Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Oregon Focused Program Integrity Review

Medicaid Managed Care Oversight

July 2025

Final Report

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I. Executive Summary

Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a focused program integrity review to assess Oregon's program integrity oversight efforts of its Medicaid managed care program for the Fiscal Years (FY) 2020 - 2022. This focused review specifically assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid managed care.

To meet the objectives of this focused review, CMS reviewed information and documents provided in response to the CMS managed care review tool provided at the initiation of the review. CMS also conducted in-depth interviews with the State Medicaid Agency (SMA) and evaluated program integrity activities performed by selected Coordinated Care Organizations (CCOs) under contract with the SMA.

This report includes CMS' observations that were identified during the focused review.

Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified **no** findings that create risk to the Oregon Medicaid program related to managed care program integrity oversight.

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid managed care program. CMS identified **ten** observations related to Oregon's managed care program integrity oversight. While observations do not represent areas of non-compliance with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of leading practices. The observations identified during this review include the following:

State Oversight of Managed Care Program Integrity Activities

Observation #1: CMS encourages Oregon to revise the CCO general contract to include the definition of a professional, including education and experience, and include a provision that this position be physically located within the state of Oregon.

Observation #2: CMS encourages Oregon to consider the inclusion of contract language that addresses conducting investigative unannounced provider site visits to ensure that all CCOs are utilizing this practice.

Observation #3: CMS encourages Oregon to amend the CCO general contract to ensure that the CCOs have a prepayment review process in place, including collaborating to strengthen parameters regarding prepayment rules, policies, and requirements.

CCO Contract Compliance

Observation #4: CMS encourages Oregon to enhance its oversight of fraud, waste, and abuse plans. While Oregon requires each CCO to submit an annual fraud, waste, and abuse plan that addresses measures to detect and prevent fraud, waste, and abuse, CMS noted that several essential program integrity elements were excluded from at least two CCO fraud, waste, and abuse plans.

Observation #5: CMS encourages Oregon to modify the CCO general contract language to develop and distribute detailed guidance for standard, appropriate member verification procedures.

Observation #6: CMS encourages Oregon to review the overpayment procedures of all contracted CCOs and to ensure the CCOs make recovering overpayments a prioritized program integrity contract requirement to promote the importance of recovering all improperly paid Medicaid managed care payments.

CCO Investigations of fraud, waste, and abuse

Observation #7: CMS encourages Oregon to work with the CCOs to improve the quality and quantity of case referrals through routinely provided specific program integrity training and frequent feedback to the CCOs regarding their case referral performance. CMS also encourages Oregon to consider establishing metrics to uniformly assess the quality and quantity of case referrals.

Observation #8: CMS encourages Oregon to provide guidance to the CCOs on elements in a referred case.

Observation #9: CMS encourages Oregon to ensure that CCOs have sufficient corrective action plan procedures in place and are utilizing them appropriately to address non-compliant Medicaid providers. Additionally, CMS encourages Oregon to ensure the full requirements of the corrective action plan are completely satisfied by the providers.

Observation #10: CMS encourages Oregon to track and collect information regarding provider self-audits.

II. Background

Focused Program Integrity Reviews

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, CMS set forth its strategy to safeguard the integrity of the Medicaid program.[1] This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring strategies that meet federal standards.

As a part of these efforts, CMS conducts focused program integrity reviews on high-risk areas in the Medicaid program, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, telehealth, and personal care services. These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and to identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

Medicaid Managed Care

Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between SMAs and CCOs that receive a set per member per month (capitation) payment for these services. By contracting with various types of CCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.

Overview of the Oregon Managed Care Program and the Focused Program Integrity Review

The Oregon Health Authority (OHA) is responsible for the administration of the Oregon Medicaid program, Oregon Health Plan (OHP). Within OHA, the Office of Program Integrity (OPI) is the organizational unit tasked with oversight of program integrity-related functions for the managed care program. The OHP utilizes the coordinated care model for managed care delivery, contracting with coordinated care organizations (CCOs) to deliver care in a specific geographic area. CCOs are capitated multisector networks of providers (physical, behavioral, and oral health) accountable for care management and to provide integrated and coordinated health care for each member. A CCO contracts with multiple delegated entities, including dental care organizations, non-emergency medical transportation providers, and behavioral health provider networks to provide services to beneficiaries assigned to a CCO. During the review period, OHA contracted with sixteen CCOs to provide health services to the Medicaid population. As part of this review, three of the sixteen CCOs providing care to Oregon Medicaid beneficiaries were

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

interviewed: Columbia Pacific, PacificSource Community Solutions, and Umpqua Health Alliance**.** Appendix C provides enrollment and expenditure data for each of the selected CCOs.

In September 2023, CMS conducted a virtual focused program integrity review of Oregon's managed care program. This review assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. As a part of this review, CMS also evaluated program integrity activities performed by selected CCOs under contract with the SMA. CMS interviewed key staff, including the CCOs' Special Investigations Units (SIUs), and reviewed other primary data. CMS also evaluated the status of Oregon's previous corrective action plan that was developed in response to a previous focused program integrity review of Oregon's managed care program conducted by CMS in 2018, the results of which can be found in Appendix A.

During this review, CMS identified a total of **ten** observations. CMS also included technical assistance and educational resources for the state, which can be found in Appendix B. The state's response to CMS' draft report can be found in Appendix D, and the final report reflects changes CMS made based on the state's response.

This review encompasses the following five areas:

A. **State Oversight of Managed Care Program Integrity Activities** - CMS established requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of CCO performance in several program integrity areas. These areas include, but are not limited to: data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under §§ 438.608.

B. **CCO Contract Compliance** - Regulations at § 438.608 require the state, through its contracts with the CCOs, to ensure that CCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, such as implementing compliance plans, payment suspensions based on credible allegations of fraud, and overpayment reporting.

C. **Interagency and CCO Program Integrity Coordination** - Within a Medicaid managed care delivery system, CCO SIUs, the SMA, and the state Medicaid Fraud Control Unit (MFCU) play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars. Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA.

D. **CCO Investigations of Fraud, Waste, and Abuse** - Regulations at § 438.608(a)(7) require states to ensure that CCOs promptly refer any potential fraud, waste, and abuse that the CCO identifies to the state Program Integrity Unit (PIU) or any potential fraud directly to the state's MFCU. Similarly, as required by § 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and CCOs.

E. Encounter Data - In accordance with § 438.242, the state must ensure, through its contracts, that each CCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each CCO.

III. Results of the Review

A. State Oversight of Managed Care Program Integrity Activities

State oversight of managed care program integrity activities is critical to ensuring that CCOs are meeting all CMS requirements and state contractual requirements. CMS established state monitoring requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of CCO performance in several program integrity areas, including but not limited to, data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under §§ 438.608.

In Oregon, these oversight and monitoring requirements are met and are addressed within the CCO general contract. The CCO general contract states that OHA is responsible for monitoring the contractor's compliance with the general contract and applicable laws and regulations. The OHA ensures compliance of the CCOs through reviewing documents submitted by the contractor, contract performance reviews, review of grievances, review of reports generated by the External Quality Review Organization (EQRO), and onsite review of documents and any other source of relevant information. The OHA Health Systems Division administers the CCO contracts and provides for contract and programmatic oversight of each CCO. The OHA OPI has oversight of fraud and abuse related activities for the fee-for-service and managed care Medicaid programs. The OPI performs audits of fee-for-service and managed care providers using the audit processes outlined in Oregon Administrative Rules 410-120-1396. The OHA contracts with Health Services Advisory Group, Gainwell Technologies, Mercer, and Myers and Stauffer to provide support for their program integrity efforts.

CMS observed that the CCO general contract requires each CCO to have at least one employee who reports to the Chief Compliance Officer. In 2022, the CCO general contract was updated to include a requirement that the individual who reports to the Chief Compliance Officer must be a professional employee and is not required to be an investigator. In addition, per the contract regulations, OHA does not require the CCO SIU staff to reside in the state of Oregon.

CMS observed that, although the review period coincided with the COVID-19 Public Health Emergency (PHE), which restricted CCOs' ability to perform unannounced investigative provider site visits, all three of the CCOs did not conduct unannounced site visits prior to the start of the PHE. CMS also observed that the CCO general contract did not address conducting investigative unannounced provider site visits.

Lastly, CMS observed that the CCO general contract does not address prepayment processes or prepayment review.

Observation #1: CMS encourages Oregon to revise the CCO general contract to include the definition of a professional, including education and experience, and include a provision that this position be physically located within the state of Oregon.

Observation #2: CMS encourages Oregon to consider the inclusion of contract language that addresses conducting investigative unannounced provider site visits to ensure that all CCOs are utilizing this practice.

Observation #3: CMS encourages Oregon to amend the CCO general contract to ensure that the CCOs have a prepayment review process in place, including collaborating to strengthen parameters regarding prepayment rules, policies, and requirements.

B. CCO Contract Compliance

Regulations at § 438.608 require the state, through its contracts with the CCOs, to ensure that CCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. These requirements extend to any subcontractor that is delegated responsibility for coverage of services and payment of claims under the contract between the state and the CCO. As part of this review, the CCO general contract was evaluated for compliance with several of these requirements, which are described in greater detail below.

The CCO general contract for Oregon is developed by OHA. The program integrity provisions of the contract are primarily overseen by the OPI within OHA.

Compliance Plans

In accordance with §§ 438.608(a)(1)(i)-(vii), states must require CCOs to implement compliance programs that meet certain minimal standards, which include the following:

1. Written policies, procedures, and standards of conduct that articulate the CCO's commitment to comply with all applicable requirements and standards under the contract, and all applicable federal and state requirements.
2. Designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors.
3. Establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the CCO's compliance program and its compliance with the requirements under the contract.
4. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the contract
5. Effective lines of communication between the Compliance Officer and employees.

6. Enforcement of standards through well-publicized disciplinary guidelines.
7. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

The CCO general contract does explicitly address the requirement that all seven compliance plan elements listed above be addressed. A review of the CCOs compliance plans and programs found that each CCO's compliance plan contained the required elements in accordance with §§ 438.608(a)(1)(i)-(vii).

Oregon reported that CCOs are contractually required to develop a fraud, waste, and abuse plan to be submitted for annual review. During the review, CMS observed that there were no compliance concerns with the fraud, waste, and abuse plans for PacificSource Community Solutions. However, during the review period, the Columbia Pacific and Umpqua Health Alliance fraud, waste, and abuse plans omitted elements including, but not limited to, cost avoidance, provider payment suspensions, site visits, and prepayment reviews.

> **Observation #4**: CMS encourages Oregon to enhance its oversight of fraud, waste, and abuse plans. While the state requires each CCO to submit an annual fraud, waste, and abuse plan that addresses measures to detect and prevent fraud, waste, and abuse, CMS noted that several essential program integrity elements were excluded from at least two CCO fraud, waste, and abuse plans.

Beneficiary Verification of Services

In accordance with § 438.608(a)(5), the state, through its contract with the CCO, must require a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

In Oregon, this requirement is met because the CCO general contract requires verification of services through mailing service verification letters to members, sampling, or other methods.

Each of the three CCOs were observed to have a beneficiary verification process in place, however, CMS observed that the contract language does not specifically address the number of verifications to be completed annually.

> **Observation #5**: CMS encourages OHA to modify the CCO general contract language to develop and distribute detailed guidance for standard, appropriate member verification procedures.

False Claims Act Information

In accordance with § 438.608(a)(6), the state, through its contract with the CCO, must require that, in the case of CCOs that make or receive annual payments under the contract of at least $5,000,000, there are written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

Oregon is compliant with this requirement. The general contract requires the CCOs to include within the fraud, waste, and abuse plan policies encompassing the False Claims Act, including whistleblower protection laws. A review of the state's policy found that OHA has written policies for Oregon Medicaid employees, contractors, CCOs, and agents that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

CMS did not identify any findings or observations related to these requirements.

Payment Suspensions Based on Credible Allegations of Fraud

Pursuant to § 438.608(a)(8), states must ensure that CCOs suspend payments to a network provider for which the state determines there is a credible allegation of fraud in accordance with § 455.23.

Oregon Medicaid CCOs are contractually required to suspend payments to providers, but only at the state's request. The CCO general contract requires the CCOs to suspend providers once the state has determined a payment suspension should be imposed and no exception applies. The CCO general contract further states that CCOs are to cooperate with OHA when OHA imposes payment suspensions or lifts a payment hold.

CMS did not identify any findings or observations related to these requirements.

Overpayments

Regulations at §§ 438.608(a)(2) and (d) require states to maintain oversight of CCOs' overpayment recoveries. Specifically, § 438.608(a)(2) requires states to ensure that CCOs promptly report all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. In addition, § 438.608(d) requires states to specify in CCOs' contracts how the CCOs should treat overpayment recoveries. This must include retention policies for recoveries of all overpayments, including overpayments due to fraud, waste, and abuse; the process, timeframes, and documentation requirements for reporting the recovery of all overpayments; and the process, timeframes, and documentation requirements for payment of recoveries to the state in situations where the CCO is not permitted to retain some or all of the recoveries. States must also ensure that CCOs have a process for network providers to report to the CCO when it has received an overpayment (including the reason for the overpayment), and to return the overpayment to the CCO within 60 calendar days. Each CCO must report annually to

the state on their recoveries of overpayments, and the state must use the results of the information in setting actuarially sound capitation rates, consistent with the requirements in § 438.4.

The state adequately addressed the requirements at §§ 438.608(a)(2) and (d). The CCO general contract requires the CCO to have internal policies and procedures for the documentation, retention, and recovery of all overpayments, and specifically for the recovery of overpayments due to fraud, waste, and abuse. In addition, the CCO general contract requires the contractors to report at least bi-annually the overpayment recoveries submitted to the state.

CMS observed that Oregon did not collect data from the CCOs on identified overpayment amounts on a regular basis prior to January 1, 2020. CMS observed that the number of overpayments identified and recovered by the CCOs are low for a managed care program of this size. According to the state, the numbers self-reported by the CCOs are not overly reliable.

> **Observation #6**: CMS encourages Oregon to review the overpayment procedures of all contracted CCOs and to ensure the CCOs make recovering overpayments a prioritized program integrity contract requirement to promote the importance of recovering all improperly paid Medicaid managed care payments.

C. Interagency and CCO Program Integrity Coordination

Within a Medicaid managed care delivery system, CCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars and beneficiaries. Each of these entities performs unique functions that are critical to providing effective oversight of the Medicaid program. The ability to reduce fraud in Medicaid managed care will be enhanced as these entities develop methods and strategies to coordinate efforts. Ineffective collaboration can adversely affect oversight efforts, putting taxpayer dollars and beneficiaries at risk.

Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA. Oregon has a Memorandum of Understanding (MOU) in place with the MFCU that meets the regulatory criteria. Specifically, there is a MOU that contains procedures by which the MFCU will receive referrals of potential fraud from CCOs as required by 455.21(c)(3)(iv). Additionally, the state meets with the MFCU quarterly to discuss case referrals.

While there is no requirement for SMAs to meet on a regular basis with its CCOs for collaborative sessions to discuss pertinent program integrity issues regarding fraud, waste, and abuse and relevant contractual concerns, such collaborative sessions are an effective and important process to ensure open communication and strong partnerships. The SMA does hold quarterly collaborative sessions with its CCOs to discuss program integrity issues, such as case referrals, leads, and administrative actions.

CMS did not identify any findings or observations related to these requirements.

D. CCO Investigations of Fraud, Waste, and Abuse

State Oversight of CCOs

Regulations at § 438.608(a)(7) require states to ensure that CCOs promptly refer any potential fraud, waste, and abuse that the CCO identifies to the state PIU or any potential fraud directly to the state's MFCU. Similarly, as required by §§ 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and CCOs.

Oregon has a process in accordance with §§ 455.13-17 and 438.608(a)(7). The CCO general contract requires the contractors to report any potential fraud, waste, or abuse within 7 days to OHA and MFCU. The referral can be sent via secure fax, phone, mail, or website.

CMS observed a lack in the quality and quantity of case referrals from the CCOs. The MFCU also indicated during the interview with CMS a concern in the quality and quantity of fraud referrals for the review period.

CMS observed that during the review period, OHA did not provide elements that should have been included in a referral. However, on January 10, 2023, OHA provided a referral template for the CCOs to report the appropriate elements on each referral.

> **Observation #7**: CMS encourages Oregon to work with the CCOs to improve the quality and quantity of case referrals through routinely provided specific program integrity training and frequent feedback to the CCOs regarding their case referral performance. CMS also encourages OHA to consider establishing metrics to uniformly assess the quality and quantity of case referrals.
>
> **Observation #8**: CMS encourages the state to provide guidance to the CCOs on elements in a referred case.

CCO Oversight of Network Providers

CMS verified whether each CCO had an established process for conducting investigations and making referrals to the state, consistent with CMS requirements and the state's contract requirements.

All three CCOs reported use of an internal or contracted SIU tasked with identifying and conducting investigations of potential fraud, waste, and abuse. Indicators of potential issues were identified through various sources including but not limited to data analytics, hotline calls, internal department referrals, and external provider/member referrals. Cases that are determined to be credible are documented and reported to the OHA and MFCU simultaneously.

Oregon's CCO general contract requires that each CCO have an established process to monitor its providers for non-compliance with contractual agreements and medical governance standards. A promising practice for CCOs to maintain such oversight is to implement corrective action plans for its network providers found to be non-compliant. CMS found that all three CCOs have a policy regarding corrective action plans for the review period. PacificSource Community Solutions utilized corrective action plans; however, Columbia Pacific and Umpqua Health Alliance did not utilize corrective action plans during the review period. CMS also noted OHA does not track or collect information on provider self-audits.

Overall, CMS found the reported CCO processes for the investigation of suspected fraud, waste, and abuse to meet CMS requirements and state contract requirements.

Figure 1 below describes the number of investigations referred to Oregon by each CCO.

Figure 1. Number of Investigations Referred to Oregon by each CCO

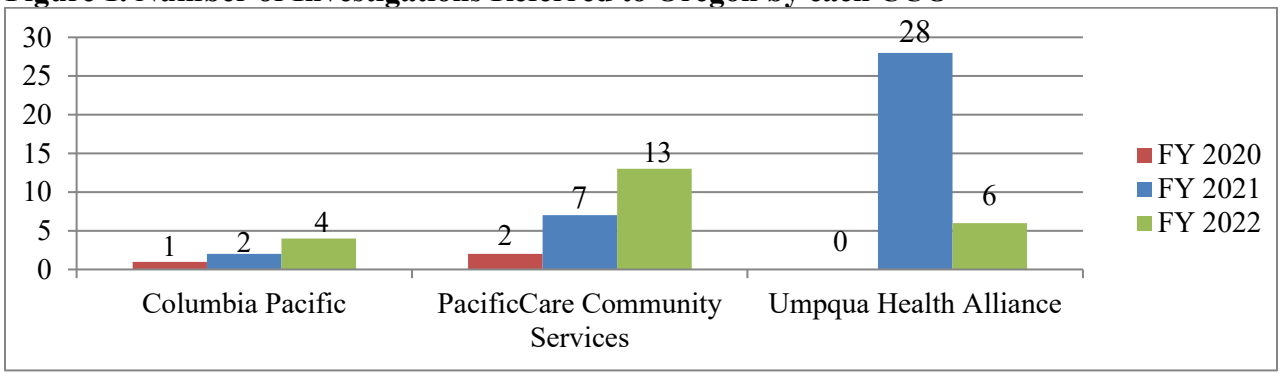

Table 1-A, 1-B, and 1-C, below, describes each CCO's recoveries from program integrity activities due to fraud and abuse. The state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process (§ 438.608(d)(4)). Without these adjustments, CCOs could be receiving inflated rates per member per month.

Table 1: CCO Recoveries from Program Integrity Activities

Table 1-A Columbia Pacific's Recoveries from Program Integrity Activities

FY	Preliminary Investigations*	Full Investigations	Total Overpayments Identified**	Total Overpayments Recovered***
2020	N/A	0	$0	$0
2021	N/A	2	$117,973.52	$1.25
2022	N/A	6	$397.99	$397.99

* OHA does not require the CCOs to distinguish between a full investigation and a preliminary investigation for managed care.
**All numbers reported by state fiscal year. OHA did not collect data from CCO's on identified

overpayment amounts on a regular basis prior to January 1, 2020.
***These numbers are self-reported by the CCO, Columbia Pacific did not report recovered overpayments to the state.

Table 1-B PacificSource Community Solution's Recoveries from Program Integrity Activities

FY	Preliminary Investigations*	Full Investigations	Total Overpayments Identified**	Total Overpayments Recovered***
2020	N/A	0	$0	$0
2021	N/A	3	$358,817.94	$268,561.50
2022	N/A	20	$15,944.92	$53,901.91

* OHA does not require the CCOs to distinguish between a full investigation and a preliminary investigation for managed care.
**All numbers reported by state fiscal year. OHA did not collect data from CCO's on identified overpayment amounts on a regular basis prior to January 1, 2020.
***OHA stated that these numbers are self-reported by the CCO and are not overly reliable.

Table 1-C Umpqua Health Alliance**'s Recoveries from Program Integrity Activities**

FY	Preliminary Investigations*	Full Investigations	Total Overpayments Identified**	Total Overpayments Recovered***
2020	N/A	0	$0	$0
2021	N/A	14	$17,577.36	$17,577.36
2022	N/A	15	$114,977.19	$112,427.67

*OHA does not require the CCOs to distinguish between a full investigation and a preliminary investigation for managed care.
**All numbers reported by state fiscal year. OHA did not collect data from CCO's on identified overpayment amounts on a regular schedule prior to January 1, 2020.
***These numbers are self-reported by the CCO, Umpqua Health Alliance did not report recovered overpayments to the state.

Observation #9: CMS encourages Oregon to ensure that CCOs have sufficient corrective action plan procedures in place and are utilizing them appropriately to address non-compliant Medicaid providers. Additionally, CMS encourages OHA to ensure the full requirements of the corrective action plan are completely satisfied by the providers.

Observation #10: CMS encourages Oregon to track and collect information regarding provider self-audits.

E. Encounter Data

In accordance with § 438.242, the state must ensure, through its contracts, that each CCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. Additionally, § 438.242 specifies that state CCO contracts must specify the frequency and level of detail of beneficiary encounter data, including allowed amount and paid amount, that the state is required to report to CMS under § 438.818. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility.

Through a review of Oregon's CCO general contract and interviews with each of the CCOs, CMS determined that Oregon was in compliance with § 438.242. Specifically, the contract language states the CCOs must have a system(s) that will provide information on areas including, but not limited to, utilization, claims, grievances, appeals, and disenrollment for other loss of Medicaid eligibility.

In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each CCO. Oregon was in compliance with § 438.602(e). Specifically, there are independent financial audits that are completed annually for each CCO that are available on the OHA website.

In addition, while it is not a requirement, regularly analyzing the encounter data submitted by CCOs will allow the state to conduct additional program integrity activities, such as identifying outlier billing patterns, payments for non-covered services, and fraudulent billing. Oregon has a process to regularly analyze CCO encounter data for program integrity purposes. Specifically, all encounter data must be submitted through the secure electronic portal to OHA at least monthly. The OHA relies on the encounter data to set capitation rates, calculate quality incentive payments, and analyze access to, and the effectiveness of care provided to the members.

CMS did not identify any findings or observations related to these requirements.

IV. Conclusion

CMS supports Oregon's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified ten observations that require the state's attention.

The state is not required to develop a corrective action plan for any observations included in this report. However, CMS encourages the state to take the observations into account when evaluating its program integrity operations going forward.

CMS looks forward to working with Oregon to build an effective and strengthened program integrity function.

V. Appendices

Appendix A: Status of Prior Review

Oregon's last CMS program integrity review was in May 2018, and the report for that review was issued in November 2018. The report contained twelve recommendations. During the virtual review in September 2023, the CMS review team conducted a thorough review of the corrective actions taken by Oregon to address all recommendations reported in calendar year 2018. The findings from the 2018 Oregon focused PI review report have all been satisfied by the state.

Appendix B: Technical Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance and educational resources for the SMA.

- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCUs.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address overpayment and recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. https://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Appendix C: Enrollment and Expenditure Data

Table C-1 and Table C-2 below provide enrollment and expenditure data for each of the selected CCOs.

Table C-1. Summary Data for Oregon CCOs

Oregon CCO Data	Columbia Pacific	PacificSource Community Solutions	Umpqua Health Alliance
Beneficiary enrollment total*	34,173	70,615	35,272
Provider enrollment total*	12,698	14,058	780
Year originally contracted	2020	2020	2020
Size and composition of SIU	4	3	2-3
National/local plan	Local	Local	Local

*As of January 1, 2022

Table C-2. Medicaid Expenditure Data for Oregon CCOs

CCOs	FY 2020	FY 2021	FY 2022
Columbia Pacific	$239 Million	$246 Million	$283 Million
PacificSource Community Solutions	$384 Million	$439 Million	$519 Million
Umpqua Health Alliance	$202 Million	$218 Million	$249 Million
Total CCO Expenditures	$825 Million	$903 Million	$1.05 Billion

Appendix D: State Response

State PI Review Response Form

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
N/A	No recommendations are included in this report.	**X**	

Acknowledged by:

Fritz Jenkins, Administrator for Program Integrity
Oregon Health Authority
[Name], [Title]

08.06.2025
Date (MM/DD/YYYY)