Oregon Health Authority

Medicaid Duplicate IDs Put Federal Funding at Risk

September 2026

Report 2026-26

Oregon Secretary of State

Oregon Secretary of State

Secretary of State **Tobias Read**
Audits Director **Steve Bergmann**

Audit Summary

Oregon Health Authority

Medicaid Duplicate IDs Put Federal Funding at Risk

OBJECTIVE

Determine whether the Oregon Health Authority (OHA) made duplicate payments for the same recipient at the same time.

SCOPE

This audit focuses on Medicaid recipients who had multiple system IDs and concurrent capitation payments made from 2020 to 2024. A capitation payment is a fixed monthly amount OHA pays to Coordinated Care Organizations (CCOs) for each recipient regardless of how many services a recipient uses.

Why this audit is important

In 2025, Oregon spent $19 billion on Medicaid, of which $13 billion was federally funded. One in three Oregonians rely on this important service. The federal government can reduce or withhold funding from states that are out of compliance with rules. Paying Coordinated Care Organizations multiple capitation payments for the same recipient reduces the funding available to other important programs in the state. Due to the critical nature of this program, OHA must run Medicaid efficiently, effectively, and in compliance with federal rules.

What we found

Federal funding could be at risk if OHA does not follow federal rules. (pg. 3)
One in three Oregonians rely on Medicaid for critical healthcare coverage. Medicaid is funded jointly by states and the federal government. If Oregon fails to follow federal rules, the federal government can withhold or reduce funding which makes up about two-thirds of the Medicaid budget. Though OHA has up to one year to remit the federal portion of overpayments back to the federal government, compliance is critical to maintaining funding for the program.

OHA made duplicate capitation payments for the same recipient during the same time. (pg.3)
We performed data matches between all Medicaid recipients from 2020 to 2024 to identify potential duplicate recipients where capitation payments were made concurrently. Out of more than 2 million IDs, we identified 645 potential duplicates and tested 56 pairs of IDs. Our testing found $230,252 in overpayments. After projecting the errors to the population, we estimate OHA made between $232,000 and $4.1 million of duplicate capitation payments for the entire Medicaid program between 2020 and 2024.

Duplicate Medicaid IDs can cause data integrity issues. (pg. 5)
When one recipient has multiple system IDs assigned to them, the system data is no longer accurate and consistent. Each duplicate ID created causes the agency to spend more time and resources cleaning up the errors. Duplicates can also cause issues with reporting accurate information to the federal government and can create issues with system contractors.

What we recommend

To comply with federal regulations, OHA should:

1. Review the other IDs that were not detail tested to determine if they are duplicates and whether overpayments occurred. Along with the tested 31 samples, remit the federal portion of the overpayments back to the federal government.

On recouping overpayments to CCOs, OHA should use the capitation reconciliation process to:

2. Recoup duplicate payments from CCOs.

To better prevent and detect duplicate IDs, OHA should:

3. Provide specific training to eligibility workers on best practices for researching applicants and potential matches.
4. Develop future system enhancements that will reduce the manual research currently performed by eligibility workers.
5. Design and implement a quality control process to better prevent and detect duplicate IDs. Included in this process should be:
    a. A mechanism to identify capitation payments once duplicate IDs are identified; and
    b. Using the established capitation reconciliation process, remit the federal portion of overpayments in compliance with federal regulations once they are identified.

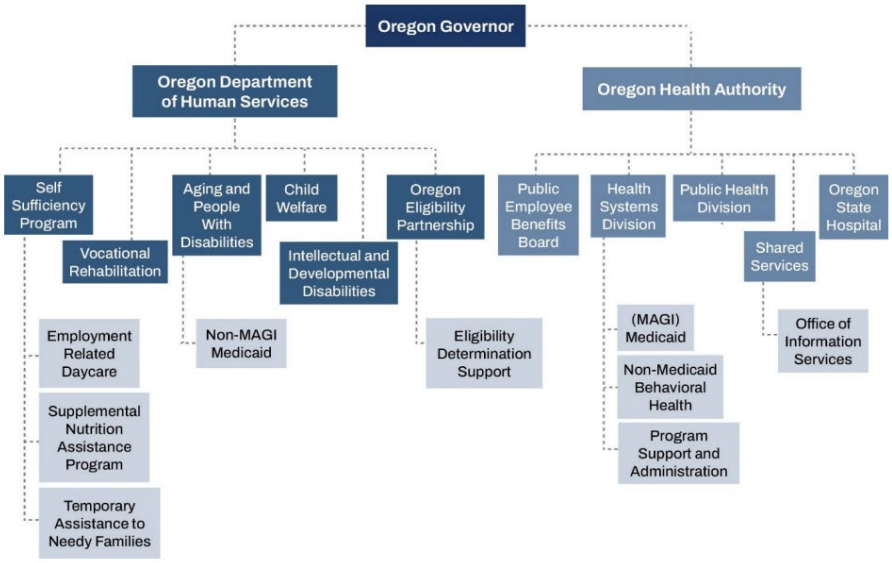
Agency response

OHA agreed with all our recommendations. The response can be found at the end of the report.

Introduction

People with low incomes or disabilities rely on Medicaid for important health care services. The Centers for Medicare and Medicaid Services administers the program at the federal level. The Oregon Health Authority (OHA) administers Oregon's program in accordance with a federally approved plan. States have flexibility in designing and operating Medicaid, but they must comply with federal requirements. While OHA is responsible for administering the program, the Oregon Department of Human Services (ODHS) helps determine who is eligible for Medicaid and other public assistance programs.

Figure 1: ODHS and OHA are both responsible for parts of Medicaid



Source: Auditor created based on 2023-25 Legislatively Adopted Budget

In 2025, Oregon spent $19 billion on Medicaid, of which $13 billion was federally funded. Medicaid is also known as the Oregon Health Plan, or OHP. As of January 2026, about 1.4 million people receive Medicaid benefits, or one in three Oregonians. Due to the size and critical nature of this program, OHA must run Medicaid efficiently, effectively, and in compliance with federal rules.

Most Oregon Medicaid recipients are enrolled in a Coordinated Care Organization

Oregon has a "no wrong door" approach for people wanting to apply for Medicaid and other programs. Oregonians can submit a single application, and it can be used to determine eligibility for multiple assistance programs, like the Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, childcare assistance through Employment Related Day Care, Medicaid, refugee, domestic violence, and long-term care services. Previously, people would have applied separately for programs, often repeating administrative work for both the applicant and for eligibility workers. Prior to the implementation of the OregONEligibility System (ONE), eligibility workers would use legacy systems to apply and determine benefits. This older system is still in place and used for some smaller programs.

There are multiple ways to enroll in the Medicaid program- online, by phone, in-person, by a certified community partner, or by paper application. The online web application will walk the applicant through entering necessary personal information and help determine if they are eligible. When a person calls to apply, they are routed to an eligibility worker who walks them through the process. People can also apply in person at a local ODHS office or through a certified community partner. They can download and print an application that can be filled out at home before going to the office or fill out an application once they are there. They are then seen by a caseworker or community partner who enters their information from the application. Paper applications are processed at local ODHS offices throughout the state. Once eligibility is established a case is created and a unique ID number is assigned. If the applicant is a returning recipient, their prior identification number will be reused.

Figure 2: There are multiple ways to enroll in Medicaid

While some recipients maintain Medicaid eligibility for long stretches of time, other recipients have less continuous eligibility. Some reasons for eligibility fluctuations can be changes in income or delays in submitting required documentation. During the pandemic, federal regulations prevented states from removing recipients from Medicaid, except when they moved to another state, were deceased, or asked for their benefits to be closed. Even if their income rose above the eligibility threshold, they were still covered. After the pandemic, the process of redetermining eligibility for recipients began. During this process, eligibility was automatically renewed using existing data like tax records and social security income. Recipients were sent a request to provide more information if not enough was available. Recipients were not required to submit a formal application. Due to this passive renewal, some recipients may not have been aware or remembered they were enrolled in the program, and benefits were being paid for their healthcare.

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 (CCOs). A CCO is a network of providers who work together in local communities to serve people who receive Medicaid. CCOs focus on prevention and helping people manage chronic conditions. Oregon currently has 16 CCOs providing coverage for more than 90% of Medicaid recipients.

OHA pays CCOs predetermined rates for each recipient every month. These are known as capitation payments. CCOs get these payments no matter how many or how few services a recipient uses in a month. CCOs pay providers in their networks for services rendered and send data about these services to OHA. This data helps to determine future capitation rates. Rates are determined based on a number of factors such as population, geography, and specific age group data. When somebody who has currently or previously received Medicaid applies for new benefits, it is important they are enrolled under their previous ID number, even if it has been years or decades since it was last used. Duplicate IDs for the same person can lead to duplicate capitation payments and data integrity issues.

Audit Results

As the state Medicaid agency, OHA is responsible for Oregon's Medicaid program. Oregon's federal funding is at risk if the program is out of compliance, which would impact OHA's ability to serve vulnerable Oregonians. From 2020 to 2024, OHA paid $37 billion in capitation payments to CCOs. During this same time, we estimate OHA paid CCOs a small fraction of that, between $232,000 and $4.1 million in overpayments for recipients enrolled in the program under duplicate IDs.

Duplicate IDs for the same person risk federal funding and can lead to overpayments and data integrity issues

Recent audits in other states have found duplicate Medicaid recipients to be a risk area and Oregon's estimated overpayments are less than some other states. While there are some processes in place to prevent and detect duplicate IDs, more should be done to comply with federal rules in Oregon. OHA should repay the federal portion of identified overpayments, recoup overpayments from CCOs, and improve controls to better prevent and identify duplicate recipients.

Federal funding could be at risk if OHA does not follow federal rules

Medicaid funding provides important healthcare coverage for Oregonians, so compliance is critical in maintaining the program. Federal rules promote consistency, support program integrity, and help prevent fraud. While states have some flexibility in operating their programs, federal rules create a baseline which helps reduce disparities in access to care and supports broader public health goals like improving health outcomes and ensuring access to essential services.

If Oregon does not comply with federal Medicaid rules, the federal government can reduce or withhold funding, which makes up about two-thirds of Oregon's Medicaid budget. Federal rules require states to return the federal portion of any overpayments. In Oregon, the federal match is about 58%, so for every $1 overpaid, OHA must refund $0.58 to the federal government.[1] Federal rules require states to remit the federal portion of overpayments within one year after identification.

We estimate OHA made between $232,000 and $4.1 million of duplicate capitation payments between 2020 and 2024

Duplicate capitation payments occur when OHA pays CCOs more than once for the same enrolled recipient for the same month of coverage. The federal government and OHA consider these overpayments. We conducted three different data matches to identify potential instances where duplicate payments were made. We then stratified the population based on the type of match and dollar amount.

We performed data matching between all Medicaid recipients from 2020 to 2024 to identify potential duplicate recipients where capitation payments were made concurrently. Out of more than 2 million IDs, we

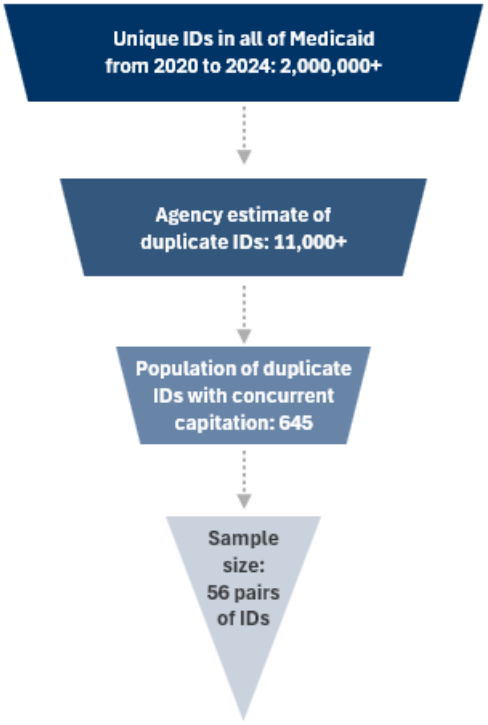
[1] Oregon's standard Medicaid matching rate is about 58%. Administrative matching rates are typically 50%.

identified 645 pairs of potential duplicate IDs. We tested 56 of those pairs and verified 31 were duplicates and 28 had concurrent capitation overpayments totaling $230,252.

Out of the 31 duplicates we identified, most had been merged before our testing, showing that the agency had appropriately identified them as duplicates. OHA had recouped or adjusted the duplicate payments for some samples before our testing was done, but there were some previously identified duplicates where the payments were not recouped. Once OHA recoups all duplicate capitation, the total overpayment will be $0.

There is a reconciliation unit within OHA that works on recouping these and other kinds of overpayments. The agency reports that improvements were made to streamline the process to get information on duplicate IDs to this unit, who identify capitation payments that need to be recouped. The new process is timelier, and enrollment and capitation changes can occur at the same time. After we completed our testing and notified the agency of the duplicates, some overpayments were recouped quickly. However, not all the overpayments were recouped by this process. OHA should improve or develop controls that will ensure once a duplicate is identified that this information is reported to this unit.

Figure 3: Duplicate IDs with concurrent capitation represent a very small portion of all Medicaid IDs



The non-duplicates were mostly twins with similar names or different people who shared the same name and birthdate. Duplicates were more likely to be caught by the agency when the social security number matched exactly between two recipients. We estimate OHA made between $232,000 and $4.1 million duplicate capitation payments between 2020 and 2024. We also found additional duplicate payments that were made on behalf of these recipients in 2025 and 2026, totaling an additional $51,285 in

overpayments.[2] OHA did not recoup most of the payments to CCOs that were made for the duplicate recipients identified. The federal government considers these to be overpayments.[3]

Figure 4: OHA made an estimated $232,000 - $4.1 million in duplicate capitation payments between 2020 and 2024

Strata	Population Total	Duplicate payments	Estimate of total duplicate payments *Low*	Estimate of total duplicate payments *Average*	Estimate of total duplicate payments *High*
Tier 1	$680,169	$6,111	$26,521	$273,595	$520,670
Tier 2	$1,615,751	$14,495	$1,490	$574,443	$1,147,396
Tier 3	$5,444,964	$132,563	$203,891	$1,020,747	$1,837,604
Tier 4	$2,640,337	$77,083	$0	$195,333	$586,346
Total	$10,381,221	$230,252	$231,902	$2,064,118	$4,092,016

Source: Auditor prepared based on OHA capitation and recipient data[4]

In the past few years, certified community partners submitted only 12%-14% of all medical applications. However, for over two-thirds of our identified duplicate samples, certified community partners helped submit one or both applications. Most applications are submitted through the online web application or by phone. Certified community partners have cited access barriers and inconsistent information given by applicants as reasons why it can be challenging to help Oregonians apply for benefits.

Duplicate IDs create data integrity issues

ODHS estimates there were more than 11,000 duplicate IDs as of March 2026. We processed over 2 million system IDs, from 2020 to 2024, and found only 645 pairs of potential duplicates with associated concurrent capitation payments. This shows that duplicates IDs with concurrent capitation payments are very small. However, system data needs to be accurate and consistent. When a single person has duplicate IDs, accuracy is eroded, creating errors which take time and resources to fix. Duplicate IDs can also cause inaccuracies in federal reporting and create more work for system contractors.

OHA should do more to prevent and detect potential duplicates in a timely manner to ensure accurate federal reporting and prevent overpayments. With the upcoming mandated federal changes, OHA must take steps to reduce improper payments, and the time staff spend on issues that could be mitigated. The agency should develop or improve existing controls to better detect and reduce duplicate IDs.

[2] Since these overpayments were made outside our scope of 2020-2024, we cannot project these errors to the population.
[3] 42 CFR § 433.304
[4] See the OSM starting on page 8 for the methodology of our data analysis.

Upcoming federal changes will increase fiscal and administrative pressure on states

Recent federal legislation made significant changes to programs, including Medicaid. By the end of 2026, many adults who gained coverage under the Affordable Care Act will be required to work or volunteer for at least 80 hours per month or be enrolled in school half time. Or meet it by earning at least 80 times the Federal hourly minimum wage to keep their coverage. Over 40% of Oregon's Medicaid recipients fall under this category, or about 600,000 people. In Oregon, eligibility is currently checked once every two years, but under the new requirements, most recipients will have their eligibility checked once every six months. These increased eligibility checks will put a strain on the state's resources.

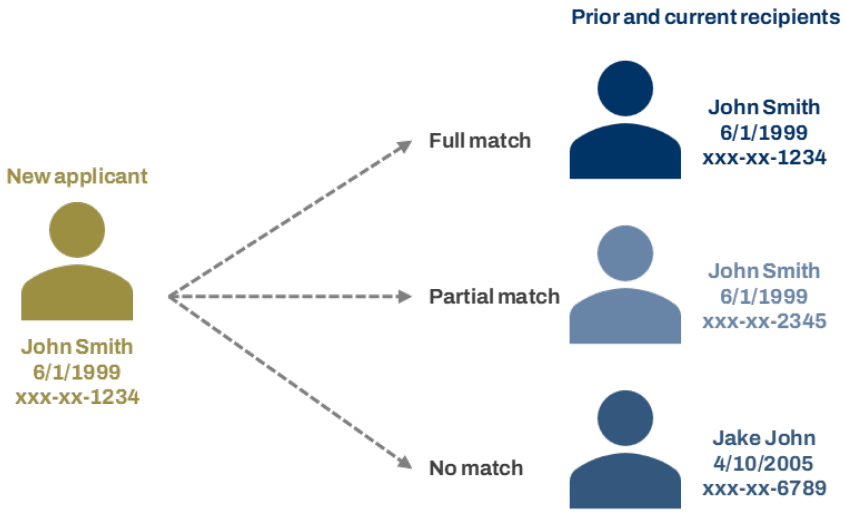
Current controls do not adequately identify duplicate recipients

Eligibility workers help Oregonians apply to many different programs. The system can identify potential duplicates, but adequate worker training is necessary for the system to be effective. Staff have not been adequately trained on how to see if applicants already have a system ID assigned to them. Properly identifying existing recipient IDs is critical to ensuring duplicate capitation payments are not being paid to CCOs.

The system can identify potential duplicates, but still relies on adequate worker training

Before a new case is created in the ONE System by an eligibility worker, a weighted match is performed where information from the new applicant is compared to people already in the system. The match is based on name, SSN, and date of birth. The higher the score, the greater the likelihood those records represent the same person. After this match has occurred, the eligibility worker is notified. If the match is partial, the worker will need to perform additional research, but this is not mandated by the system. This control only works if eligibility workers are adequately trained to research potential matches when the notice appears.

Figure 5: System controls identify full and partial matches



A different matching process is done on an ongoing basis for recipients whose first name, last name, and date of birth match exactly. These matches are researched in various systems, and any IDs that are determined to be duplicates are merged. While this match does identify some duplicates, it is limited. Our testing found slight to moderate variation between the duplicate IDs we tested, which would not be caught by this limited match. Based on these control weaknesses, OHA should design and implement a quality control process to better prevent and detect duplicate IDs.

Eligibility staff lack training to identify existing recipient IDs

There are times where identifying a previous ID can be challenging. For example, if the applicant has changed their name, spells their name differently than they did in the past, has two last names, or the wrong date of birth or SSN is entered by accident. If the prior ID is not identified, a new case could inappropriately be created. Properly identifying previous recipients is critical to ensuring duplicate capitation payments are not being paid to CCOs.

Eligibility workers have not been adequately trained to research applicants in the various systems. Training materials direct workers to look in more than one system to verify that an applicant does not have a prior ID assigned to them. The system used prior to the implementation of ONE is still used for a few small programs and houses recipient information prior to and since ONE's implementation. When a member match is done, ONE uses information stored in its database, along with information stored in the older system to complete the member matching process. This is why workers are directed to check the older system when a partial match is identified.

In this older system, users can't use a mouse and must rely on keyboard commands to navigate numerous screens. Navigation is not intuitive and users often have to flip between multiple screens, as information on a single screen can be limited. The other systems used to research applicants are more modern and can be navigated with a mouse or keyboard but are not consistently used by eligibility workers.

The agency does not provide easily accessible and comprehensive training materials for new employees explaining exactly how workers should conduct their research, like which screens should be checked, what the information on those screens means, and the multiple ways a recipient's name should be searched. Many staff we spoke to believe a significant portion of duplicate IDs could be prevented if better, more comprehensive training was given to eligibility staff. With upcoming requirements for eligibility checks occurring every six months, it is important the people involved with helping Oregonians apply for the program are adequately trained.

Recommendations

To comply with federal regulations, OHA should:

1. Review the other IDs that were not detail tested to determine if they are duplicates and whether overpayments occurred. Along with the tested 31 samples, remit the federal portion of the overpayments back to the federal government.

On recouping overpayments to CCOs, OHA should use the capitation reconciliation process to:

2. Recoup duplicate payments from CCOs.

To better prevent and detect duplicate IDs, OHA should:

3. Provide specific training to eligibility workers on best practices for researching applicants and potential matches.

4. Develop future system enhancements that will reduce the manual research currently performed by eligibility workers.

5. Design and implement a quality control process to better prevent and detect duplicate IDs. Included in this process should be:

    a. A mechanism to identify capitation payments once duplicate IDs are identified; and

    b. Using the established capitation reconciliation process, remit the federal portion of overpayments in compliance with federal regulations once they are identified.

Objective, Scope, and Methodology

OBJECTIVE

Determine whether the Oregon Health Authority (OHA) made duplicate payments for the same recipient at the same time.

SCOPE

We tested potential duplicate Medicaid IDs where concurrent capitation payments were made from 2020 to 2024.

METHODOLOGY

To meet our objective, we performed the following procedures:

- Reviewed state and federal rules related to our audit objective
- Reviewed language related to overpayments and recoupment in the OHA-CCO contracts
- Obtained and reviewed audits from state and federal entities related to duplicate IDs
- Interviewed ODHS/OHA staff
- Sampled and tested 56 pairs of potential duplicate IDs

Data Reliability

We obtained Medicaid data from OHA. This data consisted of capitation payments paid to CCOs, recipient demographic information, and claims from 2020 to 2024. To assess the reliability of the data, we traced a sample of randomly selected records from each data type and compared key fields to information in the originating systems. This provided reasonable assurance that the information we obtained was complete and accurate. Additionally, we performed data verification techniques such as comparing control totals and logic tests.

Sampling

To identify potential duplicate IDs, we performed three different matches on the recipient data:

- Match 1: unique IDs that had the same SSN
- Match 2: first 4 characters of the first name, first 4 characters of the last name, the exact date of birth, and the first 5 numbers/characters of the address
- Match 3: first 4 characters of the first name, first 4 characters of the last name, the exact date of birth, and the exact zip code

After performing the matches, we then joined them to capitation data to identify potential duplicates that had concurrent capitation payments. We then stratified the population into four tiers. From the stratification, we selected a random sample of 56 pairs out of 645 for detailed testing. The sample population was broken down into four unique strata based on match type and dollar amounts. Random samples were pulled from each stratum using a 90% confidence level.

Strata	Range	Number of matches	Population total	Samples tested
Tier 1: SSN match	$300 - $96,000	80	$680,169	8
Tier 2: Demographic match	$400 - $15,000	330	$1,615,751	8
Tier 3: Demographic match	$15,001 - $50,000	202	$5,444,964	27
Tier 4: Demographic match	> $50,000	33	$2,640,337	13
Total		645	$10,381,221	56

Testing

For the samples tested, we reviewed:

- The capitation history before, during, and after the concurrent period to identify any potential overpayments occurring outside the scope of our audit
- Medical claims data during the concurrent period
- Recipient information like case history, demographic information, and applications in the ONE system, MMIS, and the legacy system

After testing, we confirmed the accuracy of our results with the agency. We then projected the errors to the population to get a high-low range using a 95% confidence interval, as seen in the body of the report.

INTERNAL CONTROL REVIEW

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

- Control Environment
  - We considered whether management has demonstrated a commitment to train staff.
- Control activities
  - We considered whether management has designed controls to achieve objectives and respond to risks.
- Information and communication
  - We considered whether management has internally communicated the necessary quality information to achieve objectives.
- Monitoring activities
  - We considered whether management has established and operated monitoring activities to monitor the internal control system and evaluate the results.

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

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

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

We sincerely appreciate the courtesy and cooperation extended by officials and employees of OHA and ODHS during the course of this audit.

Audit team

Andrew Love, CFE, Audit Manager
Kathy Davis, Principal Auditor
Bentley Walker, MSFA, A-CPC, Senior 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 Secretary of State and is independent of other agencies within the Executive, Legislative, and Judicial branches of Oregon government. The Secretary of State has constitutional authority to audit all state officers, agencies, boards and commissions.

September 10, 2026

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

Dear Mr. Bergmann:

This letter provides a written response to the Audits Division's final draft audit report titled Medicaid Duplicate IDs Put Federal Funding at Risk.

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 recipients who had multiple system IDs and concurrent capitation payments made from 2020 to 2024.

Oregon's Medicaid program is built on a foundation of program integrity. Oregon's goal is that all eligible Medicaid members receive the health and human services they need to achieve their optimal health and to ensure federal and state fund stewardship of these resources.

The agency is concerned with the title of the audit report due to the fact that we work diligently through robust, established processes to recover and return monies, as appropriate, under the federal program guidelines. While limited duplicate capitation payments may occur, OHA is committed to correcting any duplication errors and recouping the capitation payments. OHA has a managed care reconciliation team who are constantly working to correct enrollment, reduce the number of duplicate capitation payments, and refund the appropriate funds to the federal government. OHA continues

to cooperate with state and federal oversight initiatives, and the outcomes continue to demonstrate strong state processes and compliance.

Through this audit, we identified opportunities to improve workflows between units and across multiple agencies. OHA has already taken steps to streamline processes and ensure handoffs between the units are seamless.

The audit report estimates OHA made between $232,000 and $4.1 million duplicate capitation payments between 2020 and 2024. In context, the audit report estimates that between 0.0004% to 0.0064% of the $64 Billion in Medicaid program expenditures statewide between 2020 and 2024 may stem from duplicate capitation payments. OHA is dedicated to being a responsible steward of taxpayer dollars. OHA's Managed Care Reconciliation Team maintains strong systems and processes that contribute to such a low percentage of estimated duplicate ID payments and is committed to making further operational improvements to prevent duplicate ID payments in the future.
Below is our detailed response to each recommendation in the audit.

RECOMMENDATION 1 Review the other IDs that were not detail tested to determine if they are duplicates and whether overpayments occurred. Along with the tested 31 samples, remit the federal portion of the overpayments back to the federal government.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and email address of specific point of contact for implementation**
Agree	October 31, 2026	Cheryl Ellison cheryl.a.ellison@oha.oregon.gov

Narrative for Recommendation 1:

OHA agrees with this recommendation and has already begun reviewing the other IDs. The Managed Care Reconciliation Team is updating overlapping enrollment and recouping duplicate capitation payments once the Medicaid IDs have been merged. Some cases may need

additional eligibility review before enrollment and capitation can be aligned between the IDs but we are addressing those workflows in recommendation 5.

RECOMMENDATION 2 Recoup duplicate payments from CCOs.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and email address of specific point of contact for implementation**
Agree	October 31, 2026	Cheryl Ellison cheryl.a.ellison@oha.oregon.gov

Narrative for Recommendation 2:

OHA agrees with this recommendation and has already begun reviewing the other IDs. The Managed Care Reconciliation Team is creating manual adjustments in MMIS to recoup duplicate capitation payments. Manual adjustments can take up to nine (9) days to process and be visible in the capitation history in MMIS. This is an ongoing process that will continue indefinitely.

RECOMMENDATION 3 Provide specific training to eligibility workers on best practices for researching applicants and potential matches.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and email address of specific point of contact for implementation**
Agree	June 30, 2027	Veronica Hillebrand veronica.hillebrand@odhs.oregon.gov

Narrative for Recommendation 3:

OEP (Oregon Eligibility Partnership) has established a workgroup focused on reducing duplicate client records through improved training and guidance. On June 1, 2027, OEP-LET (Oregon Eligibility Partnership Learning and Engagement Team) will add hands-on DHR (system) training

to its OEP-LET curriculum, emphasizing best practices for researching applicants and reviewing potential matches before creating a new record.

RECOMMENDATION 4 Develop future system enhancements that will reduce the manual research currently performed by eligibility workers.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and email address of specific point of contact for implementation**
Agree	December 31, 2028	Veronica Hillebrand veronica.hillebrand@odhs.oregon.gov

Narrative for Recommendation 4:

OEP has developed a future ONE system enhancement, CR 800472, designed to reduce the amount of manual research currently performed by eligibility workers by screening clients before a duplicate case record is created. This enhancement will help streamline workflows and improve data accuracy.

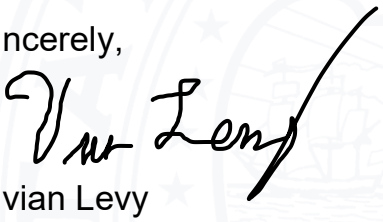
RECOMMENDATION 5 Design and implement a quality control process to better prevent and detect duplicate IDs. Included in this process should be: a) A mechanism to identify capitation payments once duplicate IDs are identified; and b) Using the established capitation reconciliation process, remit the federal portion of overpayments in compliance with federal regulations once they are identified.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and email address of specific point of contact for implementation**
Agree	June 1, 2027	Chet Lundy chet.lundy@odhs.oregon.gov

Narrative for Recommendation 5:

OHA agrees with this recommendation. We already have a process to remit the federal portion of overpayments to ensure compliance with federal regulations. While OHA already has an extensive capitation reconciliation process, there is additional opportunity to improve the quality control process between teams in multiple agencies to better prevent and detect duplicate IDs in the first place. We expect this process to be completed by June 1st, 2027.

For any additional questions, please contact:
April Gillette, Medicaid Strategic Operations & Improvement Director –
april.s.gillette@oha.oregon.gov

Sincerely,



Vivian Levy
Interim Medicaid Director
Oregon Health Authority

EC: Fariborz Pakseresht, Interim Director, OHA
Kris Kautz, Deputy Director for Administration, OHA
Rochelle Layton, Chief Financial Officer, OHA
Emma Sandoe, Medicaid Director, OHA

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Secretary of State

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