Office of the Secretary of State

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March 29, 2021

Patrick Allen, Director
Oregon Health Authority
500 Summer Street NE, E-20
Salem, OR 97301-1097

Fariborz Pakseresht, Director
Department of Human Services
500 Summer Street NE, E-15
Salem, OR 97301-1097

Dear Mr. Allen and Mr. Pakseresht:

We have completed audit work of a selected federal program at the Oregon Health Authority (authority) and Department of Human Services (department) for the year ended June 30, 2020.

Assistance Listing Number	Program Name	Audit Amount
93.777 and 93.778	Medicaid Cluster	$ 8,357,819,779

This audit work was not a comprehensive audit of your federal program. We performed this federal compliance audit as part of our annual Statewide Single Audit. The Single Audit is a very specific and discrete set of tests to determine compliance with federal funding requirements, and does not conclude on general efficiency, effectiveness, or state-specific compliance issues. The Office of Management and Budget (OMB) Compliance Supplement identifies internal control and compliance requirements for federal programs. Auditors review and test internal controls over compliance for all federal programs selected for audit and perform specific audit procedures only for those compliance requirements that are direct and material to the federal program under audit. For the year ended June 30, 2020, we determined whether the authority and department substantially complied with the following compliance requirements relevant to the federal program.

Compliance Requirement	General Summary of Audit Procedures Performed
Activities Allowed or Unallowed	Determined whether federal monies were expended only for allowable activities.
Allowable Costs/Cost Principles	Determined whether charges to federal awards were for allowable costs and that indirect costs were appropriately allocated.

Eligibility	Determined whether only eligible individuals and organizations received assistance under federal programs, and amounts provided were calculated in accordance with program requirements.
Matching, Level of Effort, Earmarking	Determined whether the minimum amount or percentage of contributions or matching funds was provided, the specified service or expenditure levels were maintained, and the minimum or maximum limits for specified purposes or types of participants were met.
Reporting	Verified the department submitted financial and performance reports to the federal government in accordance with the grant agreement and that those financial reports were supported by the accounting records.
Special Tests and Provisions	Determined whether the authority and department complied with the additional federal requirements identified in the OMB Compliance Supplement.

Noncompliance

The results of our auditing procedures disclosed instances of noncompliance which are required to be reported in accordance with the Uniform Guidance and are described below. Our opinion on the federal program is not modified with respect to these matters.

Internal Control over Compliance

Authority and department management are responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered the authority's and department's internal control over compliance with the types of requirements that could have a direct and material effect on the major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for the major program and to test and report on internal control over compliance in accordance with Title 2 U.S. *Code of Federal Regulations* Part 200*, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the authority's or department's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. *A material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. As discussed below, we identified certain deficiencies in internal control over compliance that we consider to be significant deficiencies.

Audit Findings and Recommendations

Improve controls for monitoring MMIS claims edits and audits

Federal Awarding Agency:	U.S. Department of Health and Human Services
Program Title and CFDA Number:	Medicaid Cluster (93.777, 93.778)
Federal Award Numbers and Years:	1905OR5MAP and 1905OR5ADM; 2019, 2005OR5MAP and 2005OR5ADM; 2020
Compliance Requirement:	Activities Allowed or Unallowed, Special Tests and Provisions
Type of Finding:	Significant Deficiency
Prior Year Finding:	2019-013, 2018-013
Questioned Costs:	N/A

Criteria: 42 CFR 447.45

In previous years, we reported that the Oregon Health Authority (authority) did not adequately monitor aspects of the Medicaid Management Information System (MMIS) claims edits and audits; see Audit Report 2020-14, findings 2019-014 and 2018-013. The authority used MMIS to process almost $8.2 billion in paid claims during fiscal year 2020 and relies on the system's numerous claims edits and audits function to provide assurance that payments are appropriate and to prevent and detect potential inappropriate payments.

In the response to the finding reported for 2019, the authority stated that the contractor responsible for administering the system would test 116 of the edits and audits, and the authority would test the remaining 80% or approximately 460 edits and audits. Although the authority has taken some corrective actions toward addressing the finding, such as reducing the number of staff able to configure the edits and audits, as of June 30, 2020, we noted the following:

- Management did not have a process to monitor for unauthorized changes;
- The contractor tested only 94 of the 116 edits identified for testing; and
- The authority tested approximately 15% rather than 80% of the remaining edits and audits.

Having a strategic framework and thorough understanding of these controls, including what they do and when they trigger, is critical for ensuring accurate and properly recorded payments. If the claims edits and audits are not configured and functioning correctly, there is the potential for millions of dollars of inappropriate payments.

We recommend authority management continue to implement procedures to monitor potential unauthorized changes to the application, as well as continue to verify the effectiveness and completeness of the claims edits and audits function.

Improve documentation and controls over client eligibility

Federal Awarding Agency:	U.S. Department of Health and Human Services
Program Title and CFDA Number:	Medicaid Cluster (93.777, 93.778)
Federal Award Numbers and Year:	1905OR5MAP and 1905OR5ADM; 2019 2005OR5MAP and 2005OR5ADM; 2020
Compliance Requirement:	Eligibility
Type of Finding:	Significant Deficiency, Noncompliance
Prior Year Finding:	2019-016; 2018-014; 2018-015; 2017-014
Questioned Costs:	$16,500 (known)

Criteria: 42 CFR 435.916(a); 42 CFR 435.916(b); 42 CFR 435.907(f); 42 CFR 435.914; 42 CFR 435.952(c)(2)

Federal regulations require certain conditions be met for the Department of Human Services (department) and Oregon Health Authority (authority) to receive Medicaid funding for medical claims. The requirements include redetermining client eligibility for the program every 12 months or when the agency receives information regarding a change in the client's circumstances that may affect their eligibility, obtaining signed applications, maintaining sufficient documentation supporting the client's eligibility and individual claims, and seeking additional information if information provided for an individual is not reasonably compatible with information obtained through an electronic data match.

We randomly sampled 100 clients and one Medicaid service payment associated with each client using a statistically valid sample. We reviewed agency documentation to test compliance with the eligibility requirement. For five clients, we found the issues described below.

- Two clients did not have their eligibility verified within 12 months in accordance with federal requirements.
- One client did not have a signed application on file prior to the date of the sample payment, although the department obtained a new application after our payment date.
- One client had income eligibility determined incorrectly by a caseworker causing the client to be inappropriately deemed eligible, resulting in questioned costs of $1,263.
- One client had income eligibility determined incorrectly by the Oregon Eligibility (ONE) System. The system evaluated sources of income separately, rather than combined. As a result, the client was incorrectly determined eligible resulting in questioned costs of $15,237. This system error may have resulted in multiple clients being incorrectly determined eligible.

The above issues occurred due to administrative errors by various caseworkers and a flaw in the functionality of the ONE System**.**

We recommend department and authority management strengthen controls to perform timely eligibility redeterminations and provide periodic training to caseworkers to reduce the risk of administrative errors. We also recommend management implement corrections in the ONE system to address the weaknesses identified in verifying income. Management should also review the entire duration of the claim identified to determine if there are additional questioned costs from previous years. Additionally, management should reimburse the federal agency for unallowable costs.

Improve documentation for provider eligibility determinations and revalidations

Federal Awarding Agency:	U.S. Department of Health and Human Services
Program Title and CFDA Number:	Medicaid Cluster (93.777, 93.778)
Federal Award Numbers and Year:	1905OR5MAP and 1905OR5ADM; 2019 2005OR5MAP and 2005OR5ADM; 2020
Compliance Requirement:	Special Tests and Provisions
Type of Finding:	Significant Deficiency, Noncompliance
Prior Year Finding:	2019-015; 2018-016; 2017-015
Questioned Costs:	N/A

Criteria: 42 CFR 455.436; 42 CFR 455.102 to 455.107; 42 CFR 455.414

Provider eligibility requirements for the Medicaid program differ depending upon the type of services provided; however, all providers are subject to specified database checks and are required to sign an adherence to federal regulations agreement (agreement). Typically, the agreement includes disclosures specifically required by federal regulations. Additionally, the federal regulations require that the Oregon Health Authority (authority) and Department of Human Services (department) determine eligibility for Medicaid providers and revalidate providers at least every five years by performing database checks to ensure providers are still eligible to participate in the Medicaid program.

Oregon's Medicaid program pays a specified amount to a Coordinated Care Organization (CCO) to provide all treatments for a client in a month. We performed testing for all of Oregon's 15 CCOs. We also selected a statistically valid random sample of 60 other providers in the Medicaid program with 38 providers enrolled by the authority and 22 enrolled by the department.

- For one CCO, the authority could not provide evidence that the required disclosure relating to affiliated organizations was obtained. The authority obtained the necessary disclosures after our inquiries in February 2021.
- For one CCO, the authority could not provide documentation that they had completed the required database checks before the contract became effective on January 1, 2020. The authority completed the necessary database checks after our inquiries in February 2021.
- One nursing home enrolled by the authority did not contain the required disclosures. When this provider was enrolled in the program, they were enrolled through a formal contract rather than with a Provider Enrollment Agreement (PEA). The contract did not include the sections relating to the required disclosures that would ordinarily have been included in a PEA. The authority obtained the necessary disclosures in February 2021.
- One hospital's PEA was originally obtained in 1992 and did not contain the required disclosures. In 2016, the authority implemented a policy to require updated PEAs at each 5-year revalidation. As of March 2021, a new PEA has not been obtained.
- For four providers, the department did not document database checks more recently than 2016. Federal regulations require the provider to be revalidated every five years and department policy is to revalidate at least every two years.
- For an additional four providers, the department could not provide documentation that it had completed database checks at enrollment or any subsequent revalidations. The department subsequently completed the database checks in March 2021. For one of the providers, the five-year term expired in May 2020 based upon the dates of the PEA. As there was no evidence of database checks, we cannot determine if the provider was

revalidated at that time. The department subsequently completed the database checks in March 2021.

Per department management, for the issues discussed in the final two bullets, the databases were intended to be verified through an automated process. The automated process failed, and management is investigating the necessary corrections. Other issues occurred due to incomplete record maintenance and staff error. Failure to perform the necessary background checks and retain provider enrollment agreements increases the risk of payments to inappropriate vendors.

We recommend authority management strengthen controls to ensure documentation supporting a provider's eligibility determination and revalidation is retained. Additionally, we recommend management review the automated processes to ensure databases are checked timely.

Prior Year Findings

In the prior fiscal years, we reported noncompliance and internal control findings in the Statewide Single Audit Report related to the Medicaid Program. For the fiscal year-ended June 30, 2018, see Secretary of State audit report number 2019-14, and for the fiscal year-ended June 30, 2019, see Secretary of State audit report number 2020-14, if applicable.

The findings listed below will be reported in the Statewide Single Audit Report for the fiscal year-ended June 30, 2020 with a status of partial corrective action taken.

Finding Title	Prior Year Finding Number
Improve Controls for Monitoring MMIS Claims Edits and Audits	2018-013
Improve Documentation for Client Eligibility Determinations	2018-015
Improve Controls for Monitoring MMIS Claims Edits and Audits	2019-013
Ensure MMIS Data Tables are Accurate and Updated Timely	2019-014
Improve Documentation for Provider Eligibility	2019-015
Improve Documentation and Controls for Client Eligibility	2019-016

Response to Current Year Findings

The audit findings and recommendations above, along with your responses, will be included in our Statewide Single Audit Report for the fiscal year ended June 30, 2020. Including your responses satisfies the federal requirement that management prepare a Corrective Action Plan covering all reported audit findings. Satisfying the federal requirement in this manner, however, can only be accomplished if the response to each significant deficiency and material weakness includes the information specified by the federal requirement, and only if the responses are received in time to be included in the audit report. The following information is required for each response:

1) Your agreement or disagreement with the finding. If you do not agree with an audit finding or believe corrective action is not required, include in your response an explanation and specific reasons for your position.
2) The corrective action planned for each audit finding.

3) The anticipated completion date.

4) The contact person(s) responsible for corrective action.

Please provide a response to Kelly Olson by April 5, 2021, and provide Rob Hamilton, Statewide Accounting and Reporting Services (SARS) Manager, a copy of your Corrective Action Plan.

The purpose of this communication is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this communication is not suitable for any other purpose.

We appreciate your staff's assistance and cooperation during this audit. Should you have any questions, please contact Geoff Hill or Kelly Olson at 503.986.2255.

Sincerely,

Office of the Secretary of State, Audits Division

cc: Eric Moore, DHS Chief Financial Officer
David Baden, OHA Chief Financial Officer
Margie Stanton, OHA Health Systems Director
Lori Coyner, OHA Medicaid Program Director
Dana Hittle, OHA Medicaid Program Deputy Director
Katie Beck, OHA Operations and Policy Analyst
Michael Matthews, OHA Business Implementation Analyst
Shawn Jacobsen, Controller
Sarah Landis, Chief Audit Officer
Katy Coba, Director, Department of Administrative Services
Rob Hamilton, SARS Manager, Department of Administrative Services