Secretary of State Audit Summary

Dennis Richardson, Secretary of State

Kip Memmott, Director, Audits Division

OHA: Automated Medicaid eligibility is processed appropriately, yet manual input accuracy and eligibility override monitoring needs improvement

AUDIT PURPOSE

In Oregon, over one million individuals have Medicaid coverage. Medicaid expenditures totaled $9.3 billion in fiscal year 2016, including $1.2 billion in state general funds. We conducted this audit to determine if two critical automated computer programs managed by the Oregon Health Authority accurately verify Medicaid client eligibility and accurately issue payments to healthcare providers. If these programs do not function properly, clients may inappropriately receive, or be denied, Medicaid benefits.

FINDINGS IMPACT

Manual input errors and lack of monitoring of overrides can cause inappropriate eligibility determinations and payments to providers. If agency leadership implements more effective monitoring of caseworker eligibility overrides and improves manual input accuracy, the state will better comply with eligibility requirements and increase accuracy of payments. Inaction will allow overrides and manual input errors to continue causing inappropriate payments to providers.

KEY FINDINGS

- Two critical automated computer programs appropriately determined eligibility, enrolled Medicaid clients in coordinated care organizations, and made appropriate payments to those organizations based on eligibility information received.
- Automated computer processes appropriately validated the Social Security number and citizenship status of applicants over 99.7% of the time in our review of over 425,000 records.
- We reviewed 30 eligibility determinations and found seven (23%) had manual input errors. While only one error resulted in a client being determined eligible when they were not, each of the errors related to application information that could have resulted in inappropriate eligibility determinations.
- Although their volume has significantly decreased over time, overrides of eligibility are not sufficiently monitored, meaning unauthorized overrides of Medicaid eligibility could occur.
- Our review of 72 overridden eligibility segments showed caseworkers did not take proper action to clear 25 (35%). Overridden segments are not subject to automated processes that redetermine eligibility for certain clients.
- Our 2011 audit recommendations to OHA and DHS concerning access to the Medicaid Management Information System have not been fully implemented, increasing security risk.

RECOMMENDATIONS SUMMARY

- OHA should continue efforts to improve caseworker manual input accuracy through additional training, and implement a review process for input where errors negatively affect eligibility determination.
- OHA managers should monitor eligibility overrides to prevent unauthorized validation and ensure state resources are spent appropriately.
- OHA and DHS should fully implement our 2011 audit logical access recommendations.

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Introduction

Audit Purpose

The purpose of this information technology audit was to determine whether two critical computer systems managed by the Oregon Health Authority (OHA) accurately determine Medicaid client eligibility, appropriately enroll clients with Coordinated Care Organizations (CCO), and issue accurate payments to those organizations.

We chose these systems because the majority of Medicaid eligibility determinations and payments are processed through them. If they do not function correctly, Medicaid clients may be inappropriately approved or denied for Medicaid benefits, and payments to providers may be in error.

OHA and the Department of Human Services rely on several other systems for eligibility determinations and payments. We intend to include other systems and processes related to Medicaid eligibility and payments in future audits.

Agency Response

The Oregon Health Authority generally agreed with our findings and recommendations. The full agency response can be found at the end of the report.

Background

Medicaid is a government program that provides health care coverage to low-income individuals and families. It is financed through joint federal and state funding and is administered by each state. The Oregon Health Authority (OHA) administers the Medicaid program and sets guidelines regarding eligibility and services in Oregon. Department of Human Services (DHS) staff work in partnership with OHA to ensure qualified individuals receive Medicaid coverage.

Most Medicaid clients in Oregon are enrolled with one of Oregon's 16 Coordinated Care Organizations (CCOs). CCOs deliver health care services under contracts with OHA for a prescribed monthly fee, known as a capitated payment. Medicaid clients not enrolled in a CCO receive health care services from doctors, pharmacies and other professionals who submit individual claims to OHA for the services they perform.

Oregon Medicaid provides health care coverage to approximately one million Oregonians.

OHA uses a newly implemented computer system called the Oregon Eligibility system (ONE) to determine client eligibility for certain Medicaid benefit programs.

ONE subsequently transfers eligibility information to the Medicaid Management Information System (MMIS), which enrolls clients in coordinated care organizations and pays providers for Medicaid services. MMIS processed about $6.7 billion to providers in fiscal year 2016.

If these systems do not function correctly, clients may be inappropriately approved or denied for Medicaid benefits and payments to providers may be inappropriate.

The federal Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA), was signed into law on March 23, 2010 and implemented in Oregon beginning in January 2014. The ACA allowed Oregon to expand its Medicaid program to cover individuals who were not previously eligible. As a result, Medicaid eligibility in Oregon has grown from approximately 650,000 individuals in 2013 to over 1 million by the end of 2014. Medicaid eligibility has remained at about 1 million individuals since then.

Total Medicaid expenditures have likewise increased. During Fiscal Year (FY) 2013, expenditures for Medicaid at DHS and OHA totaled about $5.5 billion; in FY 2016, this increased to about $9.3 billion. These expenditures, which consist of medical assistance payments as well as administrative expenses, are processed through several different computer systems at DHS and OHA.

The federal share of Medicaid expenditures varies by type of expenditure and by medical assistance program. For medical assistance payments made on behalf of clients, the federal share ranges from about 64% for most clients to 100% for clients deemed newly eligible for Medicaid because of the ACA. Beginning in calendar year 2017, the federal government started reducing its share of funding for these clients, which will result in an increase in the state's share of funding for these expenditures. Overall, state general fund Medicaid expenditures for fiscal year 2016 totaled over $1.2 billion.

OHA primarily uses the Medicaid Management Information System (MMIS) to pay health care providers for services they render to individuals who qualify for Medicaid. During FY 2016, MMIS processed over $6.7 billion in payments to providers, including about $4.9 billion to CCOs as capitated payments based on Medicaid enrollments.

In December 2015, OHA implemented a new computer application, the Oregon Eligibility system (ONE), specifically designed to determine whether individuals qualify for Medicaid according to the new ACA requirements. This system provides the needed core functionality to process most Medicaid applications. DHS uses other computer systems to determine eligibility for other specific groups of Medicaid clients. As of March 2017, approximately 69% of all Medicaid clients had their eligibility determined through the ONE system.

Audit Results

Our work showed that the Oregon Eligibility system (ONE) appropriately determines Medicaid client eligibility, although manual input accuracy and eligibility override monitoring need improvement. ONE also accurately transmits eligibility information to the Medicaid Management Information System (MMIS) for further processing. We also found that MMIS appropriately enrolls Medicaid clients in Coordinated Care Organizations (CCO) and ensures accurate payments are made based on information received from ONE and other eligibility systems

The ONE computer system accurately determines Medicaid eligibility, but manual procedures need improvement

Generally accepted computer controls indicate that transaction data should be checked for accuracy, completeness and validity. In addition, processes should be in place to timely detect and correct potential errors that may occur during computer processing. Any overrides applied to transaction processing should be monitored.

The ONE system receives Medicaid applications from several sources. OHA staff manually input applications they receive on paper or through telephone interviews using the Worker Portal. Applications may also enter ONE through an automatic computer interface with the federal health insurance exchange or from manual inputs by community health partners using ONE's Applicant Portal.

As part of processing, ONE queries external sources to validate the accuracy of specific information, including the applicant's Social Security number, date of birth, citizenship status, and whether the applicant is incarcerated. It also compares the applicant's reported income to external sources including federal computer systems and the state's Unemployment Insurance records to verify the level of income reported. If data does not pass these tests, ONE automatically sends the applicant a Request for Information (RFI) to provide the needed supporting documentation by a certain date.

For applications submitted through the federal exchange or the Applicant Portal that are complete, error free, and not duplicates of prior received applications, ONE determines eligibility and passes the record to MMIS without manual intervention. Applications entered through the Worker Portal, or submitted through the other sources where problems were detected, require caseworkers to direct ONE to continue processing the application to determine the applicant's Medicaid eligibility. If a caseworker accepts the eligibility determination made by ONE and identifies no other issues with the case, they authorize the determination

and the record is sent to MMIS. To date, most applications have required manual work by caseworkers in order to complete processing.

We tested automated and manual processes associated with ONE eligibility determinations. We found that ONE automated processes accurately determined Medicaid eligibility based on the information provided and accurately transferred eligibility information to MMIS for further processing. We reviewed more than 425,000 individual records and found that ONE appropriately validated the Social Security number and citizenship status of applicants, or properly sent RFIs to obtain assurance the reported information was correct, over 99.7% of the time.

However, Medicaid eligibility determinations also depend on accurate input of data that are not externally verified and on manual procedures performed by caseworkers. For example, state and federal rules do not require external validation of household composition, so accurate input of household status and size is critical for accurately determining whether household income levels qualify individuals for Medicaid. Also, while reported income is validated against external data, it often requires manual review to ensure that it is accurate. Accuracy for these elements needs improvement. In addition, caseworkers may override the eligibility determination made by ONE. Contrary to best practices, these overrides are not sufficiently monitored to ensure they were performed for approved reasons and that required actions to clear the override are taken.

Input accuracy needs improvement

Best practices indicate that information should be validated and edited as close to the point of origination as possible when information is input into a computer system. This allows errors to be caught and resolved quickly.

Though ONE appropriately ensures input is in the proper format and that certain conditions are met, it cannot determine whether input matches what is included on the application. It also cannot determine actions that should be taken when there are multiple applications or cases for a single individual, or how to interpret supplemental information received on a case, such as wage stubs submitted by applicants to prove their reported income is accurate. These actions depend on decisions and manual procedures by caseworkers.

We reviewed Medicaid eligibility determinations for 30 randomly selected individuals out of 541,577 individuals in the population to evaluate accuracy of input and eligibility determination. Although we identified errors in seven cases, only one error resulted in a client being determined eligible when they were not. For this error, the client was initially deemed eligible on a case that included only the client. A second application was submitted that added members to the client's household and reported a new income level that would have made the client no longer eligible for Medicaid benefits. OHA indicated that the first case should have been closed and the client should have been evaluated on the second case, but this did not occur. Based on our evaluation, inappropriate capitated

payments of $1,778 have been made over four months through January 2017.

The other errors had no impact on capitated payments. Two errors resulted in clients being determined eligible for the wrong benefit program and were related to household size and income evaluations by caseworkers. In both cases, the clients were eligible for Medicaid and the capitated payments would have been the same if they had been placed in the correct program. The remaining four errors were minor and had no effect on the eligibility determination or subsequent capitated payments. However, for each of the seven errors, the data element involved had the potential to affect eligibility determination or the benefit start date.

Table 1: Types of Input Errors Found During Testing

Description	Effect
The income level on a new application would have made the client ineligible, but the caseworker did not close the existing case first. (1 error)	Medicaid benefits from the first case continued, resulting in inappropriate capitated payments that totaled $1,778 for four months.
Caseworker made errors evaluating the household size and income level. (2 errors)	Clients appropriately determined eligible for Medicaid but placed in the wrong benefit program.
Caseworker incorrectly determined household size, incorrect application date entered, income attributed to wrong household member. (4 errors)	No effect on Medicaid eligibility. Each of these could have affected eligibility given other circumstances.

OHA has implemented a quality assurance process that includes reviewing weekly samples of cases to evaluate completeness and accuracy of input, and other procedures followed to enter and process Medicaid applications. This process has also identified errors in input accuracy, though not all of the data elements reviewed in the quality assurance process affect eligibility. One of the individual data elements with the highest level of errors detected is for input or validation of income. Out of 1,241 cases reviewed through December 2016, OHA detected 182 errors associated with income or income processing, or about 15%. OHA intends to develop additional training and procedures for caseworkers to improve these measures, but this work was still in process during our audit.

These errors are due in part to the complex nature of processing Medicaid applications and evaluating supporting documentation. OHA has developed multiple procedures to instruct workers on actions to take when evaluating supporting documents or clearing tasks. These procedures have been developed over the course of the first year of ONE operation and continue to undergo changes.

Inadequate monitoring of overrides

For applications requiring manual work, a caseworker must authorize the eligibility determination made by ONE, which is then transmitted to MMIS. Depending on the characteristics of the case, this determination may consist of one or more eligibility segments covering particular time periods, including a final segment that defines ongoing eligibility. The caseworker may override the determination for individual eligibility segments, though they are expected to do so only under certain circumstances. Caseworkers may also prevent ONE from sending automated RFIs to clients, which is appropriate if information can be otherwise validated. Best practices dictate that these types of overrides should be monitored to ensure they are appropriate and, if needed, cleared to allow the system to resume automated functions.

OHA has developed procedures for caseworkers to follow when overriding eligibility, including defining the specific instances when overrides should occur, and has also provided instructions on documenting and performing the override. For example, for some segments that are overridden, workers are instructed to create a system task to review the override at a later date to ensure subsequent appropriate actions are taken on a case.

However, OHA has not implemented standard processes to review or monitor overrides or actions that prevent RFIs from being issued. Without this standardized review, unauthorized overrides of Medicaid eligibility could occur, which could lead to Medicaid clients being granted eligibility when they were not eligible, or being denied benefits when they were eligible. In addition, when the final segment that defines ongoing eligibility for an individual is in "override" status, certain automated processes performed by ONE are circumvented. For example, ONE has a process to identify clients who are aging out of one type of assistance to another, and redetermine their eligibility in the new category. This redetermination could result in the client being deemed ineligible for ongoing benefits. This process is not run for an individual whose final eligibility segment is in override status.

We evaluated overrides and subsequent actions to resolve cases in override status. We found that the volume of overrides is decreasing significantly, from a peak of 10% of all eligibility segments during May 2016, to 4% in June, to less than 1% of segments from July onward. This decrease was due largely to changes in procedures.

We also reviewed 72 overridden eligibility segments out of a population of 31,059 approved segments that were overridden. We found that while these overrides were performed for approved reasons, workers did not set up a task to review the override at a later date in nine of the segments reviewed. In addition, even when a caseworker initially entered the override using established procedures, proper action to later clear the override was not taken in 25 of the segments we reviewed. These segments remained in override status and were therefore not subject to further processing procedures. Two of these records were for individuals who

should have had their eligibility redetermined due to aging out of one type of assistance to another. The overall effect of the lack of redetermination was an underpayment to CCOs of $1,809 over a period of seven months, ending January 2017.

Tests of other areas also revealed problems associated with the lack of appropriate action taken on overridden eligibility segments. For example, we tested RFIs to ensure they were appropriately resolved. We tested 75 RFIs from an overall population of 180,676. This included 14 RFIs from a population of 2,815 that we identified as high risk. We considered these to be high risk because they were still open more than one month past their expiration date and the individuals had been determined eligible. Of the RFIs we tested, 12 were not appropriately resolved for eligibility segments still in override status, including 9 from the high risk population. For these individuals, benefits should have ended after the expiration of the RFI based on an established cutoff date in ONE. However, automated processes to end benefits did not occur due to the override. In addition, no manual action had been taken to either authorize or end continuing benefits. Payments made to CCOs on behalf of these clients after the RFI expiration cutoff date totaled $18,902 from July 2016 through January 2017.

MMIS Properly Enrolls Medicaid Clients and Ensures Payments are Appropriate

ONE, along with several other eligibility source systems, sends Medicaid eligibility information to MMIS, which applies edits to these transactions and accepts or rejects the record. It creates or updates the individual's record in MMIS with information from the source system and assigns the benefit plan and other coding needed for further processing.

If clients are in a population that requires CCO enrollment, but did not choose a CCO when applying for benefits, MMIS ensures they are enrolled through an auto-enrollment process. MMIS transmits the enrollment information to CCOs, which are expected to compare this information to their own records and report back to OHA if there are differences. OHA reviews these responses and generates corrections to MMIS records, or provides further information to the CCOs, as needed.

MMIS uses a combination of eligibility information, client demographics, and enrollment data to determine and process monthly capitated payments to CCOs. It also runs weekly adjustment jobs and can adjust prior payments up to one year in the past, based on changes that would have affected those payments.

Overall, we found that MMIS controls provide reasonable assurance that Medicaid clients are appropriately enrolled in CCOs and that payments to these organizations are appropriate, based on the information received from multiple eligibility source systems, including ONE. If this information

were incorrect, it would affect the overall accuracy of MMIS processes and payments.

Specifically, we found:

- Capitation payment rates for each CCO were appropriately loaded into MMIS.
- Rates were appropriately used for payments, based on client demographics and capitation category.
- Controls were sufficient to ensure clients were appropriately enrolled in CCOs.
- OHA reconciles enrollment data with CCOs to ensure that records match, and this reconciliation shows a fairly low number of reported discrepancies.

Some prior audit findings remain unresolved

As required by audit standards, we evaluated the status of prior audit findings from an audit we completed in 2011. Specifically, our management letter made three recommendations to address MMIS logical access findings.

MMIS user roles are not well defined or documented

The prior audit found that MMIS roles granted to users appropriately restricted access to the system as a whole, but they were not sufficiently defined or designed to ensure users received only the access they needed to perform their duties. We recommended management review all MMIS user roles and make adjustments as needed to ensure they are appropriately designed to provide access based on least privilege principles.

During our current audit, MMIS security administrators indicated that reviews of roles have occurred since the prior audit, and that they are continuing to monitor them. They also reported that several roles have been modified to ensure more granular access. However, we found that MMIS roles remain generally defined. For example, a role may identify that it grants "update" access to a particular subsystem, without details regarding which pages or panels allow update and which do not. Currently, determining which users have access to which specific functions is not possible without a manual review of security subsystem settings. This lack of granularity in defining the roles increases the risk that users will have access to more functions than they need to perform their jobs.

Logical access is not reviewed

Our prior audit also identified that staff did not always remove user accounts from MMIS in a timely manner and managers were not periodically reviewing access granted to users. We recommended that

management ensure managers perform effective review of access granted to their personnel.

A current DHS/OHA policy indicates access will be reviewed annually by managers. However, MMIS security administrators reported they have no practical way to identify which users work for which managers. As a result, there is no formal, enforced process for review of MMIS access, except for existing inactivity and employee termination reports. Without an effective review, current users may retain access that is no longer needed to perform their jobs.

Audit trails were insufficient

During our prior audit, we found MMIS lacked complete audit trails to identify who granted users what access, and when. We recommended that management ensure appropriate audit trails exist to monitor changes to users' access privileges.

Currently, a variety of tools are available to show when a user was granted access, and who granted it, but some of these tools rely on manual actions to capture the information. In addition, MMIS administrators indicated that they conduct periodic scans to identify users with excessive or contradictory roles.

After considering management's current procedures, we concluded that if user access was being effectively reviewed, the risk associated with the lack of audit trails would be reduced, and therefore a potentially expensive technical modification of MMIS to develop this level of audit trail may not be justified. As a result, we consider this recommendation resolved.

Recommendations

We recommend that OHA management:

- Continue to develop strategies to evaluate and improve caseworker input accuracy. In particular, we recommend management consider implementing a review process for portions of input identified as having higher error rates and that negatively affect eligibility determination.
- Develop procedures to monitor overrides to ensure they are performed only for approved reasons and that needed subsequent actions on these cases are timely.

To fully resolve prior audit findings for MMIS, we recommend OHA and DHS management:

- Ensure system documentation is available to facilitate a granular review of permissions granted for each role.
- Ensure managers perform effective periodic reviews of access granted to their personnel.

Objectives, Scope, and Methodology

Our audit objectives were to:

- Determine whether the Oregon Health Authority's (OHA) Oregon Eligibility (ONE) system appropriately determines Medicaid client eligibility.
- Determine whether OHA's Medicaid Management Information System (MMIS) reasonably ensures that Medicaid clients are appropriately enrolled in coordinated care organizations and that payments to these organizations are accurate.

Our review of the ONE system focused on automated system processes designed to accurately process Medicaid applications and determine Medicaid eligibility. The review also evaluated the accuracy of data input by caseworkers into ONE and considered actions taken to resolve items that had been pending in the system.

Our review of MMIS primarily focused on capitated payments made to coordinated care organizations and on enrollment of clients into CCOs, regardless of the origination of the eligibility determination.

We conducted interviews with OHA and DHS personnel and observed operations and processes. We examined selected policies and procedures associated with processing of Medicaid applications through the ONE system. We also examined technical documentation relating to ONE and MMIS and their architecture.

We assessed the reliability of MMIS and ONE data by reviewing existing information about the data and the system that produced them, evaluating the queries used to download the data, and interviewing agency officials knowledgeable about the data. In addition, we traced a random sample of data to other data files, to available source documents, and to production screens. We determined that the data were sufficiently reliable for the purposes of this report.

To evaluate whether ONE appropriately determined Medicaid eligibility, we:

- obtained downloads of ONE data that included case, eligibility, RFI and override data from December 2015 through October 2016;
- randomly selected 30 individuals out of a population of 541,577 individuals with at least one approved eligibility segment and tested whether selected portions of the application such as household composition and reported income were accurately recorded or verified in the ONE system, and whether the eligibility determination made by the ONE system for these individuals was appropriate;
- randomly selected 75 requests for information (RFI) from varying populations, including 14 from a high risk population of 2,815, and evaluated whether appropriate action was taken to resolve them;

- examined whether individuals who had turned age 1 or 19 were appropriately redetermined by ONE to evaluate whether the individuals were still eligible for Medicaid under a new program;
- examined whether Social Security numbers and citizenship status had been verified from external sources, and whether appropriate RFI's were issued if they had not been verified, out of applicable populations of 445,907 individuals and 426,102 individuals, respectively;
- randomly selected 72 approved overridden eligibility segments from varying populations, out of a total summarized population of 31,059 individual, case, and type of assistance combinations and evaluated whether the override was performed for an approved reason and that appropriate action had been taken to resolve the override;
- conducted a limited review of ONE change management procedures; and
- conducted other data integrity tests to ensure basic logical conditions and eligibility requirements were met.

For the items tested through a sample, we performed the tests to evaluate the relative strength or weakness of particular controls. The sample selections and tests performed were not designed to project the results to the population.

We also tested whether eligibility determinations made in ONE were appropriately recorded in MMIS.

We obtained MMIS capitated payment data, and enrollment and eligibility records for the period of December 2015 through August 2016. We primarily evaluated the period of January 2016 through June 2016 for the tests described below. For this period, there were 6,467,147 individual capitated payment records, 5,125,876 records showing enrollment data, and 2,068,074 records for eligibility data.

To evaluate whether MMIS made proper enrollments and made appropriate capitation payments, we:

- evaluated whether the process to load capitation rates for CCOs into MMIS was appropriately controlled;
- evaluated whether capitated payments were made using the approved rates;
- evaluated whether duplicate payments to CCOs were made on behalf of individuals;
- evaluated whether payments were only made on behalf of enrolled and eligible recipients and only to recipients' selected or assigned CCO;
- evaluated whether MMIS generated capitated payments for all properly enrolled and eligible recipients;
- evaluated whether recipients in MMIS were assigned appropriate coding based on their age;

- randomly selected 30 records and evaluated whether the clients were timely enrolled with a CCO, based on the date the eligibility records were recorded in MMIS;
- evaluated whether ineligible recipients in MMIS were inappropriately enrolled with a CCO; and
- conducted limited reviews of MMIS change management and logical access procedures.

We used the ISACA publication "Control Objectives for Information and Related Technology" (COBIT), and the United States Government Accountability Office's publication "Federal Information System Controls Audit Manual" (FISCAM) to identify generally accepted control objectives and practices for information systems.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained and reported provides a reasonable basis to achieve our audit objective.

Auditors from our office, who were not involved with the audit, reviewed our report for accuracy, checking facts and conclusions against our supporting evidence.

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The courtesies and cooperation extended by officials and employees of the Oregon Health Authority and the Oregon Department of Human Services during the course of this audit were commendable and sincerely appreciated.