Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Oregon Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

CMS' Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Oregon Medicaid Program. The onsite portion of the review was conducted at the Oregon Department of Human Services (DHS) offices. The review team also met with the Director of the State's Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Office of Payment Accuracy and Recovery (OPAR) in the Administrative Services Division (ASD) of DHS. OPAR is primarily responsible for Medicaid fee-for-service (FFS) program integrity activities not related to provider enrollment. In addition, the review team met with staff from the two DHS offices responsible for provider enrollment: the Provider Enrollment Unit in the Division of Medical Assistance Programs (DMAP) and the Provider Payment Unit in the Seniors and People with Disabilities Division (SPD). This report describes five effective practices, four regulatory compliance issues, and two vulnerabilities in the State's program integrity operations.

THE REVIEW

Objectives of the Review

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

Overview of Oregon's Medicaid Program

The Oregon DHS administers the Oregon Medicaid program. As of September 2007, the program served 364,998 recipients. Medicaid expenditures in Oregon for the State fiscal year (SFY) ending June 30, 2007, totaled $2,863,069,988. The Federal medical assistance percentage for Oregon for Federal fiscal year (FFY) 2007 was 61.07 percent. Over the past three SFYs, DHS processed an average of 16.6 million claims per year for its fee-for-service (FFS) providers. In SFY 2006, 94.6 percent of all FFS claims were submitted electronically.

Oregon had contracts with 32 managed care organizations (MCOs) that had enrolled 15,747 providers. Approximately 75 percent of Oregon Medicaid recipients were enrolled in 14 fully capitated health plans, 88 percent in nine dental care organizations, and 92 percent in seven mental health organizations. At the time of the review, DHS had enrolled 18,394 FFS providers, including those serving a small primary care case management component in rural areas.

Office of Payment Accuracy and Recovery

The DHS organizational component dedicated to fraud and abuse activities is the Provider Audit Section of OPAR. At the time of our review, OPAR had approximately 195 full-time equivalent employees (FTEs), with 105 FTEs focusing on Medicaid program integrity, mainly through

audits and investigations. OPAR has one staff member dedicated to Surveillance and Utilization Review Subsystem (SURS) analysis. The remaining employees perform coordination of benefit functions, third party liability collections, auditing non-Medicaid grants to other agencies, and monitoring recipient fraud. OPAR contracts with Health Watch Technologies (HWT) to develop algorithms that can identify patterns of fraud and abuse in the State's Medicaid claims database. During SFY 2004 through SFY 2006, OPAR staff conducted an annual average of 124 preliminary screenings and full audits.

Methodology of the Review

In advance of the onsite visit, CMS requested that Oregon complete a comprehensive review guide and supply documentation in support of its answers to the review guide. The review guide included such areas as provider enrollment, claims payment and post-payment review, managed care, SURS, and the MFCU. A questionnaire was also given to the State for distribution to each of Oregon's 32 MCOs. Twenty-eight MCOs supplied responses to the questionnaire. A three-person team reviewed the answers and documents that the State and its MCOs provided in advance of the onsite visit.

During the week of September 24, 2007, the MIG review team visited the DHS offices and also met with the MFCU Director. The team conducted interviews with numerous officials from ASD, DMAP, and SPD. The team met separately with representatives of HWT and Accumentra, Oregon's External Quality Review Organization (EQRO). To determine whether the MCOs were complying with contract provisions and other Federal regulations relating to program integrity, the MIG review team reviewed managed care contract provisions and questionnaire responses, gathered information through interviews with representatives of five of the 32 MCOs, and met with staff from the DHS divisions that oversee the managed care programs: the Division of Medical Assistance Programs, the Addictions and Mental Health Division, and the Seniors and People with Disabilities Division.

Scope and Limitations of the Review

This review focused on the activities of OPAR, DMAP, and SPD. Oregon's State Children's Health Insurance Program (SCHIP) operates under Title XXI of the Social Security Act and, therefore, was not included in this review. Unless otherwise noted, DHS 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 DHS provided.

RESULTS OF THE REVIEW

Effective Practices

The State has highlighted several practices that demonstrate its commitment to program integrity. These practices include improved oversight of MCOs, high quality encounter data, creative data analysis, and extensive educational efforts.

Establishment of an MCO Collaborative

The Oregon DHS has established an MCO Collaborative to improve communication across all components of the agency that oversee the managed care programs. Key units within the agency meet on a monthly basis to discuss the full range of managed care oversight and compliance issues. OPAR's participation in the MCO Collaborative is an important step toward ensuring that the managed care programmatic areas of the agency do not overlook program integrity issues and requirements in the MCO contracting and monitoring process.

Quality of Encounter Data

The quality of Oregon's encounter data allows the State to more clearly identify patterns of service delivery and provider practices than is normally the case. This has facilitated fraud and abuse monitoring in the managed care sector; and the State will enhance its data collection and analysis tools further with the advent of a new Medicaid Management Information System (MMIS).

Innovative Data Analysis

SURS staff perform creative data analysis in identifying different types of fraud schemes, provider abuse and overpayment situations, and generate backup confirmation for queries developed through OPAR's data warehouse. The data warehouse provides many components within DHS much faster access to standard and customized reports and the ability to do innovative data mining.

Educational Efforts

DHS is committed to educating both providers and other components within the Department on program integrity issues. OPAR senior staff regularly address the annual meetings of health care groups, such as behavioral health providers, pharmacists, and residential treatment facility operators, to communicate policy standards and offer guidance. When widespread billing issues are identified, OPAR works closely with the Medicaid section to develop provider bulletins that give notice of policy expectations before administrative actions commence.

Additionally, the MIG review team identified one practice that is particularly noteworthy. CMS recognizes the strong relationship between DHS and the State's MFCU as further evidence of the Oregon program's strengths.

High level of cooperation between DHS and the MFCU

DHS and the MFCU have a Memorandum of Understanding that provides for prompt feedback on referrals from the State agency within 30 days and for the State agency to take administrative actions against referred providers at the MFCU's direction. Both entities meet frequently to discuss cases and belong to broader law enforcement and regional Medicaid workgroups. MFCU input has been responsible for the State changing the language on provider enrollment packages to conform to Federal regulations on required disclosures. DHS is currently soliciting MFCU input on a planned new MMIS

procurement to ensure that the new system will meet anticipated program integrity monitoring and research needs. DHS and MFCU staff also conduct numerous joint trainings for provider groups, managed care personnel, and State agency staff. As a result, the MFCU Director indicated that MCOs are improving in their ability to identify and report patterns of fraud and abuse within their networks.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to disclosure and reporting requirements.

MCOs do not collect required ownership, control, and relationship information.
Under 42 CFR § 455.104(a)(1), a provider or "disclosing entity" that is not subject to periodic survey under § 455.104(b) (2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of five percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. While Oregon's FFS provider enrollment packages request these disclosures in accordance with the regulations, 14 of the 28 respondents to the MCO questionnaire indicated in their questionnaire responses that they do not collect this information.

***Recommendation*:** Require MCOs that are not currently collecting required disclosures to modify their provider credentialing procedures to capture the required ownership and control disclosures.

DHS' FFS provider enrollment packages and the model managed care contract do not require providers to disclose certain business transactions.
The regulation at 42 CFR § 455.105 requires that, upon request, providers furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractors. DHS' FFS provider enrollment packages, which include an application form and provider agreement, do not require provision of business transaction information. While DHS' model MCO contracts require these disclosures, the team reviewed a sample of MCO credentialing packages and found the packages did not contain any requirement that MCO providers supply business transaction disclosures upon request.

***Recommendation*:** Modify the FFS provider agreement to require providers to supply business transaction information identified in 42 CFR § 455.105. Require the MCOs to modify credentialing forms to require disclosure of the required business transaction information upon request.

DHS does not meet Federal regulations requiring the disclosure of criminal conviction information in MCO credentialing forms. DHS does not report this information to HHS-OIG.

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 at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-OIG within 20 working days whenever such disclosures are made. While Oregon's FFS provider enrollment packages request the required disclosure information, 14 of the 28 respondents to the MCO questionnaire indicated in their questionnaire responses that they do not collect information on owners, agents or managing employees. In addition, DHS staff overseeing the FFS program and the DHS managed care staff noted that should providers supply the required criminal conviction information, the State has no procedure in place to report the providers to HHS-OIG.

***Recommendations*:** Require the disclosure of health care-related criminal convictions in all managed care credentialing packages. Develop and implement a procedure to report criminal conviction information elicited from providers in the FFS and managed care programs to HHS-OIG within 20 working days.

DHS does not report to HHS-OIG adverse actions it takes on provider applications.

The regulation at 42 CFR §1002.3(b)(2) and (b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program. DHS provider enrollment staff were unable to document that DHS reported to HHS-OIG actions taken to deny or limit provider participation during the enrollment process. None of the five MCOs interviewed reported to DHS adverse actions the MCOs took on credentialing applications; therefore, DHS could not report those adverse actions to HHS-OIG.

***Recommendations*:** Develop and implement procedures to report to HHS-OIG all adverse actions taken against and limits placed on providers applying to participate in the program. Modify MCO contracts to require that MCOs report adverse actions and limitations to DHS.

Vulnerabilities

The review team identified two areas of vulnerability involving out-of-state license verification and managed care contract monitoring practices.

Not verifying out-of-state provider licenses.

Oregon provider enrollment staff currently require a copy of an out-of-state provider's license prior to enrollment to ensure that the license is current. In the past, staff would check with the licensing board of the state that issued the license to verify that there were no adverse actions against the provider or limitations on the license. During interviews with the review team, provider enrollment staff stated that they no longer verify the status of out of-state provider licenses.

***Recommendation*:** Reinstitute a process to verify out-of-state provider licenses.

Not monitoring MCOs' verification of enrollees' receipt of services.
The regulation at 42 CFR § 455.20 requires the Medicaid agency to have a method to verify with recipients whether they received services billed by providers. OPAR regularly sends explanations of medical benefits (EOMBs) to a sample of FFS recipients. The MCO contracts require plans to have some method for verifying services. Some MCOs reported in their questionnaire responses that they used telephone surveys or compared provider claims with medical records. Other MCO responses, however, indicated that they did not verify receipt of services using EOMBs or through any other method. The State's EQRO, Accumentra, indicated during its interview with the review team that its contract did not require it to verify managed care enrollees' receipt of services.

***Recommendation*:** Monitor and enforce MCOs' contracts to ensure that MCOs are undertaking some form of verification of services.

CONCLUSION

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

- the establishment of an MCO Collaborative
- high quality MCO encounter data
- innovative SURS data analysis
- intensive educational efforts within the Department and provider community, and
- a strong relationship between the State agency and the MFCU.

CMS supports the State's efforts and encourages DHS to build upon its effective practices and look for additional opportunities to improve overall program integrity.

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

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

The corrective action plan should address how the State of Oregon will ensure that the deficiencies will not recur. The corrective action plan should include the timeframes for each

correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If DHS has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Oregon on building upon effective practices, correcting its regulatory compliance issues, and eliminating its vulnerabilities.