THE OHIO DEPARTMENT OF MEDICAID

JOHN R. KASICH, GOVERNOR JOHN B. McCARTHY, DIRECTOR

PROGRAM INTEGRITY REPORT

2014

Table of Contents

Introduction

Medicaid is a state and federally funded health plan providing medically necessary services to low-income children, pregnant women, parents, older adults and those with disabilities. During state fiscal year 2014, Ohio Medicaid served on average 2.5 million eligible Ohioans per month. Ohio's total Medicaid expenditures were $21 billion (state and federal funds) during state fiscal year 2014.

The Ohio Department of Medicaid (ODM) is the single state agency charged with administering Ohio's Medicaid program, and has the responsibility 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 furnished to consumers.

Federal requirements for Medicaid program integrity are set forth in the Code of Federal Regulations (CFR). Basic requirements include the following:

42 CFR 455.12, which requires the state Medicaid plan to include provisions for program integrity;

42 CFR 455.13 through 455.212, which 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, which 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, which 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, which sets forth requirements for utilization control (safeguards against unnecessary or inappropriate use of Medicaid services and excess payments);

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

45 CFR 92.26, which requires pass-through entities such as ODM to comply with the requirements of the Office of Management and Budget (OMB) Circular A-l33, 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, which require states to operate a Medicaid Eligibility Quality Control (MEQC) program; and

42 CFR 431.978 and 431.980, which 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

For Ohio's Medicaid program, the concept of program integrity refers to a continuum of activities that include provider enrollment and support, automated system controls, pre-payment review, post-payment review, contract management, participant eligibility testing, sub-recipient monitoring, and staff training to detect fraud, waste and abuse. Included within sub-recipient monitoring are examinations to determine whether entities receiving funding through ODM are conducting adequate monitoring of their sub-recipients and of any Medicaid disbursements.

The continuum includes efforts individually as well as collectively of those in many state agencies (ODM, the Ohio Departments of Aging, Mental Health and Addiction Services, Developmental Disabilities, Health, and Education), the Auditor of State (AOS), the Attorney General (AG), county departments of job and family services (CDJFS), and the federal government.

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 site visits of providers;
- Performing onsite reviews and audits of providers;
- Suspending and/or terminating providers for program violations;
- Reimbursing providers in accordance with established policies;
- Enrolling providers and consumers into the program in a timely and accurate manner;
- 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 timely;
- Maintaining appropriate documentation of policies, procedures and systems;
- Monitoring the utilization and quality of care by providers and consumers;
- Identifying and analyzing possible cases of fraud, waste and abuse;
- Conducting provider post-payment reviews to detect possible weaknesses within the existing payment system and to identify and collect over-payments; and
- Referring possible cases of fraud to the proper authorities to investigate and prosecute when deemed appropriate.

Provider Enrollment & Support

Ohio's Medicaid program employs a multifaceted 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 pre- and post-enrollment into the Medicaid program. In 2014, Ohio Medicaid contracted with Public Consulting Group (PCG) to conduct unannounced site visits on behalf of the department. PCG completed 298 site visits in 2014. As a result of these visits, 13 agencies were either deactivated or terminated, six applications were either denied or withdrawn, and 18 referrals were made to the Medicaid Fraud Control Unit for investigation.

Provider Enrollment

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

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 and 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 on a monthly basis 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.

Ohio's full implementation of five-year time limited agreements and revalidation of all provider agreements started in July 2013. As of January 2015, Ohio has revalidated 10,617 providers, which includes a complete re-screening of the provider. In July 2013, the ODM implemented an edit in the Medicaid Information Technology System (MITS) to terminate providers who do not submit claims within a consecutive 24-month period. This edit is a way of managing the provider master file and keeping it current with only active providers. At initial implementation, the edit found and de-activated 12,911 providers who had not submitted claims to Ohio Medicaid for 24 months or longer. This edit now runs on a daily basis.

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) on a daily basis to share information and coordinate efforts around various program integrity initiatives.

As of January 2015, Ohio has revalidated 10,617 providers, which includes a complete re-screening of the provider.

Provider Education & Resources

In 2014, the Ohio Department of Medicaid conducted 20 Basic Billing training sessions, presented at over 28 seminars and conferences, and conducted 73 provider consultations. Consultations are one-on-one provider meetings intended to assist with each provider's unique issues. These activities served to enhance communication, minimize billing issues, and strengthen provider relations. In addition to provider training, the Ohio Department of Medicaid also includes information targeted to providers on its website including billing instructions, Medicaid rules, and enrollment information.

Web Portal

The Web portal supports Medicaid providers in a variety of ways. For example, providers are able to utilize the portal to view a reader-friendly version of their remittance advices on line. 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 MITS Web portal from January 1, 2014 through December 31, 2014, resulting in payments of nearly $996 million.

Providers are also able to research Medicaid consumer eligibility via the portal. This enables providers to know immediately whether a consumer is enrolled in Medicaid, obtain any third-party insurance information the agency may have on the consumer, and receive the information regarding the consumer's Medicaid program category. From January 1, 2014 through December 31, 2014, providers submitted 22 million eligibility inquiries through the MITS Web portal.

January 1 - December 31, 2014: $996 million payments made based on approximately 3 million claims submitted through MITS.

CyberAccess

ODM contracts with Xerox, the pharmacy benefit administrator, to provide online access for Medicaid providers to view the fee-for-service pharmacy claims history for their patients. This enables providers to identify care management concerns, including potential overuse, abuse or "doctor shopping" behavior. This system, called CyberAccess, also allows a prescriber to generate an electronic prescription after verifying Medicaid coverage.

Automated System Controls

Computer information systems are used to process consumer 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 to 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 consumer 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.

For example, 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 consumer 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 consumer 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 consumers are matched against various federal income and state agency public assistance databases. Matching is done to identify public assistance consumers who may have not reported income accurately during eligibility determinations, to locate people owing monies 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, with income information for civilian and military employees from the U.S. Department of Defense and Office of Personnel Management, with information on interstate public assistance benefit payments (e.g., Temporary Assistance to Needy Families (TANF), Food Assistance and Medicaid programs), and with Workers' Compensation data from participating states.

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

The optimum 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 references 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.

In 2014, Ohio Medicaid received 198,439 requests for prior authorization. Of those, 147,088 were approved, saving the agency over $150 million.

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 consumer).

Pharmacy Point-of-Sale

The pharmacy benefit administrator, Xerox, performs 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 the Department of Medicaid updates records to reflect Medicare and health insurance coverage in the Medicaid payment system so liable third parties are billed first. This activity resulted in approximately $885 million billed charges in savings in calendar year 2014.

In calendar year 2014, Ohio Medicaid's third party liability collection vendor made $59.2 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 a consumer'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 which collected $59.2 million in calendar year 2014.

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 2014, ODM received prior authorization requests for 198,439 items at a potential cost of $242.2 million. Of the requested items, 147,088 were approved at a cost of $91.8 million dollars. As a

result of the prior authorization process, ODM spent $150.3 million less than if the process were not in place.

Post-Payment Review

If waste and abuse are suspected or apparent, ODM takes action to gain 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

Consumers enrolled in ODM-administered waiver programs (i.e., Ohio Home Care Waiver and the Transitions Carve-Out Waiver) receive a variety of home care services that are managed through various contracted case management agencies throughout the state. Case management services include needs assessment, service planning, and care coordination.

ODM contracts with the Public Consulting Group (PCG) to complete incident investigations, provider enrollment, provider oversight, quality assurance, and provider on-site reviews. PCG conducted 3,252 reviews of non-agency providers of waiver services between January 2014 and December 2014. 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 over-payments associated with billing errors, PCG referred information to ODM for potential collection. As a result of these efforts, 806 potential overpayments totaling nearly $2.4 million were referred to Ohio Medicaid for recovery.

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 issues of fraud related to ODM-administered waivers. As a result of these meetings, 180 referrals were made to MFCU against potentially fraudulent providers.

PCG conducted 3,252 reviews of non-agency waiver services providers. 806 potential overpayments totaling nearly $2.4 million were referred 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 2014, 835 providers were terminated for non-compliance with this requirement and three providers were terminated because of disqualifying criminal history.

Third-Party Liability (TPL) Collection

In addition to the cost avoidance activities that Ohio Medicaid conducts prior to paying a claim, it also sometimes pays claims and later attempts to recover the amount paid from a liable third party. The Ohio Medicaid program uses a contracted vendor to conduct TPL collection activities. In 2014, Ohio Medicaid recovered $65 million through its TPL contract.

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 utilized in cases of suspected waste and abuse. During 2014, 241 provider reviews were conducted, which identified over-payment of $1.41 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. During calendar year 2014, providers conducted 44 self-reviews, for a total over-payment of $1.73 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 Medicaid consumers. SURS also accepts referrals from MFCU to initiate any available administrative or judicial action to recover improper payments made to providers. Throughout 2014, regular meetings were held between SURS, MFCU, the Auditor of State (AOS) and Cahaba (a Zone Program Integrity Contractor for the Centers for Medicare and Medicaid Services) to discuss procedures, potential areas of risk and other relevant investigatory information.

During calendar year 2014 providers conducted 44 self-reviews, for a total over-payment of $1.73 million.

Medicaid Fraud Control Unit: Office of the Ohio Attorney General

Attorney General DeWine's Medicaid Fraud Control Unit (MFCU) ranked first in criminal convictions and second in criminal indictments among all units nationwide in federal fiscal year 2013, the most recent statistics available. News of the top ranking came in 2014, a record year in other respects as well. During calendar year 2014, the unit processed 960 complaints, posting 163 indictments (the unit's prior record was 162, set in 2012), 142 convictions, and 35 civil settlements. Recoveries totaled $23.5 million.

During calendar year 2014, the MFCU processed 960 complaints and posted a record 163 indictments.

Program Integrity Group

The Ohio Medicaid Program Integrity Group (PIG) brings together representatives from several state agencies (e.g., ODM; the Auditor of State's Office; MFCU/Office of the Ohio Attorney General) with complementary program integrity responsibilities. The group crafts data mining algorithms designed to identify fraudulent Medicaid providers and plan a coordinated response to these findings.

Medicare-Medicaid (Medi-Medi) Data Match Project

In 2014, the state of Ohio continued its participation in the Medicare-Medicaid (Medi-Medi) Data Match Project. It is a partnership between ODM, CMS, and Cahaba (a CMS Zone Program Integrity Contractor assigned to Ohio) to investigate providers for fraud and/or abuse. The goal of Medi-Medi is to analyze claims data from both programs to detect patterns that may not be evident when billings for either program are viewed in isolation, which allows for the identification of vulnerabilities in both programs.

The project targets areas of potential fraud and/or abuse through input from the Medi-Medi Steering Committee and other sources. Data methodologies are developed and analyses conducted against the centralized claim database. This can result in outcomes such as investigation of providers for fraud and/or abuse, identification of vulnerability within one or both programs, identification and collection of overpayment, or system changes to avoid future payments for fraudulent or abusive activities.

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 services 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 2014, ODM issued 650 final adjudication orders and nursing home overpayment reports resulting in the identification of $9.5 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 2014 were used for the SURS monitoring of Medicaid providers and for monitoring of NFs and ICFs/IID. During 2014, ODM issued 650 final adjudication orders (FAOs) and nursing home overpayment reports to NFs and ICFs/IID for over-payment due the state. These FAOs resulted in identified recoveries of $9.5 million due to the state.

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 24 reports with findings and interest totaling approximately $1.7 million in calendar year 2014.

Contract Management

Proper contract management ensures that deliverables are met for the contracts let by ODM. 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. The reviews are for the purpose of determining 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 2014, Permedion reviewed 16,875 inpatient cases that resulted in denials and/or adjustments to 5,287 claims for a savings of $38.4 million. Permedion also completed 1,200 outpatient reviews that resulted in 629 cases being denied for using incorrect coding for a savings of $4.7 million.

Permedion also performs pre-certifications for certain inpatient medical procedures. Pre-certification is an approval a hospital must obtain for procedures to be performed in an inpatient hospital setting that are normally performed in an outpatient setting. Permedion

receives about 80 pre-certification requests per month. In SFY 2014, Permedion completed 964 reviews that resulted in four denials and a cost savings of $44,411.

In addition, Permedion performs special reviews to determine the medical necessity of non-covered services and studies that support efforts toward ensuring higher standards of health care, quality and access to Medicaid consumers.

Managed Care

Ohio Medicaid incorporates a robust program integrity component in its managed care program. Ohio Medicaid's managed care plans (MCPs) 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, and it must include clear goals and timeliness for employee education and distribution of policies to all key contractors and agents, and an evaluation component to measure effectiveness;

- 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;

- 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 reports of fraud and abuse are shared with Ohio Medicaid's fee-for-service program staff and the Ohio AG's MFCU.

In addition to the above activity, quarterly meetings are held that include program integrity staff from the MCPs, ODM, MFCU, and AOS. During these meetings, information is shared and technical assistance is provided. These meetings assist the plans in pro-actively identifying and dealing with potential provider fraud and abuse issues.

Participant Eligibility Testing

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 consumers were eligible for services during the month under review. States are also required each month to sample and review negative actions, such as case denials or terminations, to determine whether the reason for the action was correct.

The MEQC reviews conducted by ODM consists 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 participant 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 over the review.

County Support

ODM offers training to county agency staff through statewide video conferences to all CDJFS agencies. Agenda items are based on review 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. Also discussed in the videoconferences are updates to administrative rules for Medicaid eligibility, as well as changes to specific eligibility system

ODM conducted 29 county training sessions and responded to 4,356 technical assistance questions.

screens as a result of the changes. CDJFS agencies may also request individualized videoconference training to meet their specific training needs. In calendar year 2014, 29 training sessions were conducted with counties.

In addition, 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 2014, ODM staff responded to 4,356 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

Monitoring sub-recipients is required under 2 CFR 200. This monitoring 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 currently 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 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 NET 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.

Sister State Agency Monitoring

Sub-recipient state departments receiving Medicaid funding passed-through from ODM are subject to monitoring reviews conducted on a risk-based approached by the ODM Bureau of Audit Performance (BAP). Monitoring reviews are designed to provide reasonable assurance that sub-recipient state departments are compliant with material federal and state regulations governing Ohio's Medicaid program. Although specific testing is tailored to each sub-recipient department, typical compliance provisions included within the scope of a BAP review are the allow-ability of costs, the basis for requesting federal reimbursement, the use of state matching funds, whether

costs were incurred in the proper period, and a department's process for monitoring secondary level sub-recipients.

For 2014, work was performed at the Ohio Department of Aging (ODA), the Ohio Department of Developmental Disabilities (DODD), and the Ohio Department of Mental Health and Addiction Services (DMHAS). Based on the risk assessment the work at ODA and DMHAS focused primarily on reviewing federal expenditures through the Intra-State Transfer Vouchers (ISTVs) to ensure the departments were in compliance with appropriate federal and state rules and regulations. ODM staff performed monitoring work at DODD by reviewing waiver costs, ISTVs, Medicaid claiming, provider certification process and reviewing DODD's monitoring and controls over the developmental centers.

Training for Program Integrity Staff

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. The MII 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 at no cost to the states.

Conclusion

As indicated throughout this report, ODM maintains and is continually adapting and improving its efforts to combat fraud, waste, and abuse in the Ohio Medicaid program through a complex and far-reaching 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
ODJFS	Ohio Department of Job and Family Services
ODM	Ohio Department of Medicaid
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