

Secretary of State AUDIT REPORT

Report No. 2002-02 • January 3, 2002

Department of Human Services: Oregon Medical Assistance Program Encounter Data Review



Bill Bradbury, Secretary of State
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Summary

PURPOSE

The purpose of this audit was to determine whether the accuracy and completeness of encounter data is important and, if so, has the Office of Medical Assistance Programs (office) in the Department of Human Services taken adequate steps to ensure the reliability of the information. Encounter data is the information reported by managed care plans to the state that lists the actual medical services provided to Oregon Health Plan clients.

RESULTS IN BRIEF

Encounter data is important because it is relied on extensively by the office to make management and policy decisions. Primary among these is the development of capitation payment rates, the amount paid to each managed care plan to provide medical services to Oregon Health Plan clients. During 1999-2001, managed care capitation payments totaled approximately \$1.3 billion. Due to the size of the program, even a 5 percent error could have a \$65 million impact.

We found that the office is not adequately ensuring the reliability of encounter data prior to use in management and policy decisions. The purpose of data reliability testing is not to ensure perfect data. Reliability tests should provide a basis for evaluating the quality of data to ensure that the data is correct enough for its proposed use. The result of our analysis was a realization that Oregon Health Plan funding, policy, and management decisions are being based on data of unknown and questionable quality.

We found the following:

- Reporting of prescription drug encounter data is not required. As a result, \$112 million in prescription drug

capitation rates were developed based on data of unknown quality.

- Reconciliations of submitted data are not adequate. As a result of the inability of the plans to reconcile data, data representing 21 percent of managed care enrollees was not used in the most recent capitation rate setting process in establishing base rates.
- Medical chart review is done infrequently as part of encounter data management. Further, we question the methodology and reporting of the most recent review conducted for the office by an external contractor.

In addition, we performed analytical reviews of the data and found some of the information to be inaccurate and incomplete. Testing was based on data reporting errors common in medical claims. All of our findings had potential effects on capitation rate setting.

RECOMMENDATIONS

We recommend that the office strengthen its management controls over encounter data. These should include developing policy and implementing procedures designed to provide a reasonable assurance that encounter data is reliable prior to its use in making management and policy decisions. Furthermore, policy makers should be made aware of any data limitations prior to using the data.

AGENCY RESPONSE

The Department of Human Services generally agrees with the recommendations.

Introduction

Since 1994, Oregon Medicaid benefits have been delivered through the Oregon Health Plan, a demonstration project. For 1999-2001 the budget for the program was \$2.5 billion, with \$1.5 billion being budgeted for capitation payments. The federal government pays approximately

60 percent of the cost and the state pays the remaining 40 percent.

Background

The Oregon Health Plan differs from a traditional Medicaid program in that services are to be provided primarily through managed care plans (plans), rather than on a fee-for-service basis. This approach provides the plans a pre-specified

payment amount for each client, regardless of the amount of service a client receives.

Payments are made monthly at predetermined rates based on the monthly enrollment in each plan. These payments are called capitation payments and are intended to "cover the cost(s) of the services."¹

¹ "Model Contract Exhibit B Calculation of Capitation Rates 1."

A requirement of this program is that the managed care plans report services provided to the state's Office of Medical Assistance Programs (office). These services are reported as encounter data. Encounter data is defined as "a service or bundle of services provided to one client by one provider in one time period."²

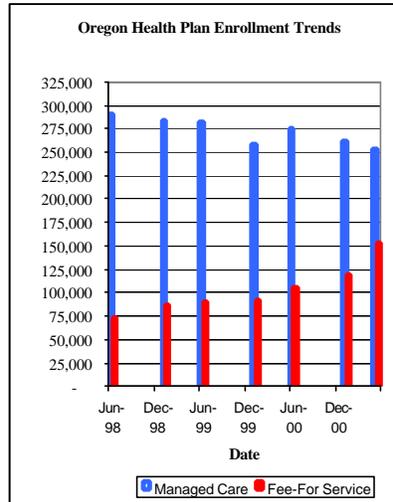
Standards on data elements and timeframes for encounter data submission are specified in the contracts between the plans and office. In addition, contracts contain provisions for imposing corrective action plans and sanctions for non-compliance with contract terms.

Encounter data is used as the basis for setting capitation rates. The office contracts with an actuary to calculate these rates. First, a base rate is calculated for all plans. These rates are then adjusted based on differences in regional costs of living and the relative health risk for each type of client enrolled.

Managed Care Enrollment is Dropping

The office's goal has been to enroll 87 percent of Medicaid clients in managed care plans. In June 1997, the office reported attaining that goal, with 294,000 people being enrolled in managed care plans. Since that time, the number and percent of enrollees has declined. In July 2001, managed care enrollment was down to 254,000 and represented only 66 percent of the Medicaid population. See Chart 1 for a graphic presentation of enrollment trends.

Chart 1



One reason for the decrease in managed care enrollment is that some plans have pulled out of the Oregon Health Plan or have reduced the number of enrollees they are willing to cover. According to the plans, the main reason they are leaving is the financial losses they have incurred through their participation in the health plan. As of April 30, 2001, a plan accounting for 19 percent of the managed care enrollment pulled out, claiming that it had lost \$6.3 million for the first half of 2000 due to its participation in the Oregon Health Plan. Another of the largest plans has threatened to pull out and has, in fact, decreased its enrollment from 35,414 enrollees as of January 1, 2000 to 5,008 as of August 1, 2001.

Audit Results

Reliability of the Data Important to the Oregon Health Plan's Success

We found that the completeness and accuracy of encounter data is important because it is used to make management and policy decisions. For example, encounter data is used by the office in developing capitation rates, evaluating quality of care, as well as in evaluating other plan activities.

Further, the federal government requires the office to report encounter information.

Unreliable data can have a significant impact on funding and providers.

The accuracy and completeness of encounter data is important because it drives the amount paid to managed care health plans. One of the cornerstones of the Oregon Health Plan is the commitment to pay rates that cover costs to managed care plans. Governor Kitzhaber stated recently that a principle of the health plan was that "we would also not shift costs to providers to balance the budget. Rather, we would not only maintain eligibility, but would also maintain a reasonable and actuarially determined rate of reimbursement for providers and make adjustments in the benefit level."³ Basing rates on encounter data of unknown or suspect quality raises the risk that rates will not accurately reflect the cost of providing services.

Because the program is so large, even small percentage errors in the data can have a huge impact on the amounts being paid and therefore dramatically affect the funding requirements of the program. For instance, during the 1999-2001 biennium, capitation payments were approximately \$1.3 billion. A 5 percent error due to inaccurate or incomplete encounter data could have a \$65 million impact.

Not only is the total amount paid for managed care services impacted by inaccurate data, but the incorrect calculation of individual plan rates could result in the unwarranted shifting of funds among plans. More precisely, the base rate is adjusted up or down based on each plan's calculated risk scores, which are calculated using each individual plan's data submissions.

² "Model Contract Exhibit D Encounter Data Minimum Data Set Requirements and Corrective Action, I. A"

³ Governor John Kitzhaber, Summit on the Oregon Health Plan, September 13, 2000.

An actuarial study done in 1997 demonstrated the impact that data completeness can have on a plan's rates. This study showed that a plan's risk score increased 11 percent after reporting information that had been previously omitted was included. To understand the impact of such a risk score adjustment, we calculated the dollar effect of a similar adjustment for a large plan using enrollment data from January 1, 2001. Increasing this one plan's risk factor by approximately 11 percent would result in an annual increase in capitation payments totaling approximately \$776,000. This sort of an adjustment would also result in an equivalent reduction in the capitation payments to the other plans.

Proper funding of the program and plans is a major management challenge when dealing with unreliable encounter data. Other challenges would exist, as well. For example, management decisions based on the encounter data could be addressing problems that do not exist. Conversely, analysis using the encounter data may not be detecting significant program problems that need to be addressed. In either case, incomplete or inaccurate information would pose a serious challenge for program managers.

Encounter Data Contains Errors, the Extent and Effects of Which are Unknown

Our testing of the management controls and their effect on reliability concluded that the encounter data contains errors. One of the results of this finding is the realization that rates are based on data that is not correct and that the extent and the effect of the errors are unknown to policy makers.

The best information available to the office, based primarily on their most recent data study, indicates that the omission rate could be as high as

15 percent. As you will see later in the report, we question the validity of this study. An error of this magnitude would be significant.

Certain Steps Needed to Detect and Prevent Significant Data Errors

According to the guidelines provided by the federal government's Health Care Financing Administration (HCFA) regarding the use of encounter data, "Before encounter data can be usefully employed for management or policy decisions, stakeholders in the system must be confident that the data are complete and contain accurate information."⁴ HCFA also notes, "No data source should be considered accurate unless data quality assessments ...(system edits, analytical reviews, and medical chart reviews)... have been conducted."⁵

It is incumbent on office management to design procedures that help to assure encounter data is complete and contains accurate information. The control design should include ongoing procedures for:

1. Contract Management and Monitoring

To ensure that all relevant encounter data are required, defined, and available for reliability testing prior to use, HCFA recommends that data definitions, data elements, and data formats be included in plan contracts. Further, it recommends that clearly defined data quality standards, and consequences of achieving or not achieving those standards, be included in contracts. It also notes that states should be prepared to monitor and enforce contract requirements.

⁴ *A Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data*, Second Edition, June 1999, page 55.

⁵ *Ibid.*

2. System Edits

System edits are an automated assessment of data to identify accuracy problems, leading to the implementation of corrective actions and monitoring of those actions for successful resolution.

3. Analytical Reviews

Analytical reviews include analyzing reported data for reasonableness, including comparisons among plans, other states, or to traditional medical care data, to identify data accuracy issues.

4. Medical Chart Review

To assess completeness and accuracy, reported data must be periodically compared to medical charts.

Since the validity of the data is so important, we reviewed the steps taken by the office to ensure data reliability.

The Office Has Not Adequately Ensured the Reliability of Encounter Data

We found that the office has not adequately ensured the reliability of encounter data because significant weaknesses exist in all of the control areas we tested (contract management and monitoring, analytical reviews, and medical chart reviews) mentioned previously.

Contract Management and Monitoring

HCFA's guidebook identifies four data collection standards that should be included in contracts between plans and the state. These include defining encounters, itemizing data elements to be collected, defining submission formats, and requiring submission of all services provided. In addition, contracts should include data completeness, accuracy, and timeliness standards. Further, good

contract management practices require that encounter data submissions be tested and monitored for conformity with contract requirements.

Prescription Drug Data Not Required, Defined, or Tested

The office does not require plans, as part of their contracts, to report prescription drug encounter information, which represents a significant portion of the Oregon Health Plan's expenses. To calculate capitation rates, the actuary requests prescription drug information directly from the plans. However, submission of this information is voluntary and not all plans participate. Further, submitted data is not uniform, as data elements are not well defined and there is no standard format. As a result, the prescription drug data that is received is subject to a very limited quality assurance process, consisting only of limited testing for duplicate entries and ineligible individuals.

The cost of prescription drugs has skyrocketed in recent years, and it is estimated costs will increase by an additional 60 percent in the next two years. Our analysis showed that in the current fiscal year, approximately 21 percent of the cost of capitation rates were attributable to prescription drugs. As a result, \$112 million in prescription drug capitation rates were developed based on information of completely unknown quality. Recently, Governor Kitzhaber was quoted as saying, "The fate of the Oregon Health Plan hinges on our ability to control prescription drug costs."⁶ Basing major program funding and policy decisions on data of completely unknown quality places the program at risk.

Further, the federal Balanced Budget Act of 1997 requires the reporting of four types of claims

files representing inpatient, long term care, pharmacy, and non-institutional services to HCFA. While the Oregon Health Plan is currently operating under a waiver and is not required to meet these standards, the current waiver is due to expire January 31, 2002. The office has requested an extension of the waiver, however, should the waiver expire, the office would further risk not being able to comply with the requirement to report prescription drug use data.

We recommend that the office require plans to report prescription drug encounter information. Appropriate controls, both management and system, over that reporting should be developed.

Regular Data Reconciliations Not Done

The office does not reconcile the data submitted electronically via a mechanism called the bulletin board. The electronic bulletin board, a process that allows the plans to submit their data via the internet, accounts for 85 percent of data submissions each month. While the office reconciles record counts for encounters reported on cartridges, it relies on the plans themselves to reconcile encounters reported via the bulletin board. Regular reconciliation provides assurance that encounter data reported is received and processed.

We noted that not all plans were reconciling the data submissions. The office does make available to the plans a weekly status report of encounters submitted by each plan. During our survey of the plans, we found that while 87 percent used the status report, only 40 percent used it to reconcile the number of claims submitted. The status report file layout is different from the layout of reported encounter data, which makes it difficult for the plans to reconcile the information.

Unreconcilable Data Excluded From Rate Setting

Twenty-one percent of the managed care enrollee data for the current rate setting period was not reconcilable and was excluded from the base capitation rate setting process.

The process for reconciling seemed to have been hampered by either data compatibility problems or a lack of training. The actuary provided data to the plans after categorizing the encounters for capitation rate setting and asked the plans to confirm that the data matched their internal records. Through our attendance at user group meetings and plan surveys, we came to understand that the plans had an incomplete understanding of the categorized data and had difficulties reconciling. In fact, the actuary's September 2000 report noted that two health plans declined to have their data used for rate setting because it was significantly different from their internal sources. Ultimately, data from only 11 plans, representing 79 percent of managed care enrollees, were used.⁷

We recommend that the office implement improved processes for reconciling encounter data records. These should include:

- Reconciling the numbers of claims submitted, and
- Evaluating the actuary's reconciliation process with the plans and either improving it or devising a more effective method.

We further recommend that the office provide periodic training and support to staff and managed care plans on the system used to categorize data for capitation rates if that system is to continue being used.

⁶ *The Oregonian* June 4, 2001 "Kitzhaber, drug lobby square off over list," A1.

⁷ "Oregon Health Plan Medicaid Demonstration Analysis of Federal Fiscal years 2002-2003 Average Costs," September 21, 2000, PriceWaterhouseCoopers.

System Edits

Automated system edits are used to ensure that acceptable values have been reported. These edits include tests such as those ensuring that date fields are populated with dates, codes reported conform to defined formats for those codes, and clients were members of the plan on the dates that services were provided.

The office relies on the Medicaid Management Information System (MMIS), an aging legacy system that is due for replacement, for system edits. An audit of the system by the Audits Division in 1997 revealed problems that appear to be ongoing.⁸ These problems included an extensive backlog of system change requests, unreliable system edits, and high staff turnover. The office has begun the replacement process of the MMIS. Given the recent review of MMIS and the impending replacement of the system, we did not specifically review MMIS.

Analytical Reviews

Analytical reviews involve examining the logical relationships between the data and trends, averages, or other norms. A review offers the opportunity to identify irregularities in reported data, determine their cause, and correct errors. A lack of such review could allow problems to go undetected and uncorrected.

The office does not have anyone regularly assigned to do analytical review of encounter data. According to the office, analytical reviews are not done, in part, because of a lack of internal resources. The office reported that the medical chart review conducted recently by a contractor was because of staff workload issues.

⁸ Report No. 97-83, *Department of Human Services Medicaid Management Information System Review*.

We performed limited testing of unbundling, diagnosis codes, service coding, and inpatient data. We identified several problem areas that the office concurred warranted further review.

Unbundled Services Not Detected

Unbundling is the practice of billing separately for certain services that should be billed as a group, panel, or bundle of services. The office reports that this problem is one of the most common identified in audits of fee-for-service claims.

We tested six months of 1999 medical claims for women with a normal pregnancy diagnosis code and identified potential problems with unbundling. For this period we found providers reported 336 complete panels of obstetrics (OB) laboratory tests. A panel includes seven distinct laboratory tests. We also noted that the individual panel components were each reported 220 to 500 times. We felt this could indicate additional panels that had been unbundled, that is, reported as their component parts.

Unbundling contributes to raising the base capitation rate due to the increase in the amount billed. For example, when we combined the components, we noted that the accumulated amount billed was \$50 to \$60 more than the cost of the standard OB panel. This is an increase in the cost of 80 percent or more.

Agency Accomplishments

In response to this finding, the office undertook a re-review of our analysis. The office stated that it "analyzed the same data and found instances of unbundling under 10 percent. The majority of the unbundled services were submitted by one lab and the office has referred this finding to its fraud investigation unit. Further, a contractor will review this area in its

lab and x-ray review. Finally, the office has submitted proposed language for the October 2001 provider guide to address this issue."

Low Rate of Secondary Diagnosis Reporting Not Detected

Our testing identified three plans with significantly lower than expected rates of secondary diagnosis code reporting. This is significant when one considers that a low rate of reporting could lead to lower capitation payments.

A correlation between a low rate of reporting and low capitation payment rate was established through a review by the actuary in 1997. That analysis showed a risk score increase of 11 percent for one plan when secondary diagnoses codes that had been omitted were included. The higher the risk score, the higher the plan's capitation rate.

One of the plans we identified as reporting a lower than expected rate of secondary diagnosis codes was one of the largest participating plans. This plan intends to discontinue participation in the health plan as of September 30, 2001. According to the plan, the reason for discontinuing was financial losses attributed to its health plan participation.

Potential Problems with Radiology Encounter Claim Data Exist

We reviewed a judgmental sample of 300 radiology claims for service in 1999 and observed several problems with the reporting of these services. We found that:

- While contracts require that plans bill their usual and customary charge for services, this did not appear to be the case. Single-view chest x-rays were billed in amounts ranging from less than \$15 per instance to more than \$200; and

- In 20 percent of our sample, the services reported were identified as the professional component without a corresponding technical component being reported. This indicated either a significant portion of missing data or misreporting, as these services should be reported as pairs.

When component reporting is undetected, it results in skewing the calculation of the capitation rate associated with these services. Rates may be overstated, if component parts are reported, or understated, if only half of the service is reported. Further, a lack of consistency in the amounts billed may impact the actuary's adjustment from amount billed to cost.

To evaluate the potential size of the problem, we totaled the amount billed for radiology encounters in 1999. We found that more than \$27 million was reported for these services.

Review of Inpatient Services Detected Potential Data Irregularities

We identified potential data irregularities when comparing inpatient services reported in encounter data for 1999 to the plans' inpatient services reported in their quarterly financial reports. We found that, while seven of 13 plans had discrepancies of less than 8 percent, six had discrepancies in excess of 20 percent. This is a probable indicator of incomplete encounter data. Generally, incomplete data will result in capitation rates being too low.

The office performed this type of analysis once in the past. The analysis found problems in this area and resulted in the only financial sanctions ever imposed.

We also reviewed inpatient encounters for inappropriate reporting of short hospital stays. Our

analysis noted a high proportion of one-day inpatient stays. We forwarded this information to the office for additional analysis.

Agency Accomplishments

The office researched this issue and identified four managed care plans whose computer systems were mis-reporting discharge dates. Some of the one-day stays noted in our analysis were in fact multiple-day inpatient stays. These plans took immediate action to correct the problem.

We recommend that the office provide for regular analytical reviews of encounter data to promote improvement of data quality. These reviews could include such things as regularly comparing services reported on quarterly financial reports to encounter data submissions.

Contract Provisions Not Enforced

We found that although instances of non-compliance with encounter data reporting were noted, in only three instances since the Oregon Health Plan inception in 1994 have contract sanction provisions been imposed on plans.

The office's contracts with the plans provide financial penalties when contract provisions have been breached. At the option of the office, it may impose sanctions on the plans for failing to provide timely reports and data, failure to provide medically necessary services, over-charging, and failure to maintain an internal quality improvement program, among other things.⁹

HCFA's guidebook on managed care data includes the following statement regarding plans and contract sanctions:

"... the state must be prepared to enforce any sanctions."¹⁰

The office does not have a program to identify contract compliance problems or regularly enforce sanctions as provided for in its contracts with plans. This failure to hold plans accountable erodes the perceived necessity of adhering to encounter data requirements and contributes to data quality problems.

We recommend that the office develop a program to monitor contract compliance and enforce allowable sanctions as specified. Alternatively, the office should consider rewriting the standard contract to provide positive incentives for compliance, rather than unenforced sanctions.

Medical Chart Review

The most definitive review of encounter data involves comparing reported information to the medical records of the clients. This allows a determination that:

- All services reported were documented in the records (detects over-reporting);
- All services provided were reported (detects under-reporting); and
- All services documented were correctly coded (evaluates accuracy of reporting).

While indications of data problems can be detected through analytical reviews, only through completing a well-designed review of medical charts can the accuracy and completeness of the reported data be determined.

⁹ "Fully Capitated Health Plan Agreement," October 1, 1999, Section 6.

¹⁰ *A Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data*, Page 54.

Medical Chart Review Not Designed to Determine Encounter Data Completeness and Accuracy

The current External Quality Review Organization (EQRO) review is only the second general medical chart review of encounter data undertaken by the office or its contractors since the Oregon Health Plan was started in 1994. Although the contracts with the EQRO stated that the data completeness and accuracy were the focus, we questioned the validity of the methodologies employed.

The present contract stated that testing should be done to establish both an encounter data omission rate and an accuracy rate. During the course of our review, we began to question whether the methodologies employed would produce either valid omission or accuracy rates. For example, we felt that the exclusion of certain subsets of encounters (such as those from children, smaller PCCMs and patients with no recorded encounters) could lead to a significant bias in the report rates. Further, we felt that the lack of an adequate explanation of the sampling methodology employed might be indicative of a poor methodology.

The office's response to our critique confirmed that producing valid omission and accuracy rates for the universe of encounter data was not the intention of the study, though this was the purpose stated in the contract between the EQRO and the office. Rather, the office stated that the purpose of the study was a "quality of clinical data review."

We further noted that the EQRO's draft report conclusions contained both omission and accuracy rates without specifically limiting their applicability. The implication was that the results were applicable to the universe of encounter data.

Finally, we noted another flaw in the EQRO's methodology that generated further doubt regarding its results. While the office's encounter data records show 4,268 records for the sample population, only 3,256 were provided to and reviewed by the EQRO. No provision was made for the missing 24 percent when the omission rate was calculated. The calculated omission rate could change by as much as five percentage points, from 15.8 percent to 20.7 percent, if the missing 24 percent reflected the same error rate as the records reviewed. This could significantly skew the conclusions presented.

Although not a definitive cause of the problems we documented, we did note that the actuary and agency program and budget staff who appear most knowledgeable about encounter data, were not involved in the contract development, development of the sampling methodologies, or the study criteria employed.

Plans' Medical Chart Reviews Not Occurring as Part of Encounter Data Management

Oregon Health Plan Administrative Rules suggest that the plans do an annual review of medical records as part of their quality improvement program.¹¹ The office relies on the plans to do these reviews as a major part of the office's quality assurance effort. We found that plan efforts may not be adequate.

We surveyed quality improvement coordinators at 15 of the plans and found that 13 plans do not perform annual medical chart reviews as part of their encounter data management process. Further, we found that encounter data omission studies had been done by only two plans.

Of additional concern is that the quality improvement reviews conducted by the office for each plan did not appear to focus on encounter data quality. We reviewed four recent reports and noted discussion of encounter data review in only one.

Without the assurance provided by the plan initiated medical chart reviews, the general medical chart reviews conducted by the office (or its contractor) become a more important data quality control. Encounter data reliability is at even greater risk when the office does not conduct or ensure that the plans include data validation as a part of regular medical chart reviews.

We recommend that the office improve its medical chart review process to help ensure actuarially sound omission and accuracy rates for encounter data by plan. The office should utilize as appropriate available encounter data expertise, such as the actuary and agency program and budget staff, to ensure that results would be usable in the rate setting process.

We also recommend that the office provide improved monitoring of plan quality improvement efforts. Before relying on these efforts, the office's quality improvement reviews should provide assurance that the plans are in compliance with the required elements of quality improvement systems.

Inadequate Encounter Data Controls Could Be Putting the Oregon Health Plan at Risk of Program Failure

There are many effects of inadequate controls. Opportunities for data improvement are lost, the quality of the data is not known, and there is a high risk that management and policy decisions based on the data may not reflect the best interests of the program and the state.

¹¹ OAR 410-141-0200 (7)(c).

While our analysis focused on the implications of using flawed data to set capitation rates, all uses are potentially impacted. Use of the data for research without an understanding of its limitations may also produce misleading results. Other high priority uses that could be impacted include quality of care studies, and analysis involving the impacts of program and policy changes.

Further, as we noted earlier, should the federal government not extend Oregon's Medicaid waiver, there is a risk that the office will be unable to comply with federal reporting requirements for prescription drug use by managed care enrollees.

Objectives, Scope and Methodology

The objective of our audit was to determine if the office has in place effective management controls to monitor and evaluate encounter data.

There are four different types of managed care organizations: mental health organizations, dental care organizations, primary care case managers, and fully capitated health plans. All of these organizations report services provided as encounter data. Our audit tests, however, focused on the fully capitated health plans.

Encounter data is processed by the Medicaid Management Information System. That system was reported on by the Audits Division in 1997. The department has initiated the process to replace the system. We chose not to review system controls for those reasons.

Our audit included reviewing:

- The *Oregon Revised Statutes* and Oregon Administrative Rules governing this program;
- The federal waiver granted to the state allowing the Oregon Health Plan as a demonstration project;
- Model and actual contracts between the state and the fully capitated health plans;
- Federal guidance provided for this program;
- New federal regulations scheduled to be implemented in June 2001;
- Provider guides for medical services; and
- Required data formats for encounter data submissions.

To evaluate management controls we:

- Attended regularly scheduled meetings between the office and representatives of the managed care plans;
- Reviewed minutes of recent meetings between the office and the plans;
- Conducted surveys of plans (encounter data contacts and quality improvement contacts);
- Interviewed office staff in various units that deal with encounter data processing, validation, and use;
- Interviewed the actuary who calculates managed care payment rates for the office;
- Reviewed reports issued by the actuary;
- Analyzed encounter data used by the actuary to calculate capitation rates and risk adjustment scores. In most cases, testing did not include either dental or mental

health encounters. (The data we analyzed included detailed data for services provided during the period July 1997 through June 1999 and limited header data for the period October 1998 through September 1999.) This analysis was not intended to be statistically projectable but, rather, to identify potential data quality issues;

- Reviewed recent Quality Improvement reports on plans issued by the office;
- Reviewed documentation of corrective action plans and sanctions imposed by the office on plans;
- Reviewed the history of external quality reviews of the Oregon Health Plan;
- Reviewed quality review reports issued both by the external contractor and produced internally;
- Reviewed and analyzed the current external quality review contract and its methodologies;
- Reviewed and analyzed plans' quarterly financial reports and compared reported inpatient admissions to encounter data inpatient data;
- Interviewed representatives of states with similar programs in place; and
- Reviewed the EQRO draft report dated March 30, 2001 and April 23, 2001.

We conducted this audit in accordance with generally accepted government auditing standards. We limited our review to those items specified in this section of the report.

Department of Human Services' Response to the Audit Report

Thank you for your review of the program and recommendations that will enhance the Department's ongoing improvement efforts to collect meaningful encounter data for rate setting and program management purposes.

The department is committed to improving the quality of the encounter data submitted by health plans and monitoring the volume and cost of Medicaid services. Nationally, Medicaid agencies have struggled to obtain reasonably complete and reliable encounter data in order to set managed care capitation rates, measure access to care, and improve quality of care. Oregon is one of the few states that have pioneered using encounter data in rate setting as a key strategy for improving the data.

The Department has taken immediate action on many of the Secretary of State's recommendations for improvements. We will continue to meet with all plans on a regular basis to address issues related to encounter data reporting, tracking costs, and ongoing rate-setting efforts.

We believe that a strong partnership role with plans, together with effective program oversight, fosters consistent data reporting.

Finally, we will continue to meet in local and national forums to improve the validity and quality of encounter data.

This report, which is a public record, is intended to promote the best possible management of public resources. Copies may be obtained by mail at Oregon Audits Division, Public Service Building, Salem, Oregon 97310, by phone at 503-986-2255 and 800-336-8218 (hotline), or internet at Audits.Hotline@state.or.us and <http://www.sos.state.or.us/audits/audithp.htm>.

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The courtesies and cooperation extended by the officials and staff of the Office of Medical Assistance Programs were commendable and much appreciated.

Auditing to Protect the Public Interest and Improve Oregon Government