Secretary of State
Oregon Audits Division

Oregon Health Authority

Recommendation Follow-up Report: Oregon Health Authority Should Improve Efforts to Detect and Prevent Improper Medicaid Payments

March 2019
Report 2019-13

Acting Secretary of State Leslie Cummings, Ph.D.
Audits Division Director Kip Memmott

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Report Highlights

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Recommendation Follow-up Results
At the time of the original audit, the Oregon Health Authority (OHA) agreed with all eight recommendations we made. Our follow-up work shows OHA has made progress to implement those recommendations, with two fully implemented and six partially implemented. While OHA has made progress, more work is still needed to fully resolve these recommendations and further improve processes to reduce improper payments.

Highlights from the Original Audit
The Secretary of State's Audit Division found OHA recovery efforts are appropriate and reasonable, but the agency should strengthen efforts to detect and prevent improper payments. We also found delays in processing eligibility for thousands of Medicaid recipients, which resulted in millions of dollars of avoidable expenditures, a critical issue the agency failed to disclose until raised in a May 2017 Auditor Alert.

Background
At the time of the original audit, Oregon's Medicaid program provided health care to one in four Oregonians with a budget of over $9 billion per year.

Purpose
The primary purpose of the original audit was to determine if OHA could improve processes to prevent, detect, and recover improper Medicaid payments. The secondary purpose was to follow up on OHA's progress to resolve Medicaid eligibility issues we raised in our May 2017 Auditor Alert. The purpose of this follow-up report is to provide a status on OHA's efforts to implement the audit recommendations.

Key Findings from the Original Audit
1. OHA has gaps in procedures for preventing certain improper payments. Insufficient management of the agency's processes for identifying and resolving payment and eligibility issues, prioritization of staffing resources, and efforts to address technology issues put taxpayer dollars at risk.

2. OHA lacks well-defined, consistent, and agency-wide processes to detect certain improper payments, especially related to coordinated care. We identified approximately 31,300 questionable payments based on our review of 15 months of data. OHA needs to continue researching these claims to determine how many were improper; OHA reported that only a small percentage were improper based on preliminary research of 2,700 claims.

3. OHA recovery efforts appear appropriate and reasonable, but may be underutilized due to OHA's limited procedures for detecting improper payments.

4. OHA reported completing the action plan to determine eligibility for the remaining backlog of 115,200 Medicaid recipients. Approximately 47,600 (41%) were deemed ineligible as a result, although this figure may decrease slightly through the end of November. Failure to address this issue in a timely fashion resulted in approximately $88 million in avoidable expenditures.

Introduction

The purpose of this report is to follow up on the recommendations we made to the Oregon Health Authority (OHA) as included in audit report 2017-25, "Oregon Health Authority Should Improve Efforts to Detect and Prevent Improper Medicaid Payments."

The Oregon Audits Division conducts follow-up procedures for each of our performance audits. This process helps assess the impact of our audit work, promotes accountability and transparency within state government, and ensures audit recommendations are implemented and related risks mitigated to the greatest extent possible.

We use a standard set of procedures for these engagements that includes gathering evidence and assessing the efforts of the auditee to implement our recommendations; concluding and reporting on those efforts; and employing a rigorous quality assurance process to ensure our conclusions are accurate. We determine implementation status based on an assessment of evidence rather than self-reported information. This follow-up is not an audit, but a status check on the agency's actions.

To ensure the timeliness of this effort, the division asks all auditees to provide a timeframe for implementing the recommendations in our audit reports. We use this timeframe to schedule and execute our follow-up procedures.

Our follow-up procedures evaluate the status of each recommendation and assign it one of the following categories:

- **Implemented/Resolved**: The auditee has fully implemented the recommendation or otherwise taken the appropriate action to resolve the issue identified by the audit.
- **Partially implemented**: The auditee has begun taking action on the recommendation, but has not fully implemented it. In some cases, this simply means the auditee needs more time to fully implement the recommendation. However, it may also mean the auditee believes it has taken sufficient action to address the issue and does not plan to pursue further action on that recommendation.
- **Not implemented**: The auditee has taken no action on the recommendation. This could mean the auditee still plans to implement the recommendation and simply has not yet taken action; it could also mean the auditee has declined to take the action identified by the recommendation and may pursue other action, or the auditee disagreed with the initial recommendation.

The status of each recommendation and full results of our follow-up work are detailed in the following pages.

Recommendation Implementation Status

Recommendation	Auditee Action	Status
1. Develop a comprehensive inventory of MMIS system controls and proactively test the effectiveness and completeness of those controls.	The agency has developed a comprehensive inventory of system controls for the Medicaid Management Information System (MMIS), but can improve its understanding of these controls and their effectiveness. Proactive testing of system controls has not yet happened. Steps are being taken to have a contractor identify the top 20% of these controls, test their effectiveness, and report results quarterly. OHA's Business Support Unit plans to develop a plan to provide 'spot testing' of the remaining 80% of controls.	**Partially implemented**
2. Adopt leading practices highlighted in the report, such as setting clear standards for acceptable program integrity efforts, and including clear expectations in CCO contracts about when a sanction will occur and the automatic penalty that will be imposed for non-compliance.	OHA has updated Coordinated Care Organizations (CCO) contracts with more clarity around program integrity requirements. Furthermore, the agency plans additional improvements for 2020 CCO contracts, including a new program integrity section with detailed sanctions and automatic penalties for non-compliance. OHA is developing mandatory joint Program Integrity and Medicaid Fraud Control Unit education and training. The training, scheduled for May 2019, will be provided by OHA and the Oregon Department of Justice. Attendance will be required for executives and compliance officers for all CCOs.	**Partially implemented**
3. Increase oversight of CCO program integrity efforts, such as approving CCO's fraud, waste, and abuse policies and reviewing how CCO's prevent, detect, and recover improper payments.	OHA's Office of Program Integrity annually reviews and approves CCO's fraud, waste, and abuse policies. Network providers who perform services on behalf of CCOs are subject to audits, with several audits currently in progress. As noted above, the agency has improved its CCO contracts with more clarity around program integrity requirements and penalties for non-compliance. Both efforts should provide increased oversight of CCOs. Once the contracts efforts are finalized and signed, the recommendation will be fully implemented.	**Partially implemented**

4. Develop robust efforts to validate the accuracy and completeness of encounter data, which may include hiring an External Quality Reviewer or developing internal monitoring efforts through the Office of Program Integrity.	OHA has contracted with an External Quality Reviewer to validate encounter data and to evaluate access, timeliness, and quality of care provided by CCOs. Draft CCO contracts include responsibilities to demonstrate accuracy, completeness, and truthfulness of information through encounter data certification and validation. OHA also intends to conduct periodic encounter data validation studies. Although some efforts have been made to ensure that the data used to set CCO rates is complete and accurate, additional controls are needed given that most Medicaid payments (approximately 75%) are issued through monthly rate payments to CCOs.	**Partially implemented**
5. Review and clarify Oregon Administrative Rules so Medicaid providers can be held accountable for improper payments.	OHA has reviewed Oregon Administrative Rules and identified areas for improvements that could help hold providers accountable for improper payments. OHA needs to complete the rulemaking processes to finalize these changes. The need to continuously review and revise Oregon Administrative Rules will continue as the Medicaid program evolves.	**Partially implemented**
6. Work with U.S. Treasury Do Not Pay center on utilizing free, sophisticated data mining techniques and explore other internal opportunities for data matching.	At the time of the original audit, efforts were in place to detect improper payments through the Provider Audit Unit and other internal processes. The agency has recently taken steps to enhance these efforts. For example, OHA has obtained historic Medicare data from the Centers for Medicare and Medicaid Services (CMS), which will be used internally to detect additional improper payments. The agency is in the process of acquiring enhanced data analytics tools to detect more improper payments than existing tools can identify. The agency performed an assessment of the services offered by the U.S. Treasury through the Do Not Pay center and chose not to engage with the center. As a result, OHA has not utilized the free, sophisticated data mining techniques available to them from the federal government.	**Partially implemented**

7. Work with CMS to explore pilot incentive programs to increase efforts to prevent, detect, and recover improper payments.	Although the agency obtained Medicare data as noted above, management told us that no opportunities existed for pilot incentive programs when the agency explored opportunities with CMS staff.	**Implemented/ Resolved**
8. Ensure there is an annual reconciliation process for all individuals in the agency's various computer systems to verify their eligibility is appropriately re-determined.	The agency has developed a monthly reconciliation process to identify individuals who need their eligibility re-determined.	**Implemented/ Resolved**

Conclusion

OHA has made progress toward improving processes around improper Medicaid payments, with six recommendations partially implemented and two recommendations fully implemented.

The agency chose to only partially implement one recommendation and reported needing more time for full implementation of five recommendations. For example, recommendations no. 2 and no. 3 will be fulfilled, in part, by a training currently in development. Additionally, the 2020 CCO contracts, which are being finalized, contain more robust contract language around program integrity.

Recommendation no. 6 had two components: (1) working with the U.S. Treasury's Do Not Pay business center; and (2) expanding internal data matching efforts. OHA performed an assessment of services and concluded that a partnership with the U.S. Treasury's Do Not Pay center would not add significant value. OHA has made efforts to improve internal data matching efforts by obtaining historic Medicare data and is in the process of acquiring new data analytics software. The agency will not be taking further action to work with the U.S. Treasury. Therefore, recommendation no. 6 will remain partially implemented.

Even after full implementation, many of the recommendations (nos. 1, 3, 4, 5, 6, and 8) will have ongoing elements. For example, OHA needs to gain a better understanding of the accuracy and completeness of the data used in the rate setting process beyond the planned improvements. The agency also needs to ensure the planned strategy of testing system controls is adequate to ensure strong preventative controls exist. Other areas where ongoing work is needed include oversight of CCOs, review of Oregon Administrative Rules, application of data matching techniques, and reconciliation of eligibility systems.

Lastly, there is a backlog in Medicaid eligibility processing and not all individuals that are identified during the reconciliation (recommendation no. 8) are processed timely. The agency is in the process of hiring additional staff, which may address some or all of the existing backlog. Therefore, continuous improvement of multiple program integrity efforts will be needed as the Medicaid program evolves.

We sincerely appreciate the courtesies and cooperation extended by officials and employees of OHA during the course of this follow-up work.

Follow-up Report Team

Will Garber, CGFM, MPA, Deputy Director

Teresa Furnish, CISA, Audit Manager

Ian Green, M.Econ, CFE, CGAP Principal Auditor

Wendy Kam, MBA, CFE, Staff Auditor

Kathy Davis, Staff Auditor

Eli Ritchie, MPA, ACDA, Staff Auditor

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Oregon Audits Division
255 Capitol St NE, Suite 500 | Salem | OR | 97310

(503) 986-2255
sos.oregon.gov/audits