Oregon Health Authority

Timely Notification of Inpatient Hospital Stays Could Help Reduce Improper Medicaid Payments

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Audit Highlights

Oregon Health Authority

Timely Notification of Inpatient Hospital Stays Could Help Reduce Improper Medicaid Payments

Why this audit is important

- Oregon spent over $11 billion on Medicaid programs in 2020, which is more than one-third of the state's total budget. Auditors analyzed over $215 million in payments for individuals who experienced extended inpatient hospital stays.
- The cost of health care in Oregon is projected to grow faster than the state's economy.
- National Medicaid expenditures are expected to increase by 30% from 2019 to 2024.
- The federal government estimates the national improper payment rate for Medicaid is 21%, which represents about $86 billion. Improper payments are not necessarily indicative of fraud and could be overpayments, underpayments, or claims that do not have adequate supporting documentation.
- Spending funds on improper payments diverts dollars that could otherwise be spent on services for Medicaid recipients.

What we found

1. OHA lacks timely notification of inpatient hospital stays. This results in some claims being paid when services were not provided because the Medicaid client was in the hospital. (pg. 6)
2. Our testing of 25 hospital inpatient stays identified $52,344 in improper payments made to providers not associated with the hospital who likely did not provide services. Approximately $1.6 million in additional payments were identified as high risk of being deemed improper. The testing focused on three areas generally not allowed during a hospital stay: in-home services, non-emergency medical transportation (NEMT), and private duty nursing. (pg. 6)
    a. In-home services are provided to clients with disabilities and are intended to keep clients in their home and out of facilities. Our testing found $49,875 in improper payments, representing 42 claims. We estimate approximately $1.3 million in other in-home service claims that are at high risk of being improper. (pg. 7)
    b. Our testing found $1,644 in improper payments across 73 NEMT claims. We estimate $211,507 in other NEMT claims that are at a high risk of being improper. (pg. 9)
    c. Our testing found $825 in improper payments over three private duty nursing claims. We estimate $5,982 in other private duty nursing claims that are at a high risk of being improper. (pg. 10)

What we recommend

We made two recommendations to OHA. OHA agreed with both of our recommendations. The response can be found at the end of the report.

OREGON SOS OREGON AUDITS DIVISION

Introduction

The purpose of this audit was to determine if the Oregon Health Authority (OHA) was appropriately processing claims for ancillary services when Medicaid clients are in an extended, inpatient hospital stay. For this audit, we collaborated with OHA, who helped to identify the general scope, but did not determine the ancillary services tested. We also partnered with the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG), whose mission is to provide objective oversight to promote the economy, efficiency, effectiveness, and integrity of HHS programs, as well as the health and welfare of the people they serve.

According to the federal Office of Management and Budget, the Medicaid program is at risk of issuing significant improper payments. In 2020, the Centers for Medicare and Medicaid Services (CMS) estimated the national improper payment rate for Medicaid was 21%, which represents about $86 billion. Improper payments are not necessarily indicative of fraud. These are payments that did not meet statutory, regulatory, administrative, or other legal requirements. Overpayments, underpayments, fraud, waste, and abuse are all considered improper payments.

Improper payments

Spending funds on improper payments diverts dollars that could otherwise be spent to provide services to Medicaid recipients.

- National Council of State Legislatures

The federal government estimates health care expenditures will increase by 30% from 2019 to 2024. OHA estimates the cost of health care in Oregon is projected to grow faster than the state's economy. Due to the size and dollar amounts that flow into this program, it is important the state take steps to reduce improper payments.

Medicaid is one of the largest and most complex programs in the country

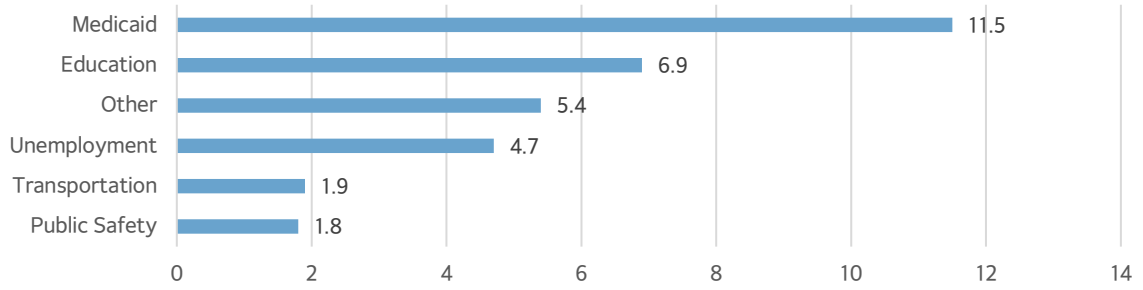
Medicaid is a state and federal government program that provides health care coverage to low-income adults, children, pregnant women, the elderly, and people with disabilities. It is financed through federal and state funding and is administered by each state. Some states, like Oregon, expanded coverage under the Affordable Care Act of 2010, which significantly increased enrollment in the program.

Medicaid in Oregon

Approximately 26% of Oregonians received benefits through the Oregon Health Plan in 2020.

Approximately 1.1 million Oregonians are enrolled in the state's Medicaid program, known as the Oregon Health Plan. Oregon spends more on Medicaid than it does on any other program area, including education, transportation, and public safety. In 2020, Oregon spent approximately $11.5 billion on Medicaid, with $3.1 billion from the state and $8.4 billion in federal funds.

Figure 1: Medicaid expenditures made up more than a third of Oregon's budget in 2020 (in billions)



Source: OAD Financial Condition Report fiscal year 2020

OHA is charged with administering the Medicaid program in Oregon

Medicaid is one of the most complex government programs in the country. Each state operates its Medicaid program differently within the parameters set by the federal government. CMS is responsible for oversight of all state Medicaid programs. CMS allows states flexibility with administering Medicaid, including what services are provided. Oregon participates in multiple demonstration programs and waivers, which encourage innovation and allow the state to operate the Medicaid program outside of normal federal rules.

OHA is charged with administering Oregon's Medicaid program. OHA is one of the largest agencies in Oregon with an annual budget of over $23 billion and over 4,200 full-time employees across seven divisions. OHA works closely with other state and local agencies, as well as Tribal governments to provide services and health care to millions of Oregonians.

Medicaid is the largest program under OHA and accounts for 71% of the agency's 2019-21 biennial budget. OHA's Health Systems Division oversees the Medicaid program and sets guidelines regarding eligibility and services in accordance with federal requirements.

OHA Divisions

- External Relations Division
- Fiscal and Operations Division
- Health Policy and Analytics Division
- Health Systems Division
- Office of Equity and Inclusion
- Oregon State Hospital
- Public Health Division

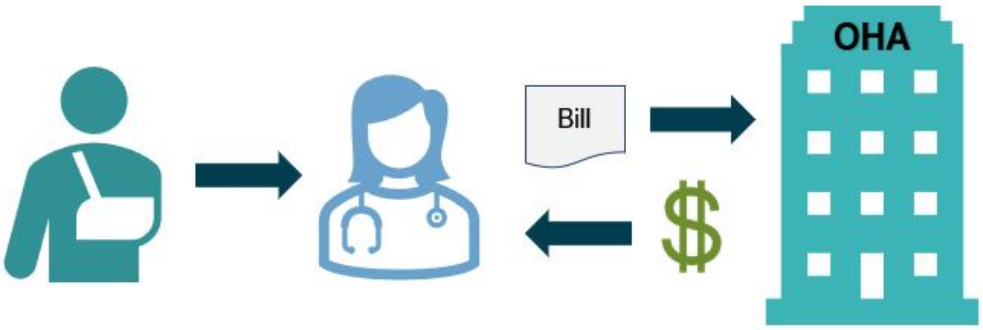
OHA's Program Integrity Audit Unit helps to prevent fraud, waste, and abuse in the Medicaid program. This unit audits Medicaid providers and contractors for compliance with state and federal requirements. Auditors in this unit have specialized knowledge and experience, including Registered Nurses, Certified Professional Coders, Certified Professional Medical Auditors, and research analysts. OHA is also subject to regular audits of Medicaid at the state and federal level. This work helps to ensure funding is being used as intended — to support the health, safety, and well-being of people in Oregon. Because Medicaid is so large and complex, these audits cannot identify every risk within the program. OHA uses the Medicaid Management Information System (MMIS) to pay most health care providers for services they render to individuals who are eligible for Medicaid. Controls within MMIS are the primary way OHA prevents improper payments. The agency plans to quarterly review the top controls to help mitigate risks associated with improper payments.

The Oregon Department of Human Services (ODHS) oversees some Medicaid-funded programs that provide care to clients in their own homes or communities. These programs serve eligible, low-income individuals. Although ODHS operates some pieces of Medicaid, ultimate responsibility for the program falls to OHA.

Medicaid services are provided to participants in two primary ways

Oregon uses both a fee-for-service (FFS) and a coordinated care model to deliver services. The FFS model is more straightforward: a Medicaid client visits a health care provider, the provider bills OHA directly for approved services, and OHA then pays the provider. About 9% of Medicaid clients in Oregon are FFS, which is generally more expensive than coordinated care.

Figure 2: Visual of fee-for-service payment model

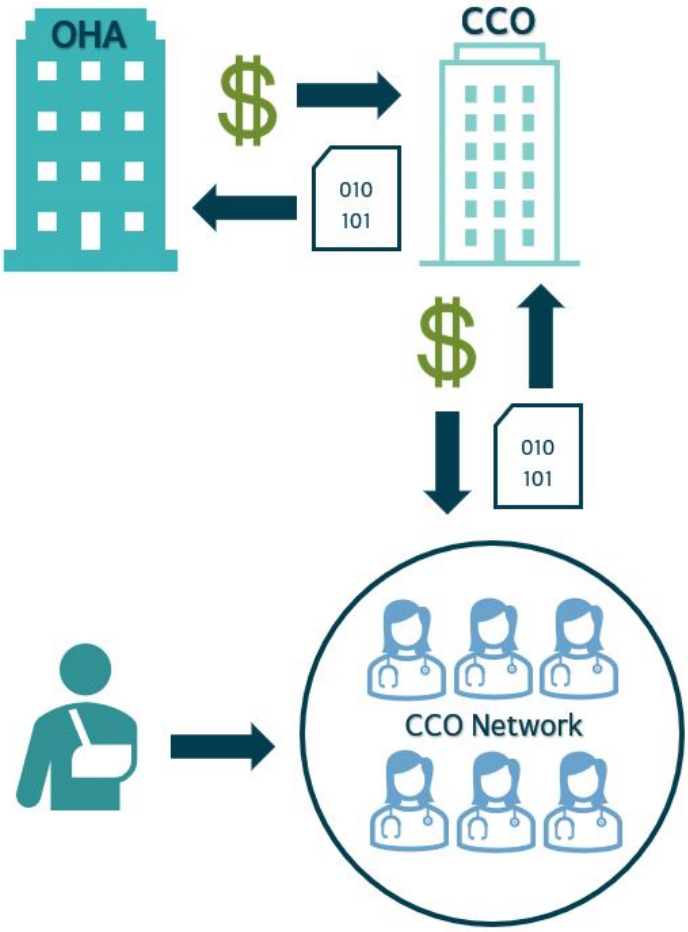


The coordinated care model involves coordinated care organizations, or CCOs. A CCO is a network of all types of health care providers (physical health care, addictions and mental health care, and dental care providers) who work together in their local communities to serve people who receive health care coverage under Medicaid. CCOs focus on prevention and helping people manage chronic conditions. Oregon currently has 16 CCOs that provide coverage across the state; over 90% of Medicaid clients are enrolled in a CCO.

OHA pays CCOs predetermined rates, known as capitated payments, every month for each Medicaid client for covered services. CCOs get these payments no matter how many or how few services a Medicaid client uses in a month. In 2022, the average capitated payment will be $485.84, but rates vary between CCOs, client age ranges, and other factors. CCOs pay providers in their networks for services rendered and send encounter data to OHA. This data shows the services provided to clients and helps set future rates for capitated payments.

Some Medicaid clients may have additional health care coverage, such as Medicare or private insurance. Medicare is distinct from Medicaid, in that Medicare is federal health insurance for people 65 or over, certain younger people with disabilities, and people with End-Stage Renal Disease, otherwise known as kidney failure. Other health care coverage is always billed first because Medicaid is the payor of last resort.

Figure 3: Visual of coordinated care payment model



Hospital inpatient services are a critical piece of the Medicaid program

Medicaid is a critical safety net program that helps individuals and families receive access to health care services. Examples include, but are not limited to, inpatient and outpatient hospital stays, transportation to and from medical appointments, screenings and preventative services, dental care, maternity care, behavioral health care, and home and community-based services.

Hospital inpatient services often begin with a visit to an emergency room followed by a doctor's recommendation of admission. If a patient is eligible for Medicaid, inpatient and outpatient services are covered while the client is in the hospital. Services and other billing details depend on which kind of health plan the patient has or if the patient also has other insurance.

Inpatient stays can vary in length. The average length of inpatient stays in 2015 was about six days, but complicated and severe diagnoses can extend stays to months or years. When a Medicaid client visits an emergency room, or is admitted to the hospital, hospitals notify the client's CCO and care network, but not the Oregon Health Authority directly. This notification helps CCOs to coordinate care for their clients. OHA generally does not know of an inpatient stay until a claim is submitted by the hospital months after the patient has been discharged.

The COVID-19 pandemic had a major effect on Medicaid

In response to the COVID-19 emergency and federal relief legislation, OHA implemented several temporary policy changes effective March 18, 2020, that extend through the national emergency period. These changes were intended to help existing Medicaid clients keep their coverage during the pandemic and to simplify the application process for Oregonians newly eligible for Medicaid due to the pandemic.

Individuals who were receiving Medicaid benefits on or after March 19, 2020, will not have their benefits closed, except for deaths, incarcerations, out-of-state residency, or voluntary benefit closure. During this time, OHA is accepting self-attestation of necessary information to determine eligibility, except for citizenship and immigration status. Any federal stimulus payments or increased unemployment payments are not counted toward income for eligibility purposes.

Since the beginning of the pandemic, total Medicaid enrollment has increased by 24%. Our testing did not cover any services or inpatient stays that occurred during this timeframe.

Audit Results

As the state Medicaid agency, OHA is responsible for all aspects of Oregon's Medicaid program. OHA has the difficult task of managing service delivery for vulnerable populations while balancing the need to be prudent and efficient with state resources.

We found OHA lacks timely notification of inpatient hospital stays, which results in some claims being paid when services were not provided because the Medicaid client was in the hospital. Our testing identified $52,344 in improper payments made to providers who billed for services that were likely not provided while Medicaid clients were in the hospital. We also identified approximately $1.6 million in other claims that are at high risk of being improper.

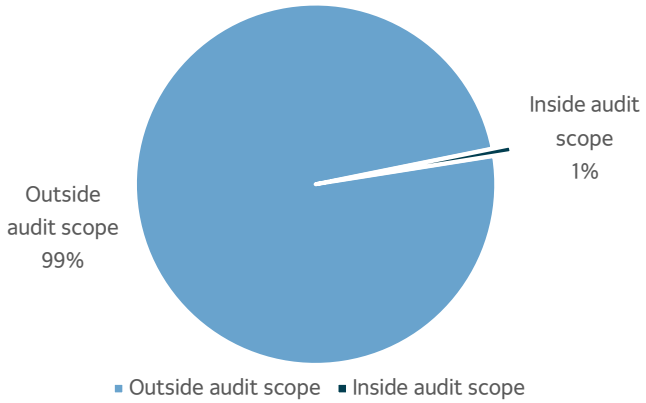
OHA paid for unallowable services while Medicaid clients were admitted to a hospital

When Medicaid clients are admitted to the hospital, some services are generally not allowable by Medicaid. For example, in-home services like personal hygiene would be covered under the hospital's daily room and board rate. If a client has a continuous hospital stay, meaning they were in the hospital for the entire dates of service, there should not be any transportation costs charged to the program, unless the client was being transferred to a new level of care in a different medical facility.

We conducted testing of Medicaid claims to determine the risk of improper payments. For this testing, we judgmentally selected 25 different inpatient hospital stays lasting three or more days from January 2017 to February 2020 which resulted in 134 service claims to Medicaid. Our testing focused on three different types of claims generally not allowed during a hospital stay: in-home services, non-emergency medical transportation, and private duty nursing.

Of these 134 service claims, we determined OHA improperly paid providers for 118 of them, amounting to $52,344. Of the 25 inpatient stays tested, 80% had improper payments associated with them. These findings represent a small portion of overall Medicaid expenditures, as our testing period covered more than three years and $30 billion in total Medicaid expenditures. While the proportion is small, there is still the risk of improper payments, which represent significant dollars that could be redirected to providing services to Oregonians.

Figure 4: The claims within our audit scope represent a small portion of overall Medicaid claims



Source: OAD auditor calculations based on HHS-OIG data and OHA legislatively adopted budgets

However, our analysis went beyond this initial sample. We reviewed all claims that could have occurred during an inpatient stay. Building upon the knowledge gained during testing, we identified another $1.6 million in claims at a higher risk of being improper. This amount is an estimate; further review is required to make a formal determination whether a payment is considered improper.

Figure 5: Thousands spent on services never provided and many more payments identified as high risk

	Improper payments	High-risk payments
In-home services	$49,875	$1,337,774
NEMT	$1,644	$211,507
Private duty nursing	$825	$5,982
Total	$52,344	$1,555,263

Source: OAD auditor calculations based on HHS-OIG data

It would be impossible for OHA to implement controls that would prevent all improper payments while processing claims efficiently, and maintain a primary focus of increasing the quality, reliability, and availability of health care. Instead, OHA takes a risk mitigation approach to minimize the number of improper payments that do occur. For example, OHA has an agreement with the contractor for MMIS to test the effectiveness of the top 20% of system controls. OHA plans to test the remaining controls on a plan developed by the agency. Audits of providers are also an important piece of risk mitigation and help to ensure compliance with state and federal requirements, as well as preventing and detecting improper payments. In this context, OHA has an opportunity to focus on implementing additional controls that are cost-effective at reducing improper payments relating to inpatient hospital stays.

Improper payments

The improper payment amounts represent payments to providers for services likely not provided to Medicaid clients.

In-home services keep Medicaid clients in their homes and active in their communities

In-home services are provided to eligible Medicaid clients with disabilities.[1] These services are intended to keep clients in their home and out of nursing or long-term care facilities. ODHS offers these services through multiple programs and under certain Medicaid waiver programs.

In-home service providers include both homecare workers and personal support workers. Both provide similar services, such as activities of daily living and instrumental activities of daily living. Activities of daily living are basic supports for everyday activities. Instrumental activities of daily living are activities related to living independently in the community. Some clients may also receive chore worker services, which are provided when a client may be in danger of bodily harm. The main difference between homecare and personal support workers is the different programs that support and fund them. For our audit purposes, we combined these two programs into a broad category called in-home services.

Homecare workers can be spouses, family members, or independent providers. Personal support workers are independent providers or work for an in-home health agency. Providers must pass

[1] See OAD Report 2017-23, titled 'Consumer-Employer Provider Program Needs Immediate Action to Ensure In-Home Care Consumers Receive Required Care and Services' and the follow-up report, 2019-05.

background checks and are required to monitor the health and well-being of the client and notify the client's case manager if there are changes in the client's physical status, like a hospitalization. The client is responsible for verifying the hours worked by the provider. As implied by the name, in-home services are not allowable for a client during an inpatient hospital stay.

In-home services

Activities of daily living include eating, toileting, grooming, dressing, bathing, and transferring.

Instrumental activities of daily living include meal preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling in the community.

Chore services include deep cleaning to remove hazardous debris or dirt in the home to ensure the home is safe and allows for independent living.

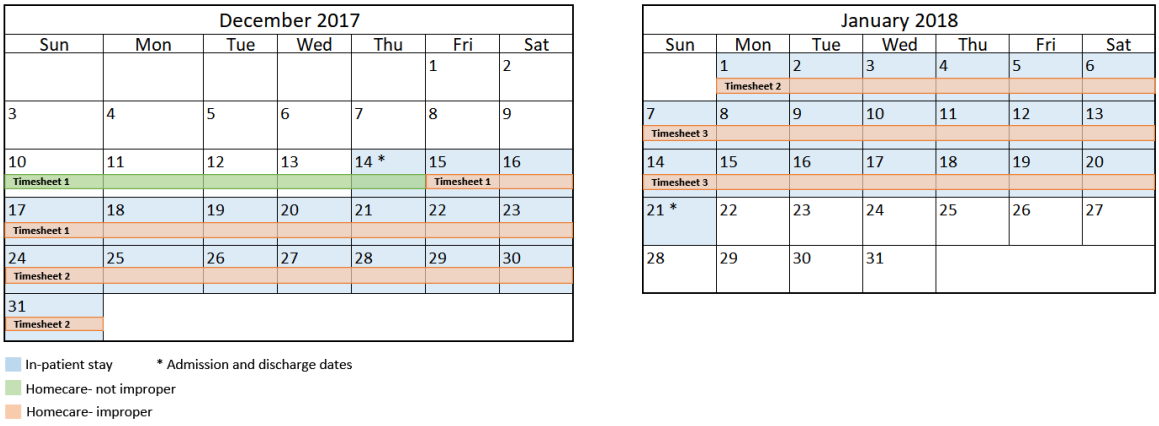
- 42 C.F.R. § 441.505 and OAR 411-035-0040

We reviewed 49 claims for in-home services and 42 had improper payments totaling $49,875. We tested 16 inpatient stays for personal care and homecare services. Some in-home claims are processed through OHA's MMIS, but most are processed through other systems. The process for reviewing timesheets varies depending on what program clients fall under and the type of provider.

For one personal care sample we tested, the Medicaid client was living in an adult foster home and was receiving personal services. The client went on vacation with a guardian to another state at the beginning of the month. Two weeks later, the client got sick and was admitted to a hospital in the vacationing state. The client spent a month and a half in the hospital and passed away. The adult foster home provider was paid a total of $15,169 for providing two months and three days of personal care, while the Medicaid client was on vacation or in the hospital. Adult foster care providers should not bill for personal services for any day the foster care client is not in the home overnight.

In one of our homecare samples, the client was in the hospital for 38 consecutive days, with most of that time spent in the intensive care unit. During the inpatient stay, the homecare worker submitted three timesheets for a total improper payment of $2,759. We did not question any service that occurred on the admission or discharge dates.

Figure 6: Homecare samples had multiple timesheets that crossed over the hospital stay



Source: OAD auditor analysis of HHS-OIG data

Many homecare samples had multiple timesheets that crossed over partially or wholly within the inpatient stay. As mentioned earlier, when there is a change in a client's status, such as a hospitalization, the homecare worker is required to notify the client's case manager. Case managers are also generally responsible for reviewing and approving the timesheets for homecare workers. If a case manager does not know when their client is in the hospital, it is difficult to prevent improper payments for homecare. We reviewed notes from case managers and found instances where the case manager was never notified of the hospitalization. These kinds of improper payments can be difficult to identify as most in-home services are processed and paid in a different system than the hospital inpatient claims.

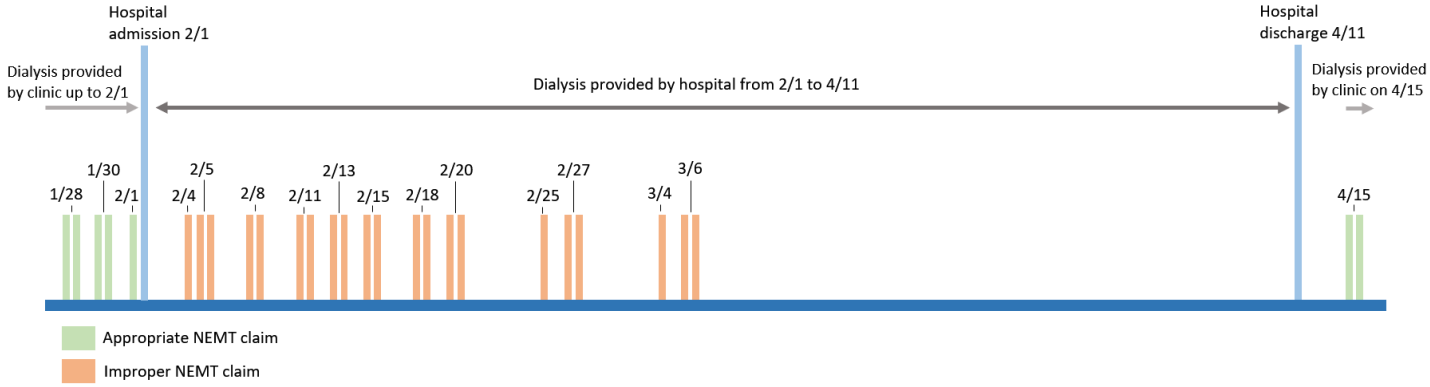
NEMT services are crucial to Medicaid clients who might otherwise miss critical medical appointments

Transportation associated with a medical emergency, such as having a heart attack or being seriously injured in a car accident, are examples of emergency transportation covered by Medicaid but were outside the scope of this audit. Non-emergency medical transportation (NEMT) is an important benefit for people who need assistance getting to and from medical appointments. In Oregon, NEMT is allowable for medical services covered under the Oregon Health Plan, such as: physical therapy, laboratory testing, chemical dependency care, and dental appointments. Grocery shopping or running errands are not allowed.

Oregon rules require NEMT providers to verify the client's eligibility and that they are obtaining a covered medical service before transportation. The provider is also required to assess the client's access to other means of transportation, like driving their own car, public transportation, or getting a ride from a friend or family member. Clients can schedule their transportation a month in advance, or even longer if they need life sustaining services. If a client fails to show up for a transportation appointment, the NEMT provider should not bill for the no-show. NEMT services are not generally provided when a client is an inpatient at a hospital. Instances of allowable NEMT services during an inpatient stay would involve a transfer to another facility for a new level of care.

We identified $1,644 in improper payments to NEMT providers from 73 claims. The dollar amount associated with each NEMT charge was relatively low, but claims were typically more frequent than other types of services tested.

Figure 7: Improper NEMT claims continued to occur during the inpatient stay



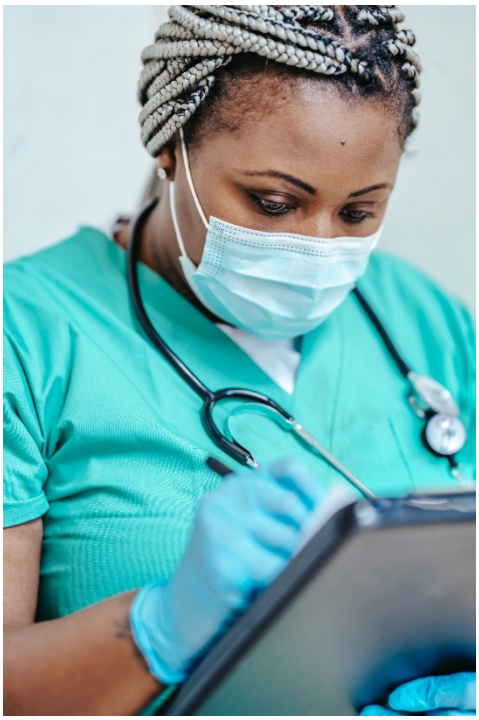
Source: OAD auditor analysis of HHS-OIG data and MMIS information

In one of our samples, the client was receiving outpatient dialysis treatment, which would require ongoing transportation multiple times per week to a dialysis clinic. We identified outpatient dialysis claims and corresponding NEMT, confirming the need for NEMT services. The client was then admitted to the hospital, where they stayed for more than two months. Almost three weeks of this time was spent in the intensive care unit. While staying in the hospital, the outpatient dialysis claims stopped, as expected given the hospital was providing dialysis as an inpatient service. However, we identified 21 NEMT claims, with the origination and destination addresses continuing to be the client's home and the outpatient dialysis clinic. After the client was discharged from the hospital, the NEMT claims continued, and the outpatient dialysis charges resumed. The transportation charges before and after the inpatient stay appear reasonable; however, we considered any transportation billed during the inpatient stay as an improper payment.

These findings show a pattern of NEMT providers submitting claims for Medicaid clients while those clients were in the hospital. Clients with specific medical needs that require regular transportation would likely book that service in advance. In speaking with agency staff, a possible cause could be that providers are billing based on booked rides, rather than on actual transportation provided.

Federal audits in other states have consistently identified NEMT as an area vulnerable to fraud, waste, and abuse. A recent audit conducted by HHS-OIG identified more than $14 million in NEMT high-risk payments in Massachusetts's Medicaid program.[2] For about half of the samples tested, the Medicaid client did not receive an allowable service on the date of the NEMT billing. This audit did not focus solely on NEMT during an inpatient stay but does highlight a concern for the area and a greater need for monitoring.

Private duty nursing services are invaluable to Medicaid clients and their families



Clients who are approved for private duty nursing services have greater medical needs requiring the skills of a registered nurse or a licensed practical nurse. There are specific programs that provide skilled nursing services to certain groups. Children in the Medically Fragile Program at ODHS have very intense medical needs and depend on specialized medical technology and skilled nurses for their health. Direct nursing services are provided to individuals over the age of 21 with a developmental disability who have complex health management and support needs. Long-term care nursing is provided to people of all ages receiving Aging and People with Disabilities and Developmental Disabilities services.

Private duty nursing is considered supportive to the care provided to a client by the client's family, foster parents, and delegated caregivers. Nursing services should be medically appropriate, and clients need to receive prior authorization from OHA before providers can be paid. Providers must send

[2] See HHS-OIG Report A-01-19-0004

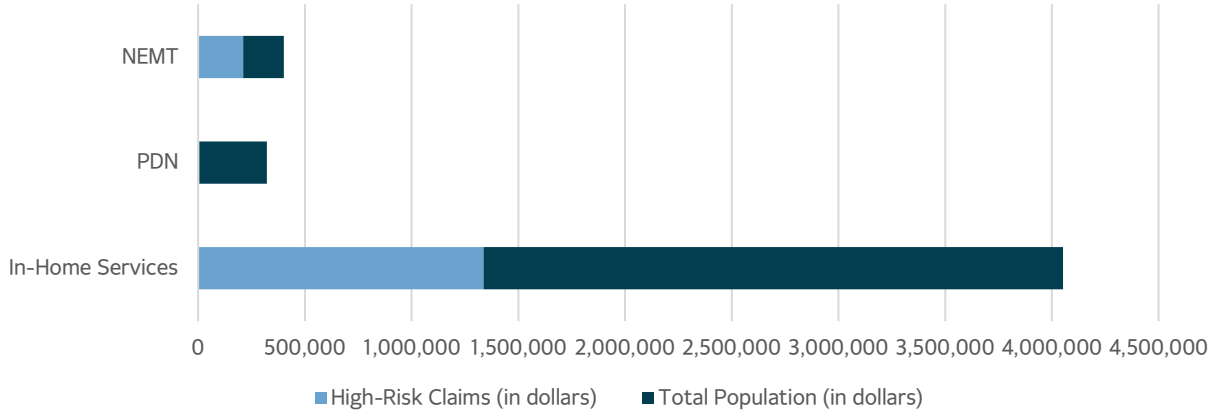
the client's diagnosis, length of treatment, and other information to OHA, which will then review the information and supporting documentation and approve or deny the services. Private duty nursing is separate from the nursing services provided at a hospital; for this reason, Medicaid does not cover this service for a client during an inpatient hospital stay.

We tested six private duty nursing samples and identified $825 in improper payments over three claims. Private duty nursing requires a prior authorization before OHA will pay the provider. Most of the prior authorizations in our samples were submitted monthly and detailed specific units of service that were allowable. For one sample, the prior authorization was done differently and was for a specified number of service units within a span of six months. During the period for the authorization, the client was hospitalized, and the provider improperly billed. Like the NEMT testing, it appears this provider may have billed for nursing services booked, rather than services provided. Our testing indicated this area is lower risk for improper payments than the other categories we tested.

In addition to identifying improper payments, our analyses identified approximately $1.6 million in payments that are high-risk for being improper

After testing, we analyzed all claims that could have occurred while a client was in the hospital. From this group, we removed claims with a lower risk of being improper, such as claims where the client was not continuously in the hospital. We also removed claims that were likely a one-way NEMT transfer between medical facilities, transportation for a parent or guardian while a child was inpatient, and private duty nursing claims billed monthly. The remaining claims are instances where it is unlikely services would ever be allowable while the client was in the hospital and have a higher risk of being improper payments; however, detailed testing would be needed to determine whether they are improper.

Figure 8: Our analysis identified over 17,000 high-risk claims, representing over $1.5 million



Source: OAD auditor analysis of HHS-OIG data

For NEMT, we identified over 10,000 claims, representing $211,507, that are high risk for being improper. Out of these high-risk claims, most were encounter claims that occurred at the CCO level, meaning these expenditures were not made directly by OHA. The dollar amounts for a single NEMT claim are relatively small, with many being under $20 for a one-way trip. However, there is a risk improper NEMT claims could influence future capitation rates. While we cannot estimate the potential

effect, a very small change to a monthly capitation payment could translate into millions of dollars per year.

After reviewing the private duty nursing population, we identified 109 high-risk claims for $5,982. The number of clients receiving these services is much less than NEMT or in-home services; however, the amount spent per client is much higher. The additional controls around prior authorizations appear to be effective at preventing most improper payments while the client is in the hospital.

In-home services had the largest number of high-risk payments, at over 7,200 claims for $1.34 million. Most of these claims were not processed through MMIS and would be difficult to detect, especially if the agency was not aware of the hospitalization. We did not identify any specific trends or risks with this population; however, there is a general risk for improper payments.

Various information systems, complex program rules, and multiple agencies pose challenges to preventing and detecting improper payments

Detecting and preventing improper payments is challenging, and there is not a one-size-fits-all solution. For the concurrent services we tested, some were paid at the CCO level, some were paid directly by OHA, and others were processed through systems at ODHS. The mix of claim types adds an additional layer of complexity in an already complex program. Due to these challenges, there may be some instances where the cost for OHA to implement certain controls is more than the potential savings. Yet auditors identified some potential cost-effective opportunities to implement controls that would mitigate the risk of improper payments.

Risk of improper payments exacerbated by varying service provider submission requirements

Medicaid providers have one year from the date of service to submit claims for payment, but the process can take longer. Billing timelines vary between different services and providers. For the data used in our work, in-home services tend to be processed the quickest, typically within 24 days, while private duty nursing is processed on average, about 43 days after services are rendered. NEMT providers have a wide range, with some claims processing within a month, while the average was 95 days. Hospital claims were processed about 78 days after the client was discharged. Based on these averages, claims for NEMT, private duty nursing, and in-home services could be processed before an inpatient claim covering the same time frame.

Providers also bill differently depending on the service. NEMT providers tend to submit a claim for each instance of transportation. For example, if a NEMT provider takes a Medicaid client from their home to a doctor's appointment and then back home, the provider would typically submit two claims for that day. If a client is receiving a significant amount of private duty nursing services, those are usually billed monthly. In-home services are generally billed twice a month, regardless of the client receiving services for each of those days or only partially. For our testing, we had to request further supporting documentation to determine the actual service dates when the claim was a date range, like in-home services or private duty nursing.

Hospitals must follow the 12-month billing guidelines, but they also have specific rules to follow when billing for inpatient stays. Such as if a client is discharged from a hospital but is then readmitted within 30 days — to the same hospital for the same or related diagnosis — the hospital is required to combine these visits into one claim. In these instances, the dates of service on the claim make it appear the client was in the hospital for longer than they actually were. These types of claims could produce false positives when matching to services generally not allowable during an inpatient stay.

Not all services are processed through MMIS, resulting in a lack of some controls to identify certain improper payments

Some Medicaid-funded transactions, like homecare and some personal care, are processed through different systems. These transactions are not linked or matched up to MMIS data, making it difficult to detect improper payments.

MMIS is the primary system OHA uses to process most Medicaid payments. In 2020, MMIS processed almost $8.2 billion in paid claims. OHA relies on the system's numerous edits and audits to provide assurance payments are appropriate and to prevent and detect potential improper payments. Edits and audits help ensure a claim adheres to program rules before being paid. We reviewed a listing of current edits and audits and did not identify any that would prevent or detect the scenarios we identified in our testing.

Previous Secretary of State audits have recommended OHA improve controls for monitoring MMIS edits and audits.[3] In the 2020 Single Audit Report, OHA agreed and committed to continuing to

[3] See finding 2020-20 in the Fiscal Year 2020 State of Oregon Statewide Single Audit Report. See also the first recommendation in OAD report 2017-25.

implement processes to ensure edits and audits are monitored and tested for accuracy and effectiveness.

Edits and audits

Edits review the claim for information such as format, provider and recipient eligibility, consistency, and reasonableness. For example, an edit could prevent payments for claims not for a current Medicaid client.

Audits review the claim against historical information to prevent payment for duplicate services and to ensure service limits are not exceeded. For example, an audit could prevent payment for a service that was paid for in the prior month.

OHA has access to tools that could help contribute to a solution

The Electronic Visit Verification (EVV) and the Collective system are tools ODHS and OHA have access to that could help prevent some improper payments and could notify the agencies when a Medicaid client is admitted to the hospital. EVV is a part of a federal law requiring states to verify Medicaid clients are receiving in-home services.[4] Unless an exception has been granted, personal care workers use this system, and the rollout for homecare workers is underway. Providers must also have a smart phone to be able to access and use the system.

When a provider uses EVV, they clock in and clock out using their smartphone. The smartphone saves the GPS location of where the clock in and out took place. This helps to ensure the provider is in the client's home while providing services. Paper timesheets are still used for the client to review, but EVV adds an extra level of assurance. If used properly, EVV can help reduce the number of improper payments by ensuring clients are appropriately receiving services.

EVV Requirements

Items required to be verified:

- Type of service performed;
- Individual receiving the service;
- Location of service;
- Individual providing the service; and
- The time the service begins and ends.

- H.R.34 - 21st Century Cures Act

EVV is not infallible, though. There is a risk of billing errors since providers can use their own systems. Providers can also obtain exceptions to EVV use, which circumvents the control. Even with these challenges, this system gives greater assurance that Medicaid clients are receiving the services they need in their homes.

The Collective Platform is Oregon's statewide infrastructure to share critical information across healthcare systems. OHA uses the Collective Platform to help inform and coordinate patient care across its CCO and FFS platforms. When a client visits the emergency room, the Collective sends the information to the client's care network, which could include their CCO, primary care physician, specialists, and other providers. These health care providers can use this information to ensure the client is receiving the appropriate care and services needed.

Currently, case managers for clients who receive in-home services have access to the system and can search to see if a client has been admitted to the hospital, but there is no proactive notification. Timely

[4] See the H.R.34 - 21st Century Cures Act.

notification of a client's hospital admission could help case managers to better coordinate services to them and potentially prevent improper payments to in-home providers. OHA also does not receive notification of inpatient admissions, and typically would not know of an inpatient stay until the hospital claim was processed by MMIS. If existing system functionality could be used to inform OHA of hospital admissions, it could help the agency avoid improper payments as opposed to attempting to recoup dollars that have already been paid out.

Recommendations

In order to comply with Medicaid program requirements, we recommend OHA:

1. Reimburse the federal government for the federal portion of the identified improper payment amount.

In order to reduce the risk of improper payments, we recommend OHA:

2. Develop and implement cost-effective controls that would prevent or detect improper payments for unallowable services while a Medicaid client is inpatient.

    a. Consider ways timely notification of hospital admissions could be integrated efficiently into claims processing.

Objective, Scope, and Methodology

Objective

The objective of this audit was to determine whether OHA processes Medicaid claims in accordance with program policies for services billed while a client is in an extended hospital stay.

Scope

This audit covers paid Medicaid claims from January 2017 to February 2020 for recipients who experienced extended in-patient hospital stays. The scope did not include Medicaid claims during the COVID-19 pandemic.

Methodology

To address our objective, we conducted interviews or corresponded with multiple stakeholders, including OHA and ODHS personnel, staff at Health and Human Services Office of the Inspector General, a member of the Legislature, the Legislative Fiscal Office, and auditors from other state audit offices. We reviewed state and federal rules related to the program and our audit objective.

We obtained Medicaid data from the Health and Human Services Office of the Inspector General, which contained hospital claims and concurrent services billed to the program. We also obtained final paid Medicaid claims data from OHA and homecare data from ODHS. To assess the reliability of the data, we traced a sample of randomly selected claims across multiple files and systems to provide reasonable assurance the information we obtained was complete and accurate. Additionally, we performed a variety of data verification techniques such as comparing control totals, verifying data formatting, and reviewing scripts and coding used to generate this information.

Internal control review

We determined the following internal controls were relevant to our audit objective.[5]

- Control Activities
    - We considered whether management has designed control activities to prevent improper payments while a Medicaid client was in the hospital and whether management has designed information system and related control activities to achieve objectives and respond to risks.
- Monitoring Activities
    - We considered whether management was effectively monitoring internal controls that could prevent improper payments and whether management remediated identified internal control deficiencies on a timely basis.

Deficiencies with these internal controls were documented in the results section of this report.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require we plan and perform the audit to obtain sufficient, appropriate

[5] Auditors relied on standards for internal controls from the U.S. Government Accountability Office, report GAO-14-704G.

evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We sincerely appreciate the courtesies and cooperation extended by officials and employees of OHA and HHS-OIG during the course of this audit.

Audit team
Ian Green, M.Econ, CGAP, CFE, CISA, CIA Audit Manager
Kathy Davis, Senior Auditor
Bentley Walker, MSFA, Staff Auditor

About the Secretary of State Audits Division

The Oregon Constitution provides that the Secretary of State shall be, by virtue of the office, Auditor of Public Accounts. The Audits Division performs this duty. The division reports to the elected Secretary of State and is independent of other agencies within the Executive, Legislative, and Judicial branches of Oregon government. The division has constitutional authority to audit all state officers, agencies, boards and commissions as well as administer municipal audit law.

Medicaid
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Kate Brown, Governor

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December 8, 2021

Kip Memmott, Director
Secretary of State, Audits Division
255 Capitol St. NE, Suite 500
Salem, OR 97310

Dear Mr. Memmott,

This letter provides a written response to the Audits Division's final draft audit report titled 'Timely Notification of Inpatient Hospital Stays Could Help Reduce Improper Medicaid Payments'.

The Oregon Health Authority (OHA) appreciates the role of the Secretary of State Audits Division in providing oversight of Oregon's State funded programs on behalf of taxpayers and the people we serve. The scope of this audit was focused on Medicaid payments for three outpatient services that would not appropriately be provided to an individual in an inpatient hospital setting.

- Non-Emergent Medical Transportation (NEMT) for Oregon's Medicaid covered services; excluding the dates of admission and release from an inpatient hospitalization or moves in hospital settings where a level of care change was required.
- In-home services are designed to assist eligible Medicaid members that are assessed as meeting specific criteria for services and supports in their homes and communities. These services keep members out of the more disruptive and costly settings such as nursing facilities and preserves the facility capacity for individuals who truly need the higher level of care.
- Private duty nursing (PDN) is designed to support Medicaid eligible children who meet specific medical needs criteria and reside in their own or family home. This service keeps children out of the more disruptive and costly settings such as hospitals and preserves hospital capacity.

OHA appreciates the Secretary of State's acknowledgment that the scale of this audit was small. We believe the sample size was too small to provide a representative sample of Oregon's Medicaid population. During the period of January 2017 to February 2020, the timeframe the audit reviewed, Oregon served an average of 998,056 members each month through its

Medicaid program. The scale of the audit was based on a judgmental selection of 25 inpatient hospital stays. This represents approximately .0025% of the average population served by Medicaid during that timeframe.

OHA is the single state Medicaid agency for Oregon and holds the ultimate responsibility for the administration and compliance of Oregon's Medicaid program. OHA works with other state agencies, tribal governments, and local programs via agreements and contracts to provide medically appropriate services to eligible Oregonians.

- NEMT services are delivered to fee-for-service ("open card") members through NEMT brokerages contracted directly with OHA and to Coordinated Care Organization (CCO) members through NEMT vendors contracted with the CCOs.
- In-home services are provided through State Plan authorities and Medicaid Waivers. For some of those authorities, an Inter-Governmental Agreement with the Oregon Department of Human Services (ODHS). ODHS determines the eligibility for services and contracts with home care workers, personal support workers, in-home care agencies and certified programs to provide services.
- Private duty nursing (PDN) is provided through Oregon's Medicaid State Plan primarily through an Inter-Governmental Agreement with the Oregon Department of Human Services (ODHS) for children needing PDN for longer than 60 days. ODHS determines the eligibility for PDN services, enrolls licensed practical nurses and registered nurses to provide PDN services, and prior authorizes the services. OHA conducts the same activities and functions for children who need PDN services for fewer than 60 days.

The Oregon Health Authority's Program Integrity Audit Unit (PIAU) supports the responsible stewardship of Medicaid funds through oversight of Medicaid's compliance to prevent fraud, waste, and abuse in Oregon's Medicaid system. They accomplish this by auditing the Medicaid delivery and billing systems, as well as Medicaid providers and contractors. OHA devotes the PIAU resource to the areas of greatest financial risk to the Medicaid system, or where there has been an identified need. Not all improper payments are a result of intentional fraud, waste, and abuse. With that in mind OHA works with Oregon's Medicaid providers to educate and provide technical assistance in a good faith effort to collaborate with our provider community. Where intentional fraud, waste, and abuse are identified OHA works with the Federal Government, law enforcement, and the appropriate licensing and governing boards to ensure justice and financial reconciliation occurs on behalf of the Oregonians we serve.

Below is our detailed response to each recommendation in the audit.

RECOMMENDATION 1
Reimburse the federal government for the federal portion of the identified improper payment amount.

Agree or Disagree with Recommendation	Target date to complete implementation activities	Name and phone number of specific point of contact for implementation
Agree	June 30, 2022	Travis Labrum 503-603-4935

Narrative for Recommendation 1

OHA is reviewing the NEMT claims and will pursue the appropriate actions to reimburse the Centers for Medicare and Medicaid Services (CMS) for any improper payments. Additionally, technical assistance will be provided to the NEMT brokerages and providers found to be inappropriately billing. If intentional fraud, waste, or abuse is identified through this research and outreach OHA will pursue the appropriate legal remediations.

OHA is collaborating with ODHS on the In-home service and private duty nursing for children that involves cross agency funding. ODHS has committed to researching the individual claims identified through the audit to determine necessary actions including repaying the Centers for Medicare and Medicaid Services for any inappropriate billing.

RECOMMENDATION 2

Develop and implement cost-effective controls that would prevent or detect improper payments for unallowable services while a Medicaid client is inpatient.

- **Consider ways timely notification of hospital admissions could be integrated efficiently into claims processing.**

Agree or Disagree with Recommendation	Target date to complete implementation activities	Name and phone number of specific point of contact for implementation
Agree	January 1, 2023	Steve Westberg 503-931-6729

Narrative for Recommendation 2

OHA is collaborating across program areas to identify cost-effective automation and process improvements.

<u>Cost-effective automation:</u>

OHA is assessing the feasibility of expanding its current software analytical tools to perform pre and post-payment reviews. This could facilitate the automated review of payments to providers.

Process:

Until OHA can accomplish a cost-effective automation, OHA will conduct a quarterly data pull to include In-Patient claims where there is an additional claim type for the same dates of service as the In-Patient stay. The data elements of that report will include the following: Member Information, From Date of Service to Date of Service, and Claim Type. This quarterly report will be sent to the Medicaid Policy Unit in the Health Systems Division for assessment, analysis, and determination regarding any further action on those claims. If the Medicaid Policy Unit determines there is some potential solution that can be administered, they will work collaboratively with the MMIS team to determine the best course of action, or if any action can be taken in the current system environment. The inpatient claims data will also be shared with ODHS for review and remediation of claims outside of MMIS.

During the Public Health Emergency related to COVID-19, beginning in 2020, OHA and ODHS collaborated on an emergency waiver to Home and Community Based Services (HCBS) to stabilize the system and offer additional supports to Medicaid eligible individuals. Specifically, one part of the waiver allowed OHA and ODHS to provide personal care supports while an individual was hospitalized. OHA and ODHS have found that the waiver has provided a necessary benefit to the members we serve. Jointly, we have included this flexibility as a new, ongoing service as part of the state's 1915(k) and 1915(i) state plan amendments to be a permanent component of HCBS to eligible individuals. Approvals for HCBS providers to serve individuals in hospitals are made by the case management entities or the central policy teams.

Additionally, ODHS is currently researching further controls the agency can put in place to prevent future inappropriate billing from occurring and will be included in OHA discussions regarding potential automation of reviews. As the single state Medicaid agency for Oregon, OHA holds the ultimate responsibility for the administration, compliance, and accuracy of Oregon's Medicaid program and will establish quarterly meetings with ODHS to ensure mechanisms are in place to identify and implement cross systems risks and mitigation.

Please contact Dana Hittle at 503-991-3011 with any questions.

Sincerely,

Dana Hittle
Interim Medicaid Director
Oregon Health Authority, HSD

cc:
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OREGON SOS

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Shemia Fagan

OREGON AUDITS DIVISION

Audits Director
Kip Memmott

This report is intended to promote the best possible management of public resources.
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