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Medicaid Integrity Program

Oregon Comprehensive Program Integrity Review

Final Report

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Table of Contents

Executive Summary and Introduction

The Centers for Medicare & Medicaid Services (CMS) regularly conducts reviews of each state's Medicaid program integrity activities to assess the state's effectiveness in combating Medicaid fraud, waste, and abuse. Through state comprehensive program integrity reviews, CMS identifies program integrity related risks in state operations and, in turn, helps states improve program integrity efforts. In addition, CMS uses these reviews to identify noteworthy program integrity practices worthy of being emulated by other states. Each year, CMS prepares and publishes a compendium of findings, vulnerabilities, and noteworthy practices culled from the state comprehensive review reports issued during the previous year in the *Annual Summary Report of Program Integrity Reviews.*

The purpose of this review was to determine whether Oregon's program integrity procedures satisfy the requirements of federal regulations and applicable provisions of the Social Security Act. A related purpose of the review was to learn how the State Medicaid agency receives and uses information about potential fraud and abuse involving Medicaid providers and how the state works with the Medicaid Fraud Control Unit (in Oregon called the Medicaid Fraud Unit or MFU) in coordinating anti-fraud and abuse activities. Other major focuses of the review include, but are not limited to: provider enrollment, disclosures, and reporting; pre-payment and post-payment review; methods for identifying, investigating, and referring fraud; appropriate use of payment suspensions; False Claims Act education and monitoring; managed care oversight at the state level; and program integrity activities conducted by Oregon's Coordinated Care Organizations (CCOs). CCOs are managed health care delivery models that provide, arrange, or subcontract for comprehensive medical services to 95% of all Medicaid beneficiaries in Oregon. At the time of the review, there were 17 CCOs under contract by the state.

In 2012, Oregon was awarded a demonstration waiver under the authority of Section 1115(a)(1) of the Social Security Act to improve the delivery of health care services to Medicaid beneficiaries by operating and testing the concept of CCOs. The state also reorganized its structure and created the Oregon Health Authority (OHA) which is now the single-state agency for the Medicaid program. Medicaid enrollment was approximately 569,000 in 2012 with expenditures nearing $4.6 billion; the Federal Medical Assistance Percentage matching rate was 62.91%.

The review of Oregon's program integrity activities found the state to be in compliance with many of the program integrity requirements. However, the review team identified a number of vulnerabilities and instances of regulatory non-compliance in its program integrity activities, thereby creating risks to the Medicaid program. The risks are related to the implementation of core program integrity functions, oversight of managed care, provider enrollment practices and reporting, and fraud detection and investigation. Several of the issues described in this review were also identified in CMS's 2010 review and are still uncorrected. CMS will work closely with the state to ensure that all issues, particularly those that remain from the earlier review are satisfactorily resolved as soon as possible. These issues and CMS's recommendations for improvement are described in detail in this report.

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/disclosures, managed care, and relationship with the MFU. A four-person team reviewed the responses and materials that the state provided in advance of the onsite visit. The review team also conducted in-depth telephone interviews with representatives from the MFU and five CCOs.

During the week of September 17, 2013, the CMS review team visited the OHA and the Department of Human Services (DHS) and conducted interviews with numerous OHA and DHS officials involved in program integrity. The team also conducted sampling of provider enrollment applications, program integrity cases, and other primary data to validate Oregon's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of both the OHA and DHS but also considered the work of other components and contractors responsible for a range of program integrity functions, such as provider enrollment, managed care, and non-emergency medical transportation (NEMT). Oregon operates its Children's Health Insurance Program (CHIP) as both a Title XXI Medicaid expansion program and a stand-alone Title XXI program. The same effective practices and risks discussed in relation to the Medicaid program also apply to the expansion program. The stand-alone CHIP program operates under the authority of Title XXI and is beyond the scope of this review. Unless otherwise noted, Oregon 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 that the OHA and DHS provided.

Medicaid Program Integrity Unit

In Oregon, anti-fraud and abuse activities are performed by the OHA and various DHS program offices but program integrity oversight is the principal responsibility of the Provider Audit Unit (PAU). At the time of the review, the PAU had 10 full-time equivalent positions allocated to Medicaid program integrity functions and a new program integrity director as of August 2012. The PAU falls under the Office of Payment Accuracy and Recovery (OPAR), which is a shared services office between the OHA and DHS. The OPAR director is also designated as the program integrity director; however, there is no central program integrity oversight of the Oregon Medicaid program. For example, the PAU provides program integrity oversight for traditional fee-for-service (FFS) but oversight of the managed care program is the responsibility of the Division of Medical Assistance Programs (DMAP); and this includes program integrity. The lack of centralized program integrity oversight is further discussed in Risk Area 1.

The table below represents the total number of preliminary and full investigations, and the amount of identified overpayments related to program integrity activities in the last four state fiscal years (SFYs).

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified***	Amounts of Overpayments Collected****
2009	205	14	$2,738,868	$3,047,931
2010	47	33	$2,663,319	$3,633,048
2011	28	9	$1,594,624	$2,076,667
2012	37	15	$392,644	$1,059,421

* Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.
**Full investigations are conducted by the MFU when preliminary investigations provide reason to believe fraud or abuse has occurred. Cases are resolved through a referral to MFU and accepted for criminal prosecution or referred back to the state for administrative or legal disposition. In Oregon, many investigations originate as full investigations by the MFU, bypassing the preliminary stage within the state.
***The overpayments identified are the result of the PAU efforts only, and do not include global overpayments. The state provided additional information on the total amount of overpayments identified by all units in the OHA as follows: SFY 2009 - $3,063,972; SFY 2010 - $6,312,653; SFY 2011 - $5,332,661; and SFY 2012 - $7,052,857.
****The overpayments collected may include collections from previous years and are the result of the PAU efforts only and do not include global settlements.

Results of the Review

The CMS review team found regulatory compliance issues and vulnerabilities related to program integrity in the Oregon Medicaid program. Several of these issues represent risks to the integrity of the state's Medicaid program. These issues fall into four areas of risk and are discussed below. To address these issues, Oregon should improve oversight and build more robust program safeguards.

Risk Area 1: Risks were identified in the state's implementation of core program integrity activities.

Coordination and Oversight of Program Integrity Operations

Oregon created the OPAR which is a shared services office between the OHA and DHS that is intended to provide program integrity services but does not identify a central unit responsible for coordinating oversight of these activities throughout the state. The PAU (within the OPAR) has principal responsibility for conducting preliminary investigations, referring cases to the MFU, and performing audits for the OHA and DHS; however, other components within the OHA and DHS also perform these functions and do not coordinate their activities and information.

For example, the OHA performs some program integrity activities and can make referrals directly to the Oregon MFU without notifying the PAU. CCOs and their subcontractors can refer cases to the MFU but are not contractually required to notify the PAU. CCOs can also report adverse actions taken to limit a provider's participation in the Medicaid program directly to the U.S. Department of Health & Human Services-Office of Inspector General (HHS-OIG) without notification to the PAU or OHA. Other components within DHS, such as Aging and People with Disabilities (APD) and the Office of Developmental Disability Services (ODDS) can report fraud referrals to the MFU or adverse actions taken on their providers but do not share this information with the PAU. The PAU will meet on occasion with the OHA and DHS program offices to discuss individual cases of interest, but these meetings are not routinely scheduled.

Case Tracking System

Since the 2010 CMS review, the PAU developed a "Fraud and Abuse Log" to track incoming complaints related to possible fraud and abuse from external sources. The log is maintained in a Microsoft Excel spreadsheet and notes the source and scope of the complaint. If the initial review of a complaint warrants further review of records (an audit), it is transferred to a "Master Log" which contains all routine and focused audits conducted by the PAU. The Master Log is maintained in a Microsoft Access database and includes information about the complaint, the provider, scope of the audit, and the outcome. However, complaints made to other components of the state agency, such as the waiver programs in the APD and ODDS do not maintain a case tracking system and do not routinely notify or send cases to the PAU.

The lack of a centralized tracking system where all state agency components can enter and view complaint data limits the state's ability to track problem providers who operate in different programs. In addition, the lack of centralized tracking makes it difficult for the state to assess the scope of the potential fraud and abuse activity across the entire Medicaid program and to consider this information in developing its work plan.

Program Integrity Work Plan

The PAU does not have a detailed, formal work plan for program integrity activities that encompasses all Medicaid programs to include FFS, managed care, waiver, and NEMT. A work plan for FFS activities was in place until December 2012 when the PAU had a change in leadership. The OPAR management team indicated that a draft work plan was in progress when a new PAU manager was announced in April 2013 and that it was making numerous changes in policies and procedures.

During the onsite review, the team found some documents that contained elements of a work plan, but none of them were complete with regard to Medicaid. For example, OPAR published a biennial report for 2011-2013 that documented some of the outcomes of previous program integrity activities; however, no information on future objectives was available. Likewise during interviews, the PAU managers provided the team with a document labeled "*Work Plan: State Fiscal Year 2013-14*." This document identified general goals, such as reintroducing "an audit work list that will include potential audits for staff to work on," increasing "data mining capabilities," and setting "metric standards for auditing, how many audits, how often, etc." However, the document did not list more specific provider targets or program integrity metrics. In addition, the OPAR shared services agreement contained a list of SFY 2013- 2015 work plan goals for all its work units. But it too was general in nature and listed 6 of the 11 performance goals for the PAU as "TBD" (to be determined).

In lieu of a formal work plan, staff from the PAU meet monthly to identify data mining targets for the next month. However, meeting minutes are not maintained that would show the history of targets addressed, why specific targets were identified (trends), and outcomes from previous months' work. In addition, although 95 percent of Oregon's Medicaid beneficiaries are currently enrolled in managed care, and the state is moving toward operating entirely under managed care, the PAU has not identified how it will monitor managed care services as discussed further in Risk Area 2.

The lack of a written work plan makes it difficult for the state to determine whether sufficient priority is given to high risk provider types or high risk services and whether adequate program integrity resources are being used to oversee the full range of Medicaid programs.

Written Policies and Procedures for Key Program Integrity Functions

At the time of the review, the PAU was undertaking some changes in policies and procedures due to changes in leadership. During the onsite visit, the PAU presented a draft version of the policies and procedures which were being developed but had yet to be implemented. Although there were policies to address key functions like staff training, audits and the use of the Surveillance and Utilization Review Subsystem (SURS), screening of incoming referrals, and referrals to the MFU, the compilation did not contain any policies or procedures related to payment suspensions for cases involving a credible allegation of fraud. There was also no guidance on oversight of managed care and other special programs, such as NEMT or Home and Community Based Services (HCBS) waiver programs. The absence of written policies and procedures leaves the state vulnerable to inconsistent operations and ineffective functioning in the event the state loses experienced program integrity staff.

Recommendations:

- Develop and implement integrative mechanisms to further coordinate program integrity activities across the OHA and DHS to include coordinating information and activities of the CCOs. Ensure that written policies and procedures are completed and implemented that address all program integrity functions and practices.
- Finalize the program integrity work plan to include specific training goals or work load targets for all components of program integrity, such as investigations and audits. Share the work plan with other units in the state agency to facilitate coordination and incorporate program integrity within the mainstream of agency operations.
- Develop a centralized case tracking system that all components can view and/or enter fraud/abuse complaints. Ensure that other components of the state agency refer suspected cases of fraud and abuse to the PAU for appropriate case tracking.

Risk Area 2: Risks were identified related to the state's oversight of managed care.

Monitoring Fraud and Abuse Activities

The PAU has not developed methods for detecting and investigating fraud, waste and abuse in the managed care environment even though the state moved nearly 95 percent of beneficiaries into managed care. Despite the availability of high quality encounter data from the CCOs, the PAU does not analyze CCO or subcontractor data for aberrant billing or service patterns. Data mining activities are the responsibility of the CCOs.

In addition, the DMAP who has direct responsibility for oversight of the managed care delivery system performs limited monitoring of the fraud and abuse activities in the state's CCOs. During the review, PAU staff indicated that regular meetings with the DMAP do not take place to discuss issues related to fraud and abuse monitoring in managed care. The lack of coordination

and oversight of the CCOs by the PAU and DMAP leaves the state unable to determine if the CCOs are adequately performing basic program integrity functions.

Fraud and Abuse Referral Process by CCOs

The state's model contract with the CCOs contains language on where to report provider fraud but the wording may cause confusion and misrouting of suspected cases of fraud and abuse. The contract states "Contractor shall promptly refer all suspected cases of fraud and abuse, including fraud by its employees and Subcontractors to the Medicaid Fraud Control Unit. Contractor may also refer cases of suspected fraud and abuse to the MFU or to the DHS PAU prior to verification." As worded, the CCOs can refer suspected fraud and abuse cases to the MFU without notifying the State Medicaid agency or PAU. This could leave state staff unaware of provider issues that may require administrative actions or that have FFS or managed care implications.

At the time of the review, no referral activity was found in the managed care program and the MFU acknowledged that it had not received fraud referrals from any of Oregon's CCOs. The MFU also noted that it had not been asked by the state to provide training on the referral process to OHA managed care staff or CCO staff.

In addition, the CCO model contract did not require CCOs to include information on how to report fraud, waste, and abuse in member handbooks. The review team was provided a document compiled by the OHA and entitled "MCE handbook references to fraud" which revealed that only 3 of 17 plan handbooks had sections advising enrollees where they could report suspected fraud. The handbooks of the other 14 plans only referred to fraud as grounds for a member sanction, using language such as, "the plan may disenroll you if you commit fraudulent or illegal acts." The absence of information on how members can report suspected fraud puts the state at risk that network provider and beneficiary fraud will go unreported and undetected.

Recommendations:

- Develop tools to monitor the program integrity activities of the CCOs to ensure that contract requirements are met and to determine the adequacy and effectiveness of fraud and abuse efforts. Plan meetings between the CCOs and the PAU, DMAP, and MFU to discuss potential cases and to share information about fraud and abuse activities. Develop procedures for the PAU to analyze the encounter data submitted by the CCOs and subcontractors for aberrant billing or service patterns.
- Amend the CCO model contract or develop an alternative process to require CCOs to notify the PAU when referring suspected fraud and abuse cases to the MFU. Determine the level of effort the CCOs are expending to identify potential fraud and take corrective action as appropriate. Identify and facilitate training opportunities between CCOs and the MFU. Require all CCOs to include information on how to report fraud, waste, and abuse in member handbooks.

Risk Area 3: Risks were identified in the state's provider enrollment practices.

Capturing Ownership and Control Disclosures at Enrollment

During the 2010 CMS review, the state was cited for not collecting all the required ownership and control disclosures from FFS providers, the fiscal agent, and CCOs. Oregon modified their provider enrollment form DHS 3974 to list the regulatory requirements at 42 CFR 455.104, but the form still includes some language from an older version of 455.104 which is no longer in effect. The DHS 3974 form also includes a section for managing employees and board members at the end of the application rather than in the area of the form that includes those with ownership and control interests in the disclosing entity and related subcontractors. The technical issues identified with the modified provider enrollment form may cause confusion and the omission of required disclosure information as evidenced during the sampling process of CCO enrollment forms.

The review team found that the CCOs were not submitting the full range of ownership and control information that the new form was designed to solicit. In some cases, names of managing employees and senior managers as well as officers or board members were left blank, and in other cases missing information included addresses, dates of birth, and Social Security numbers. As a result, the OHA cannot ensure that excluded or debarred parties did not receive federal health care funds through Medicaid managed care contracts.

Oregon's contract with the CCOs and their network providers requires compliance with Medicaid disclosure requirements in federal regulations at 42 CFR 455.100 through 106. The review team questioned whether the CCOs were routinely collecting complete ownership and control information from the providers that they or their subcontractors credentialed. In Oregon's managed care program, network providers are credentialed (and re-credentialed) using a standard Oregon Practitioner Credentialing Application. This form does not solicit the range of ownership and control information that would be required to ensure that persons with direct and indirect ownership and control interests, agents and managing employees are not excluded or debarred from federal contracting. The plans that were interviewed could not document that such information was fully furnished in supplementary forms or documentation.

For example, Oregon requires plans to send information to OHA about network providers who submit managed care encounter data so that the state's Medicaid Management Information System will recognize them as managed care-only providers. An abbreviated managed care provider enrollment form, the DMAP-3108, is used for registration purposes. The 3108 form requests the name, date of birth (DOB), and Social Security Number (SSN) of persons with 5 percent or greater ownership and control interests. It asks for the name and address of managing employees but not their DOB or SSN; and it does not ask for any information on agents. The gaps in the information solicited by the form may negatively impact the ability of CCOs or the state to perform the federal database checks on providers and affiliated parties that would be necessary to ensure that federal dollars are not flowing to excluded or debarred persons. This is discussed in the section on exclusion searches below.

In Oregon's NEMT program, transportation providers must complete a special DMAP form 3118 application and agreement in addition to the standard DHS 3974 enrollment application.

The DMAP 3118 does not solicit the enhanced disclosure information as required by 42 CFR 455.104, and the DHS 3974 has the technical issues as described above.

Criminal Offense Disclosures

The regulation at 42 CFR 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs since the inception of those programs for each person with ownership or control interest in the provider, or who is an agent or managing employee of the provider. Two of the Oregon CCOs interviewed by the CMS review team did not complete the criminal conviction disclosure section of the DHS 3974 enrollment form. Both organizations were enrolled in the Medicaid program despite leaving the section blank. The form does not contain instructions or a space for the enrolling entity to enter a response if there are no criminal conviction disclosures to report. By failing to confirm whether entities had health care-related criminal convictions to disclose, the State Medicaid agency again placed itself at risk of contracting with entities that may otherwise not be permitted to receive federal health care funds through managed care contracts.

The Oregon Practitioner Credentialing Application used by the CCOs to credential and re-credential their network providers contains attestation language related to disciplinary actions and criminal charges. However, this language does not meet the requirements of 42 CFR 455.106 because it does not ask if the provider has ever been convicted of a criminal offense related to Medicare, Medicaid or Title XX programs. Instead it asks if the provider has ever been suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review. In this regard the form does not meet the baseline requirements of Oregon's contract with the CCOs which mandated compliance with the Medicaid disclosure requirements in federal regulations at 42 CFR 455.100 through 106.

Requesting Business Transaction Information

Although the CCO contracts require compliance with the federal regulation on business transaction disclosures at 42 CFR 455.105, the CCO provider agreements reviewed by the team do not contain such disclosures upon request by the Secretary of the U.S. Department of Health & Human Services or the State Medicaid agency. This is a repeat concern from the previous CMS program integrity review in May 2010.

Termination or Denial of Enrollment

At the time of the review, the state was not uploading or downloading data on provider terminations from CMS's provider terminations database, which state agencies use to identify providers who have been terminated by Medicare or another state's Medicaid or CHIP program as required by 42 CFR 455.416. The OHA does not have an alternate process to check punitive disenrollment actions by other state and federal health programs. Without such processes, the state has no means of determining if providers terminated by Medicare or another state's Medicaid or CHIP program are improperly enrolled in the Oregon Medicaid program.

Exclusion Searches

The regulation at 42 CFR 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE), the Excluded Parties List System (EPLS) on the System for Award Management (SAM)[1], the Social Security Administration Death Master File (DMF), and the National Plan and Provider Enumeration System (NPPES) upon enrollment and reenrollment. State agencies must also check the LEIE and EPLS no less frequently than monthly.

The state reported that it checks providers against the LEIE and EPLS at the time of enrollment and reenrollment; however, during a demonstration of their enrollment process, staff did not check the enrolling provider against the LEIE and was under the impression that the new link for SAM now included all exclusions and, therefore, was the only required database to be checked. In addition, although the state is performing monthly searches of the Medicare Exclusion Database (which includes the LEIE information) for FFS and managed care providers, it is not conducting monthly checks against the EPLS.

Regarding the enrollment of managed care providers, the model managed care contract requires CCOs to have written policies and procedures for conducting a full range of credentialing and screening activities with regard to providers, programs, and facilities seeking to participate (or remain) in the plan's network. This requirement is consistent with the Section 6402 of the Affordable Care Act and the implementing regulations at 42 CFR 455 Subpart E. However, CCOs do not fully comply with this contract provision. In part, this is due to their not collecting the full range of ownership and control disclosures from network providers, as discussed above, although all persons with 5 percent or greater ownership or control interest, agents and managing employees must be regularly searched. In part, it also due to the inconsistent practices of the CCOs and their subcontractors, which do not meet the frequency and completeness standards in the regulation. For example, in their review guide responses, several plans were unclear about the frequency with which they checked the LEIE and EPLS for excluded and debarred persons. One plan's response indicated that EPLS searches were not performed, while another said that the only affiliated parties it searched were "owners." Without greater oversight in this area, neither the state agency nor the CCOs can ensure that federal dollars do not flow to excluded or debarred parties.

HCBS waiver providers who are not required to obtain a National Provider Identifier are checked against the LEIE at the time of enrollment, reenrollment, and on a monthly basis thereafter. At the time of the review, HCBS waiver providers were also checked against the EPLS at the time of enrollment and reenrollment, but not on a monthly basis thereafter due to system limitations. The APD's provider enrollment unit also checks persons with ownership and control interests, managing employees, and administrators against the appropriate databases and with the Secretary of State's office prior to licensing and enrollment, but there was no indication that affiliated parties were searched against the LEIE and EPLS on an ongoing monthly basis.

[1] In July 2012, the EPLS was migrated into the new System for Award Management (SAM).

In its transportation program, Oregon Medicaid contracts with eight NEMT brokers. The transportation brokers indicated that they collect disclosures and check the LEIE and EPLS for transportation companies at the time of enrollment, but not monthly. However, while the drivers employed by the NEMT transportation companies are subject to a fingerprint background check and a division of motor vehicle background check, they are not checked against the LEIE or EPLS.

State Agency Exclusion Notices

When the state terminates[2] a provider for any reason, a letter is generated to the provider; however there is no notification sent to other state agencies, the state licensing board, the public, beneficiaries, and others as the regulation at 42 CFR 1002.212 requires.

False Claims Act Education

The state is not following its compliance review protocol in accordance with its State Plan on False Claims Act education requirements. The State Plan (section 4.42-A) requires the state to annually determine what providers are covered entities following Section 1902(a)(68) of the Social Security Act [42 U.S.C. 1396a(a)(68)] and to verify that providers are meeting the requirements of the federal rule during the audit unit's regular schedule. The CMS review team was informed that the state had not been screening providers to determine if the law applied to them, nor was it doing any type of monitoring to confirm provider compliance.

Recommendations:

- Make further revisions to DHS 3974 by updating the language relating to 455.104 and moving the section used to identify managing employees and board members to the ownership and control section of the form. Additionally, ensure information is solicited on criminal convictions over the entire duration of the applicable federal health programs, and add space on the form and instructions explaining how disclosing entities must signify when they have no criminal history information to report. Inventory the 3974s submitted by contracted CCOs and ensure that ownership and control and criminal history information is disclosed and subjected to the required federal database checks.
- Revise the Oregon Practitioner Credentialing Application or develop or utilize an existing form to solicit the full range of ownership and control disclosure information from CCO network providers. Add a new question to determine if the provider has ever been convicted of a criminal offense related to Medicare, Medicaid or Title XX programs.
- Revise the DMAP 3118 form to solicit the enhanced disclosure information found at 42 CFR 455.104 for NEMT providers.
- Revise all provider agreements to ensure that business transaction disclosures are made upon request in accordance with 42 CFR 455.105.

[2] For reporting purposes, CMS refers to state actions in accordance with this regulation as "terminations" whether the state calls them "terminations" or "exclusions".

- Develop and implement procedures to upload/download provider termination information to/from CMS's provider terminations database to report and identify providers terminated by Oregon Medicaid or other federal and state health programs.
- Ensure that state agency exclusion notices are sent to other state agencies, the state licensing board, the public, beneficiaries, and others as required by 42 CFR 1002.212.
- Ensure that names of any person with an ownership or control interest or who is an agent or managing employee of FFS and managed care providers, HCBS waiver providers, transportation companies and providers, and CCOs is checked against the LEIE, EPLS, Social Security Administration Death Master File and NPPES upon enrollment and reenrollment, and against the LEIE and EPLS on a monthly basis.
- Implement the compliance review protocol associated with the state's False Claims Act education requirements which is outlined in Oregon's approved State Plan.

Risk Area 4: Risks were identified in fraud detection and investigation.

Suspension of Payments in Cases of Credible Allegation of Fraud

Oregon routinely exercises good cause exceptions for all cases of credible allegations of fraud referred to the MFU. In addition, Oregon does not document these good cause exceptions, and it does not provide annual summary reporting of payment suspension information to CMS as required by 42 CFR 455.23(g)(3). The Memorandum of Understanding (MOU) executed in 2012 by the Oregon MFU, OHA, and DHS outlines the referral process pursuant to which DHS or OHA refers a case to the MFU. In the MOU, the MFU requests that DHS and OHA file a good cause exception to the payment suspension requirement in all cases in which a credible allegation of fraud is referred. The basis for this agreement is that payment suspensions could jeopardize MFU investigations while they are in progress. The team reviewed a sample of the state's fraud referrals to the MFU and noted that good cause exceptions were not in writing and were not included as part of the case files. This is a technical compliance issue. Moreover, in failing to consider individual referral situations on a case-by-case basis, the state runs the risk of making improper payments to some providers that could be safely cut off because the providers are aware they are under investigation. To this extent, the state's procedures are not consistent with the intent of the regulation to limit payments to potentially fraudulent providers wherever possible. The state indicated that although the MFU exercises a good cause exception for all cases in which a credible allegation of fraud is referred, the MFU does withdraw the law enforcement exception once enough evidence is gathered to prosecute, and payments are suspended as a result.

In addition, the team noted that as of October 1, 2013, Oregon had not filed any annual reports with summary information on payment suspensions to CMS as required by the regulation at 42 CFR 455.23(g) (3).

Recommendations:

- Refine current payment suspension practices to ensure that the OHA and DHS perform a full case-by-case review to weigh the benefits of suspending payments over the exercise of a good cause exception in an effort to increase the use of payment suspension as an

effective tool of the state. Amend the MOU accordingly to reflect this change. Ensure that good cause exceptions are documented in writing and included with the case file. Continue to work with the MFU to lift good cause exceptions as soon as possible and suspend payments on a consistent, timely basis. Obtain access to the web portal and report payment suspension information to CMS as required.

Effective Practices

As part of its comprehensive review process, CMS also invites each state to self-report practices that it believes are effective and demonstrate its commitment to program integrity. CMS does not conduct a detailed assessment of each state-reported effective practice.

Collection of high quality encounter data

Oregon requires that encounter data submitted by the CCO's be 99% complete and accurate or it is returned to the plan. The state has strict contract requirements which mandate timely submission of data no less frequently than monthly. Also, the state maintains detailed internal policies and procedures on the handling and analysis of encounter data, which is stored in the MMIS and the SURS systems. The data is reviewed by several units within the state (Data Analytics Unit, Actuarial Services Unit, and the Electronic & Encounter Data Unit) for multiple purposes. The Data Analytics and Actuarial Services Units review the encounter data and apply the same validity edits as is completed for FFS data.

Although the state's work on encounter data has placed it in a strong position to data mine for patterns of fraud and abuse by individual providers, the team found this activity was not being completed as further discussed in Risk Area 2.

Name and Tax Identification Number (TIN) Verifications with the Internal Revenue Service (IRS)

Oregon's Medicaid provider screening and enrollment efforts include validating submitted names and TINs with the IRS as a screening step along with other available IRS batch screenings. The validation of TINs helps save time and makes the process more efficient when enrollment staff must confirm potential excluded persons or entities. It has also resulted in a large reduction in the number of Form 1099 TIN/name mismatches and associated IRS penalties. Between the 2003 tax year and 2011 reporting period, the state agency was able to reduce the number of mismatches from 660 to 18.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Oregon to consider utilizing:

- Use the program integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the state's program integrity efforts and to identify best practices to develop a centralized case tracking tool and to address areas of risk outlined in Risk Area 1.

- 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 assistance as needed to conduct exclusion searches and training of managed care staff in program integrity issues.
- Continue to take advantage of courses at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Course topics related to program integrity oversight of managed care may be useful to Oregon. More information can be found at http://www.justice.gov/usao/training/mii/ .
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Access the annual program integrity review summary reports on CMS's website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html. These reports contain information on noteworthy and effective program integrity practices in states. We recommend that Oregon review the effective practices related to provider screening and enrollment to address the issues outlined in Risk Area 3.
- Consult CMS's Medicaid Payment Suspension Toolkit at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance.html to develop a payment suspension process that is consistent with federal regulations and guidance. CMS can also refer Oregon to states that are further along in this process to address the areas of non-compliance identified is Risk Area 4.

Summary

The risks identified in this report, particularly those that are uncorrected, repeat risks that remain from the time of the agency's last comprehensive program integrity review in 2010 should be addressed immediately.

We require the state to provide a corrective action plan (CAP) within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place and identify which area of the State Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. Please provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

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

Division of Medical Assistance Programs
John A. Kitzhaber, MD, Governor

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January 23, 2015

Peter Leonis
Director, Division of the Division of Field Operations North
U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
Via email: Peter.Leonis@cms.hhs.gov

Dear Mr. Leonis:

Oregon is pleased to have the opportunity to respond to the 2013 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 of the four identified risk areas and recommendations. We have already begun working on corrections and anticipate these corrections will be implemented within the 90 day timeframe you requested.

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 seriously and will continue to put resources, expertise and energy to our program integrity work.

Sincerely,

Judy Mohr Peterson
State Medicaid Director
Oregon Health Authority