Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Oregon Focused Program Integrity Review

Final Report

November 2018

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of Oregon to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected coordinated care organizations (CCOs) under contract with the state Medicaid agency. The review also included a follow up on the state's progress in implementing corrective actions related to CMS's previous comprehensive program integrity review conducted in calendar year 2013.

Background: State Medicaid Program Overview

The Oregon Health Authority (OHA) is the single state Medicaid agency for Oregon. The Oregon Health Plan (OHP) is the state Medicaid program under OHA that provides health care coverage for working families, children, pregnant women, single adults, seniors, and others. The Oregon Department of Human Services (DHS) and OHA have an interagency agreement that outlines shared operational and programmatic oversight responsibilities of the Medicaid program. However, OHA retains ultimate administrative authority and responsibility for the operation and oversight of the Medicaid program. Oregon is a Medicaid expansion state. The state's Federal Medical Assistance Percentage is 62.5%.

The large majority of Medicaid beneficiaries receive services through managed care delivery, via the Section 1115 Demonstration Waiver. In FFY 2017, approximately 885,000 Oregon Medicaid beneficiaries, which is approximately 92 percent of all OHP beneficiaries, were enrolled in a CCO to receive Medicaid benefits. In sum, 1.072 million beneficiaries were served by the OHP in FFY 2017.

Methodology of the Review

In advance of the onsite visit, CMS requested that Oregon and the CCOs selected for the focused review complete a review guide that provided the CMS review team with detailed insight into the operational activities of the areas that were subject to the focused review. A three-person review team has reviewed these responses and materials in advance of the onsite visit.

During the week of May 22-24, 2018, the CMS review team visited OHA. CMS conducted interviews with numerous state staff involved in program integrity and managed care. The CMS review team also conducted interviews with three CCOs and their compliance units. In addition, the CMS review team sampled certain program integrity cases and other primary data to validate the program integrity practices of the state and the selected CCOs.

Results of the Review

The CMS review team identified areas of concern with the state's managed care program integrity oversight, which create risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved, particularly those that remain from the earlier review. These issues and CMS's recommendations for improvement are described in detail in this report.

Section 1: Managed Care Program Integrity

Overview of the State's Managed Care Program

There are approximately 885,000 beneficiaries, or 92 percent of the state's Medicaid population, were enrolled in sixteen CCOs during FFY 2017. The state spent approximately $4.724 billion on managed care contracts in FFY 2017.

The OHP utilizes the coordinated care model for managed care delivery. The CCOs primary functions are to integrate and coordinate physical, behavioral, and oral health care; reward outcomes rather than volume in the payment system; align incentives across medical care and long-term care services and support; and partner with community public health systems to improve health. The CCOs focus on prevention, chronic disease management and early intervention, while working to reduce waste and inefficiencies in the health care system. As part of the mission of the program, the CCOs have created innovation within their own communities that did not exist within a standard managed care model. The CCOs are community-level entities that finance health care and are governed through a partnership of provider, payers that assume risk for Medicaid enrollees, and community-based organizations. The CCOs have defined service areas of which they operate within the state.

Each CCO contracts with multiple delegated entities, including risk accepting entities, managed care organizations (MCOs), managed care entities (MCEs) dental care organizations, non-emergency transportation providers, and behavioral health provider networks to provide services to beneficiaries assigned to a CCO. Contracting with multiple delegated entities provides beneficiaries with greater access to care and Medicaid services. Each CCO is responsible for providing oversight of contracted delegated entity networks to ensure that services are being rendered in accordance with state and federal guidelines.

Summary Information on the Plans Reviewed

The CMS review team interviewed three CCOs as part of its review. The three CCOs reviewed were Willamette Valley Community Health (WVCH), Eastern Oregon CCO (EOCCO), and Health Share of Oregon (Health Share).

The WVCH is a local plan that became operational in 2012. The WVCH serves approximately 103,000 beneficiaries in Marion and Polk Counties in Oregon. In FFY 2017, WVCH reported Medicaid expenditures of $504.5 million. The WVCH does not contract with Medicare, and

they don't have a commercial line of business. The WVCH contracts with nine delegated entities to administer Medicaid services to CCO beneficiaries. The WVCH has a total of 12 full-time employees (FTEs). Four FTEs are dedicated to overall compliance oversight. Two of the four FTEs spend approximately 35 percent of their time dedicated to identifying fraud, waste, and abuse. The WVCH does not have a special investigations unit (SIU), nor do they regularly initiate claims data mining to identify aberrant providers. The WVCH relies on their third party administrator (TPA) to perform claims analytics to identify aberrant providers. The WVCH has also contracted with an auditing firm to conduct a limited amount of claims audits. Contracted delegated entities are responsible for performing their own program integrity and oversight, independently.

The EOCCO provides comprehensive care to Medicaid beneficiaries in twelve rural counties in central and eastern Oregon and serves approximately 46,979 beneficiaries. In FFY 2017, EOCCO reported Medicaid expenditures of $245.4 million. The EOCCO contracts with the following five partnering organizations to provide coordinated care; Moda Health Plan, Inc., Greater Oregon Behavioral Health, Inc. (GOBHI), Oregon Dental Society Community Dental, Advantage Dental, and Capitol Dental. The EOCCO's ownership structure is comprised of eight entities. The largest ownership interests are held by Oregon Dental Society Community Health (ODSCH), a subsidiary of Moda, Inc., and GOBHI. The ODSCH and GOBHI each hold a 29 percent ownership interest in EOCCO. The EOCCO is managed by a board of directors, and the GOBHI Chief Executive Officer (CEO) is the CEO of the EOCCO Board of Directors. Program administration and program integrity oversight of EOCCO is performed by Moda, Inc., located in Portland, Oregon. The Moda SIU is a shared unit responsible for identifying fraud and abuse for EOCCO, and Moda commercial lines of business. The SIU has two FTEs, which devote approximately five percent of their time to identifying fraud and abuse for the EOCCO Medicaid plan. The Moda SIU contracts with Change Healthcare, a third-party claims analysis and processing contractor and monitors this contractor internally via the SIU. The Moda Medicaid compliance officer also serves as the Medicaid compliance officer for EOCCO. The Medicaid compliance officer oversees the activities of the SIU and reports these activities to the Moda Board of Directors Compliance Committee, as well as to the EOCCO Board of Directors**.**

Health Share officially became Oregon's largest CCO in September 2012. Health Share serves approximately 320,000 OHP beneficiaries in Clackamas, Multnomah and Washington counties. In FFY 2017, Health Share reported Medicaid expenditures of $1 billion. Health Share subcontracts with sixteen MCEs for service delivery; which includes nine dental health plans, three behavioral health plans, and four physical health plans. In addition, Health Share subcontracts with one non-emergency medical transportation broker. The sixteen MCEs maintain their own SIU, investigate and report fraud and abuse allegations, provide oversight of contracted provider networks, and processes their own claims. Health Share also maintains a contract with a TPA on behalf of the behavioral health plans. The TPA processes authorizations and claims, pays providers and submits encounters to OHA. Health Share's quality assurance and compliance team is responsible for all program integrity related activities. The director of quality assurance and compliance is the compliance officer for the company. In addition to the compliance officer/director, the quality assurance and compliance team is comprised of six FTEs; which include three clinical quality assurance specialists, two quality assurance

specialists, and one quality assurance coordinator. The six FTEs spend approximately ten percent of their time on auditing, analyzing and investigating Medicaid fraud or abuse.

Enrollment and expenditure information for each CCO as of April 2018 is summarized below:

Table 1.

	WVCH	EOCCO	(Health Share)
Beneficiary enrollment total	101,071	46,762	316,797
Provider enrollment total	1597	11,517	18,990
Year originally contracted	2012	2012	2012
Size and composition of SIU	0	2 FTEs	0
National/local plan	Local	Local	Local

Table 2.

MCOs	FFY 2015	FFY 2016	FFY 2017
WVCH	$485.0 million	$497.6 million	$504.5 million
EOCCO	$219.9 million	$235.4 million	$245.4 million
Health Share	$1.1 billion	$1.1 billion	$1.0 billion

State Oversight of MCO Program Integrity Activities

The OHA conducts a substantial amount of administrative, operational, and programmatic functions of the Medicaid program. The OHA and DHS have a robust interagency agreement to ensure collaboration in the administration of the OHP. The OHA is responsible for procuring and administering CCO contracts, and establishing policies and procedures for program integrity and Medicaid program oversight. The Health Systems Division (HSD) within OHA verify provider qualifications, and prevent excluded providers from participating in the Medicaid program. The HSD is also responsible for managing Medicaid financial expenditures, and processing encounter data from CCOs. The DHS/OHA interagency agreement does not address the responsibilities of each unit in detail, but there are informal expectations for the dissemination of information. The DHS staff are not dedicated solely to Medicaid administration, and service multiple social service lines of business on behalf of the State. The state should consider enhancing the interagency agreement to illustrate detailed oversight responsibilities of each division responsible for oversight and administration of program integrity activities. A more detailed interagency agreement that specifies which state unit(s) are responsible for all aspects of administration, monitoring, oversight, and lines of communication may be beneficial towards creating a more unified understanding regarding Medicaid monitoring and oversight responsibilities.

HealthInsight Assure contracts with OHA as their External Quality Review Organization (EQRO). The contracted EQRO activities include compliance reviews, every three years, of

MCE compliance with 42 CFR 438 for: Enrollee Rights, grievance and appeals system, certifications and program integrity, and quality assessment and performance improvement. The program integrity review protocol developed by HealthInsight reviews CCO compliance with 42 CFR 455 and 42 CFR 438, Subpart H, and was last utilized in 2014. Neither OHA, nor the EQRO, have conducted assessments to measure CCO SIU and program integrity effectiveness. The OHA's contract with all CCOs indicates the CCOs are required to conduct compliance and program integrity assessments of all contracted delegated entities, annually.

The OHA has not provided guidance to CCOs on what metrics should be utilized to perform program integrity assessments. Further, OHA does not have a process to verify and ensure CCOs are performing compliance and program integrity reviews, annually. Each CCO interviewed onsite had not conducted program integrity assessments of any delegated entities in the last three FFYs. Therefore, the CCOs are not in compliance with this provision of OHA's contract. On average, the three CCOs reviewed indicated they spend approximately fifteen percent of their time dedicated to identifying and investigating fraud and abuse. Overall, the CCOs are providing limited oversight of managed care expenditures. The OHA should consider assisting CCOs in creating a tool to measure SIU and program integrity effectiveness. The OHA should consider revising internal procedures to ensure CCOs are compliant with the contract provision requiring annual program integrity reviews. Over 90 percent of beneficiaries that receive Medicaid services in Oregon are enrolled with CCOs. Thus, exercising adequate oversight over managed care expenditures should be a priority to safeguard the Medicaid program. The OHA should review and refine program integrity strategies and efforts to ensure managed care expenditures have adequate oversight. The multi-layered CCO/delegated entity delivery system poses more challenges than a traditional managed care delivery system to mitigate fraud and abuse, which may require enhanced efforts on behalf of OHA and CCOs.

MCO Investigations of Fraud, Waste, and Abuse

As required by 42 CFR 455.13, 455.14, 455.15, 455.16, and 455.17, the state does have an established process for the identification, investigation, referral and reporting of suspected fraud, waste, and abuse by providers and MCOs.

Oregon's CCO contract states, "CCO shall promptly refer all suspected cases of fraud and abuse, including fraud, in accordance with 42 CFR 455.23, by its employees and subcontractors to the Medicaid Fraud Control Unit (MFCU) and OHA/DHS Program Integrity Audit Unit (PIAU). Referrals are accepted via email, U.S. Mail, and telephone." The OHA contract indicates suspected fraud should be referred "promptly," but does not provide a defined timeline for when referrals should be reported. The OHA created a suspected fraud referral document, with input from the MFCU, to aid CCOs and MCEs in reporting suspected fraud to the PIAU. Upon receipt of a suspected fraud referral from a source, an OHA designated FTE in PIAU records and tracks the contact. The referral is triaged and assessed for a credible allegation of fraud. The assessment includes claims look back, and data mining when necessary. Suspected fraud referrals are forwarded to the MFCU to evaluate, generally within one day of the assessment. The MFCU reviews the suspected fraud referral, and advises OHA within one day to two weeks with an acceptance or rejection of the suspected fraud referral. The state tracks the dispositions of cases, which are reconciled on a monthly basis using an internal tracking spreadsheet. The CCO contract indicates CCOs are required to advise OHA and the MFCU, simultaneously, of

suspected fraud. OHA stated not all CCOs are including OHA on all suspected fraud referrals that are made to the MFCU. Suspected fraud referrals that are submitted directly to the MFCU, without OHA's knowledge, are reconciled every month with the MFCU. The CCOs failure to include OHA on all suspected fraud referrals pose a vulnerability to OHA's ability to be fully compliant with the payment suspension policy in 42 CFR 455.23.

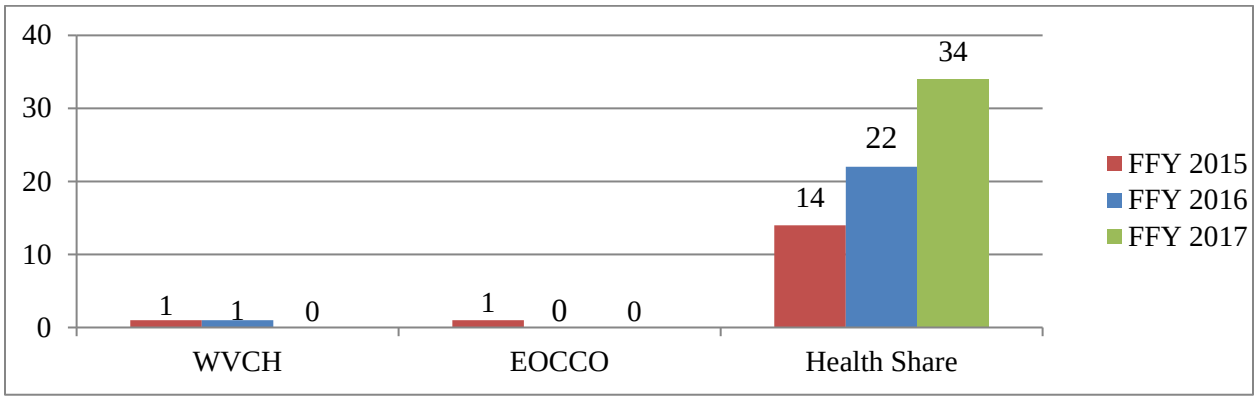
The WVCH utilizes EthicsPoint to track investigations and complaints related to fraud and abuse. The WVCH reported zero preliminary and full reviews conducted in FFY 2017. The WVCH relies on referrals from delegated entities and outside sources in order to initiate preliminary and full reviews. Upon receipt of an allegation of fraud, the Chief Compliance Officer is responsible for coordinating with the appropriate internal departments, and determines the audit process based upon the circumstances. The Chief Compliance Officer is responsible for notifying OHA and/or the MFCU when a suspected allegation of fraud has been identified.

The EOCCO's five contracted partnering organizations are responsible for independently performing their own program integrity and oversight. The EOCCO does not have employees, or a SIU. The Moda SIU is responsible for investigating referrals of fraud, waste and abuse that come from partnering organizations, providers and other internal sources, such as the third-party contractor and hotline. Moda uses internal system edits and conducts programmatic reviews of data to further detect and address coding errors. Change Healthcare uses claims management tools to identify inconsistent relationships among claims data as well, and reports this information directly to Moda. Upon receipt of a referral or identification of erroneous billing, the SIU conducts a preliminary review of the suspected fraud to determine if OHA or the MFCU should be notified.

Health Share's Quality Assurance (QA) and compliance team is responsible for program integrity activities. Suspected fraud referrals are logged in an internal fraud and abuse tracking log. The compliance officer or designee creates a case file and an investigative plan, if necessary. The investigation is completed as timely as possible, not to exceed twenty calendar days. Upon completion of the investigation, Health Share's compliance officer reviews the preliminary results with the QA review team. The results of the investigation are reported to the Compliance Committee, and all suspected fraud, waste, and abuse is referred to the MFCU and the PIAU within two business days. Confirmed fraud, waste, and abuse is referred to the MFCU and PIAU within 24 hours.

Table 3 lists the number of referrals that WVCH, EOCCO, and Health Share's SIU made to the state in the last three FFYs. Overall, the number of Medicaid provider investigations and referrals by each of the CCOs is low, compared to the size of the plan. The level of investigative activity has not changed over time.

Table 3.



CMS conducted a provider sampling exercise, consisting of five provider files, to review and determine if OHA adhered to federal guidelines on suspected fraud referrals from MCEs and CCOs. Each provider file reviewed had inconsistencies with federal guidelines on how to handle suspected fraud allegations. In each instance where a case investigation was referred to the MFCU, and accepted for criminal investigation, OHA did not impose a provider payment suspension in accordance with 42 CFR 455.23, nor was a good cause exception invoked. Also, OHA did not promptly refer suspected fraud to the MFCU as required. On one occasion, OHA, a CCO, and a delegated entity utilized additional measures to reconcile improper billing that was not evaluated to determine if there was a credible allegation of fraud. On two occasions, CCOs or their contracted delegated entities, recouped overpayments due to suspected allegations of fraud or abuse. The CCOs terminated the providers after recouping overpayments for services not rendered, and did not refer the suspected fraud to OHA or the MFCU. The OHA did not report the terminated providers to CMS as required. On another occasion, OHA received a Medicare revocation notice for a provider shared by two contracted CCOs. The OHA did not direct the CCOs to formally terminate the provider from their networks. Providers who have been revoked by Medicare are ineligible to receive Medicaid reimbursements.

MCO Compliance Plans

The state does require its MCOs to have a compliance plan to guard against fraud and abuse in accordance with the requirements at 42 CFR 438.608. The state does have a process to review the compliance plans and programs.

As required by 42 CFR 438.608, the state does review the MCE's compliance plan and communicates approval/disapproval with the MCEs.

The PIAU reviews all CCO compliance plans and is reviewed annually, which is documented within the Transformation and Quality Strategy (TQS) guidance document. The TQS provides direction and guidance to CCOs on contract deliverables. During the most recent review cycle, all reviewed compliance plans were not in compliance with 42 CFR 438.608. The PIAU advised the identified CCOs of the compliance plan inadequacies. Amended, compliant compliance plans are required to be re-submitted within 45 days for review. Identified non-compliance is used to identify areas for potential trainings and instruction. Each CCO interviewed provided the

review team with a copy of their compliance plan that has been submitted to the state. A review of the amended compliance plans revealed they were in compliance with 42 CFR 438.608.

Encounter Data

The OHA does collect and review encounter data. At the time of the review, OHA did not regularly analyze encounter data for fraud, waste, and abuse trends.

The CCO contract provides guidance on encounter claim submissions. The CCOs are required to attest to the accuracy, completeness and truthfulness of information required by OHA, in accordance with 42 CFR 438.604 and 438.606. The OHA contract further states that CCOs are required to submit valid encounter data at least once per calendar month, on forms or formats specified by OHA, in accordance with state guidelines. The OHA contract allows for corrective actions and monetary penalties to be imposed when more than ten percent of any encounter data submission can't be processed due to missing, or erroneous information. However, OHA does not regularly implement corrective actions or monetary penalties outlined in the contract for non-compliant encounter submissions.

The three CCOs interviewed had varying levels of direct access to encounter data. Delegated entities who contract with CCOs are responsible for maintaining and providing accurate encounter data to contracted CCOs. Contracted delegated entities are generally responsible for conducting their own data mining, and analyzing claims data to identify potential fraud and abuse. Each contracted delegated entity utilizes various algorithms for data mining.

Overpayment Recoveries, Audit Activity, and Return on Investment

The state does not require CCOs to return to the state or report on overpayments recovered from providers as a result of MCO fraud and abuse investigations or audits. However, the state does require the CCOs to offset overpayment recoveries on their financial report for rate setting purposes. Total overpayments recouped by a CCO are deducted from the total calculated annual capitation rate the following year. When CCOs, or contracted MCEs identify and recoup overpayments, CCOs are required to submit adjusted encounter data to reflect the appropriate level of service provided. The CCOs rely on contracted MCEs to submit accurate encounter data, which is certified by the CCO, in accordance with OHA guidelines. Even though overpayments may be reported to OHA by the CCOs, the encounter adjustment from the CCO is the official record OHA utilizes for rate setting purposes. The OHA administrative rulebook which details the rules promulgated by OHA requires CCOs to correct encounter data, and submit accurate encounter data within specific timelines. However, there are no OHA overpayment provisions that explicitly require CCOs to accurately adjust encounter submissions after an overpayment has been identified and recouped. The three CCOs interviewed had varying policies and safeguards on ensuring encounters are adjusted after overpayments are identified and recouped. At least one CCO had no policies or procedures to ensure encounters are appropriately adjusted. Oregon's Medicaid managed care capitation rate development relies on the data submitted by plans, and adjusted encounters factor into the capitation rates of the CCOs. However, OHA does not have adequate safeguards to ensure CCOs re-submit accurate, adjusted encounter data when overpayments are reported and recouped from providers. Original encounters that were originally submitted to record services rendered should be adjusted

accordingly to reflect actual services rendered as overpayment recoveries are processed. The CCOs may be receiving inflated capitation rates without consideration of the adjusted encounters that are required to calculate accurate capitation rates. The OHA should consider drafting more explicit contract language, develop an effective internal process for reconciling recovered overpayments with CCO encounter submissions, and implement a process to verify adjusted encounters are submitted as required.

The table below shows the respective amounts reported by WVCH for the past three FFYs.

Table 4-A.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2015	0	1	$4700	$3,900
2016	5	3	$0	$0
2017	0	0	$0	$0

The WVCH has conducted five preliminary investigations and four full investigations in the last three FFYs. All investigations were initiated as a result of a referral from another source. No investigations were the result of proactive claims data mining. In the last three FFYs, WVCH reported $3,900 in recovered overpayments as the result of one full investigation in FFY 2015. The WVCH attributes low overpayment recoveries to the lack of data mining/analytic software available for compliance oversight. Also, increasing compliance oversight responsibilities reduce the limited staff's time to proactively identify suspected fraud.

The table below shows the respective amounts reported by EOCCO for the past three FFYs.

Table 4-B

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2015	1	1	$8,113.29	$8,113.29
2016	0	0	$0	$0
2017	0	0	$0	$0

The EOCCO reported one full investigation was conducted in in the last three FFYs. The overpayment recoveries recorded in FFY 2015 were the result of a genetic testing provider audit. The EOCCO identified the reported overpayments through a live claim review process. If providers are repetitively flagged by this process, they are taken off the CCO provider panel and reported to the EOCCO compliance officer. CMS conducted case sampling of program integrity activities initiated by contracted delegated entities. The case sampling revealed the delegated entities conducted several audits that resulted in recoupments of over $100,000.00, which were recouped by the delegated entities, but were never referred to OHA or the MFCU for suspected

fraud. Therefore, suspected fraud audits and reviews conducted by contracted delegated entities are not reflected in EOCCO's reported investigations activity.

The table below shows the respective amounts reported by Health Share for the past three FFYs.

Table 4-C.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2015	83	20	$235,726	$111,428
2016	47	20	$247,313	$80,469
2017	80	24	$1,251,834	$624,859

Health Share's overpayments identified and recovered significantly increased in FFY 2017 primarily due to a processing error by a TPA that resulted in inadvertent overpayments to a group of providers. Reimbursements were recouped from the providers and reflected in the overpayments recovered. Health Share also stated that the variances in identified and recovered overpayments for FFY 2015, FFY 2016, and FFY 2017 may be attributed to investigations spanning multiple years and the fact that recovered amounts do not always correlate to the years in which they were identified. Health Share utilizes pre-payment review as a cost avoidance measure. Health Share's contracted delegated entities have placed a total of three providers on prepayment review in the last three FFYs. Two providers are currently on prepayment review since June 2015 and January 2017 respectively. One provider remained on prepayment review for a seventeen month period during FFY 2016 to FFY 2018.

Overall, the amount of overpayments identified and recovered by the CCOs appear to be low for a managed care program of Oregon's size. Although CCOs are not required to return reported overpayments from their network providers to OHA, reported overpayments are factored into establishing annual case rates. The OHA should review internal procedures to ensure they are receiving a clear accounting of any recoupments undertaken by CCOs and MCEs. Without appropriate encounter adjustments, the rates paid to the CCOs may be inflated per member per month.

Payment Suspensions

In Oregon, Medicaid CCOs are contractually required to suspend payments to providers at the state's request. The state confirmed that there is contract language mirroring the payment suspension regulation at 42 CFR 455.23.

None of the CCOs interviewed have imposed a payment suspension, at the direction of OHA, in the last three FFYs in accordance with 42 CFR 455.23. Further, OHA has not directed any payment suspensions to any contracted CCOs in the last three FFYs. Some CCOs reviewed do not have a clear suspension procedure to ensure that payment suspensions are executed appropriately.

The WVCH had at least one suspected fraud referral that resulted in a MFCU criminal investigation. The provider admitted wrongdoing, resigned from the employer, and settled with the MFCU before prosecution. The MFCU placed the provider on the OIG LEIE as a result of the investigation. A payment suspension was never imposed, and a documented good cause exception was not provided. The WVCH has policies that cite 42 CFR 455.23, and requirements for compliance. The WVCH advised CMS that they do not have adequate procedures to ensure payment suspensions directed by OHA are executed appropriately.

The EOCCO places providers on pre-payment claim review when allegations of suspected fraud are identified by audits or investigations. The EOCCO placed eleven providers on prepayment review in FFY 2017. Providers remain on prepayment review indefinitely until the audit process is completed and a determination is established. Audit and investigation findings, that verify suspected fraud allegations, can result in provider termination. Verified cases of suspected fraud, resulting in provider termination, are reported to the state by the EOCCO compliance officer.

Health Share and their sixteen MCEs have policies and procedures to suspend provider payments upon receipt of payment suspension notification from the PIAU. In the last three FFYs, Health Share referred two suspected fraud referrals to OHA. Health Share did not receive acknowledgment the referral was accepted, or any guidance on imposing payment suspensions.

Suspected fraud referrals are not managed in accordance with 42 CFR 455.23. The CCOs reviewed indicated that they do not receive regular communication from the MFCU and OHA about submitted suspected fraud referrals. The OHA has compliant policies in the CCO contract that require payment suspensions in accordance with 42 CFR 455.23. However, OHA advised CMS that provider payment suspensions are rarely considered in order to aid the MFCU in their criminal investigations. The OHA has not imposed a provider payment suspension in the last three FFYs, even though suspected fraud referrals from CCOs have resulted in provider exclusions and criminal investigations. Despite a lack of imposed payment suspensions, OHA has not developed clear policies or criteria to define good cause exceptions for avoiding payment suspensions. Explicit good cause exception criteria is necessary to bypass payment suspensions when the MFCU accepts a credible allegation of fraud referral for a criminal investigation. The OHA is not in compliance with 42 CFR 455.23, or their own policy on provider payment suspensions. The OHA should create strategies to become compliant with the federally mandated provisions of 42 CFR 455.23, including developing criteria, policies, and procedures for identifying good cause exceptions when a payment suspension should not be utilized. In addition, OHA should review procedures to ensure CCOs are able to effectively suspend provider payments at the direction of OHA. Some CCOs reviewed indicated they do not have procedures and safeguards to ensure they are able to execute payment suspensions mandated by OHA.

Terminated Providers and Adverse Action Reporting

The CCO contract states that CCOs are not required to provide written notice of termination to the state unless there is a ***material change*** in the provider network. According to the OHA contract, a material change means “Any circumstance in which Contractor experiences a change in operations that is reasonably likely to affect Contractor’s Participating Provider capacity or reduce or expand the amount, scope or duration of Covered Services being provided to

Members." The OHA contract provides several examples of what may be considered a material change, which are primarily based on standards to ensure robust provider accessibility and coordination of care for CCO beneficiaries.

The OHA contract does not include clear language requiring CCOs and delegated entities to differentiate between "for cause" or "without cause," provider terminations. Thus, CCOs and delegated entities are not required to identify and report providers that have been terminated "for cause." As a result, OHA does not have a method or procedure to identify CCO providers that may have been terminated for adverse actions that would rise to the level of "for cause." CMS guidance indicates "for cause" adverse action terminations may include, but is not limited to, termination for reasons based upon fraud, integrity, or quality[1]. Section 6501 of the Affordable Care Act mandates that state Medicaid agencies effectively terminate providers that have been terminated "for cause." The OHA should develop adverse termination criteria consistent with Section 6501 of the Affordable Care Act, and amend the CCO contract to mandate prompt reporting of adverse action terminations. The OHA should ensure CCOs and delegated entities develop similar criteria for adverse terminations, and develop clear reporting requirements for providers that have been terminated for adverse actions. Further, OHA should consider developing a policy and procedure for ensuring providers terminated by CCOs and delegated entities for adverse actions are effectively terminated from all CCO networks within the OHP, and subsequently reported to CMS as required in Section 6501 of the Affordable Care Act.

The OHA does not regularly review other state terminations lists within TIBCO to identify providers that have been terminated from other state Medicaid programs. 42 CFR 455.16 indicates that providers that have been terminated for adverse actions in another state are not eligible to participate in Medicaid. The OHA does not have internal processes to routinely review Medicare revocation provider lists. The OHA's failure to routinely monitor state terminations and Medicare revocations poses a vulnerability to the Medicaid program. The OHA should develop internal processes to report adverse action terminations to CMS, and develop procedures to ensure state termination and Medicare revocation lists are reviewed no less than monthly.

The WVCH has not received any provider termination notices from OHA with a mandate to terminate a provider. The WVCH does not have a policy or procedure for terminating providers at the direction of OHA, or to ensure delegated entities terminate at the direction of OHA. The WVCH does not have clear provider termination policies and procedures to ensure contracted delegated entities terminate and report providers that were terminated for adverse actions. The WVCH has not terminated a provider for cause in the last three FFYs. The WVCH provided evidence that one provider was terminated in FFY 2015, without cause, but would actually qualify as a "for cause" adverse action termination.

Similarly, EOCCO nor their five partnering organizations notify OHA at the time of termination, disenrollment or de-credentialing. The CCO provides a delivery system report to the OHA on an annual basis that includes all current providers. The CCO reports providers terminated based on adverse action to the National Provider Data Bank and shares information about suspected or

[1] https://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/6501-Term.pdf

proven fraud with other CCOs and relevant parties through their participation in the Healthcare Fraud Task Force Work Group.

Health Share does not notify the OHA at the time of termination, disenrollment or de-credentialing. All provider terminations are listed on the Health Share delivery system network report, and submitted to the OHA annually. The annual termination report does not indicate rationale for the terminations. Health Share has not received any provider termination notices from OHA in the past three FFYs.

Table 5:

MCOs	Total # of Providers Dis-enrolled or Terminated in Last 3 Completed FFYs		Total # of Providers Terminated For Cause in Last 3 Completed FFYs	
WVCH	2015 2016 2017	1 0 0	2015 2016 2017	0 0 0
EOCCO	2015 2016 2017	494 743 580	2015 2016 2017	7 10 1
Health Share	2015 2016 2017	1262 1336 1372	2015 2016 2017	3 12 16

Compared to the number of providers in each of the CCO's networks, and compared to the number of providers dis-enrolled or terminated for any reason, the number of providers terminated for cause by the CCOs appear to be low. The state does not regularly notify CCOs of adverse actions taken against providers. In the last three FFYs, OHA did not report any "for cause" state terminations to CMS. As previously mentioned, OHA does not have defined criteria regarding "for cause" adverse action termination, nor a requirement to report such terminations.

Federal Database Checks

The regulation at 42 CFR 455.436 requires that the state Medicaid agency must check the exclusion status of the provider or 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); the Social Security Administration's Death Master File (SSA-DMF); the National Plan and Provider Enumeration System upon enrollment and reenrollment, and check the LEIE and EPLS no less frequently than monthly.

The OHA is responsible for enrolling all OHP Medicaid providers. The CCO providers that only render services to CCO network beneficiaries, and do not participate in the OHP FFS program, are enrolled as an "encounter only" providers. The OHA does not credential CCO, "encounter

only" providers. Credentialing is the responsibility of the CCOs and contracted delegated entities. The OHA's CCO contract lacks language requiring SAM/EPLS and SSA-DMF database checks, which is not in compliance with 42 CFR 455.436. Two CCOs interviewed do not utilize the SSA-DMF database for credentialing. The OHA should amend the CCO contract, and require CCOs to credential providers in accordance with 42 CFR 455.436 in its entirety.

The OHA has not formally established categorical risk levels for Medicaid provider types. 42 CFR 455.434 requires that the State Medicaid agency establish categorical risk levels for providers and provider categories for those that pose an increased financial risk of fraud, waste or abuse to the Medicaid program. In addition, 42 CFR 455.432 requires that the State Medicaid agency conduct pre-enrollment and post-enrollment site visits of providers who are designated as ''moderate'' or ''high'' categorical risks to the Medicaid program. The OHA should create policies and procedures to establish categorical risk levels for Medicaid providers, and ensure the CCOs and contracted delegated entities credential providers accordingly.

The OHA does not consistently require CCOs to complete, and submit disclosure of ownership forms. The CCOs interviewed did not collect disclosure of ownership forms from contracted delegated entities, or other individuals that are required to complete disclosures of ownership. The OHA disclosure of ownership forms were amended several times from FFY 2015-2017, and were not in full compliance with the standards of 42 CFR 455.104-106. Compliant disclosure of ownership template forms, and the timely collection of accurate and complete forms would aid OHA in identifying conflicts of interest within the complex CCO ownership structures. Several CCOs are partially owned by MCEs and delegated entities that have been contracted by the CCOs to provide Medicaid services. It is not uncommon for a CCO, who is responsible for providing oversight of contracted MCEs and delegated entities, to be partially owned by a MCE or delegated entity that the CCO is responsible for exercising oversight over. The OHA should ensure that disclosure of ownership documents are in compliance with federal guidelines, are completed by the appropriate entities and individuals, and are collected in accordance to federal guidelines.

Recommendations for Improvement

- Consider revising interagency agreement to clearly outline specific programmatic oversight functions and program integrity responsibilities.
- Consider assisting CCOs in developing tools to measure SIU and program integrity effectiveness. Further, consider revising internal procedures to ensure CCOs are compliant with the contract provision requiring annual program integrity reviews. Overall, OHA should refine program integrity strategies and efforts to ensure adequate oversight of managed care expenditures.
- Collaborate with the CCOs to develop and enhance suspected fraud case referrals. Coordinate with CCOs and delegated entities to ensure SIU staff are adequately identifying, investigating, and referring suspected fraud to OHA.
- Improve the state's ability to analyze encounter data reported by CCOs, and perform state-initiated data mining activities in order to identify fraud, waste, and abuse issues with MCO network providers.
- Verify that identified and collected overpayments are fully reported by the CCOs and that they are incorporated into the rate-setting process.
- Adhere to payment suspension requirements in the federal regulation at 42 CFR 455.23, and ensure CCOs and delegated entities develop compliant programmatic procedures in compliance with 42 CFR 455.23.
- Develop adverse provider termination criteria consistent with Section 6501 of the Affordable Care Act, and CMS guidance. Further, ensure CCOs and delegated entities develop similar criteria for adverse terminations, and subsequently develop clear reporting requirements for providers that have been terminated for adverse actions.
- Develop internal processes to report adverse action terminations to CMS, and develop procedures to ensure state termination and Medicare revocation lists are reviewed no less than monthly.
- Develop policy and procedure for ensuring providers terminated by CCOs and delegated entities for adverse actions are effectively terminated from all CCO networks within the OHP, and subsequently reported to CMS as required in Section 6501 of the Affordable Care Act.
- Ensure that the CCOs or its delegates responsible for enrollment and credentialing functions, are performing all required federal database checks for the organization (42 CFR 455.436) and for all others required (42 CFR 438.610) at the appropriate time intervals specified in the regulations.
- Formally identify high risk provider types to ensure compliance with 42 CFR 455.434, and subsequent federal regulations pertaining to provider categorical risk.
- Create disclosure of ownership forms in compliance with the elements listed in 42 CFR 455.104-106. Further, require disclosing entities identified by federal guidelines to complete, and submit disclosure of ownership forms as required to effectively identify potential conflicts of interest.

Section 2: Status of Corrective Action Plan

Oregon's last CMS program integrity review was in September 2013, and the report for this review was issued in December 2014. The report contained 13 risk areas. During the onsite review in May 2018, the CMS review team conducted a thorough review of the corrective actions taken by Oregon to address all issues reported in calendar year 2013. The findings of this review are described below.

Risk Areas -

1. ***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.***

   Status at time of the review: Not Corrected

   Oregon reported that policies and procedures have not been developed, and informational materials have not been produced.

2. ***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.***

   Status at time of the review: Not Corrected

   Oregon reported that the CCO audit tools are being revised to reflect current state information and a plan will be developed to initiate the audits. Oregon will provide CMS a copy of the work plan once completed.

3. ***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 PIAU for appropriate case tracking.***

   Status at time of the review: Not Corrected

   Oregon reported that the use of SharePoint was explored, however, at the time, OHA had very narrowly restricted the way the system could be used. In addition, its use had to be approved by an OIS/OHA committee and then approved by DHS also. Eventually it was decided to put that idea on hold. In the meantime, the MFCU and PIAU have set up a system to share worksheets between the two units on a regular basis and are keeping in close communication. The MFCU sends their tracking logs to the PIAU on a bi-monthly basis. The PIAU sends their tracking log to the MFCU on a quarterly basis or as requested.

4. ***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.***

   Status at time of the review: Not Corrected

   Oregon reported that the CCO monitoring forms have not been used in the period between 2016 and the current date; however, the PIAU is revisiting the forms and updating them with current information to include citations from the new managed care rules. With the authorized hiring of new staff (seven auditors), the unit is developing plans to revisit the CCO auditing and monitoring. Policies and procedures for PIAU to analyze CCO encounter data have not been developed. Meetings between the CCOs and the PIAU, the state Program and MFCU are still in the planning stages.

5. ***Amend the CCO model contract or develop an alternative process to require CCOs to notify the PIAU when referring suspected fraud and abuse cases to the MFCU. 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 MFCU. Require all CCOs to include information on how to report fraud, waste, and abuse in member handbooks.***

   Status at time of the review: Not Corrected

   Oregon reported that training has not started, however, discussion between PIAU and MFCU is beginning.

6. ***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.***

   Status at time of the review: Not Corrected

   Oregon provided the CMS review team with a copy of the OHA 3974 form. However, the revised form is still not in accordance with 42 CFR 455.104.

7. ***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.

Status at time of the review: Not Corrected

Oregon provided the CMS review team with a copy of the OHA 3974 form. However, the revised form is still not in accordance with 42 CFR 455.104 and 42 CFR 455.106.

8. ***Revise the DMAP 3118 form to solicit the enhanced disclosure information found at 42 CFR 455.104 for NEMT providers.***

Status at time of the review: Not Corrected

Oregon's provider enrollment form team made the determination to revise OHA 3974 form to meet the needs of the NEMT provider disclosure needs for NEMT providers. Oregon provided the CMS review team with a copy of the OHA 3974 form. However, the revised form is still not in accordance with 42 CFR 455.104.

9. ***Revise all provider agreements to ensure that business transaction disclosures are made upon request in accordance with 42 CFR 455.105.***

Status at time of the review: Not Corrected

Oregon provided the CMS review team with a copy of the OHA 3974 form. However, the revised form is still not in accordance with 42 CFR 455.105.

10. ***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.***

Status at time of the review: Not Corrected

Oregon reported that it will develop a new process to upload information on terminated providers under any Oregon Medicaid program to the database for use by CMS and other state Medicaid programs. Enrollment procedures will be developed to incorporate the review of the CMS provider terminations database for all OOS provider enrollments. Oregon will provide the CMS review team with a copy of the policies and procedures to upload/download provider termination information to/from CMS's provider terminations database.

11. ***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.***

Status at time of the review: Not Corrected

Oregon reported that policies and procedures will be developed to incorporate the notification requirements for compliance to 42 CFR 1002.212. Oregon is currently completing the process for excluding providers on a discretionary basis. Oregon reported that once completed, the process will comply with 42 CFR 1002.212 and its posting requirements.

12. 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.

Status at time of the review: Not Corrected

Oregon reported to the CMS review team that two change requests were written to include all of the MMIS name fields where the data is recorded for those individuals with ownership and control interest or who is an agent or managing employee of the provider; and to expand the monthly exclusion check to include the EPLS data in the monthly MED exclusion process. The change requests CR 20103 and CR 20104 are currently being tested and will be completed by June 1, 2018 when both changes are in production.

13. Implement the compliance review protocol associated with the state's False Claims Act education requirements which is outlined in Oregon's approved State Plan.

Status at time of the review: Corrected

Oregon reported that an attestation form was developed to secure the attestations of the provider populations subject to the educational requirements of Oregon's False Claims Act. Oregon provided the CMS review team with a copy of the attestation form.

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 (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.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to Oregon are based on its identified risks include those related to managed care. 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.
- 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 Regional Information Sharing Systems (RISS) as tool to identify effective program integrity practices.
- Access the Toolkits to Address Frequent Findings: 42 CFR 455.436 Federal Database Checks website at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf.
- Access the Toolkits to Address Frequent Findings: Payment Suspension Toolkit website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance.html.

Conclusion

The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations 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. The state should 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 CAP should identify those corrections as well.

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