

Encounter Data Not Always Substantiated by Medical Records

For the beneficiaries associated with the 100 sampled beneficiary enrollment months, the principal diagnoses CMS used to determine the risk factors could not be substantiated by the medical records for 14 beneficiaries.

For one beneficiary, the provider was unable to locate the medical records pertaining to the beneficiary's hospital visit. The risk factors CMS assigned the remaining 13 beneficiaries were based on inpatient hospital stays for which providers incorrectly coded the principal diagnoses. For the 13 beneficiaries with incorrectly coded principal diagnoses, CommunityCare received overpayments for 6 beneficiaries and received underpayments for 3 beneficiaries. Payments for the remaining four beneficiaries were not affected.

Insufficient Internal Controls

The unsubstantiated encounter data occurred because CommunityCare's internal controls were not sufficient to:

- prevent the loss of at least one medical record,
- prevent coding errors at the provider level, and

[2]Our definition of valid encounter data was developed from CMS guidance, which states that encounter data are (1) based on principal discharge diagnoses as coded by the providers, (2) based on inpatient encounters exceeding one day, and (3) generated in facilities covered under the PIP-DCG model.

- detect incorrectly coded diagnoses before they were submitted to CMS.

While CommunityCare's provider agreement requires the maintenance of medical records, this internal control was not sufficient to prevent the loss of at least one medical record. We recognize that the large number of members for whom medical records must be maintained makes probable the occasional loss of a medical record. However, we believe it is the plan's ultimate responsibility to ensure that providers maintain medical records.

CommunityCare also lacked sufficient internal controls to prevent coding errors. CommunityCare acknowledged that barriers to obtaining complete and accurate encounter data from providers exist. Further, CommunityCare does not have policies or procedures in place to train its providers on correct coding practices.

Finally, CommunityCare lacked sufficient internal controls to detect coding errors before submitting encounter data to CMS. Although CommunityCare performs audits of medical records to detect errors, these audits are limited to claims equal to or in excess of $20,000.

Estimated Overpayment

Based on our sample, we estimated that payments to CommunityCare would have been reduced by approximately $50,000[3] during calendar year 2003 if CommunityCare had submitted accurate and supportable encounter data to CMS. The payment differential was based on the 10 percent phase-in of the PIP-DCG model. The payment difference would have been 10 times higher if risk adjustment had been fully implemented.

RECOMMENDATIONS

To improve internal controls related to unsubstantiated encounter data, we recommend that CommunityCare:

- strengthen internal controls to ensure that providers maintain medical records;

- insert into provider contracts provisions that promote the accurate recording of encounter data; and

- train providers to code diagnoses accurately.

[3]We estimated that payments would have been reduced by approximately $50,000 using a projection of the erroneous payments from our sample. The $50,000 is based on the point estimate at the 90-percent confidence interval. At the 90-percent confidence interval, the point estimate was $49,710. The lower limit was $1 and the upper limit was $99,420.

COMMUNITYCARE'S COMMENTS AND OFFICE OF INSPECTOR GENERAL'S RESPONSE

CommunityCare did not take exception to most of our findings. However, CommunityCare partly disagreed with our finding that medical records did not always support encounter data. In addition, CommunityCare expressed concerns about our recommendation on how to prevent unsubstantiated encounter data. We continue to believe that our recommendations are valid, but agree with some of CommunityCare's comments regarding our recommendations and have made appropriate changes. CommunityCare's comments are discussed below and included in their entirety as an Appendix.

Missing Medical Record

CommunityCare does not believe that the missing medical record discussed in our findings is indicative of a widespread problem. CommunityCare stated that it routinely requests medical records from its contracted providers, and rarely is unable to obtain those records. Although CommunityCare believes a missing medical record is a rare event, we believe it is CommunityCare's responsibility to strengthen internal controls to ensure providers maintain medical records. We revised our recommendation in the final report to address their concern.

Prevention of Coding Errors

Citing inherent conflicts of interest, CommunityCare did not agree with our recommendation that CommunityCare train providers in proper coding practices. CommunityCare stated that the theoretical benefits of having the plans train providers in coding practices is outweighed by the potential for abusive upcoding. CommunityCare suggested that it would be more appropriate for an independent organization such as the Department of Health and Human Services or the National Center for Health Statistics to lead such provider training efforts. We continue to believe that our recommendation is valid.

Concerning our recommendation that provider contracts include provisions to promote accurate recording of encounter data, CommunityCare stated that its contracts already require providers to maintain and report accurate encounter data to the plan. We reviewed a contract between CommunityCare and one of its providers and, while there is a provision pertaining to the maintenance of full and complete encounter data, the contract does not specifically address requirements for the accuracy of the data. In addition, the contract does not make clear what corrective action should be taken if the provision is not met. We believe that contracts should explicitly state the requirement for accurate coding and the corrective action to be taken if a provider does not meet the contractual provision regarding encounter data.

Regarding our finding that CommunityCare lacked internal controls necessary to detect incorrectly coded diagnoses before it submits the encounter data to CMS,

CommunityCare questions whether such internal controls would prove sufficiently cost-effective if performed on claims that do not reach at least a material threshold. Currently, CommunityCare limits its reviews to claims equal to or in excess of $20,000. We agree that the decision to implement internal controls should be subject to a review of costs and benefits. However, we believe the current $20,000 threshold is too high to effectively detect erroneous encounter data.

Estimated Overpayment

CommunityCare's Medical Director and certified professional coder conducted a medical review of the errors originating from Saint Francis Hospital (one of the hospitals that provided services to beneficiaries in our sample). In half of the cases reviewed, CommunityCare did not agree with all of OFMQ's findings. CommunityCare offered to expand its review to include the remaining encounters we identified as errors and to discuss the rationale behind the disagreements. We realize that experts can disagree as to how a claim should be coded. However, we stand by OFMQ's determinations.

Other Matters

As a separate technical matter, CommunityCare mentioned that the draft report referred to its M+C plan as CommunityCare Oklahoma. CommunityCare stated that the proper name of the plan is Senior Health Plan. We have revised the final report to reflect the proper name of the plan.

APPENDIX

Community
Managed Healthcare Plans Of Oklahoma

March 15, 2007

Via FedEx: # 7923 0719 3220
Mr. Gordon L. Sato
Regional Inspector General
Department of Health & Human Services
OIG, Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

RE: CommunityCare HMO
Report No. A-06-06-00104

Dear Mr. Sato:

Please accept this letter as CommunityCare HMO's response to the Office of Inspector General's (OIG) draft report concerning the audit of Medicare encounter data that CommunityCare submitted in 2002, and which served as the basis for the capitation payments it received from the Centers for Medicare and Medicaid Services (CMS) in 2003. We appreciate the opportunity to review the auditors' findings and offer comments.

As a technical matter, the draft report refers to CommunityCare as both "CommunityCare HMO" and "CommunityCare Oklahoma." The entity that actually holds the contract with CMS is CommunityCare HMO, and its Medicare Advantage plan is called Senior Health Plan (H3755). There is no CommunityCare entity named CommunityCare Oklahoma.

The draft report is comprised of two primary findings—that: (1) the plan's encounter data were not always substantiated by the medical records; and (2) unsubstantiated encounter data resulted in CommunityCare being overpaid approximately $50,000 in 2003. Finding (1) is further comprised of three sub-findings—that the plan lacked sufficient internal controls to: (a) prevent the loss of one medical record; (b) prevent coding errors at the provider level; and (c) detect incorrectly coded diagnoses before the data were submitted to CMS. CommunityCare's comments concerning each finding and sub-finding follow, and are referred to in accordance with the above summary:

Comments re: Finding 1(a):

Of the fourteen beneficiaries whose medical records the auditors selected for review, one hospital was unable to locate inpatient records for one individual. This resulted in a recommendation that CommunityCare determine whether that failure represents a widespread issue among its plan providers and, if so, take appropriate corrective action. As the draft report states, the large number of members for whom plan providers maintain medical records makes probable the occasional loss of a medical record. CommunityCare believes that this instance is, in fact, an example of just such an occasional loss and not indicative of a widespread problem. That belief is based on the fact that CommunityCare routinely requests medical records from its contracted

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www.ccok.com

providers in order to perform various plan functions (e.g., utilization management/review; grievances/appeals). Rarely is CommunityCare unable to obtain records from the provider in those instances.

Comments re: Finding 1(b):

With regard to preventing coding errors at the provider level, CommunityCare does not agree that it is in Medicare's best interest for health plans to train providers in proper coding practices. Although that recommendation may appear reasonable as a way to reduce improper coding, it fails to take into account the inherent conflict of interest health plans face vis-à-vis their payments under the PIP-DCG model. Because health plans receive a higher capitation payment if their members' risk-adjusted scores reflect ICD-9 coding indicative of higher utilization, CommunityCare believes that the theoretical benefits of having the plans train providers in coding practices is outweighed by the potential for abusive upcoding. In addition, because providers typically participate in multiple plans, there is also the likelihood that providers will receive conflicting information from those plans.

CommunityCare believes it is more appropriate for the Department of Health and Human Services (DHHS) and/or the National Center for Health Statistics (NCHS) to train providers in proper coding practices because those agencies are jointly responsible for promulgating and revising the ICD coding system. In addition, those agencies are free from the financial conflict that is present at the plan level, and are able to serve as a central repository for ICD coding information, thus minimizing the risk that providers will receive conflicting training.

With regard to the recommendation that CommunityCare include provisions in its provider contracts to promote accurate recording of encounter data, CommunityCare's contracts already require providers to maintain and report accurate encounter data to the plan. CommunityCare is willing to consider additional provisions, and would be interested in any specific suggestions the OIG or the auditors have in that regard.

Comments re: Finding 1(c):

The auditors recommended that CommunityCare implement internal controls to detect incorrectly coded diagnoses before it submits the encounter data to CMS. The auditors would, no doubt, agree that detecting coding errors, particularly those at the fourth or fifth digit, requires a detailed review of the medical record by trained personnel. CommunityCare processed nearly half a million Medicare claims last year and, as the draft report indicates, CommunityCare already employs a registered nurse who is also a certified professional coder to review high-dollar claims. CommunityCare questions whether that exercise would prove sufficiently cost-effective if performed on claims that do not reach at least a material threshold.

Comments re: Finding (2):

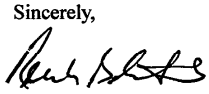
The OIG's final finding was that payments to CommunityCare would have been reduced by approximately $50,000 had all of the plan's encounter data been substantiated. During the exit

conference with the auditors on January 31st, CommunityCare requested a copy of their financial analysis so the plan could determine the appropriateness of that conclusion. We received copies of the related claim data on February 22nd. In the interest of time, our Medical Director, along with our certified professional coder, conducted a medical record review of the audited claims that originated from Saint Francis Hospital. Based on that clinical review, CommunityCare does not agree with all of OFMQ's proposed recoding or revisions to the member's PIP-DCG score in half of those cases. We would be happy to expand our review to include the remaining claims and discuss the rationale behind these disagreements with OFMQ and/or the auditors before a final report is issued.

Finally, the auditors indicated at the exit conference that, because the estimated $50,000 overpayment represented an immaterial portion of the plan's total Medicare capitation from CMS in 2003 (i.e., approximately 4/100ths of 1%), they intended to recommend that CMS not pursue recoupment. Although that recommendation does not appear explicitly in the draft report, CommunityCare agrees with that recommendation. Please let us know if the OIG intends to offer a different recommendation to CMS, so that we may discuss it further with you.

Thank you again for the opportunity to comment on the draft report. If you have any questions or wish to discuss our comments, please do not hesitate to call me at (918) 594-5264, and I will be happy to arrange a meeting with appropriate plan representatives.

Sincerely,



Remsen H. Beitel, III
V.P., General Counsel