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November 28, 2017

Mr. Kip Memmott
Director, Audits Division
Secretary of State,
255 Capitol St. NE, Suite 500
Salem, OR 97301

RE: Oregon Health Authority Response to Final Draft Improper Medicaid Payment Performance Audit Report

Dear Mr. Memmott,

This letter provides a written response to the Audits Division's final draft audit report titled, *Oregon Health Authority Should Improve Efforts to Detect and Prevent Improper Medicaid Payments*, as provided to the Oregon Health Authority (OHA) on November 22, 2017 (referred to herein as the "final draft report"). Thank you for the opportunity to review and respond to the final draft report.

I appreciate your close attention to OHA's Medicaid enrollment and eligibility processes and your commitment to producing an accurate audit. OHA is responsible for providing access to critical healthcare services for nearly 1 million Oregonians and for driving transformation of the state's healthcare system. OHA is also a large, complex agency and has a duty to be transparent, accountable, and make wise use of public resources. As the agency's new director, audits are an important part of my and my team's ability to assess what is working well and where improvement is needed, as well as possible vulnerabilities, risks, and opportunities. The final draft report identifies several areas for improvement with which we agree and are either currently taking steps to address or will begin doing so. However, there are findings and conclusions with which we disagree and areas where additional clarification or context is needed to present a complete and accurate analysis.

It is also important to note that, since September 1, the new OHA leadership team has worked closely with managers and staff to gain an understanding of ongoing and emerging issues. OHA has lacked rigor and comprehensiveness in its research, analysis, resolution, and communication of significant operational issues. This has been evident throughout our research of recently disclosed issues, including those relating to payments for dual eligible clients and retroactive eligibility terminations, and underlies some of the findings noted in the final draft report. As you are aware, I am establishing a formal issue resolution process to ensure that OHA leadership is aware of, understands the scope of, and implements effective resolutions to ongoing and emerging issues.

While we establish the framework for this process, we have begun documenting known issues, both past and ongoing. We have shared a preliminary summary of those issues with you, as documented in a letter to Governor Kate Brown on November 17 and as noted in the final draft report. Many of these issues still require additional research and analysis to assess the cause, scope, impact, and next steps for resolution.

Through the issue resolution process, which will include a review of existing documentation of issues and risks, we will create and regularly update an issue log and prioritize the research, analysis, and resolution of issues. We will provide updates to the Governor and legislators about this work on a bi-weekly basis, and we will post regular updates to our website. We will notify you of these updates and continue to provide you with copies of our completed internal audits.

This letter includes our responses to the findings and recommendations, as well as our responses to those aspects of the final draft report that require additional clarification or with which we disagree.

FINAL DRAFT COMMENTS

We reviewed the final draft report for accuracy and completeness to ensure that the narrative provides appropriate context for the analysis, findings, and recommendations. We appreciate the audit team's significant efforts to obtain a complete and accurate understanding of the Medicaid program and our existing program integrity functions. However, we identified a few issues that require additional clarification and points with which we disagree, as outlined below.

Report Highlights¹

This section provides a high-level summary of the audit findings, including the following conclusive statement: “[D]elays in processing eligibility for thousands of Oregon’s Medicaid recipients resulted in millions of dollars of avoidable Medicaid expenditures, a critical issue the agency failed to disclose until raised in a May 2017 Auditor Alert.”

It is not accurate to characterize the cost of benefits provided to clients who were eligible for the Oregon Health Plan at the time those costs were incurred as avoidable for three important reasons. These reasons are also recognized in the final draft report.² First, Oregon Health Plan clients remain eligible for benefits until they are determined no longer eligible. Second, it is not possible to assess whether a client who was determined no longer eligible would have also been determined no longer eligible at some earlier date. As such, we cannot conclude whether and to what extent any expenses could have been avoided if redeterminations had occurred sooner. Finally, many clients whose benefits were terminated were closed due to non-response, and benefits for some of these clients may still be retroactively reinstated through the end of November 2017. As recognized in the final draft report, the number of clients in the clean-up population whose benefits had been terminated as of November 6 dropped from the original count of 55,000 (48%) to 47,600 (41%) due to retroactive reinstatements. The number of people whose benefits were terminated due to non-response, as well as those initially found ineligible, may continue to decline until the end of the 90-day retroactive benefits period.

We also believe that the statement about the agency’s failure to disclose the eligibility redetermination clean-up issue is overstated. It is more accurate to state that OHA has lacked rigor and comprehensiveness in its research, analysis, resolution, and communication (both internal and external) of significant operational issues. As previously noted, this has also been evident to OHA’s new leadership team and I am establishing a formal issue resolution process to address this. We note that the agency did communicate generally about the redetermination clean-up work in correspondence with the federal government and in testimony to legislative committees. Converted case renewals – the process of renewing clients and moving them from legacy systems into the current system – were completed by the February 2017 date reported

¹ See page 3 of the final draft report.

² See pages 30-32 of the final draft report.

to the legislature, and OHA noted the need for clean-up work related to redeterminations. We agree that OHA should have been more specific and proactive in quantifying and communicating about the size of the redetermination clean-up population, but we also understand that the agency first quantified the size of this population in May 2017, just prior to the release of the Auditor Alert. We are committed to improving the transparency of Medicaid operations going forward.

Key Findings³

This section summarizes the key audit findings. The first three findings relate to procedures for preventing, detecting, and recovering improper payments. The final finding relates to the timeliness and impact of OHA's redetermination clean-up work. Our comments on these findings are discussed below.

Key Finding 1

We concur with the finding that OHA has gaps in procedures for preventing certain improper payments and that insufficient management of our processes for identifying and resolving issues and processes for prioritizing resources to address them have contributed to these gaps and our ability to address them timely. As previously noted, I am establishing a formal issue resolution process to address this.

Key Finding 2

We also agree that OHA can improve its internal controls and testing of system edits as it relates to prevention of improper payments. As noted later in the final draft report, OHA does have several processes in place to detect and prevent improper payments that are well-defined, consistent, and agency-wide. These processes include work performed by the Provider Audit Unit (PAU) and Data Matching Unit (DMU), as well as data validation performed by actuaries and the triennial federal Payment Error Rate Measurement (PERM) audit.

The second finding also states that the audit team identified approximately 31,300 questionable payments. It is also noted that OHA provided additional analysis of a sample of 2,700 of these payments, indicating that the vast majority (98%) of the sampled claims were appropriate payments. This analysis included the application of program rules, including services provided to clients enrolled in Coordinated Care Organizations (CCOs) that are reimbursed on a fee-for-service (FFS) basis (carve outs). We expect that the application of program rules to the remaining payments will significantly reduce the number of payments requiring further research.

We agree that additional research is required to quantify the scope of any improper payments, identify next steps for resolution and measures to improve prevention and detection of future improper payments. We have already made adjustments for most of the payment errors identified in the 2,700-payment sample, and we will review and adjust any errors noted in the remaining payments. However, the statement that the audit identified 31,300 questionable payments implies a level of conclusiveness that is inconsistent with the analysis of the 2,700-payment sample and the recognition that further research and analysis are required. It is also inconsistent with the acknowledgement in the final draft report⁴ that “[n]ot all of these potential duplicates are improper” in recognition of the complexity of the program rules noted above.

³ See page 3 of the final draft report.

⁴ Please see page 16 of the final draft report.

Key Finding 3

We agree that improper payment detection procedures can be enhanced, particularly through the use of technology and analytic tools and implementation of more rigorous and comprehensive processes for researching, analyzing, and resolving issues. However, the characterization of OHA’s current procedures as “limited” is overstated and inconsistent with existing detection work performed by various teams throughout OHA, which is also recognized in the final draft report.

Key Finding 4

This finding is very similar to the statement included in the *Report Highlights* section previously discussed in this letter. Please refer to that discussion for our comments on this finding.

Audit Results⁵

The key findings noted in this section of the final draft report are also addressed in the *Report Highlights* or *Key Findings*. Please refer to our comments related to those sections, as previously discussed in this letter. We note two additional comments on the findings contained in the *Audit Results* below.

State and Federal Investment in Program Integrity Efforts⁶

The final draft report discusses requirements to repay federal funds associated with any identified improper payments and possible disincentives or strategic decisions a state may face in investing in program integrity functions. While we agree with the facts surrounding requirements to repay federal funds, OHA has a responsibility to ensure program integrity and to take reasonable measures to identify and recover improper payments, regardless of funding source. It is important to recognize the cost-benefit analysis that the state and the federal government must perform in investing in program integrity efforts.

Opportunity Lost Due to Delayed Completion⁷

As discussed in the *Report Highlights* section of this letter, it is not possible for the audit to conclude whether and to what extent expenses could have been avoided if redeterminations had occurred sooner. It is also important to note that the Medicaid portion of OHA’s budget is driven by caseload forecasts, which included a forecast of the impact of future redeterminations on the caseload.

RECOMMENDATIONS

Below you will find our detailed responses to each recommendation included in the final draft report.

| RECOMMENDATION 1 | | |
|--|---|--|
| Develop a comprehensive inventory of MMIS system controls and proactively test the effectiveness and completeness of those controls. | | |
| Agree or Disagree with Recommendation | Target date to complete implementation activities (Generally expected within 6 months) | Name and phone number of specific point of contact for implementation |
| Agree | January 2019 | Bob Costa (503-947-5213) |

⁵ Please see pages 16 through 29 of the final draft report.

⁶ Please see page 26 final draft report.

⁷ Please see page 33 of the final draft report.

OHA Response to Recommendation 1:

We agree that OHA should develop a comprehensive inventory of MMIS system controls. We also agree that OHA has opportunities to enhance or improve upon current procedures for testing and monitoring the effectiveness and completeness of these controls. We note that the frequency of improper payments due to system edits is extremely low, but we agree that OHA has not had a documented plan for testing claims edits.

A team of OHA staff from the Office of Payment Accuracy and Recovery (OPAR), the Office of Program Integrity (OPI), the Provider Services Unit, and the MMIS BSU will be formed to review processes, identify opportunities for improvement, and propose prioritization of resources to address identified areas for improvement. These may include recommendations for process changes or enhancements or documentation of existing procedures.

We acknowledge that the documentation for existing procedures should be improved, but it is important to note existing, effective procedures. Many FFS claims are auto-adjudicated through the MMIS system, with some claims requiring manual intervention to finalize payment. The PAU within OPI monitors for spikes in the usage of certain edits and requests validation of the edit from the Claims Unit, when appropriate. The Claims Unit coordinates with the MMIS BSU to review the correctness of the edit.

The audit team identified a specific gap in our procedures to review and verify that system edits are working as intended. As a result, OHA has identified a small percentage of questionable payments that will require adjustments. OHA’s Health Systems Division (HSD) has developed a preliminary approach to address this noted deficiency. This approach will include:

- Development of testing processes for the top 20% of MMIS edits with the most significant financial impact.
- Monitoring of remaining edits to confirm accurate functionality, using daily MMIS reports that detail denied or partially-denied claims and the edit that stopped payment. A monthly report will be created to flag edits not shown on the daily reports for testing.

It is estimated that one full-time staff could effectively test and validate 10 edits per week, or approximately 500 edits per year, and monitor all remaining edits. We will need to evaluate existing resources and constraints related to ongoing technology projects, but we expect to implement these activities by January 2019.

| RECOMMENDATION 2 | | |
|--|---|--|
| Adopt leading practices highlighted in the report, such as setting clear standards for acceptable program integrity efforts, and including clear expectations in CCO contracts about when a sanction will occur and the automatic penalty that will be imposed for non-compliance. | | |
| Agree or Disagree with Recommendation | Target date to complete implementation activities (Generally expected within 6 months) | Name and phone number of specific point of contact for implementation |
| Agree | January 2019 | Fritz Jenkins (503-947-1109) Rhonda Busek (503-945-6552) |

OHA Response to Recommendation 2:

We agree with this recommendation and had begun taking steps to address it prior to this audit. OPI has hired an Operations and Policy Analyst 4 (OPA4) to work with HSD and with CCOs to strengthen the program integrity and accountability constructs over the next two contract cycles. As the 2018 CCO contract is in the final stages of review, we expect to complete implementation with the 2019 CCO contract.

| RECOMMENDATION 3 | | |
|---|---|--|
| Increase oversight of CCO program integrity efforts, such as approving CCO's fraud, waste, and abuse policies and reviewing how CCO's prevent, detect, and recover improper payments. | | |
| Agree or Disagree with Recommendation | Target date to complete implementation activities (Generally expected within 6 months) | Name and phone number of specific point of contact for implementation |
| Agree | January 2019 | Fritz Jenkins (503-947-1109) |

OHA Response to Recommendation 3:

We agree with this recommendation and had begun taking steps to address it prior to this audit. As noted in our response to Recommendation 2, OPI has hired an OPA4 to work with HSD and with CCOs to strengthen the program integrity and accountability constructs over the next two contract cycles. OPI is also in the process of hiring seven Government Auditor 2 (GA2) positions to audit the medical claims of network providers. In addition, OPI supports systematic training of CCO Compliance Officers, as coordinated by the External Quality Review Organization (EQRO), Health Insights. OPI works with Health Insights to set the agenda, provide the subject matter experts and facilitate sessions related to compliance, auditing, and oversight. As the 2018 CCO contract is in the final stages of review, we expect to complete implementation with the 2019 CCO contract.

| RECOMMENDATION 4 | | |
|---|---|--|
| Develop robust efforts to validate the accuracy and completeness of encounter data, which may include hiring an External Quality Reviewer or developing internal monitoring efforts by the Office of Program Integrity. | | |
| Agree or Disagree with Recommendation | Target date to complete implementation activities (Generally expected within 6 months) | Name and phone number of specific point of contact for implementation |
| Agree | January 2019 | Fritz Jenkins (503-947-1109) Chelsea Guest (503-383-6260) |

OHA Response to Recommendation 4:

We agree with this recommendation and had begun taking steps to address it prior to this audit. While several teams throughout OHA validate encounter data on a regular basis to ensure accurate metrics reporting, rate development, and contract compliance, encounter data is not currently audited against medical chart notes. As noted in our response to Recommendation 3, OPI is also in the process of hiring seven GA2 positions to audit medical claims of network providers. The target date to complete implementation activities also aligns with the implementation of the 2019 CCO contract.

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| RECOMMENDATION 5 Review and clarify Oregon Administrative Rules so Medicaid providers can be held accountable for improper payments. | | |
| Agree or Disagree with Recommendation | Target date to complete implementation activities (Generally expected within 6 months) | Name and phone number of specific point of contact for implementation |
| Agree | July 2018 | Fritz Jenkins (503-947-1109) Rhonda Busek (503-945-6552) |

OHA Response to Recommendation 5:

We agree with this recommendation and had begun taking steps to address it prior to this audit. As noted in our response to Recommendation 2, OPI has hired an OPA4 to work with HSD and with CCOs to strengthen the program integrity and accountability constructs over the next two contract cycles. This position will also review Medicaid administrative rules and work with stakeholders to update them for clarity and to enhance program integrity.

| | | |
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| RECOMMENDATION 6 Work with U.S. Treasury Do Not Pay center on utilizing free, sophisticated data mining techniques and explore other internal opportunities for data matching. | | |
| Agree or Disagree with Recommendation | Target date to complete implementation activities (Generally expected within 6 months) | Name and phone number of specific point of contact for implementation |
| Agree | January 2018 | Fritz Jenkins (503-947-1109) Chuck Hibner (503-932-6338) |

OHA Response to Recommendation 6:

We agree with the recommendation and plan to have OPI’s newly hired OPA 4 review the program. While we are aware of the U.S. Treasury Do Not Pay program and have previously considered the utility of this service, we are always looking for high-value activities and resources to ensure program integrity. OPI has also hired an additional Research Analyst 4 and is investing in specialized program integrity software to enhance OPI’s data analysis capabilities.

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| RECOMMENDATION 7 Work with CMS to explore pilot incentive programs to increase efforts to prevent, detect, and recover improper payments. | | |
| Agree or Disagree with Recommendation | Target date to complete implementation activities (Generally expected within 6 months) | Name and phone number of specific point of contact for implementation |
| Agree | October 2018 | Fritz Jenkins (503-947-1109) |

OHA Response to Recommendation 7:

OPI will engage with CMS and other state program integrity offices, through the Medicaid Integrity Institute and the National Association for Medicaid Program Integrity (NAMPI), to explore potential pilot incentive programs. The target date to complete implementation is aligned with the scheduled date for the next NAMPI national conference.

| RECOMMENDATION 8 | | |
|---|---|--|
| Ensure there is an annual reconciliation process for all individuals in the agency's various computer systems to verify their eligibility is appropriately re-determined. | | |
| Agree or Disagree with Recommendation | Target date to complete implementation activities (Generally expected within 6 months) | Name and phone number of specific point of contact for implementation |
| Agree | January 2018 | OHA: Fritz Jenkins (503-947-1109) DHS: Sam Osborn (503-373-1758) |

OHA Response to Recommendation 8:

We agree that the annual renewal process should be completed for all individuals determined eligible for Medicaid, CHIP and other medical programs. OHA has implemented monitoring processes and reports to keep annual renewal on track. As of September 2017, the Member Services Unit, the primary team responsible for eligibility determinations, is housed within DHS. As the single state Medicaid agency, OHA is ultimately responsible for the eligibility process and will collaborate with DHS on additional process improvements to conduct regular review and reconciliation across the eligibility determination systems.

Thank you and your team for your work on this audit engagement and for the opportunity to respond to the final draft report. Please contact OHA's chief financial officer, Laura Robison, at 503.877.8957 with any questions.

Sincerely,



Patrick M. Allen
Director

CC: Fariborz Pakseresht, Director, DHS
Laura Robison, Chief Financial Officer, OHA
Dave Lyda, Chief Audit Officer, OHA/DHS