

**Department of Health and Human Services  
Centers for Medicare & Medicaid Services**

**Medicaid Integrity Program  
Oregon Comprehensive Program Integrity Review  
Final Report  
June 2011**

**Reviewers:  
Bonnie Harris, Review Team Leader  
Leatrice Berman Sandler  
Annette Ellis  
Alice Holden  
Mark Rogers**

**Oregon Comprehensive PI Review Final Report  
June 2011**

---

---

**TABLE OF CONTENTS**

---

Introduction.....	1
The Review .....	1
Objectives of the Review .....	1
Overview of Oregon’s Medicaid Program.....	1
Program Integrity Section .....	2
Methodology of the Review.....	2
Scope and Limitations of the Review .....	3
Results of the Review .....	3
Effective Practices .....	3
Regulatory Compliance Issues.....	4
Vulnerabilities.....	8
Conclusion .....	15
Official Response from Oregon .....	A1

---

---

## **INTRODUCTION**

---

---

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Oregon Medicaid Program. The MIG review team conducted the onsite portion of the review at the Department of Human Services (DHS). The review team also conducted a phone interview with the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Provider Audit Unit (PAU) within the Administrative Services Division of DHS, which is primarily responsible for Medicaid program integrity oversight. This report describes three effective practices, five regulatory compliance issues, and nine vulnerabilities in DHS' program integrity operations.

---

---

## **THE REVIEW**

---

---

### ***Objectives of the Review***

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Oregon improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

### ***Overview of Oregon's Medicaid Program***

The DHS administers the Oregon Medicaid program. In January 2010, the program served 505,760 beneficiaries. During State fiscal year (SFY) 2009, Oregon's total Medicaid expenditures were \$3,965,935,835. Of that figure, total fee-for-service (FFS) expenditures amounted to \$700,605,694. The Federal medical assistance percentage (FMAP) for Oregon in Federal fiscal year (FFY) 2009 was 62.45 percent. However, with adjustments attributable to the American Recovery and Reinvestment Act of 2009, the State's effective FMAP was 71.58 percent for the first two quarters of FFY 2009 and 72.61 percent for the third and fourth quarters.

Most of the Oregon Medicaid program operates as a Medicaid reform demonstration under the authority of Section 1115 of the Social Security Act. This authority allowed an eligibility expansion, greater flexibility in the Medicaid coverage package, and the large-scale conversion to managed care delivery systems. At the time of the review, the DHS had contracts with 33 managed care organizations (MCOs). These in turn contracted with 41,124 providers (not an unduplicated figure) and were part of 3 separate delivery systems. Approximately 88 percent of Oregon Medicaid beneficiaries were enrolled in 14 fully capitated health plans, 85 percent in 8 dental care organizations, and 90 percent in 9 mental health organizations. The DHS also contracted with one chemical dependency organization and one physician care organization.

### ***Program Integrity Section***

The PAU, within the Administrative Services Division, is the primary organizational component dedicated to Medicaid fraud and abuse activities for FFS providers. Several other divisions also have significant program integrity responsibilities under the direction of their own management, especially in DHS' managed care and home and community based care programs. These include the Addictions and Mental Health Division (AMH), which is responsible for the mental health services delivery system, the Division of Medical Assistance Programs (DMAP), which is responsible for physical health and dental services, and Seniors and People with Disabilities Division (SPD), which oversees long-term care programs. All of these divisions are within DHS. At the time of the review, PAU had 9 of 11 authorized full-time equivalent (FTE) employees focusing on Medicaid program integrity. The DMAP had an additional 16.2 FTEs assigned to program integrity functions. The table below presents the total number of investigations and overpayment amounts collected for the last four SFYs as a result of program integrity activities within DHS. While data on overpayments identified were not available, the amount of overpayments collected includes program integrity activities and recoveries from all four program areas tracked by the Office of Financial Services.

**Table 1**

<b>SFY</b>	<b>Number of Preliminary Investigations*</b>	<b>Number of Full Investigations**</b>	<b>Overpayments Identified Through PI Activities</b>	<b>Overpayments Collected Through PI Activities</b>
2006	153	18	Not tracked	Included with SFY 2007
2007	122	16	Not tracked	\$5,407,374
2008	180	14	Not tracked	\$762,376
2009	205	11	Not tracked	\$3,063,979

\* Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation. The DHS does not have a central tracking system for preliminary investigations. As a rough proxy of preliminary investigations, the report lists the total number of Medicaid post-payment claims reviews and audits undertaken in the past four SFYs.

\*\* Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition. Figures represent cases referred to the MFCU.

### ***Methodology of the Review***

In advance of the onsite visit, the review team requested that Oregon complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosure, managed care, and the MFCU. A five-person review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of May 17, 2010 the MIG review team visited the offices of DHS. The team conducted interviews with numerous officials from PAU, AMH, DMAP, and SPD staff. Finally, to determine whether the MCOs were complying with contract provisions and other Federal

regulations relating to program integrity, the MIG team interviewed managed care staff within DMAP. The team also reviewed the managed care contract provisions and gathered information through interviews with representatives of six MCOs, including two each of the fully capitated, dental care and mental health organizations. In addition, the team conducted sampling of provider enrollment applications, program integrity case files, and other primary data to validate DHS' program integrity practices.

### ***Scope and Limitations of the Review***

This review focused on the activities of PAU, but also considered the work of other departments within DHS responsible for a range of program integrity functions, including provider enrollment, managed care and non-emergency medical transportation (NEMT). The Children's Health Insurance Program in Oregon operates as a stand-alone program under Title XXI of the Social Security Act and was, therefore, excluded from this review.

Unless otherwise noted, PAU provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information provided.

---

---

## **RESULTS OF THE REVIEW**

---

---

### ***Effective Practices***

As part of its comprehensive review process, the CMS invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Oregon reported practices regarding extensive training of providers, an effective working relationship with the MFCU, and a managed care collaborative workgroup.

#### ***Extensive training of providers***

The DHS provides extensive ongoing training to all providers. This has included:

- a) Training by PAU on Federal and State regulations; audit processes and standards; typical audit findings; how to identify fraud, waste and abuse; and information on CMS issues such as the Medicaid Integrity Program and Payment Error Rate and Measurement reviews.
- b) With the implementation of the new Medicaid Management Information System (MMIS) in December 2008, additional provider training by DMAP on learning and using the new MMIS system. In addition, DMAP has provided training on tamper-resistant prescription pad requirements; entering the National Drug Code on claims for physician-administered drugs; provider enrollment and billing for medication therapy management services; prescriber National Provider Identifier requirements on pharmacy claims; and prior authorization requirements for long-acting opiates.
- c) Training by the AMH on documentation of mental health records and coding.

The DHS' provider education occurs in various forms, including in-service training sessions, professional association conferences, provider letters, and technical assistance offered to individual providers. Training has been offered to the broad range of provider types and their organizations, including hospital, home health, hospice and durable medical equipment (DME) provider associations, mental health and substance abuse providers, Medicaid MCO contractors, and the Association of Oregon Counties.

In the 18 months prior to the review, the PAU indicated that it provided 10 trainings in concert with provider groups, DHS program and policy staff, and/or the MFCU. Following the trainings with mental health, DME, and transportation providers and similar training for Federally Qualified Health Centers, DHS reported seeing an increase in self-referrals. In addition, DHS auditors noted improvement in documentation and billing during follow-up audits for those providers who are on a corrective action plan.

***Effective working relationship with the MFCU***

Both the PAU and the MFCU indicated they have a close and effective working relationship. The PAU and MFCU meet frequently to discuss pending and active cases, and have a Memorandum of Understanding that provides for feedback within 30 days on referrals from the State agency. The collaboration has made each more effective in its role. Cases sampled were compliant with the "MIG Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit" document issued in September 2008. This was affirmed by the MFCU director's statement that his office receives well-documented case referrals from DHS on a consistent basis. Both units mentioned that each provides valuable training to the other, and as a result, the MFCU conviction rate has increased greatly. The ongoing interaction between these two entities promotes a high level of communication that contributes to the success of both units.

***MCO collaborative workgroup***

The Prepaid Health Plan Collaboration Group is a workgroup forum that ensures DMAP and AMH policies are consistently applied in managed care. This venue consists of the vetting of MCO monitoring and oversight activities of delivery systems, claims, quality improvement and fiscal solvency. The matrix used by the group, includes representation from the Program Integrity office to track with accuracy the status of each health plan and the issues requiring agency attention. The group has an increased awareness as to the authority of the group and the consistent application of appropriate interventions ranging from general concerns and monitoring, to informal work plans, to sanctions including but not limited to formal corrective actions plans, financial penalties, closing of enrollment and contract termination.

---

***Regulatory Compliance Issues***

The State is not in compliance with Federal regulations regarding certain disclosure, referral, and notification activities.

***The DHS does not capture all required ownership, control, and relationship information from FFS providers, the fiscal agent, and MCOs.***

Under 42 CFR § 455.104(a)(1), a provider, or “disclosing entity,” that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

**Seniors and People with Disabilities Division Disclosure Issues**

During 2008 and 2009, DHS revised the provider enrollment materials used by DMAP to enroll the large majority of Oregon providers to conform to 42 CFR § 455.104. However, SPD uses other application forms and processes to license and contract with long term care (LTC) and community based care (CBC) entities.

The SPD disclosure requirements are not the same across LTC and CBC provider types, and each application package fails to conform to one or more of the requirements listed in 455.104(a)(1)-(a)(3). Specifically, SPD licenses and enrolls all nursing facilities and CBC entities and providers, which include assisted living facilities, residential care facilities for the elderly and disabled, group homes, adult foster care homes, and in-home health worker/personal care services. At the point of licensure, SPD captures some ownership and control disclosures but does not uniformly capture the full range of disclosure information required by 42 CFR § 455.104 for any LTC or CBC provider type except residential care and assisted living facilities. For example, SPD captures names and addresses of owners and operators of nursing facilities and the names of other nursing homes owned by owners/operators. However, the applications do not capture the name and address of each person with an ownership or control interest in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. They also do not indicate whether any of the named parties have a parent, child, sibling, or spouse relationship. Although DHS states that it captures owners and operators who hold a 5 percent interest in the provider entity, its provider enrollment rules for nursing home applications in the Oregon Administrative Rules [OAR 410-120-1260(6)(b)(A-C) and (6)(e)] require ownership disclosures for parties with a 10 percent ownership interest. This is true for several other provider types as well.

## **Oregon Comprehensive PI Review Final Report**

### **June 2011**

#### **MCO Disclosure Issues**

In addition, the contract between DHS and the MCOs does not fully meet the requirements of 42 CFR § 455.104. While some ownership and control disclosures are required for MCOs and their subcontractors in Exhibit D of the contract, not all of the regulatory requirements are met. Again for example, the contract does require the disclosure of family relationships among persons with ownership and control interests. The managed care staff indicated they proposed a plan to implement the revised provider enrollment application form used for FFS providers in order to satisfy this requirement. However, the form has not yet been put into use.

#### **Fiscal Agent Disclosure Issue**

Finally, DHS does not request disclosure information from the fiscal agent regarding ownership or control interests in other disclosing entities as required under the regulation at 42 CFR § 455.104(c).

NOTE: The CMS team reviewed the managed care and fiscal agent contracts and other provider agreements for compliance with 42 CFR § 455.104 as it was effective at the time of the review. That section of the program integrity regulations has been substantially revised and the amendment was effective on March 25, 2011. The amendment adds requirements for provision of Social Security Numbers and dates of birth as well as more complete address information regarding persons with ownership or control of disclosing entities, and requires disclosures regarding managing employees. Any actions the State takes to come into compliance with 42 CFR § 455.104 should be with that section as amended.

**Recommendation:** Modify FFS provider enrollment forms and MCO and fiscal agent contracts to capture all required ownership, control, and relationship information.

---

#### ***The DHS provider enrollment agreements and contracts do not require providers to disclose certain business transactions. (Uncorrected Repeat Finding)***

The regulation at 42 CFR § 455.105(b) (2) requires that, upon request, providers furnish to the State or the U.S. Department of Health and Human Services information about certain business transactions with wholly owned suppliers or any subcontractors.

This is a repeat finding from the previous CMS program integrity review in September 2007. Although DMAP's provider enrollment application references 42 CFR Subpart B regarding the collection of ownership and control disclosures, there is no reference to this subpart in the DMAP provider agreement, nor does the agreement contain specific language about the ongoing obligation to disclose business transactions upon request and within the 35-day time frame also stated in the regulation. Oregon's administrative rules at OAR 410-120-1260(6)(c) identify the requirements of 42 CFR § 455.105, but the rules are also not cited or expressly incorporated by reference in the provider agreement. In addition, the SPD's contracts, which serve as the provider agreement, do not reference 42 CFR § 455.105.

**Recommendation:** Modify provider enrollment agreements and SPD contracts to meet the requirement at 42 CFR § 455.105(b).



***The DHS does not require disclosure of criminal conviction information for owners, agents, and managing employees of individual providers, LTC and CBC entities, and managed care contractors. (Uncorrected Partial Repeat Finding)***

The regulation at 42 CFR § 455.106 states that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) whenever such disclosures are made.

This is a partial repeat finding from the previous CMS program integrity review in September 2007. The DHS is not in compliance with the requirements on health care-related criminal conviction disclosures for several reasons: The DMAP individual provider form asks only for criminal conviction disclosures for the provider. It does not ask for health care-related criminal conviction information for owners, persons with control interests, agents or managing employees as required in 42 CFR § 455.106(a)(1). The SPD also does not request complete criminal conviction disclosures at the point of Medicaid contracting; and SPD does not have a policy consistent with 42 CFR § 455.106(b)(1) for reporting convictions to HHS-OIG.

In addition, the 42 CFR § 455.106 requirements are not in DHS' contracts with MCOs. While Exhibit D of the contract contains a statement that the contractor may be in default if it knowingly employs someone who has been convicted of a felony or misdemeanor, there is no disclosure requirement. The DMAP managed care staff proposed to adopt the DHS-3974 FFS provider enrollment form in order to satisfy this requirement, but the form has not yet been put into use. Since criminal conviction disclosures are not solicited, the Medicaid agency cannot forward them to HHS-OIG as required.

***Recommendation:*** Modify the DMAP individual FFS provider application and the SPD and MCO contracts to meet the requirements of 42 CFR § 455.106.

---

***The DHS does not report to HHS-OIG adverse actions taken on all provider applications or actions to limit the ability of providers to continue participating in the Medicaid program. (Uncorrected Partial Repeat Finding)***

The regulation at 42 CFR § 1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

This is a partial repeat finding from the previous CMS program integrity review in September 2007. Although SPD reported that on occasion it has reported the exclusion of enrolled providers to HHS-OIG, DHS does not have an a uniform or written agency-wide policy in place and does not report adverse actions systematically to HHS-OIG, including adverse actions taken on provider applications for reasons of fraud, quality or integrity.

**Recommendation:** Develop and implement procedures to ensure notification to DHS and reporting to HHS-OIG whenever adverse actions are taken on provider applications or limitations placed on the ability of providers to participate in the Medicaid program for reasons of fraud, integrity or quality.

---

***The DHS does not provide required notifications about excluded providers.***

Under the regulation at 42 CFR § 1002.212, if a State agency initiates exclusion pursuant to the regulation at 42 CFR § 1002.210, it must provide notice to the individual or entity subject to the exclusion, as well as other State agencies; the State medical licensing board, as applicable; the public; beneficiaries; and others as provided in §§ 1001.2005 and 1001.2006.

During interviews with DMAP and SPD staff, both divisions revealed that they had separate and incomplete protocols for notifying relevant parties of State-initiated exclusions. These are primarily aimed at notifying internal State agency divisions and the MFCU. Staff members mentioned that their divisions will occasionally report exclusions to State licensing boards or other parties, but there is no written, consistent policy or practice meeting the breadth of the requirement in 42 CFR § 1002.212.

**Recommendation:** Develop and implement policies and procedures to ensure that all parties identified by the regulation are notified of State-initiated exclusions.

---

***Vulnerabilities***

The review team identified nine areas of vulnerability in the State's program integrity practices. These involved the fragmentation of program integrity functions and the failure to collect certain required disclosure information from managed care network and NEMT providers, as well as the failure to report adverse actions against managed care providers, to capture managing employee information, and to conduct complete searches for excluded individuals and entities within managed care networks. In addition, the team observed a lack of MMIS edits to avoid duplicate claims payments and inadequate oversight of claims processed outside of the MMIS.

***Insufficient coordination of program integrity activities across divisions within DHS.***

The program integrity function is not centrally organized within the Oregon Medicaid agency. The DHS oversight of the program integrity function and the surveillance and utilization review program is assigned to PAU staff, although staff in AMH, DMAP, and SPD performs some program integrity functions. Under this decentralized program integrity structure, DHS does not consistently use its authority to oversee provider activities. This is exemplified in several ways. Most notably, DHS does not have a comprehensive tracking system for fraud referrals and does not make use of payment suspensions and withholds. It also does not monitor whether providers are in compliance with False Claims Act education standards across divisions, and does not comprehensively oversee MCO program integrity activities.

Following the CMS February 2001 review, Oregon established an 800 number, a secure fax and email that are checked daily for complaints. However, the State still lacks a central tracking

## **Oregon Comprehensive PI Review Final Report**

### **June 2011**

system to capture all fraud and abuse complaints, including referrals to the MFCU. This was identified during a previous CMS program integrity review in February 2001 and remains a concern. While PAU maintains a master log of AMH and DMAP suspected fraud and abuse cases and MFCU referrals, this tracking system does not include cases from the MCOs overseen by AMH and the Managed Care section of DMAP, nor does it include any SPD cases. The SPD maintains its own database that is not fed into the PAU master log. The decentralized tracking system also makes it difficult, and at times impossible, for DHS to report what cases have been opened for investigation, how many have been referred to the MFCU, and how many have been closed. Fraud and abuse complaints and referrals to the MFCU from the MCOs are not always sent directly or concurrently to AMH, DMAP or PAU, as required under the MCO contract. This hinders DHS from evaluating referrals to allow for a quicker reaction to emerging issues and for the identification of cross-cutting issues and scams that may have an effect on other MCOs and FFS Medicaid. Use of a central point for referring to the MFCU may alleviate the communication problems noted by one MCO that has reported problems hearing back from the MFCU on its referrals. It also would allow the PAU to fully monitor ongoing issues, trend specific billing and reporting problems, and identify providers who may be repeat offenders in different delivery systems.

The absence of centralized program integrity oversight has also hindered DHS from exercising its option to withhold provider payments in cases of suspected fraud or willful misrepresentation and has made it difficult to take consistent administrative actions across provider types, although the Oregon Administrative Rules give the State agency this authority. The DHS has in a few instances taken actions, such as notifying the enrollment section to suspend a provider number or taking liens against a provider's personal property. However, DHS reported that, since 2008, it has been reluctant to stop payments to providers unless a repayment or recoupment is due.

The DHS has created and disseminated a comprehensive *Provider Guide* on how to comply with the requirements for employee education on the False Claims Act under 42 U.S.C. § 1396a(a)(68). This guide provides detailed explanations of what the Federal statute means on false claims, along with guidance on establishing compliance programs. In addition, the guide explains how this requirement will be monitored and includes a sample version of a compliance monitoring tool. However, while AMH and DMAP have engaged in provider monitoring to spot check for compliance, there is no indication that SPD has engaged in any look-behind activities to ensure that False Claims Act education is being provided.

The DHS, likewise, does not exercise the same degree of program integrity oversight in its managed care programs that it does over FFS providers. The DHS has an effective general monitoring process over its managed care programs through the use of a "silo buster" in which AMH and DMAP worked collaboratively to develop a matrix to rank each MCO on features such as the delivery system, encounter data quality, quality improvements, and financial measures. However, the monitoring of MCO program integrity activities remains relatively weak. For example, little attention is paid to how plans instruct enrollees on what fraud and abuse is and how to report it. The oversight staff within DHS does not have substantive knowledge of the fraud and abuse cases that each MCO is investigating and referring for prosecution, nor does DHS require any reporting of such activities.

## **Oregon Comprehensive PI Review Final Report**

### **June 2011**

More generally, without a centralized program integrity function, DHS may encounter problems involving unreported issues, duplication of effort, jurisdictional conflicts, and poor coordination of program integrity efforts. At some point in time, the overall organization runs the risk of having manageable issues increase in severity to the point where large overpayments or losses to actual fraud may be incurred.

***Recommendation:*** Organize all program integrity activities in a centralized unit.

---

#### ***Not collecting all required ownership and control disclosure information from MCO network providers and NEMT providers.***

Neither the DHS MCO contract nor existing policies and procedures require the MCOs to collect the full range of ownership and control disclosures from MCO network providers that Federal regulations at 42 CFR § 455.104 would otherwise require from FFS providers. In their internal credentialing process, DHS' MCOs use the Oregon Practitioner Credentialing Application which does not ask for information on persons with ownership and control interests in the provider, family relationships among such persons, and interlocking relationships of ownership and control with subcontractors. Consequently, these individuals cannot be searched for HHS-OIG exclusions.

Per DMAP's managed care staff, MCOs are supposed to have their network providers meet the current 42 CFR § 455.104 requirements by completing one of two Ownership and Control Disclosure Statements: the DHS-3973 Form for individuals or the DHS-3974 Form for entities. However, DMAP was unable to provide the review team with a policy reflecting this requirement, and only one of the plans interviewed stated it uses the DHS forms. All managed care providers are enrolled in the Oregon MMIS using the DMAP Provider Application – Encounter Data Form DHS-3108. This form is only used to enter the provider into the MMIS for encounter data information. It collects only the practitioner's name and address and plan name but nothing on ownership and control. This leaves DHS vulnerable to having undetected excluded parties in ownership and control positions of providers or subcontractors which serve Medicaid managed care enrollees and who are not otherwise enrolled in the FFS Medicaid program.

Furthermore, DMAP contracts with units of local government for transportation broker services through an Intergovernmental Agreement which does not require the collection of ownership and control disclosures from drivers. In response to review team requests, DHS did not provide evidence that broker contracts with vendors and individual drivers are in compliance with 42 CFR § 455.104.

NOTE: The CMS team reviewed the managed care and transportation contracts and other provider agreements for compliance with 42 CFR § 455.104 as it was effective at the time of the review. That section of the program integrity regulations has been substantially revised and the amendment was effective on March 25, 2011. The amendment adds requirements for provision of Social Security Numbers and dates of birth as well as more complete address information

## **Oregon Comprehensive PI Review Final Report June 2011**

regarding persons with ownership or control of disclosing entities, and requires disclosures regarding managing employees. Any actions the State takes to come into compliance with 42 CFR § 455.104 should be with that section as amended.

**Recommendation:** Modify the MCO contract and NEMT broker agreement to require the disclosure of complete ownership, control, and relationship information from all MCO network providers and transportation drivers.

---

### ***Not requiring MCO providers to disclose business transaction information, upon request. (Uncorrected Repeat Vulnerability)***

This is a repeat concern from the previous CMS program integrity review in September 2007. Neither the DHS contracts with MCOs nor the MCO provider agreements require network providers to disclose the same business transaction information on request which Federal regulations at 42 CFR § 455.105 would otherwise require of FFS providers. In their internal credentialing process, DHS' MCOs use the Oregon Practitioner Credentialing Application. This includes a provider agreement which does not contain the necessary business transaction disclosure language or a reference to the applicable Federal regulation or State rules.

**Recommendation:** Modify MCO contracts and network provider agreements to require disclosure upon request of the required business transaction information.

---

### ***Not requiring the disclosure of health care-related criminal conviction information during the managed care credentialing process and enrollment of transportation providers. (Uncorrected Repeat Vulnerability)***

This is a repeat concern from the previous CMS program integrity review in September 2007. While discussions with PAU staff indicated that the State agency has attempted to address it, DHS' MCO contracts still do not require MCO providers and affiliated personnel to disclose health care-related criminal conviction information which Federal regulations at 42 CFR § 455.106 would otherwise require of FFS providers. The Oregon Practitioner Credentialing Application used by the MCOs does not contain language with sufficient specificity to meet the regulatory requirement. Section XX of the application asks if the practitioner has been charged with a felony or misdemeanor criminal violation. It does not ask agents, owners, directors and managing employees for similar disclosures.

During interviews, DMAP staff mentioned that as part of Oregon's response to the September 2007 review findings, MCOs are now required to capture criminal conviction disclosures from their providers using either the DHS-3973 or DHS-3974 Ownership and Disclosure Statements or equivalent forms. However, the review team could not locate a policy implementing this requirement, and only one of the plans interviewed stated that it uses the DHS forms. The DMAP Provider Application Form DHS-3108 used to enroll managed care providers into the MMIS for encounter data purposes also does not require criminal conviction disclosures.

## **Oregon Comprehensive PI Review Final Report**

### **June 2011**

The transportation broker contract likewise is not fully compliant. It requires the disclosure of criminal convictions of persons with an ownership or control interest in a provider when such information becomes known to a regional broker. It also requires criminal background checks for all drivers (either contractors or employees). However, the transportation contract does not contain language requiring the broker to collect health care-related criminal conviction disclosures from managing employees or agents or vendors.

**Recommendation:** Develop and implement procedures to collect health care-related criminal conviction information from MCO and transportation network providers and to make timely reports of relevant disclosures submitted by all providers to HHS-OIG as required.

---

#### ***Not requiring MCOs to report denials of provider credentialing and network provider terminations to DHS.***

The DHS managed care contracts do not specifically require the reporting of denied MCO provider applications or network provider terminations when such actions are taken for program integrity reasons. There is a requirement to comply with all disclosure requirements of 42 CFR 1002.3(a) in Exhibit E of the contract, but this is not specific enough. Exhibit K of the contract requires an annual Capacity Report from the MCOs that includes data for each participating provider panel. However, an updated Capacity Report is only required when the loss of a medical provider or group will have a substantial impact on member access in a service area. If a provider is denied enrollment or is terminated for a program integrity-related cause that did not result in a significant impact on access, that information is not being reported in a Capacity Report and might not be conveyed at all or in a timely manner. In addition, AMH managed care staff and one mental health organization reported that while credentialing denials had been reported to division staff in the past, this occurred only informally and not in the last four years. The failure of MCOs to notify the Medicaid agency of adverse actions taken for program integrity reasons may make it easier for problem providers to find their way into other MCOs and the FFS program undetected. It also precludes DHS from reporting such actions to the HHS-OIG, as the regulation at 42 CFR § 1002.3(b) would require in the FFS program.

**Recommendation:** Develop and implement procedures to ensure notification to DHS and reporting to HHS-OIG whenever adverse actions are taken on MCO provider applications or limitations are placed on the ability of MCO network providers to participate in their MCOs for reasons of fraud, integrity or quality.

---

#### ***Not capturing managing employee information on provider enrollment forms.***

Under 42 CFR § 455.101, a managing employee is defined as “a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency.”

The DHS does not solicit managing employee information on its current FFS provider enrollment forms, nor does the Oregon Practitioner Credentialing Application used by the

## **Oregon Comprehensive PI Review Final Report**

### **June 2011**

MCOs. Thus, the State would have no way of knowing if excluded individuals are working for providers or health care entities in such positions as billing managers and department heads.

***Recommendation:*** Develop and implement procedures to capture information on managing employees in the MMIS or in an alternative repository that would permit ongoing exclusion checks to be performed.

---

#### ***Not conducting complete searches of individuals and entities excluded from participating in Medicaid.***

On June 12, 2008, CMS issued a State Medicaid Director Letter (SMDL #08-003) providing guidance to States on checking providers and contractors for excluded individuals. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers to screen their own staff and subcontractors for excluded parties.

In general, DHS staff does not follow the SMDL directives on exclusion checking as prescribed. The FFS program and transportation brokers in Oregon do not conduct exclusion searches that are fully consistent with this guidance, and practices are inconsistent across the divisions of the State agency. For example, in the FFS program, DMAP staff does not check owners, managing employees, and Board of Director members for exclusions. They check only provider names. The SPD staff checks owners and operators and entity names but not managing employees or major subcontractors of its Medicaid contracted entities. The DHS staff likewise does not check transportation drivers or contractors against the HHS-OIG List of Excluded Individuals/Entities (LEIE) or other exclusion databases. The DHS was also not able to furnish evidence that regional brokers (which are government authorities) check their subcontractors, vendors, and drivers or that the vendors check their employees or drivers.

The team found that DHS staff checks the LEIE when providers apply to the FFS Medicaid program and only quarterly thereafter, rather than on a monthly basis. All the MCOs interviewed similarly check for exclusions at enrollment, but either annually or only every three years thereafter when providers are recredentialed.

Further, DHS does not maintain information on provider-affiliated parties of interest in a searchable format. While DHS' provider applications collect the names of owners, operators and in some instances managing employees on FFS entity applications, DMAP does not enter this information into the MMIS or another searchable data repository. The SPD maintains a database, but it does not include managing employees and owners. This precludes automated exclusion checks on all relevant individuals from being undertaken on an ongoing basis.

NOTE: A new regulation at 42 CFR § 455.436, effective March 25, 2011, now requires States to check enrolled providers, persons with ownership and control interests, and managing employees for exclusions in both the LEIE and the Excluded Parties List System (EPLS) on a monthly basis.

## **Oregon Comprehensive PI Review Final Report**

### **June 2011**

**Recommendations:** Develop and implement policies and procedures for appropriate collection and maintenance of disclosure information to ensure that FFS provider enrollment staff, MCOs and transportation brokers conduct complete exclusion searches using the LEIE (or the Medicare Exclusion Database) and the EPLS at the time of provider enrollment, re-enrollment, and at least monthly thereafter. Refer for guidance as needed to SMDLs #08-003 and #09-001, which can be found on the CMS website.

---

#### ***Not having MMIS edits in place to avoid paying nursing home claims for individuals going into hospice.***

During interviews, DHS acknowledged that the MMIS does not have edits in place which would prevent payment of nursing home claims when an individual transfers to hospice. The PAU relies upon the program staff to monitor payments and report if they find duplication. It is not clear how or if this problem will affect DHS' efforts to obtain CMS certification of Oregon's new MMIS. The PAU reported that this issue existed before the current MMIS went into operation in December 2008.

**Recommendations:** Develop and implement procedures to ensure edits are in place to avoid making duplicate payments when an individual transitions from nursing home to hospice. Ensure that Federal financial participation on any duplicate payments previously made and not properly adjusted are promptly reported and returned to CMS.

---

#### ***Not providing adequate oversight of claims processed outside of MMIS.***

The DHS indicated that claims for services for home care workers (HCW) and in-home agencies are paid through a voucher system within SPD. Such claims do not go through the MMIS. Hence, they are not subject to the edits, audits, and general safeguards of the standard claims processing system. The SPD division indicated that it reviews in-home agency cost reports and HCW billings for purposes of rate-setting. The division also performed a targeted review of HCW services to evaluate care management plans and identify service duplication issues. However, there is no indication that the results of these reviews were shared with PAU. Although, information on processed HCW claims is loaded into the surveillance and utilization review subsystem, at the time of the review, PAU indicated that it was not reviewing these billings as part of routine auditing. This leaves the State potentially vulnerable to improper billing practices for a type of service that is prone to fraud and abuse across the country.

**Recommendation:** Develop and implement procedures to ensure adequate oversight of claims processed outside of the MMIS.



---

---

## **CONCLUSION**

---

---

The State of Oregon applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. These practices include:

- extensive training of providers,
- an effective working relationship with the MFCU, and
- an MCO collaborative workgroup.

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of five areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, nine areas of vulnerability were identified. The CMS encourages DHS to closely monitor each area of vulnerability that was identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require Oregon to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Oregon will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If Oregon has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Oregon on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

**Official Response from Oregon  
August 2011**

Division of Medical Assistance Programs

John A. Kitzhaber, MD, Governor

**Oregon  
Health  
Authority**

500 Summer Street NE, E49  
Salem, Oregon 97301-1079  
Voice – (503) 945-5772  
FAX – (503) 373-7689  
TTY – (503) 378-6791  
[www.oregon.gov/OHA](http://www.oregon.gov/OHA)

August 11, 2011

Robb Miller, Director  
The Division of Field Operations  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Mr. Miller

Oregon is pleased to have the opportunity to respond to the 2010 final Medicaid Program Integrity Review. The Oregon Health Authority and The Department of Human Services jointly want to thank you and your staff for assisting Oregon Medicaid in its ongoing program integrity efforts.

Enclosed with this letter is the required corrective action plan pertaining to each noncompliant area noted in the report. In addition, Oregon did take advantage of the opportunity to respond to areas of vulnerability as called out in the report. It is our belief our program integrity efforts are advancing and are being strengthened by the additional “sets of eyes” reviewing and commenting on our work.

In general, all non-compliant areas have been addressed and are corrected at this time. Also enclosed with the corrective action plan are the new or updated documents and forms OHA and DHS are currently using to come in to compliance with the Code of Federal Regulations. Further, the noted vulnerability regarding the coordination of program integrity activities has had considerable attention in the past year, and a summary of that attention is provided as well.

Thank you for your cooperation and guidance in assisting the OHA and DHS to be stronger and more effective in our program integrity efforts. We take these matters quite seriously and will continue to put resources, expertise and energy to our program integrity work.

Sincerely,



Judy Mohr Peterson, Director  
Division of Medical Assistance Programs  
Oregon Health Authority

Enclosures