Oregon Health Authority

Without Federal Action, States Will Continue to Pay Millions of Dollars in Duplicate Medicaid Payments

October 2024

Report 2024-29

Oregon Secretary *of* State
Audits Division

Audit Highlights

Oregon Health Authority

Without Federal Action, States Will Continue to Pay Millions of Dollars in Duplicate Medicaid Payments

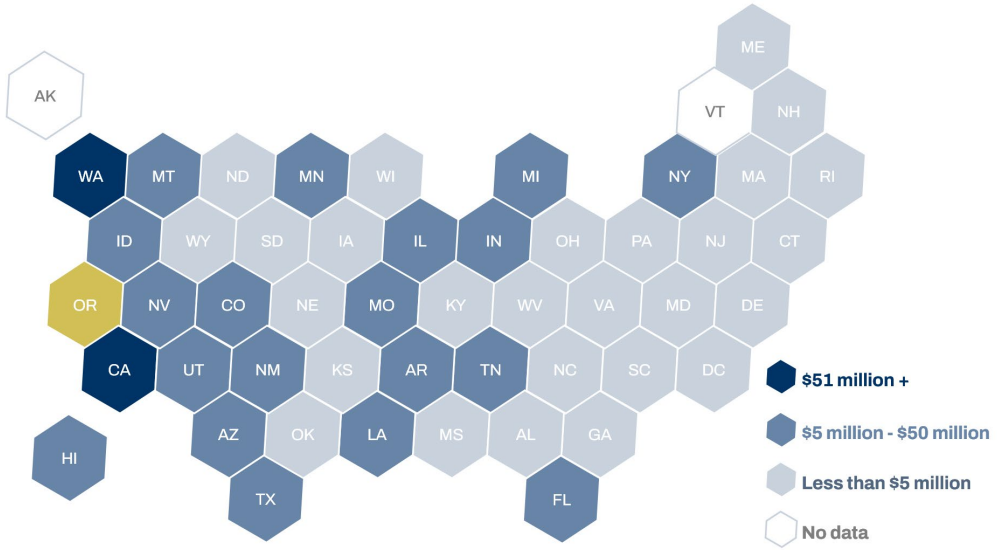
WHY THIS AUDIT IS IMPORTANT

- In 2024, Medicaid served over 1.4 million Oregonians, with spending totaling more than a third of the state's budget. Concurrent enrollment is a nationwide issue costing U.S. taxpayers billions of dollars annually. The Office of Payment Accuracy and Recovery (OPAR) at the Oregon Department of Human Services helps address concurrent enrollment for OHA.
- Concurrent enrollment occurs when a person is enrolled in Medicaid in multiple states at the same time. This means two or more states are paying for the same person to have Medicaid benefits at the same time — a wasteful expenditure of limited tax dollars.

WHAT WE FOUND

1. We found more needs to be done by the federal government to help states identify Medicaid concurrent enrollment. We estimate Oregon potentially spent $29 million on improper Medicaid benefits for recipients residing in Washington from 2019 to 2022. The federal government relies on individual states to identify concurrent enrollments. States do not have access to federal information that could help identify duplicate benefits. (pg. 5)
2. States with the largest concurrent enrollment with Oregon were California and Washington at $134 million and $65 million, respectively. Some payments are appropriate as many recipients would have been living in Oregon at the time; however, payments for recipients living outside of Oregon would be improper. (pg. 6)

Oregon paid about $445 million for Medicaid recipients enrolled in Oregon and one or more other states at the same time from 2019 to 2022. A large portion of those are improper payments.



WHAT WE RECOMMEND

We made four recommendations to OPAR. OPAR agreed with all of our recommendations. The response can be found at the end of the report.

Oregon Secretary of State
Audits Division

Secretary of State **LaVonne Griffin-Valade**
Audits Director **Kip R. Memmott**

Innovative partnerships can help states save money and prevent improper payments

For this audit, we collaborated with the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) and the Washington State Auditor's Office. When governments share expertise, technology, or information, government operations can become more efficient and help protect taxpayer dollars.

U.S. Department of Health & Human Services
Office of Inspector General

HHS-OIG is an independent, objective, oversight agency with dual reporting responsibility to the Secretary of Health and Human Services and to Congress. HHS-OIG works with the Department of Justice, other executive branch agencies, Congress, states, the private sector, and others to improve government operations, compliance, and the recovery of misspent funds. Data analytics and risk assessments are used to identify emerging issues and target high-risk areas to ensure the best use of audit resources.

Office of the Washington State Auditor
Pat McCarthy

Established in the state Constitution 1889, the Washington State Auditor's Office reflects a commitment to making sure public money is spent wisely and in the public interest. Auditors in this office:

- Review financial information and compliance with state, federal, and local laws on the part of all local governments including schools and all state agencies;
- Perform special investigations of fraud and whistleblower cases and referrals from their Citizen Hotline;
- Conduct performance audits of state agencies and local governments; and
- Produce several annual reports addressing state, local and internal matters.

Introduction

The purpose of this audit was to determine if the Oregon Health Authority (OHA) could improve the identification of Medicaid recipients receiving benefits in multiple states. For this audit, we partnered with the Office of the Washington State Auditor and the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG).

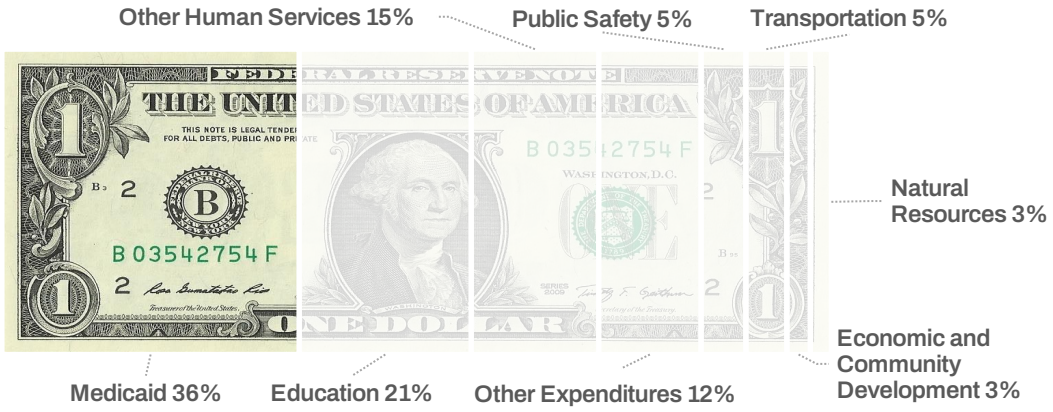
The Washington State Auditor's Office provides citizens with independent and transparent examinations of how state and local governments use public funds and develop strategies to make government more efficient and effective. The mission of HHS-OIG is to provide objective oversight to promote the economy, efficiency, effectiveness, and integrity of HHS programs, as well as the health and welfare of the people they serve.

Medicaid is one of the largest programs in the country

Medicaid provides health care to people with low incomes and people with disabilities. States and the federal government jointly fund and administer the program. The Centers for Medicare and Medicaid Services (CMS) administers the program at the federal level and OHA administers Oregon's program in accordance with an approved plan. Each state has flexibility in designing and operating its Medicaid program but must comply with federal requirements.

In 2023, Oregon spent more on Medicaid — also known as the Oregon Health Plan — than it did on any other area, including education, transportation, and public safety combined. As of June 2024, about 1.4 million people in Oregon receive Medicaid benefits. In 27 counties, more than one-third of the population receives Medicaid benefits.

Figure 1: Oregon spends more than a third of its budget on Medicaid



Source: 2023 Financial Condition Report

Most Oregon Medicaid recipients are enrolled in a Coordinated Care Organization

Oregon uses two separate models to deliver services: fee-for-service and coordinated care. In the fee-for-service model, a Medicaid recipient visits a health care provider, the provider bills OHA directly for approved services, and OHA pays the provider.

The coordinated care model involves coordinated care organizations, or CCOs. A CCO is a network of all types of health care providers (physical, behavioral, and dental) who work together in local communities to serve people who receive coverage under Medicaid. CCOs focus on prevention and helping people manage chronic conditions. Oregon currently has 16 CCOs providing coverage across the state for more than 90% of Medicaid recipients.

OHA pays CCOs predetermined rates every month, known as capitated payments, for each Medicaid recipient for covered services. CCOs get these payments no matter how many or how few services a recipient uses in a month. In 2024, the average capitated payment is $518, but rates vary among CCOs, 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 recipients and helps set future rates for capitated payments.

Program eligibility is generally determined by income

Medicaid provides health coverage to individuals and families, including children, parents, people who are pregnant, elderly people with certain incomes, and people with disabilities. Some states, like Oregon, have expanded their Medicaid programs to cover other adults below a certain income level. Income, residency, and disability are all factors OHA uses to determine eligibility for the program.[1]

Figure 2: An adult Medicaid recipient generally needs to make $2,510 or less a month to qualify

Family size	Adults (19-64)	Pregnant Individuals	Parent or caretaker
1	$2,510	$2,385	$462
2	$3,407	$3,237	$601
3	$4,304	$4,089	$719
4	$5,200	$4,940	$877
5	$6,097	$5,792	$1,025
6	$6,994	$6,644	$1,173

Source: Oregon Department of Human Services

Only Oregon residents are eligible for Medicaid, meaning they must be currently living in Oregon and intend to remain in the state. People who are here with a job commitment or are looking for work are also eligible. There is no minimum amount of time a person is required to be residing in the state, nor do applicants need to provide proof of residency, like a utility bill or rental agreement. Recipients who leave the state but intend to return, like college students or people caring for a sick relative in another state, would still be considered residents.

These broad residency rules make it easier for people to apply for benefits; however, these same rules can challenge a state's ability to determine residency and verify eligibility. If one state determines a recipient is now a resident of that state, the state previously providing Medicaid benefits should close their benefits. Only one state should be paying for a person's Medicaid at a given time.

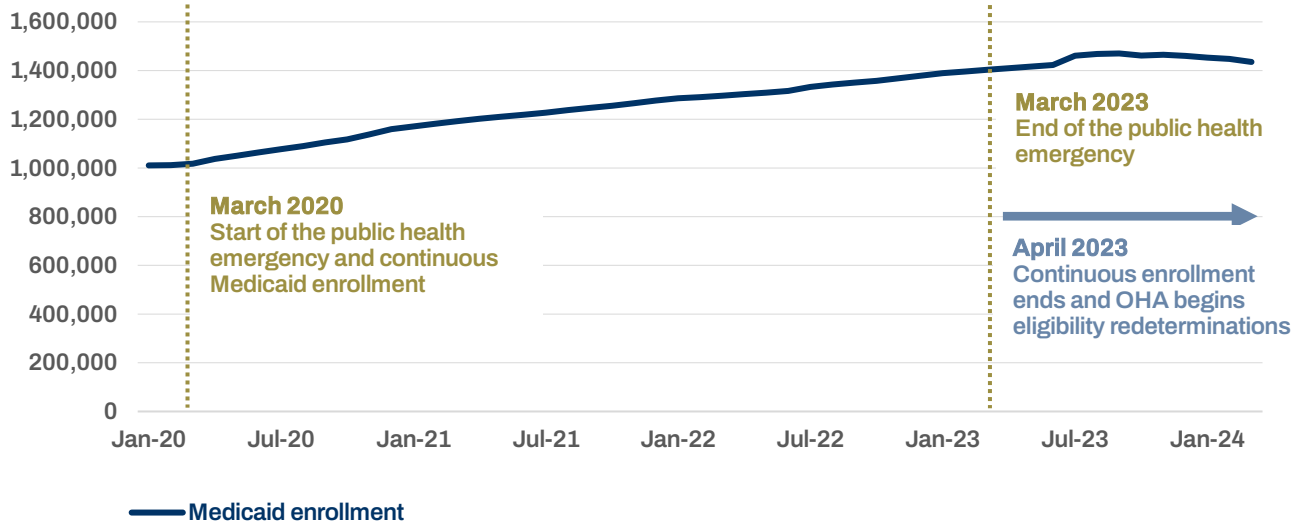
[1] See OAR 410-200 for more eligibility details.

The pandemic changed how the Medicaid program operated

At the beginning of the pandemic, the Families First Coronavirus Response Act was passed in Congress, which gave states a temporary increase in federal funds for Medicaid if they agreed to certain conditions.[2]

With increased funding, one of the conditions OHA agreed to was allowing continuous enrollment in the program until the end of the public health emergency. This meant OHA could not remove anyone from the program unless the recipient requested their benefits be closed or moved out of state. Annual eligibility redeterminations were not resumed until April 2023. The federal government gave states over a year to return to normal eligibility and enrollment operations.

Figure 3: During the pandemic, the Oregon Health Plan saw enrollment increase by more than 40%



Source: OHA enrollment data

Oregon has one of the highest rates in the country of keeping people enrolled in the program since restarting eligibility redeterminations. While most people have kept their benefits, Oregon's Legislature passed House Bill 4035 in 2022 to establish the Bridge Program, which addresses the gap in coverage.[3] Under this new program — which is mostly federally funded — adults with income between 138% and 200% of the federal poverty level will be eligible for most Medicaid services, like medical, dental, and behavioral health care.[4]

The federal government estimates annual national Medicaid expenditures will increase to over $6 trillion by 2030. State officials estimate the cost of health care in Oregon will grow faster than the economy. Due to the size and dollar amounts flowing into this program, it is important the state take steps to ensure the program is run efficiently and effectively to better serve Oregonians.

[2] Families First Coronavirus Response Act
[3] HB 4035
[4] See OHP's Bridge program for more information

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.

Concurrent enrollment

Concurrent enrollment occurs when a person is enrolled in Medicaid in multiple states at the same time. This means two or more states are paying for the same person to have Medicaid benefits at the same time — an inappropriate expenditure of limited tax dollars.

While we did identify small changes OHA could implement to improve results, we found much more needs to be done at the federal level to support states in identifying Medicaid concurrent enrollment. In our testing of duplicate benefits between Washington and Oregon from 2019 to 2022, we estimate Oregon potentially spent $29 million on Medicaid benefits for recipients who were not residing in Oregon.

States do not have access to real-time enrollment data from other states. This information could help identify duplicate benefits either when a recipient applies or during the redetermination process. During our audit we determined the federal government does not actively monitor duplicate capitation payments, but rather relies on individual states to identify them. This finding is similar to what HHS-OIG has found in other audits.

To perform this audit, we were given information on concurrent enrollment in other states from HHS-OIG, a federal government entity. However, the federal government does not proactively share this information with states researching concurrent payments. The federal government could leverage the data it collects to reduce improper payments. Innovative programs, like the U.S. Treasury's Do Not Pay Business Center, have proven results that save taxpayer money using existing federal databases. Do Not Pay could be used to help bridge the gap states face around identifying duplicate payments related to concurrent enrollment.

Improper payments

The Payment Integrity and Information Act of 2019 defines an improper payment as "payments that should not have been made or were made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements." Congress considers duplicate payments to be improper payments.

Medicaid programs paid millions of dollars in benefits for people living in other states

HHS-OIG has conducted audits in multiple states and consistently identified concurrent Medicaid enrollment as an area of concern. A 2022 HHS-OIG audit found nearly all states made some capitation

payments for Medicaid recipients enrolled in two states at the same time.[5] This prior audit looked at just two months of payments among 47 states and identified $72.9 million in August 2019 and $117.1 million in August 2020 was spent for recipients in concurrently enrolled states. It is likely the U.S. has spent billions of dollars on duplicate benefits since the pandemic began. While Medicaid is funded mostly through federal dollars, states make a substantial contribution.

HHS-OIG noted CMS relies on individual states to identify concurrent enrollment yet does not provide states with timely data necessary to identify these potential improper payments. A federal agency that is not CMS receives and disseminates enrollment data from states on a quarterly basis. This means information is outdated before states even begin to work concurrent enrollment matches. The HHS-OIG has recommended CMS provide states with current enrollment data and assist them in using this information. However, CMS does not agree; the agency has stated in response to these recommendations that they consider these possible solutions to be redundant, inefficient, and potentially confusing to states.

An increased risk to the program is the pressure recipients may feel to not tell OHA when people in their household have moved out of state, in fear that other benefits might be reduced.[6] As Medicaid recipients do not receive funds directly or have out-of-pocket medical costs, they may not understand the magnitude of duplicate payments and the importance of notifying OHA of an out-of-state move. A transition period of 1-2 months for states to end and start coverage is reasonable, so our testing covered three or more months of duplicate enrollment to account for this transition.

Reducing concurrent enrollment

Reducing concurrent enrollment does not take away benefits from eligible recipients. Instead, it eliminates wasteful duplicate payments to CCOs. Recipients can still receive their benefits in the state in which they reside.

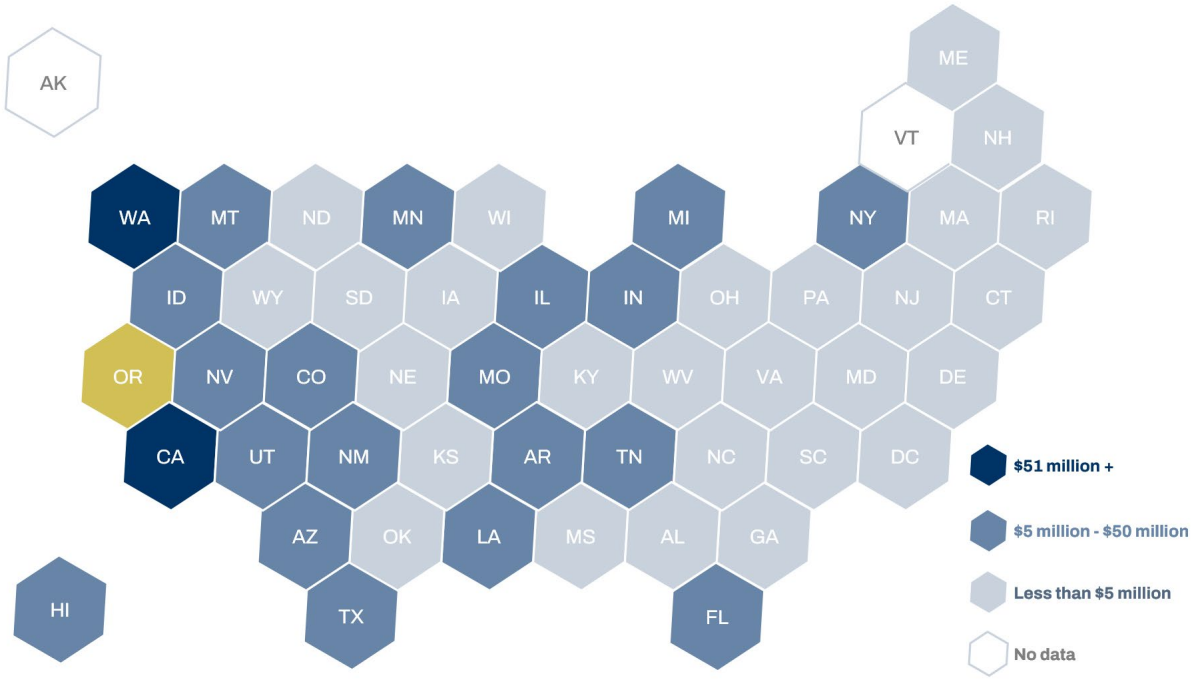
Concurrent enrollment has cost Oregon millions of dollars

From 2019 to 2022, the states with the largest concurrent enrollment with Oregon were California and Washington. In that timeframe, Oregon paid $134 million in benefits to recipients also receiving benefits from California, and $65 million in benefits to recipients enrolled in Washington. Most states with concurrent enrollment with Oregon amounted to less than $10 million. In total, Oregon paid $445 million for Medicaid recipients enrolled in two or more states at the same time. The total amount is not necessarily improper. Payments would be appropriate for recipients living in Oregon; however, payments for recipients living outside of Oregon would be improper.

[5] HHS-OIG concurrent enrollment report September 2022

[6] Benefits like the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance to Needy Families (TANF) are based on income and household size. A reduction in household size could reduce these benefits.

Figure 4: From 2019 to 2022, Oregon paid about $445 million for Medicaid recipients enrolled in Oregon and one or more states at the same time



Source: HHS-OIG concurrent enrollment data

About 3% of Oregon's Medicaid recipients were also enrolled in another state. In conjunction with the Washington State Auditor's Office, we tested a joint sample of 100 recipients enrolled in both Washington and Oregon's Medicaid programs. We tested recipients who were disabled or qualified under modified adjusted gross income (MAGI) thresholds, because their capitation payments tended to be higher dollar amounts.[7] Capitation payments for children are generally less than adult rates, so we selected fewer samples to test. As seen in Figure 5, we tested 997 months and determined 490 months were improperly paid by Oregon, or 49%.

Figure 5: Almost half (49%) of months tested were determined to be improper

Stratum		Recipients tested	Months tested	Improper months
3-5 months	Disabled	5	17	8
	MAGI adult	5	19	9
	MAGI child	5	18	3
6+ months	Disabled	45	556	229
	MAGI adult	35	342	208
	MAGI child	5	45	33
Total		100	997	490

Source: Oregon Audits Division

[7] Modified adjusted gross income is the figure used to determine eligibility for Medicaid and the Children's Health Insurance Program. MAGI is adjusted gross income plus untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest.

After testing, the 100 recipients were placed in the following categories:

Oregonian: 34 recipients that auditors determined were residing in Oregon at the time of concurrent enrollment; no improper payments were identified for Oregon.

Washingtonian: 38 recipients that auditors determined were residing in Washington at the time of concurrent enrollment and were identified as improper payments.

Partial: 16 recipients that auditors determined were residing in Oregon and Washington during the concurrent enrollment period and were able to identify specific time periods for improper payments for both states.

Washegonian:[8] Nine recipients that auditors determined were residing in Oregon and Washington during the concurrent enrollment but could not identify specific time periods for each state; as such, no improper payments were identified. Payments associated with these recipients were not included in our error calculation or projection. Some of these recipients were unhoused or lived in cities along the Oregon-Washington border.

Other: Two recipients where little information was present and one recipient that auditors did not believe lived in either state, but there was a lack of evidence in both states; as such, no improper payments were identified. Payments associated with these recipients were not included in our error calculation or projection.

[8] A term coined by the Washington State Auditor's Office and Oregon Audits Division to describe individuals with overlapping residency in both states.

Figure 6: We estimate Oregon paid about $29 million in benefits for people who actually lived in Washington

Strata		Total population	Testing errors in sample	Error % in sample	Potential total improper payments
3-5 months	Disabled	$2,709,041	$1,149	8%	$221,092
	MAGI adult	$14,895,657	$6,599	46%	$6,796,338
	MAGI child	$3,401,327	$575	15%	$499,774
6+ months	Disabled	$7,032,880	$336,198	40%	$2,813,492
	MAGI adult	$26,102,505	$93,620	53%	$13,868,036
	MAGI child	$6,563,160	$10,779	82%	$5,393,498
Total		$60,704,570	$448,920		$29,592,230

Source: Oregon Audits Division

Improper payments

Out of almost $61 million in payments to CCOs for people enrolled in both Oregon and Washington at the same time, we estimate about $29 million was potentially improper.

We also selected a small sample from six other states to test for concurrent enrollment. We randomly selected five recipients from each state and tested 417 months. In our testing, we identified 124 months where there was strong evidence the recipient was not living in Oregon at the time. Improper payment amounts for these 30 samples totaled $67,000. As this was a small sample, the errors cannot be reliably projected to get an estimate of the total error population. However, all our testing suggests a high risk for millions of dollars of improper payments, highlighting the need for states to have access to timely and reliable data to identify and prevent concurrent payments.

Figure 7: Other states we tested had an average error rate of 30%

State	Recipients tested	Months tested	Improper months	Improper %
Arizona	5	33	22	67%
California	5	83	12	14%
Colorado	5	126	18	14%
Idaho	5	29	28	97%
Hawaii	5	93	34	37%
Nevada	5	53	10	19%
Total	**30**	**417**	**124**	**30%**

Source: Oregon Audits Division

There are inherent challenges in identifying residency for some people

For some people who move frequently, like children splitting time between households and people who are unhoused, determining which state they reside in can be difficult. Frequent movement, especially along border cities between states, makes it challenging for OHA to determine their residency. This increases the likelihood of improper payments due to concurrent enrollment.

The lack of a permanent mailing address, the variability of living situations, and existing Medicaid residency requirements can contribute to unhoused individuals being enrolled in Medicaid in two or more states at the same time. Our testing found instances of unhoused people living in the Portland metropolitan area that moved frequently between Oregon and Washington, sometimes within the same month.

Some children may live in multiple households, spending varying amounts of time with non-custodial relatives or parents. Agency staff reported difficulty in determining where some of these children spent most of their time, also increasing the risk of duplicate enrollment in multiple states.

One potential solution to this problem is to require the Fee-For-Service program upon enrollment or redetermination for recipients who frequently move. In this model, OHA pays providers directly for services, rather than giving CCOs capitated payments to cover health care for a recipient that may or may not use any services in a month. The federal government should identify controls that address risks related to frequent movers.

Concurrent enrollment data provided to states is not timely and has errors

States are required to participate in the Public Assistance Reporting Information System (PARIS), which is not administered by CMS. PARIS is a data matching service that matches recipients of public assistance to check if they receive duplicate benefits in two or more states.

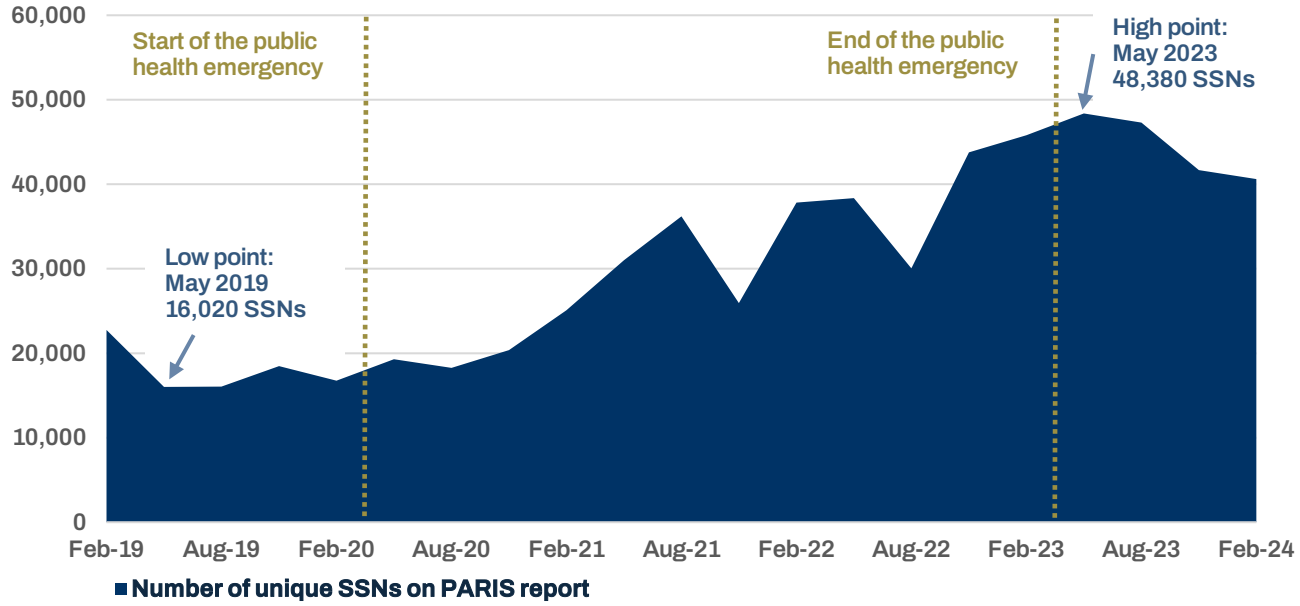
On a quarterly basis, states send enrollment information about Medicaid and other public assistance recipients from the last three months to the corresponding federal agency.[9] That information gets matched to other states' data and matches are then sent back to each state for review. The matches are not maintained in a database and there is no requirement for how much time or the frequency that states spend on identifying and reviewing potential concurrent enrollments. By the time the matches are sent to states, the information is already months old. This control is designed to find errors after people have enrolled in multiple states.

In Oregon, the Office of Payment Accuracy and Recovery is responsible for reviewing the PARIS matches. This office is a shared service between OHA and the Oregon Department of Human Services (ODHS) that helps ensure the agencies spend tax dollars responsibly and works to improve payment accuracy, recover overpayments, and investigate fraud. The Office of Payment Accuracy and Recovery has 2.5 full-time employees that review the PARIS matches.

For the past four years, Oregon's PARIS matches have averaged about 33,000 unique social security numbers per quarter. Staff report reviewing about 20% of the matches before the next quarterly report comes out. This leaves an average of over 26,000 matches unreviewed before the next report is issued. The public health emergency's continuous enrollment requirement increased the number of duplicate benefits in every state. In Oregon, concurrent enrollment matches have been over 40,000 per quarter since the end of 2022.

[9] PARIS matches identify concurrent enrollment in Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Worker's Compensation, and Childcare. See the OSM for additional details.

Figure 8: PARIS social security number matches more than doubled during the public health emergency



Source: PARIS data from the Administration for Children and Families

A recipient will continue to show up in the PARIS report until their benefits are closed in one or more states. Currently, when the Office of Payment Accuracy and Recovery receives PARIS data, the matches are divided among staff to review. They look at several data sets for each recipient to determine if they may be residing out of state. They will then look to see if a recipient has any health care claims during the concurrent enrollment period, case notes, and where the recipient is spending their SNAP benefits. The Office of Payment Accuracy and Recovery will also reach out to other state Medicaid agencies if more information is needed.

Agency staff have stated concerns about errors in some PARIS data, causing false matches when a recipient did not actually have concurrent enrollment. Staff also reported difficulties in getting requested information from other state Medicaid agencies, especially in states where Medicaid is administered at the county level, like California.

The Office of Payment Accuracy and Recovery could improve the current processes to better identify concurrent enrollment. While these improvements will not fix the problem, adding additional staff to review PARIS matches and risk triaging the PARIS report will help the division to be more efficient with limited resources. Prioritizing the following could improve efficiency:

- Recipients who have had PARIS matches for longer amounts of time;
- Matched recipients that are part of a household group; and
- Recipients who have matches in states from which the agency is able to request and readily receive information.

The quarterly PARIS matches are the primary tool states have to identify this issue, but this process is not timely or as accurate as it should be. CMS, the federal oversight entity of Medicaid, receives data from states that could be utilized to better identify concurrent enrollment. However, CMS has rejected recommendations from HHS-OIG to provide this data. Since the end of continuous enrollment, the number

of duplicate benefits has decreased, but the issue will continue to persist unless states are provided with the appropriate data.

Improving controls can reduce improper payments

PARIS is a decades-old system that is only partially effective because the reports are not timely, and the data has accuracy issues. This control could be dramatically improved to help reduce tens of millions in improper payments.

States cannot implement preventive controls around concurrent enrollment without federal action

If a state suspects an individual resides in another state, federal rules prevent the denial or termination of benefits without providing the person with an opportunity to provide additional information. Furthermore, prior to terminating Medicaid benefits, proper notice must be given to the recipient.[10] If the recipient does not respond to the request or provide sufficient information, the state can begin the termination process.

To prevent duplicate payments from occurring, states would need real-time access to enrollment data when a recipient applies for benefits and notification when a recipient applies for benefits in a different state. Federal rules would also need to be adjusted to accommodate these changes. States already possess the technology to check other federal databases for the program. Federal databases are currently used to help verify income and other eligibility information. Adding another check against a federal database of Medicaid recipients currently enrolled in other states would help minimize duplicate payments associated with concurrent enrollment.

The Oregon Audits Division recently assessed the state's Medicaid eligibility system, known as the ONE system. One of the objectives of this audit was to determine whether the system has sufficient controls to completely and accurately determine and maintain eligibility and benefits for the Medical and SNAP programs in the system in accordance with rules and laws.[11] The audit found the system was largely working as intended.

The U.S. Department of Treasury's Do Not Pay Business Center could help reduce improper payments due to concurrent enrollment

In 2013, Congress passed the Improper Payments Elimination and Recovery Improvement Act, which provided guidance on the application of a new government service to help eliminate improper payments. In response to the act, federal executive agencies are required to review payments and awards through the U.S. Treasury's Do Not Pay Working System. This act was repealed in 2019 and replaced by the Payment Integrity Act, which continued the requirement for federal agencies to use Do Not Pay.

[10] See 42 CFR §435.952(d)
[11] See OAD report 2024-27

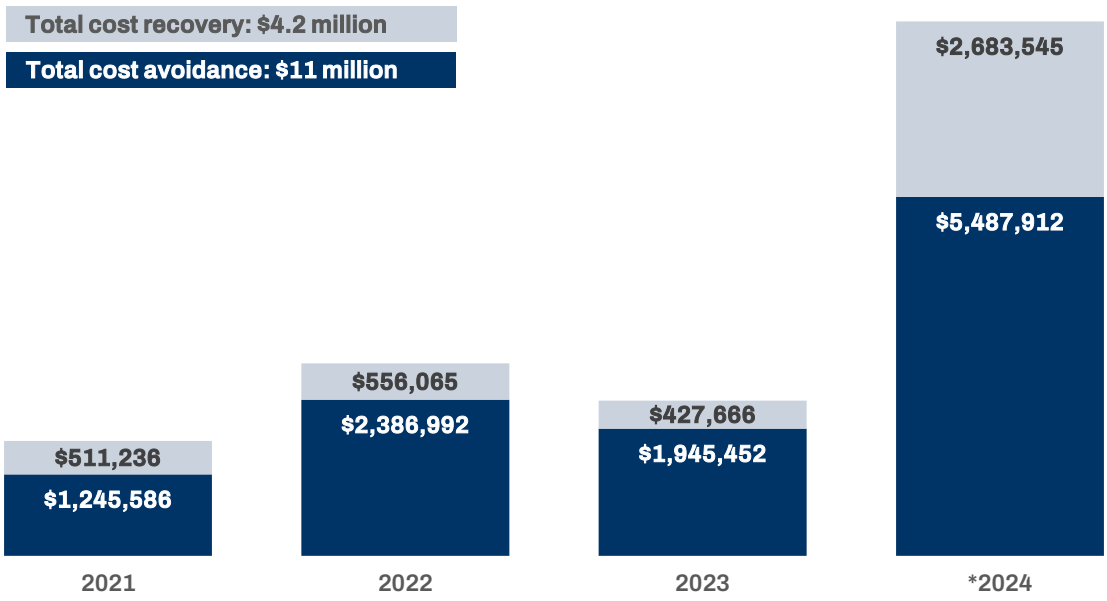
Do Not Pay is a free service for all government agencies administering federally funded programs. It provides a variety of services, from detecting potential improper payments already issued to helping prevent future improper payments. The federal government offers Do Not Pay free of charge because it helps reduce improper payments and saves money across multiple programs, including those administered at the state level.

Do Not Pay has access to multiple data sources and the service is constantly seeking to expand the number of data sources available.[12] Do Not Pay staff perform batch matching against these data sources and an online worker portal for government employees is available to search against these data sources on demand. Lastly, Do Not Pay provides other assistance, including custom analytics, data quality checks, preventative controls development, and risk scoring. Do Not Pay's access to various data sources and their goal of reducing improper payments puts the agency in a unique position to provide states with concurrent enrollment data and custom analytics.

Oregon has saved over $15 million using Do Not Pay services since 2020

In 2020, our office issued an audit report evaluating the costs and benefits of using Do Not Pay services. The report identified over $790,000 in improper payments and over $6 million in prevented improper payments.[13] After the audit, the Office of Payment Accuracy and Recovery agreed to fully implement services offered by Do Not Pay to identify deceased and other ineligible recipients and providers in public assistance programs that should not receive payments.

Figure 9: The Office of Payment Accuracy and Recovery has saved the state over $11 million by working with Do Not Pay since 2021



Source: The Office of Payment Accuracy and Recovery cost avoidance and recovery data

[12] Do Not pay has access to the Social Security Administration's Death Master File and the Credit Alert Verification Reporting System, among other systems.

[13] See Oregon Audits Division report 2020-05

As of June 2024, the Office of Payment Accuracy and Recovery estimates the state has saved over $11 million in payments that would have been made to ineligible recipients or providers, and about $4 million in recovered improper payments. For every $1 spent on staff time, the agency realizes savings of $126, an extremely high return on investment.

Duplicate Medicaid benefits are a nationwide risk, costing the U.S. billions of dollars annually. Due to the cost savings OHA/ODHS have achieved, we believe Oregon and other states should work with Do Not Pay to identify concurrent enrollment and reduce improper payments.

Audit recommendations will be an important tool for states to reduce millions of dollars in improper payments from concurrent enrollment

While the Office of Payment Accuracy and Recovery can take action to reduce improper payments, such as hiring additional staff to perform program integrity activities, these efforts alone are not sufficient to address the risk of concurrent enrollment.

The federal government should provide states with timely enrollment data and support. Early identification of concurrent enrollment will save public monies. It is important the federal government take steps to ensure Medicaid is run efficiently and effectively to better serve recipients and save taxpayer dollars. As we noted in our findings, the federal government already collects the data needed to identify concurrent enrollment — the same data we used to perform this audit. Instead, the federal government relies upon states, which do not have ready access to timely and reliable information to identify these improper payments.

According to Do Not Pay, one of the primary reasons improper payments occur is the inability of programs to access information needed to validate payment accuracy. The federal government, either through CMS or Do Not Pay, should provide states with easy access to information needed to reduce improper payments related to concurrent enrollment.[14]

[14] See the Appendix for additional information on improper payments and examples.

Recommendations

To support states' efforts to identify and prevent improper payments, the U.S. Treasury's Do Not Pay Business Center should:

1. Complete a pilot project with Oregon and Washington to find opportunities to address risks with concurrent enrollment.

To help states identify and prevent improper payments timely, the federal government should:

2. Provide states with matched enrollment data that identify Medicaid beneficiaries who were concurrently enrolled in a Medicaid managed care program in two or more states.

3. Identify internal controls that would address risks around concurrent enrollment with Medicaid recipients who are unhoused or children living in multiple households.

To identify and prevent improper payments due to concurrent enrollment, we recommend the Office of Payment Accuracy and Recovery:

4. Submit a budget request for an additional four FTE for the Data Matching Unit.

5. Develop a process to triage PARIS matches within the Data Matching Unit.

6. Work with U.S. Treasury's Do Not Pay Business Center on a joint Washington and Oregon pilot project for concurrent enrollment.

7. Implement a process by 2026 to recoup duplicate enrollment payments from CCOs for recipients who live out of state.

Objective, Scope, and Methodology

OBJECTIVE

The objective of this audit was to determine if opportunities exist at OHA to improve identification of Medicaid managed care recipients receiving benefits in multiple states concurrently.

SCOPE

This audit covers concurrent capitation payments made to Oregon CCOs and Washington managed care entities from January 1, 2019, to December 31, 2022.

METHODOLOGY

To meet our objective, we performed the following procedures:

- Corresponded with staff at HHS-OIG;
- Corresponded and worked with auditors from the Office of the Washington State Auditor;
- Reviewed state and federal laws, rules, and regulations related to our audit objective;
- Obtained and reviewed audits, reports, and documents from federal entities and other states related to our audit objective;
- Conducted interviews or corresponded with OHA/ODHS personnel and management; and
- Reviewed, verified, sampled, and tested data obtained by both HHS-OIG and OHA.

Data Reliability:

We obtained Medicaid data from HHS-OIG. This data consisted of capitation payments paid to Oregon CCOs while the recipient was also enrolled in Medicaid in one or more other states. HHS-OIG did the initial matching of these claims across states and provided them to our office and the Office of the Washington State Auditor for review and testing. We also obtained final paid Oregon Medicaid capitation data from OHA for the same time period as the HHS-OIG data provided. Social security numbers were the primary means of identifying recipients with concurrent payments in two or more states.

To assess the reliability of the data, we traced a sample of randomly selected capitation payments across multiple files and systems to provide reasonable assurance the information we obtained from HHS-OIG 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.

Sampling:

In conjunction with the Office of the Washington State Auditor, we selected a random sample of 100 recipients for detailed testing. The sample plan was produced by the Office of the Washington State Auditor and approved by both our management teams. An HHS-OIG statistician provided assistance related to generating estimates after the sampling plan was developed.

The sample population was broken down into six unique strata and a predetermined number of random samples were pulled from each stratum. The sample strata are as follows:

- Three to five months of concurrent payments

    - Blind and Disabled
    - MAGI Adult
    - MAGI Child
- Six or more months of concurrent payments
    - Blind and Disabled
    - MAGI Adult
    - MAGI Child

The number of samples pulled for each stratum for the Washington testing can be found in the body of the report on page 7.

For the other states' testing, we randomly selected five recipients from the following states: Arizona, California, Colorado, Idaho, Hawaii, and Nevada. As this was a small sample, we did not project the errors to the population.

Testing:

Employing the information sources outlined below, our office worked with the Office of the Washington State Auditor to determine whether a recipient was living in the state of Oregon or Washington at the time concurrent payments were made.

For the 100 Washington recipients tested, the following information was reviewed to determine if the recipient was a resident of Oregon or Washington during the concurrent enrollment period:

- Oregon auditors provided Washington auditors with summary conclusions based on the following sources:
    - Capitation history before, during, and after the concurrent enrollment;
    - Medical claims data, including the physical location of the provider, before, during, and after the concurrent enrollment;
    - System case file information including caseworker notes, application information, and recipient correspondence before, during, and after the concurrent enrollment;
    - Location of Supplemental Nutrition Assistance Program (SNAP) spending during the concurrent enrollment; and
    - Department of Motor Vehicles data for individuals requesting an Oregon license or revoking an Oregon license.
- Washington auditors provided Oregon auditors with summary conclusions based on the following sources:
    - Medical claims data;
    - System case file information including caseworker notes and applications;
    - Employment data, including hours worked in Washington during the concurrent enrollment;
    - School enrollment data for recipients enrolled in a Washington public school; and
    - Licensing data for individuals requesting a Washington license or revoking a Washington license.

Our findings from the selected samples were then projected to the entire population. We estimated total improper payments using a simplified model. Our estimate is sufficient to identify the potential effect due to concurrent enrollment and the need for policy makers to address this risk but does not have the same

precision and rigor as a statistically valid methodology. Detailed results of this testing can be found in the body of the report on page 7.

For the other states' testing, the following information was reviewed to help determine if a recipient was a resident of Oregon during the concurrent enrollment period:

- Capitation history before, during, and after the concurrent enrollment;
- Medical claims data, including the physical location of the provider, before, during, and after the concurrent enrollment;
- System case file information including caseworker notes, application information, and recipient correspondence before, during, and after the concurrent enrollment;
- Department of Motor Vehicles data for individuals requesting an Oregon license or revoking an Oregon license.

It was outside the scope of this audit to determine what impact a reduction of concurrent enrollment would have on subsequent capitation rates. There is a limitation on the duplicate payment amount identified and the associated cost savings. Removing individuals from the risk pool may result in capitated rates calculated by actuaries to increase, resulting in lowered net savings.

INTERNAL CONTROL REVIEW

We determined that the following internal controls were relevant to our audit objective.[15]

- Risk Assessment
    - We considered whether the federal government has designed information systems and control activities to help states alleviate concurrent payments in the Medicaid system and respond to the risk of this occurring.
    - We considered whether management of the Office of Payment Accuracy and Recovery unit has designed control activities to prevent concurrent payments from continuing to being made and whether management has designed information systems and related control activities to achieve that objective and respond to risk.
- Control activities
    - We considered whether the federal government has designed control activities to ensure that the PARIS system contains accurate and timely information so that states can review system matches, risk assess, and correct concurrent payments as the federal government intends.
    - We considered whether the Office of Payment Accuracy and Recovery unit management has designed control activities to ensure PARIS matches are reviewed in a timely manner and risk assessed or triaged appropriately.
- Monitoring activities
    - We considered whether the federal government is effectively monitoring the PARIS system's internal control functions so that inaccurate, untimely, or poorly formatted data is not being sent to states making it harder for them to identify and eliminate concurrent payments.

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

- We considered whether the Office of Payment Accuracy and Recovery management is effectively monitoring internal controls that could identify concurrent payments and whether management remediates 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 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 objectives. We believe that 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/ODHS, HHS-OIG, and the Washington State Auditor's Office during the course of this audit.

Audit team

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

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 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.

Appendix A: United States' Treasury Do Not Pay Business Center Factsheet on Improper Payments

Why does the federal government make improper payments?

Improper payments can happen for a number of reasons. It is important to identify the root causes of improper payments for agencies to detect and prevent them. Do Not Pay can help agencies identify some of the reasons improper payments are made.

While improper payments can have many causes, the federal government has categorized root causes of error into five categories for reporting purposes. This chart from the Office of Management and Budget's M-21-19 Memorandum defines and gives examples of each cause category:

Cause Category	Definition	Examples include but are not limited to…
Statutory Requirements of Program Were Not Met	An exception in that a payment made to an otherwise qualified recipient for the right amount, but the payment process failed to meet all regulatory and/or statutory requirements. All Technically IPs will fall into this cause category.	When a vendor is paid the contracted amount for services provided; however, the person authorizing the services did not have the legal authority needed from the contracting officer to authorize the services, or, when a vendor is paid the correct amount for services provided but the contract the agency used to secure the services did not meet all of the requirements in the Federal Acquisition Regulation.
Unable to Determine whether Proper or Improper	A payment that could be either proper or improper, but the agency is unable to determine whether the payment was proper or improper as a result of insufficient or lack of documentation. All Ups will fall into this cause category.	When an agency is required to verify income prior to issuing a payment to a beneficiary and a beneficiary's case file lacks updated income information or pay stubs and the agency has no other way of verifying whether a change in income has occurred since the last time they issued a benefit. The beneficiary may still be qualified to receive benefits, but they might have also had an increase or decrease in income affecting their eligibility for the program. Therefore, because the reviewer does not have the information needed (updated income) during the time of the review, it is unknown whether an overpayment or underpayment has been made.
Data/Information Needed Does Not Exist	A situation in which there is no known database, dataset or location currently in existence that contains the data/information needed to validate the payment accuracy prior to making the payment.	When a recipient's eligibility is dependent on the length of time a child spent with their guardian – no database or dataset is currently in existence containing this type of information; when a medical provider fails to provide proof of a broken leg (required by statute or regulation) to support a claim – no database or location is currently in existence containing x-rays or any other type of information that can confirm a leg is actually broken.

Cause Category	Definition	Examples include but are not limited to…
Inability to Access Data/Information	A situation in which the data or information needed to validate payment accuracy exists but the agency or entity making the payment does not have access to it.	When a statutory constraint prevents a program from being able to access information that would help prevent IPs (for example, not confirming a recipient's earnings or work status through existing databases due to statutory constraints, or a beneficiary failing to provide an agency with information on earnings, and the agency does not have access to databases containing the earnings information).
Failure to Access Data/Information	IPs are attributed to human errors to access the appropriate data/information to determine whether or not a beneficiary or recipient should be receiving a payment, even though such data/information exists and is accessible to the agency or entity making the payment.	When agency with access to the death master file fails to verify eligibility prior to approving entitlements; when an entity has access to the information that would verify a beneficiaries household income and the entity making the payment does not check that information prior to payment.

Source: U.S. Treasury's Do Not Pay Business Center

October 18, 2024

Kip Memmott, Director
Secretary of State, Audits Division
255 Capitol St. NE, Suite 180
Salem, OR 97310

Dear Mr. Memmott:

This letter provides a written response to the Audits Division's final draft audit report titled *Without Federal Action, States Will Continue to Pay Millions of Dollars in Duplicate 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 intent of this audit was to determine whether opportunities exist at OHA to improve identification of Medicaid managed care recipients receiving benefits in multiple states concurrently.

The SOS office made four recommendations to OHA and outlined several recommendations to the U.S. Treasury's Do Not Pay Business Center, and the Center's for Medicare and Medicaid Services. OHA will respond specifically to the four recommendations for us.

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

RECOMMENDATION 1 Submit a budget request for an additional 4 FTE to the Data Matching Unit		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	December 31, 2027	Nicky Jeffreys (503) 602-3873

Narrative for Recommendation 1:
Office of Payment Accuracy and Recovery (OPAR) will be submitting a Policy Option Package (POP) for 4 additional FTE's in the next legislative session for approval and funding.

RECOMMENDATION 2 The Data Matching Unit should develop a process to triage PARIS matches.		
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, 2025	Nicky Jeffreys (503) 602-3873

Narrative for Recommendation 2:
The Data Match Unit (DMU) will relook at how PARIS matches are done and prioritized. The team will research and work towards completing cases in a more efficient way by working the oldest cases on the report as well as processing low-effort cases first.

RECOMMENDATION 3 Work with US Treasury's Do Not Pay Business Center on a joint WA/OR pilot project for concurrent enrollment.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	December 31, 2025	Nicky Jeffreys (503) 602-3873

Narrative for Recommendation 3:
The Data Match Unit (DMU) is open to working with US Treasury's Do Not Pay Business Center on a joint WA/OR pilot project for concurrent enrollment. Data sharing agreements, policy and procedures will need to be developed by both states. Once the data sharing agreements are executed, and matching is completed, OPAR will know more on specifics on how this work will be completed.

RECOMMENDATION 4 By 2026, implement a process to recoup duplicate enrollment payments from CCOs for recipients who live out of state.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	March 31, 2026	Nicky Jeffreys (503) 602-3873

Narrative for Recommendation 4
OPAR Data Match Unit will develop and implement a process for identifying CCO members who live out-of-state. The process will include the recoupment of capitation payments made to a CCO for these out-of-state CCO members where it has been validated that the member was living out-of-state at the time of Oregon CCO enrollment.

For any additional questions, please contact:

Nicky Jeffreys - Administrator Office of Payment Accuracy and Recovery - Nicky.M.Jeffreys@odhsoha.oregon.gov

April Gillette – Medicaid Strategic Operations & Improvement Director – April.S.Gillette@oha.oregon.gov

Sincerely,

Sejal Hathi, MD MBA
Director

EC: Kris Kautz, Deputy Director for Administration, OHA
Rochelle Layton, Chief Financial Officer, OHA
Emma Sandoe, Medicaid Director, OHA
Vivian Levy, Medicaid Deputy Director, OHA

Oregon Secretary of State
Audits Division

Secretary of State **LaVonne Griffin-Valade**
Audits Director **Kip R. Memmott**

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

Copies may be obtained from:

Oregon Audits Division
255 Capitol St NE, Suite 180
Salem OR 97310
(503) 986-2255

audits.sos@oregon.gov
sos.oregon.gov/audits