



# THE OHIO DEPARTMENT OF MEDICAID

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# PROGRAM INTEGRITY REPORT 2015

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# Introduction

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*Medicaid is a state and federally funded insurer providing medically necessary services to low-income children, pregnant women, parents, older adults and those with disabilities. During state fiscal year 2015, Ohio Medicaid served on average 2.96 million eligible Ohioans per month. Ohio's total Medicaid expenditures were \$23.5 billion (state and federal funds) during state fiscal year 2015.*

*The Ohio Department of Medicaid (ODM) is the single state agency charged with administering Ohio's Medicaid program, and is responsible for minimizing fraud, waste and abuse in the Medicaid program. The State is required to report fraud and abuse to the U.S. Department of Health and Human Services (HHS) and must also have a method to verify whether services reimbursed by Medicaid were actually provided to beneficiaries.*

## The Code of Federal Regulations (CFR) outlines requirements for Medicaid program integrity, including:

**42 CFR 455.12** - requires the Medicaid state plan to include provisions for program integrity;

**42 CFR 455.13 through 455.212** - set forth requirements for a state fraud detection and investigation program, including methods for identifying, investigating and referral of suspected fraudulent activity, reporting to the federal government, and cooperation with the state Attorney General's Medicaid Fraud Control Unit;

**42 CFR 455.23** - requires the department to withhold payments from a Medicaid provider in instances where there is a known investigation of a credible allegation of fraud involving that provider; and

**42 CFR 455.400 through 455.470** - require the state to screen applicants to be a Medicaid provider and to re-enroll and screen existing Medicaid providers every five years to verify that the applicant or provider is properly licensed, has been subjected to the proper federal database and criminal records checks according to the risk level associated with that type of Medicaid provider, and that identifying and contact information are accurate.

## Additional federal requirements include, but are not limited to:

**42 CFR 456:** sets forth requirements for utilization control (safeguards against unnecessary or inappropriate use of Medicaid services and excess payments);

**42 CFR 456.3:** mandates implementation of a statewide Surveillance Utilization Review (SUR) function;

**45 CFR 92.26:** requires pass-through entities such as ODM to comply with the requirements of the Office of Management and Budget (OMB) Circular A-133, Audits of States, Local Governments and Non-Profit Organizations, including monitoring of sub-recipients to provide assurance that Medicaid funds are used for

authorized purposes and in compliance with federal and state laws and the provisions of contracts and sub grant agreements;

**42 CFR 431.810 and 431.812:** require states to operate a Medicaid Eligibility Quality Control (MEQC) program; and

**42 CFR 431.978 and 431.980:** require states to conduct Payment Error Rate Measurement (PERM) reviews.

**Section 5162.132** of the Ohio Revised Code requires ODM prepare an annual report on the department's efforts to minimize fraud, waste and abuse in the Medicaid program. This report serves to address that requirement using a calendar year reporting period.

## Overview

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*ODM created the Bureau of Program Integrity in late 2014. The newly-established bureau was designed to coordinate activities across ODM business units and external stakeholders in order to better detect fraud, waste and abuse. Program Integrity also supports internal and external preventions efforts, including cost containment, compliance and quality of care. This comprehensive approach recognizes that there is one Medicaid program, regardless of the form it takes in delivering services. We are all responsible for ensuring program integrity as part of our everyday work, and we each have a role in the fight against fraud, waste and abuse.*

*Therefore, while Program Integrity is a functioning business unit, program integrity is the continuum of activities carried out to safeguard Ohio's Medicaid program and those it serves. These activities include provider enrollment and support, automated system controls, pre-payment review, post-payment review, contract management, participant eligibility testing, sub-recipient monitoring, staff training, and more. ODM monitors its providers, sub-recipient network, and managed care plans to better regulate program integrity risk, promote compliance, and provide technical assistance and training throughout Ohio's Medicaid system.*

*Key stakeholders in Ohio Medicaid's program integrity continuum include ODM business units and staff, Ohio's Attorney General and Auditor of State, several state agencies (the Ohio Departments of Aging, Mental Health and Addiction Services, Developmental Disabilities, Health, and Education), healthcare-related boards, the managed care plans, county departments of job and family services (CDJFS), and the federal government. Ohio Medicaid also coordinates with other states.*

**Program integrity activities occur across all aspects of the Medicaid program and include such efforts as:**

- » determining whether providers are billing properly;
- » conducting unannounced pre- and post-enrollment provider site visits;
- » performing onsite provider reviews and audits;
- » suspending and/or terminating providers for program violations;

- » reimbursing providers in accordance with established policies;
- » conducting provider post-payment reviews and audits to identify and collect over-payments and also identify possible utilization issues;
- » enrolling providers and consumers into the program promptly and accurately;
- » ensuring the reliability of databases used for determining reimbursement rates;
- » educating providers and consumers on their responsibilities and rights;
- » responding to provider and consumer questions effectively and promptly;
- » maintaining appropriate documentation of policies, procedures and systems;
- » coordinating program integrity related policies and procedures;
- » monitoring the utilization and quality of care by providers and consumers;
- » identifying and analyzing possible cases of fraud, waste and abuse; and
- » referring possible cases of fraud to the proper authorities to investigate and prosecute when deemed appropriate.

## Provider Enrollment & Support

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*Ohio's Medicaid program employs a multi-faceted approach to ensure Medicaid providers are paid correctly and appropriately. Beginning with provider enrollment and continuing through to payment, ODM utilizes a variety of methods to promote program integrity.*

*42 CFR 455.432 requires that state Medicaid agencies conduct on-site visits of provider types that have been identified as being at a heightened level of risk for fraud, waste, and abuse. These visits are to take place both before and after enrollment into the Medicaid program. Ohio Medicaid contracts with Public Consulting Group (PCG) to conduct unannounced site visits on behalf of the department. PCG completed 397 site visits in 2015. As a result of these visits, six agencies were terminated, 19 applications were either denied or withdrawn, and five referrals were made to the Medicaid Fraud Control Unit for criminal investigation.*

### Provider Enrollment

ODM is responsible for screening all applicants to Ohio's Medicaid provider network, including hospitals, individual providers and other organizational providers. The process begins with the submission of an online application.

ODM Provider Enrollment has built system interfaces with various federal databases (e.g., System for Award Management Exclusion Database, Medicare Exclusion Database, and the Social Security Administration Death Master File) and State of Ohio exclusion databases (e.g., Auditor of State Department of Developmental Disabilities Abuser Registry) and the National Plan and Provider Enumeration System. Applicants, disclosed owners and/or individuals with controlling interest in the provider are screened against these resources upon submission of the application to determine if they are excluded from receiving federal funding for various program integrity reasons.

In addition to completing the above screenings, Provider Enrollment staff review applications and other supporting documentation to verify licensure requirements or other required certifications based on the provider type. When applications are incomplete, applicants are contacted in writing to obtain the needed information or supporting documentation. Once applicants are able to demonstrate they meet all applicable requirements for their provider type, enrollment is completed and providers are issued a welcome letter with their new seven digit Medicaid number.

As an ongoing program integrity initiative, the entire provider master file is compared to the federal System for Award Management Exclusion Database and the Medicare Exclusion Database monthly to ensure providers who have been terminated and excluded in other states for either Medicaid/Medicare fraud or other disqualifying reasons are also terminated in Ohio. Additionally, Ohio submits all terminations and exclusions that are initiated in Ohio to a national database for inclusion in the federal exclusion databases.

*As of January 2016, Ohio has revalidated 24,161 providers, which includes a complete re-screening of the provider.*

Ohio's full implementation of five-year time limited agreements and revalidation of all provider agreements started in July 2013. As of January 2016, Ohio has revalidated 24,161 providers, which includes a complete re-screening of each provider.

During 2015, ODM also fully implemented the federal requirement of enrolling Ordering, Referring and Prescribing providers as Ohio Medicaid providers. This program integrity initiative identifies the provider who orders, refers or prescribes on a billing provider's claim. ODM has enrolled approximately 6,000 providers for this purpose.

As an additional program integrity effort, compliance staff in the Network Management Bureau review monthly actions taken by professional licensing boards (as available on public resources such as their respective websites) to determine if any Ohio Medicaid providers have been disciplined by their professional licensing boards. Compliance staff members interact with the AG's Medicaid Fraud Control Unit (MFCU) daily to share information and coordinate efforts around various program integrity initiatives.

## Provider Education & Resources

In 2015, the Ohio Department of Medicaid led 20 Basic Billing training sessions, presented at over 37 seminars and conferences, and conducted 70 provider consultations. Consultations are one-on-one provider meetings intended to assist with each provider's unique issues. These activities serve to enhance communication, minimize billing issues, and strengthen provider relations. In addition to provider training, ODM also includes resources for providers on its website, such as billing instructions, Medicaid rules, and enrollment information.

## Web Portal

The Web portal supports Medicaid providers in a variety of ways. Providers are able to utilize the portal to view a reader-friendly version of their remittance advices online. Providers are also able to submit claims via the Web portal. Claims submitted through the portal are adjudicated more quickly, and providers may search the portal for the status of submitted claims. Approximately 3 million claims were submitted through the Web portal from January 1, 2015 through December 31, 2015, resulting in payments of nearly \$960 million.

Providers are also able to research Medicaid beneficiary eligibility via the portal. This enables providers to know immediately whether an individual is enrolled in Medicaid, obtain any third-party insurance information the agency may have on the individual, and receive the information regarding the individual's Medicaid program category. From January 1, 2015 through December 31, 2015, providers submitted over 24 million eligibility inquiries through the Web portal.

## Automated System Controls

Computer information systems are used to process applications for eligibility and provider claims for payment, and to verify and update third-party insurance coverage. Edits have been put in place to act as controls to the various systems and help reduce errors.

## Medicaid Information Technology System (MITS)

MITS is Ohio's claims processing system. During the adjudication cycle and prior to payment, claims are reviewed to ensure completeness and accuracy of submitted data, verify eligibility and determine proper payment amounts. There are a variety of edits in place to accomplish these objectives, and they are programmed into the system based upon Medicaid coverage and payment policies for health care systems.

A series of system edits is performed daily to prevent payment of duplicate claims. Exact duplicate edits are set up for those situations in which Medicaid regulations only permit a provider to be paid for rendering one service to a beneficiary on a specific date or dates. Potential duplicate of conflict edits are used for unique situations in which Medicaid may permit payment of two claims to be a provider for treating the same individual on a date of service. Sometimes edits are used to flag or "mark" claims in the system. Marker edits can be used for many reasons, including research and analysis purposes, to more easily identify claims affected by certain policy changes, to drive payment or pricing logic, or to create reports used in operational areas.

## Public Assistance Reporting Information System (PARIS)

PARIS is a computer matching system through which social security numbers of public assistance beneficiaries are matched against various federal income and state agency public assistance databases. Matching is done to identify individuals receiving public assistance who may not have reported income accurately during eligibility determinations, to locate people who owe money to states due to the over-issuance of benefits, and to identify people receiving concurrent benefits from multiple states.

The PARIS matching process is managed by the HHS Administration for Children and Families (ACF). The ACF provides states participating in PARIS with pension and compensation information from the U.S. Department of Veteran Affairs, income information for civilian and military employees from the U.S. Department of Defense and Office of Personnel Management, information on interstate public assistance benefit payments (e.g., Temporary Assistance to Needy Families (TANF), Food Assistance and Medicaid programs), and Workers' Compensation data from participating states.

*January 1 - December 31, 2015: \$960 million payments made based on approximately 3 million claims submitted through MITS.*

## Income and Eligibility Verification System (IEVS)

Ohio operates the IEVS as required by 42 USC 1320b-7(b). IEVS is a computerized system that matches the social security numbers of individuals receiving public assistance to other provider databases, including those of the Social Security Administration, Internal Revenue Service, State Wage Information Collection Agency, and Unemployment Compensation. When a match with any of these databases occurs, the information is returned to the state, which generates an electronic alert to the county eligibility worker responsible for the case. The county eligibility worker is required to determine whether the new match information affects the amount of benefits the individual or family is receiving and adjust the benefits accordingly.

## Pre-Payment Review

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*The ideal time to discover an inappropriate Medicaid claim is before payment is made. Therefore, pre-payment screenings are performed on claims submitted by providers.*

### Limit Parameters within MITS

MITS has a Reference subsystem that contains the reimbursable amounts for all procedure, drug and diagnostic codes. When a claim is submitted by a provider for reimbursement, MITS automatically checks the Reference subsystem and calculates the allowed amount for each claim. MITS has system edits that help prohibit billed amounts from exceeding the allowed reimbursable amounts.

There are also additional utilization and review edits programmed into MITS. These edits include quantity or dollar limits placed on certain codes to prohibit a provider from receiving more than the Medicaid thresholds, as well as edits that require certain conditions to be in place for a claim to be paid (e.g., a labor and delivery claim would not be paid for a male beneficiary).

### Pharmacy Point-of-Sale

The pharmacy benefit administrator, Xerox, performs a prospective drug utilization review during point-of-sale (real-time) claims adjudication. This prospective review includes screening for therapeutic duplication, overuse and drug interactions. Claims may be denied if the prescription exceeds established limits, including refilling too soon.

### Third-Party Liability Cost Avoidance

Cost avoidance occurs when a provider of services bills and collects a claim from a liable third party before sending the claim to Medicaid. The Cost Avoidance Unit (CAU) within ODM updates records to reflect Medicare and health insurance coverage in the Medicaid payment system so liable third parties are billed first. This activity generated approximately \$832 million in savings in calendar year 2015.

*In calendar year 2015, Ohio Medicaid's third party liability collection vendor made \$66 million in collections.*

The CAU cannot always identify all liable third parties upfront because eligibility for commercial insurance coverage or Medicare may be retroactively granted, or because the unit has missing or incorrect information regarding an individual's insurance carrier. In these instances, the third party insurance information is not available until post-payment. For these claims, Ohio Medicaid uses a

contracted vendor to conduct third-party liability (TPL) collection activities. This vendor collected \$66 million in calendar year 2015.

## Prior Authorization

Prior authorization is the approval a provider must obtain before providing certain services, equipment and supplies in order to be reimbursed under Medicaid. The prior authorization process addresses medical necessity as well as cost containment.

In 2015, ODM received prior authorization requests for 171,638 items at a potential cost of \$244.4 million. Ohio Medicaid approved 131,391 items at a cost of \$93.2 million dollars. ODM saved \$151.1 million because of the prior authorization process.

*In 2015, Ohio Medicaid received 171,638 requests for prior authorization. Of those, 131,391 were approved, saving the agency over \$150 million.*

## Post-Payment Review

*If waste and abuse are suspected or apparent, ODM takes action to ensure compliance and recoup inappropriate payments through audits and reviews in accordance with rule 5160:1-27 or 5160:26-06 of the Ohio Administrative Code. Where fraud is suspected, ODM refers the case to the Ohio AG's MFCU for further investigation.*

## ODM-Administered Waivers

Individuals enrolled in ODM-administered waiver programs receive a variety of home care services that are managed through three contracted case management agencies. Case management services include needs assessment, service planning, and care coordination.

*PCG conducted 6,800 reviews of non-agency waiver services providers. 2,299 potential overpayments totaling just over \$6.1 million were referred to Ohio Medicaid for recovery.*

ODM contracts with the Public Consulting Group (PCG) to complete incident investigations, provider enrollment, provider oversight, and provider on-site reviews. PCG conducted 4,315 reviews of non-agency aide and 2,485 reviews of non-agency nursing providers of waiver services between January 2015 and December 2015. These reviews were used to identify issues that violated program rules and to educate providers about rule requirements. PCG and ODM worked with providers to address identified issues.

Issues that continued after being addressed resulted in further action, which could include provider sanctions and/or termination. Reviews are also used to uncover evidence of possible overpayments. For routine overpayments associated with billing errors, PCG referred information to ODM for potential collection. These efforts led to the referral of 2,299 potential overpayments, totaling just over \$6.1 million, to Ohio Medicaid for recovery.

Further, ODM requires all non-agency waiver providers to submit an annual criminal history report completed by the Bureau of Criminal Identification and Investigation. In 2015, 1,080 providers were terminated for non-compliance with this requirement.

As an additional program integrity measure, ODM holds bi-weekly meetings with PCG, the Ohio AG's MFCU, sister-state agencies and managed care companies to review potential fraud related to ODM-administered waivers. These meetings resulted in 215 referrals to MFCU against potentially fraudulent providers.

## Surveillance & Utilization Review

The ODM Surveillance and Utilization Review Section (SURS) is charged with helping the agency detect Medicaid fraud, waste and abuse. Various methods of audit and review are applied in cases of suspected waste and abuse. In 2015, 482 provider reviews were conducted and identified over-payment of \$9.68 million.

During the course of normal operations, Medicaid providers sometimes discover instances when they were overpaid by the Medicaid program. When this occurs, providers contact the department with the overpayment information and remit payment. Providers conducted 55 self-reviews in 2015 to remit \$2.52 million in over-payments.

*During calendar year 2015 providers conducted 55 self-reviews, for total over-payment of \$2.52 million.*

When SURS receives a complaint regarding potential Medicaid fraud or identifies any questionable practices, it conducts a preliminary review to determine the appropriate course of action. If the results of the review give SURS reason to believe that an incident of fraud has occurred in the Medicaid program, SURS refers the case to MFCU. MFCU conducts a statewide program to investigate and prosecute (or refer for prosecution) violations of all applicable state laws pertaining to fraud in the

administration of the Medicaid program, the provision of medical assistance, or the activities of providers of medical assistance under the State Medicaid plan.

SURS refers all cases of suspected provider fraud to MFCU, as mandated by 42 CFR 455.21(a) (l). As needed, SURS supports MFCU by providing copies of records and access to computerized data and provider information it has collected, while protecting the privacy rights of individuals receiving Medicaid benefits. SURS also accepts referrals from MFCU to initiate any available administrative or judicial action to recover improper payments made to providers. Throughout 2015, regular meetings were held between ODM, MFCU, the Auditor of State (AOS) and other program integrity partners to discuss procedures, potential areas of risk and other relevant investigatory information.

## Medicaid Fraud Control Unit: Office of the Ohio Attorney General

Attorney General DeWine's Medicaid Fraud Control Unit (MFCU) ranked first in criminal indictments and second in criminal convictions among all units nationwide in federal fiscal year 2014, the most recent statistics available. The unit processed 1,289 complaints in calendar year 2015, posting 150 indictments, 144 convictions, and 15 civil settlements. Recoveries totaled \$32.7 million.

## Program Integrity Group

The Ohio Medicaid Program Integrity Group (PIG) brings together representatives from ODM, the Auditor of State's Office, and the Office of the Ohio Attorney General to craft data mining algorithms designed to identify fraudulent Medicaid providers and plan a coordinated response to these findings.

## Cost Report Audits

ODM, as the single state Medicaid agency, is required under 42 CFR 447.202 to have a system in place to assure appropriate audits of Medicaid payments if they are cost-based. Cost-based systems require Medicaid providers to submit cost reports detailing the actual administrative and direct service costs they incur to run their programs. ODM currently monitors the following cost report types as submitted by Medicaid providers:

- » Developmental Centers: associated with the Ohio Department of Developmental Disabilities;
- » PASSPORT: associated with the Ohio Department of Aging;
- » Nursing Facilities (NFs); and
- » Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)

*During 2015, ODM issued 1,477 final adjudication orders and nursing home overpayment reports resulting in the identification of \$26 million recoveries due to the state.*

Based on state rule, ODM utilizes a risk-based approach to audit Developmental Center and PASSPORT agency cost reports at least once every three years. The majority of Medicaid audit resources for calendar year 2015 were used for the SURS monitoring of Medicaid providers and for monitoring of NFs and ICFs/IID. During 2015, ODM issued 1,477 final adjudication orders (FAOs) and nursing home overpayment reports to NFs and ICFs/IID for overpayment due to the state. These FAOs resulted in identified recoveries of \$26 million due to the state.

In 2015, FAOs increased by 127% and identified recoveries increased by 174% over 2014 results. LTC-related cash collections, which includes certain overpayments identified in 2015 and those from prior periods, increased by about 55% from just over \$12.6 to about \$19.6 million.

## The Ohio Auditor of State (AOS)

The AOS audits Medicaid providers under Section 117.10 of the Ohio Revised Code. Under a letter of arrangement with ODM, the AOS issued 21 reports with findings and interest totaling approximately \$2.5 million in calendar year 2015.

# Contract Management

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*Proper contract management ensures that ODM contract deliverables are met. Each agreement has a contract manager who examines invoices, receives deliverables and corresponds with the entity if questions arise.*

## Inpatient Hospital Review Contract

Permedion is an ODM contractor that performs retrospective reviews primarily focused on inpatient hospital care. These reviews determine whether the care provided meets medical necessity and quality care standards. The hospitals that are the subject of a review may appeal findings to Permedion; if the finding is upheld at that level, the provider may request a review by SURS. In SFY 2015, Permedion reviewed 16,662 inpatient cases that resulted in denials and/or adjustments to 6,133 claims for a savings of \$39.4 million. Permedion also completed 1,372 outpatient reviews that resulted in 497 cases being denied for using incorrect coding for a savings of \$1.3 million.

Permedion also performs pre-certifications and prior authorizations for certain inpatient medical procedures. Pre-certification requires hospitals to obtain approval for procedures to be performed in an inpatient hospital setting that are normally performed in an outpatient setting. Prior authorization requires hospitals to obtain approval for a procedure that is normally not covered by the Medicaid program. Permedion receives about 150 pre-certification and prior authorization requests per month. In SFY 2015, Permedion completed 1,799 reviews that resulted in 56 denials and a cost savings of \$491,593.

In addition, Permedion performs special reviews to determine the medical necessity of services not covered and studies that support higher standards of health care, quality and access to individuals served by the Ohio Medicaid program.

## Managed Care

Ohio Medicaid incorporates a robust program integrity component in its managed care program. Managed care and MyCare Ohio health plans must comply with all applicable state and federal program integrity requirements in addition to requirements contained in the provider agreements. Ohio Medicaid's managed care plans (MCPs) and MyCare Ohio plans (MCOPs) are required to engage in the following program integrity activities:

- » Implementation of a documented fraud and abuse compliance program that includes administrative and management arrangements to guard against fraud and abuse. The compliance plan must designate staff responsibility for plan administration., It also must include clear goals and timelines for employee education and distribution of policies to all key contractors and agents, and an evaluation component to measure effectiveness;
- » Employee education about false claims recovery, rights of whistleblowers and policies for any health plan contractors and agents regarding false claims recovery;
- » Monitoring for embezzlement or theft, underutilization of services, and claims submission and billing;
- » Submission of an annual report summarizing fraud and abuse activity for the previous year and identification of any proposed changes in the coming year;

- » Prompt reporting of all instances of fraud and abuse;
- » Active monitoring for prohibited affiliations;
- » Disclosure to ODM of ownership and control information for the MCP;
- » Disclosure of information of persons convicted of crimes in accordance with 42 CFR 455.106;
- » Notification to ODM when an MCP denies credentialing to a provider for program integrity reasons;
- » Submission of statements to ODM certifying the accuracy, completeness and truthfulness of data that may affect MCP payment; and
- » Mailing Explanation of Benefits statements to a sample of consumers.

All MCP and MCOP reports of alleged fraud and abuse are shared with Ohio Medicaid's Program Integrity Bureau, Provider Network Management Bureau, Long Term Care Services and Supports Bureau and is communicated through Ohio Medicaid Program Integrity meetings to fee-for-service program staff and the Ohio AG's MFCU.

Quarterly Managed Care Program Integrity Group meetings are held to educate and train health plan compliance staff, and share information concerning fraud, waste and abuse among law enforcement and the health plans. The quarterly meetings include program integrity staff from the MCPs, ODM, MFCU, and AOS. These meetings assist the health plans in pro-actively identifying and dealing with potential provider fraud and abuse issues.

## Participant Eligibility Testing

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*Determining an individual's Medicaid eligibility is the first step toward connecting prospective beneficiaries to coordinated health care coverage. In many ways, successful program integrity begins by ensuring that Medicaid benefits are only extended to those individuals who qualify for them.*

### Medicaid Eligibility Quality Control Reviews

42 CFR 431.810 and 431.812 require states to conduct Medicaid Eligibility Quality Control (MEQC) reviews of active Medicaid cases each month to determine if beneficiaries were eligible for services during the month under review. States are also required to sample and review negative actions, such as case denials or terminations, monthly to determine whether the reason for the action was correct.

The MEQC reviews conducted by ODM consist of a review of the County Department of Job and Family Services (CDJFS) case record and an investigation to verify income, resources and other factors of eligibility. The error findings from these pilot reviews are reported to each CDJFS as they are identified and to CMS on a semi-annual basis. The report to CMS identifies all types of Medicaid eligibility errors and the corrective actions taken by ODM (e.g., training and technical assistance to county job and family service agencies) to address error findings from the review.

## County Support

ODM offers training to CDJFS staff through statewide video conferences. Agenda items are based on findings from various review activities (MEQC reviews, the OMB Circular A-133 audit of the state of Ohio, and CMS program reviews), questions submitted to the technical assistance unit, and suggestions from CDJFS and ODM component units. Updates to administrative rules for Medicaid eligibility, as well as changes to specific eligibility system screens as a result of the changes, are also discussed during the videoconferences. CDJFS agencies may request individualized videoconference training to meet their specific training needs. In calendar year 2015, 55 training sessions were conducted with counties.

Additionally, ODM issues a monthly online newsletter for CDJFS workers, creates desk aids to assist in the implementation of new eligibility policy, and operates a technical assistance mailbox to respond to inquiries from CDJFS staff regarding Medicaid eligibility policy and case processing. In calendar year 2015, ODM staff responded to 4,284 technical assistance questions from counties.

To identify additional county needs, ODM uses the Business Intelligence Channel reporting system to identify potential issues with eligibility determinations. ODM staff review cases for appropriate case processing and eligibility determinations made by CDJFS staff and contact the agencies to assist in correcting cases when necessary.

## Sub-Recipient Monitoring

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*Monitoring sub-recipients is required under 2 CFR 200 and includes review of current work performed by sub-recipients and the resolution of any required audits.*

### County Monitoring

The Ohio Department of Job and Family Services (ODJFS) audit staff conduct county sub-recipient monitoring on behalf of ODM. ODJFS reviews of counties are risk-based and generally cover compliance testing and internal control. A technical assistance report, summarizing issues identified and corrective action plans, is issued after each review. These reports are provided to help improve processes and internal controls.

As part of this testing, the ODM protocol includes review of cost allocation for administrative costs claimed to Medicaid, consideration and possible review of direct charge Medicaid claims, and a review of the county Non-Emergency Transportation program for procurement, accounting, and program compliance as well as consideration of the related internal control structures. Any open AOS County Single Audit findings related to Medicaid receive follow up to determine if the issues have been resolved as part of the planning and risk assessment process.

*ODM conducted 55 county training sessions and responded to 4,284 technical assistance questions.*

## Sister State Agency Monitoring

Sub-recipient state agencies receiving Medicaid funding passed through from ODM are subject to monitoring reviews conducted on a risk-based approach by the ODM Bureau of Program Integrity (BPI). Monitoring reviews help provide reasonable assurance that sub-recipient state agencies are compliant with key federal and state regulations governing Ohio's Medicaid program. The overall objective is to ensure Medicaid program and fiscal operations across the Medicaid network are operating efficiently and effectively and include program integrity processes and controls. Monitoring represents a host of activities, including the provision of technical assistance in coordination with fiscal, policy and operations stakeholders.

BPI staff participated in regularly occurring activities in 2015 to help ODM monitor and support sister state agency activities such as performing a risk assessment and review of claimed costs, supporting provider enrollments & suspensions, managing fraud and abuse referrals, reviewing AOS audit work performed for DODD, and coordinating and reviewing AOS audits of Medicaid providers operating in the sister state agency portion of the network. In addition, BPI staff provided technical assistance to:

- » update the ODE Medicaid School Program cost report and audit procedures,
- » clarify the eligibility of transportation costs claimed by DODD local boards,
- » review and approve a local Passport agency indirect cost plan with ODA,
- » support policy changes for the redesign of ODMHAS behavioral health services,
- » update policy and procedures to support the ODH lead programs, and
- » improve the home health fraud referral process used by sister state agencies.

BPI effort related to sister state agencies is designed to not only monitor compliance, but also to prevent and detect fraud, waste and abuse and promote quality of care for individuals served by the Medicaid program.

## Training for Program Integrity Staff

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### Medicaid Integrity Institute

In September 2007, the CMS Medicaid Integrity Group established the Medicaid Integrity Institute (MII), the first national Medicaid program integrity training program. The mission of the MII is to provide effective training tailored to meet the ongoing needs of state Medicaid program integrity employees, with the goal of raising national program integrity performance standards and professionalism. ODM employees are regularly nominated and accepted to participate in the training program, which focuses on developing a comprehensive program of study addressing aspects of Medicaid program integrity, including fraud investigation, data mining and analysis, and case development. Training at the MII is provided at no cost to the states.

## Conclusion

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*The Ohio Department of Medicaid is continually adapting and improving its efforts to combat fraud, waste, and abuse in the Ohio Medicaid program through a complex and comprehensive collaboration of federal, state, local, and private entities in the health care industry. Cooperative, multi-faceted actions in prevention, detection, and recovery are critical to maintaining essential services in a cost effective and efficient program.*

# Acronyms

ACF	Administration for Children and Families
AG	Ohio Attorney General
AOS	Ohio Auditor of State
BAP	Bureau of Audit Performance
CAU	Cost Avoidance Unit
CDJFS	County Department of Job and Family Services
CFR	Code of Federal Regulations
CGI	Consultants to Government and Industry
CMS	Centers for Medicare and Medicaid Services
DODD	Department of Developmental Disabilities
FAO	Final Adjudication Order
FFY	Federal Fiscal Year
HHS	U.S. Department of Health and Human Services
ICFs/IIDs	Intermediate Care Facilities for Individuals with Intellectual Disabilities
IEVS	Income Eligibility and Verification System
ISTV	Intra-State Transfer Vouchers
MCP	Managed Care Plan
MEQC	Medicaid Eligibility Quality Control
MFCU	Medicaid Fraud Control Unit
MII	Medicaid Integrity Institute
MITS	Medicaid Information Technology System
NFs	Nursing Facilities
ODA	Ohio Department of Aging
ODH	Ohio Department of Health
ODJFS	Ohio Department of Job and Family Services
ODM	Ohio Department of Medicaid
ODMHAS	Ohio Department of Mental Health and Addiction Services
OMB	U.S. Office of Management and Budget
PARIS	Public Assistance Reporting Information System
PASSPORT	Pre-Admission Screening System Providing Options & Resources Today
PCG	Public Consulting Group
PERM	Payment Error Rate Measurement
PIG	Program Integrity Group
SURS	Surveillance and Utilization Review Section
TANF	Temporary Assistance to Needy Families
TPL	Third-Party Liability