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November 17, 2017

The Honorable Governor Kate Brown
254 State Capitol
Salem, OR 97301

RE: Oregon Health Authority Update on Ongoing and Emerging Issues

Dear Governor Brown,

As I noted in my November 9, 2017 letter, the Oregon Health Authority (OHA) is instituting 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. As we establish the framework for this process, we have begun documenting known issues, both past and ongoing. Many of these issues still require additional research and analysis to assess the cause, scope, impact, and next steps for resolution.

Below is a preliminary summary of those issues, and we note that this is likely not an exhaustive and final list of all known issues facing the agency. It is also likely that the details of these issues will evolve as we research them and consult in more detail with subject matter experts. This is not unexpected, given the complexity of OHA's programs and information systems and the lack of rigor and comprehensiveness in its research, analysis, resolution, and communication of significant operational issues. 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 you and legislators with updates about this work on a bi-weekly basis, and we will post regular updates to our website.

ISSUES RELATING TO POSSIBLE PAYMENT ERRORS

The following issues have either been confirmed to have resulted in payment errors or have been identified as possibly resulting in payment errors and require further research to confirm the issue. While the status of each issue, including our most recent estimate of the impact, is included in the summaries below, many of these issues still require additional research and analysis. As such, we expect our understanding of the cause, scope, and impact of these issues to evolve.

Dual Eligible Population

Status: Partially resolved; system changes implemented for 2016 and forward; additional research and analysis required for 2014 and 2015.

Estimated Impact: Preliminary estimates as of October 2016 indicated $74 million in over-claimed federal funds. As research and analysis are ongoing, the final figure is likely to change.

Summary: OHA identified two issues related to the dual eligible population that occurred during 2014, 2015, and part of 2016: (1) OHA paid full capitation rates to Coordinated Care Organizations (CCOs) for

some dual eligible members, rather than the correct (lower) capitation rates that reflect Medicaid as the payer of last resort; and (2) in some cases, dual eligible members were not properly coded in the Medicaid Management Information System (MMIS) with the appropriate eligibility category, leading to the federal government paying the 100% match rate associated with Medicaid-only Affordable Care Act (ACA) expansion members (i.e., MAGI Adults) in cases when the match rate should have been lower (about 64%). OHA made system and process changes in 2016 to ensure that CCOs are paid the correct capitation rate for dual eligible members and that the correct federal match rate is claimed going forward. These system changes also corrected capitation rates retroactively to the beginning of 2016, and OHA has repaid over-claimed federal funds for 2016. For 2014 and 2015, our analysis of the scope of this issue and next steps for resolution is ongoing.

Retroactive Terminations
Status: Not yet confirmed; additional research and analysis required.
Estimated Impact: Preliminary estimates as of July 2017 indicated $17.3 million in federal funds that may need to be repaid. It is still unclear whether these are all payment errors. As research and analysis are ongoing, the final figure is likely to change.
Summary: This issue relates to capitation and fee-for-service payments made, dating back to January 2014, in situations when OHA staff retroactively terminated eligibility without also retroactively terminating enrollment for certain clients. Initial documentation and discussion of this issue identified several possible causes. However, additional review and discussion of the initial documentation has prompted further research and analysis to ensure we are accurately identifying the issue, causes, scope, and appropriate resolution. While this research is ongoing, OHA has changed system privileges to appropriately limit authority to process retroactive terminations.

Bariatric Surgery Payments
Status: Partially resolved; rate adjustments processed and overpayments in process of being recouped.
Estimated Impact: $1.5 million in overpaid claims in process of being recouped.
Summary: Bariatric surgery claims from 2009 through 2015 were paid at an incorrect, higher rate than the appropriate Medicare reimbursement rate. Rate adjustments were processed in MMIS and recoupment of overpayments was initiated in October 2016. As of October 2017, most of the overpayments have still not been repaid by providers, resulting in an accounts receivable balance of $1.1 million. OHA will be following up with providers to ensure recoupment of overpayments.

Fee-for-Service Payments while Enrolled in CCOs
Status: Not yet resolved; system change request awaiting review and approval.
Estimated Impact: Not yet known; additional research and analysis required.
Summary: There are situations in which a client is enrolled in a CCO but also has had fee-for-service (FFS) claims paid during the same time period. While some services are carved out and would be appropriately paid for on a FFS basis, some of the identified FFS claims do not meet this definition and should not have paid. An example of this occurred in December 2016, when pharmacy claims for CCO clients were paid on a FFS basis during a 3-day period, resulting in payment of claims that may not have been covered by a CCO or would have been paid by the CCO at different rates (about a $165,000 impact to state funds). We are working to identify a process to stop processing certain claims when billed by a specific type of provider, as identified in the working draft report. As we further review these issues, additional change requests may be required.

Post-Delivery Coverage for CAWEM Plus Clients
Status: Not yet confirmed; additional research and analysis required.
Estimated Impact: Not yet known; it is still unclear whether these are all payment errors.
Summary: While preparing system changes required to implement HB 3391 (2017), OHA staff discovered a reporting and funding issue related to the Citizen/Alien-Waived Emergency Medical (CAWEM) populations. CAWEM clients receive coverage for emergency services, which we can claim federal funds for under Medicaid (Title 19). If a CAWEM client becomes pregnant, additional benefits are covered under CAWEM Plus to cover the unborn child. Under CAWEM Plus, the client's services are federally funded under the Children's Health Insurance Program (CHIP) (Title 21). Upon delivery, CAWEM Plus clients should transition back to the more limited benefits provided under CAWEM. Initial review indicates that this transition may not always occur if the client or the client's provider does not notify us of the delivery date. If this is the case, we may be providing coverage for which the client may no longer be eligible to receive and that we may be over-claiming federal funds and/or funds from the incorrect federal funding source. There also may not be an existing process to refinance such expenditures retroactively upon notice of delivery.

CAWEM Clients Enrolled in CCOs
Status: Resolved; eligibility corrected and overclaimed federal funds have been refinanced with general funds.
Estimated Impact: $25.7 million in payment errors and over-claimed federal funds.
Summary: Some CAWEM clients were incorrectly shown in MMIS as non-CAWEM clients for a period of time, incorrectly allowing them to be enrolled in CCOs and receive expanded benefits. Eligibility for this group was corrected in MMIS and federal funds were reclassified to general funds in the June 23, 2017 financial cycle.

Capitation Payments for Deceased and Incarcerated Clients
Status: Partially resolved; system changes implemented to address deceased clients but system change request in design for incarcerated clients.
Estimated Impact: Not yet known; additional research and analysis required.
Summary: Capitation payments are made to CCOs at the beginning of each month to cover care for their clients during the month. If a client is incarcerated or dies, capitation payments should be retroactively adjusted to recoup any payments made after the date of incarceration or death. This is not occurring correctly in the system and capitation payments have not been fully recouped from CCOs. Currently, the system is recouping capitation payments for up to 12 months preceding the date the action is taken to note the date of death or incarceration.

Long-Term Residential Services Eligibility
Status: Not yet resolved; additional research and analysis required.
Estimated Impact: Not yet known; additional research and analysis required.
Summary: Long-term residential services are provided to two different client populations through two distinct programs: (1) the 1915(i) Home and Community-Based Services (HCBS) State Plan Option provides serves clients requiring mental health services, and (2) the Oregon Supplemental Income Program Medical (OSIPM) serves clients who are aged, blind, or disabled. In the past, these two populations were aggregated into a single HCBS waiver, but they have been since been separated into the two distinct programs described above. Despite the separation of the programs, the same financial

rules used to determine eligibility have continued to be applied to both programs, which may not be appropriate.

Case Mismatch Across Systems
Status: Not yet resolved; additional research and analysis required.
Estimated Impact: Not yet known; additional research and analysis required.
Summary: There are situations where an individual in one system is incorrectly matched to a record in another system. This can cause errors in clients' demographic and contact information, eligibility data, and CCO enrollment data, risking incorrect payments and the need for recoupment, as well as clients' privacy. Manual processes are in place to identify and correct mismatches and report any privacy breach incidents. Additional research and analysis is required to identify and implement permanent resolution.

ISSUES RELATING TO ALLOCATION OF FEDERAL AND STATE FUNDS
The following issues have either been confirmed to have resulted in incorrect allocation of funds or incorrect information on financial statements, or have been identified as possibly resulted in incorrect allocation of funds or incorrect information on financial statements, requiring further research to confirm the issue. While the status of each issue, including our most recent estimate of the impact, is included in the summaries below, many of these issues still require additional research and analysis. As such, we expect our understanding of the cause, scope, and impact of these issues to evolve.

Payments to Institutions for Mental Disease (IMDs)
Status: Partially resolved; system changes implemented and retroactive adjustments made for overclaimed federal funds; additional research and analysis required to claim additional federal funds.
Estimated Impact: $9.7 million in over-claimed federal funds ($3.4 million related to capitation payments; $6.3 million related to FFS payments), which were refinanced with general funds in 2017; additional research and analysis required to quantify amount of unclaimed federal funds that can be pursued.
Summary: Federal funding cannot be used for expenditures associated with clients residing in an IMD. If the fact that a client is residing in an IMD is in the system at the time of payment, the capitation or FFS payment will be correctly funded with general funds only. However, we are often notified that a client was residing in an IMD after a payment has been processed, and the system did not have the ability to retroactively adjust the funding source. Systems changes have been implemented to correct this and retroactive adjustments were made in May and June of 2017. We also may not always timely reflect when a client is discharged from an IMD, which would allow us to resume claiming federal match funds. Additional analysis is required to quantify any federal funds that can be claimed and to ensure timely recognition of discharge dates going forward.

Payments for Certain Procedures Related to Termination of Pregnancy
Status: Partially resolved; system changes implemented and additional research in process to finalize amount to be refinanced.
Estimated Impact: Preliminary estimates as of October 2017 indicate $1.8 million in over-claimed federal funds. The final amount to be refinanced is being analyzed.

Summary: Three procedure codes that may be used to pay termination of pregnancy procedures were recently determined not to be eligible for federal funding. System changes have been implemented and additional analysis is in progress to confirm the final amount of federal funds to be refinanced.

Services Provided to Tribal Members at Non-Tribal Facilities
Status: Not yet resolved; change request in design.
Estimated Impact: Not yet known; additional research and analysis required but would increase OHA's ability to claim federal funds for these services going forward.
Summary: CMS provided guidance that we can claim 100% federal funds match for services provided to tribal members at non-tribal facilities if the tribe has a coordination agreement with the provider. We have been claiming federal funds for these claims at a lower match rate. System changes are in process to automate the corrected federal match rate for these claims.

Enhanced Federal Funding for Preventive Services
Status: Not yet resolved; change request awaiting review and approval.
Estimated Impact: Not yet known; additional research and analysis required but would increase OHA's ability to claim federal funds for these services going forward.
Summary: Certain preventive services are eligible for a 1% increase in the federal funds match rate. The system is not currently configured to claim the enhanced match rate for these services. System changes to automate the corrected federal match rate for these claims are being reviewed.

Tribal Targeted Case Management Services
Status: Not yet resolved; change request in design.
Estimated Impact: Not yet known; additional research and analysis required.
Summary: CMS has stated that targeted case management (TTCM) services related to social services programs provided to a subset of tribal clinics should be claimed at the traditional Federal Medical Assistance Percentages (FMAP) rate rather than at 100% federal funds match. System changes to automate the corrected, lower federal match rate for these claims are being reviewed.

Prescription Drug Rebate Credits
Status: Not yet resolved; additional research and analysis required.
Estimated Impact: Estimated $22.3 million in credit balances for drug rebates owed to labelers as of October 2017. As research and analysis are ongoing, the final figure is likely to change.
Summary: When we receive drug rebates, a portion of that rebate may be owed to a labeler. This information is not being captured in our financial systems to issue payment or post a credit against any outstanding invoices for labelers for its portion of the rebate. Our drug rebate revenues may be overstated, and we may need to repay labelers and/or apply credits to outstanding invoices from labelers.

Nursing Facility Coinsurance and Post-Acute Care Claims
Status: Not yet resolved; system change undergoing testing.
Estimated Impact: $14.1 million shift from Department of Human Services' (DHS's) Aging and Persons with Disabilities (APD) budget to OHA's Health Systems Division (HSD) budget.
Summary: Coinsurance payments for nursing facilities and post-acute care have been incorrectly hitting the APD budget, rather than the HSD budget, since September 2016 due to the unintended

impact of a system change. These claims will continue to charge against APD's budget until the system change is implemented, but manual budget adjustments will be made in the interim. This did not result in any incorrect claiming of federal funds.

Prior Period Adjustments for Public and Private Providers
Status: Not yet resolved; change request awaiting review and approval.
Estimated Impact: Not yet known; additional research and analysis required.
Summary: This change was initially suggested by auditors with the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) in October 2015 and relates to the FMAP rate applied to prior period adjustments. The OIG's position differentiated between public and private providers, as follows: (1) for public providers, the state should claim the FMAP rate in effect when the service was provided (not the rate in effect when the adjustment was posted); and (2) for private providers, the state should use the FMAP rate in effect at the time the was posted. Note that OIG auditors were preliminarily reviewing Oregon's Medicaid claim adjustments to determine whether to proceed with an audit. Based on their initial analysis, the OIG decided not to proceed with an audit.

Posting of Cash Payments
Status: Not yet resolved; additional research and analysis required.
Estimated Impact: Estimated $20 million in unposted cash revenue; research and analysis are ongoing and the final figure is likely to change.
Summary: OHA receives cash medical payments from the Division of Child Support (DCS) for clients in custody, and some of these payments have yet to be posted to the appropriate trust account in MMIS. Application of these revenues to the appropriate trust account will reduce state and federal costs for these clients.

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Please don't hesitate to contact me with any questions you may have.

Sincerely,

Patrick M. Allen
Director

CC: Fariborz Pakseresht, Director, DHS