Annual Report
Program Integrity
2022

Governor Mike DeWine • Lt. Governor Jon Husted • Director Maureen Corcoran

50 W. Town St., Suite 400 • Columbus, OH 43215 • medicaid.ohio.gov

Table of Contents

Introduction

Ohio Department of Medicaid (ODM) spent calendar year (CY) 2022 addressing the ongoing public health emergency and launching its Next Generation of Medicaid program. The Next Generation of Medicaid promotes transparency and accountability, and ODM's program integrity work is integral to this vision. In 2022, ODM implemented OhioRISE, a specialized Medicaid managed care plan with tailored services to meet the needs of youth with complex needs, the Single Pharmacy Benefit Manager (SPBM) and centralized credentialing and Provider Network Management (PNM).

ODM continues to improve its monitoring of Ohio's managed care organizations (MCO), while working cooperatively with them and other program integrity partners to prevent and identify fraud, waste, and abuse in the Medicaid program. Through regular meetings with MCO special investigative unit (SIU) staff, including the Ohio Attorney General's Medicaid Fraud Control Unit (MFCU) and ODM experts, ODM's program integrity efforts continue to evolve. This collaboration continues to produce strong results.

Several audits, including the federal Payment Error Rate Measurement (PERM) review, previously identified high error rates in Ohio's member eligibility determination process. The federal PERM auditors were clear in stating that these errors did not necessarily indicate that payments were made inappropriately or on behalf of ineligible individuals, but often the benefits eligibility system, Ohio Benefits, did not maintain documentation as required, or caseworkers did not follow all the necessary steps in the eligibility determination processes. Based on previous PERM results ODM established a dedicated team to work with partner state agencies to fix system defects and improve Ohio Benefits functionality. Significant progress was evident when CMS released results of Ohio's reporting year (RY) 2022 PERM audit. Ohio's estimated Medicaid improper payment rate dropped from 44.28% in Reporting Year (RY) 2019 to 8.23% in the RY 2022 report. Similarly, the Children's Health Insurance Program (CHIP) improper payment rate also showed a notable decline with the 2022 error rate of 12.08% as compared to the previous rate of 55.41%. CMS leadership have commended Ohio's work and progress.

During the year, ODM continued to focus on improving its response to external audits and eligibility determination oversight. ODM focused on improving responses to audits to ensure federal and state partners received accurate and complete information. The department also prioritized corrective action plan monitoring and remediation efforts.

Overview

ODM's Bureau of Program Integrity (BPI) coordinates activities across ODM business units and external stakeholders to effectively prevent and detect fraud, waste, and abuse.

BPI, other ODM businesses units, and our program integrity partners conduct a variety of activities to ensure Ohioans receive the care they need from qualified providers, and that ODM correctly pays for these services. These activities include provider enrollment and support, automated system controls,

law-enforcement coordination, pre-payment and post-payment review, managed care oversight, participant eligibility reviews, monitoring of other state agencies, staff training, and more. ODM monitors its providers, sub-recipient network, and MCOs to regulate program integrity risk, promote compliance, and provide technical assistance and training throughout Ohio's Medicaid system.

Key stakeholders in ODM's program integrity continuum include ODM business units and staff, Ohio's Attorney General and Auditor of State, several state agencies including the Ohio Departments of Aging, Developmental Disabilities, Education, Health, and Mental Health and Addiction Services, Office of Budget and Management, healthcare-related boards, MCOs, county departments of job and family services (CDJFS), and the federal government. Ohio Medicaid also coordinates with other states. It is through building relationships with these stakeholders and partners that ODM is implementing a thorough, well-rounded program integrity approach.

Provider Network Management and Support

ODM employs a multifaceted approach to ensure it pays Medicaid providers correctly and appropriately. Beginning with provider enrollment and continuing through post-payment reviews, ODM uses a variety of methods to promote program integrity for both fee-for-service and managed care payments.

State and federal laws require provider screening and enrollment. ODM contracts with approximately 170,000 providers and screens each at initial enrollment and then monthly against various federal exclusion databases that identify individuals and organizations prohibited from receiving payment from or participating in the Medicaid program. Ohio also requires fingerprinting and background checks for owners and managing employees of high and moderate-risk provider organizations and conducts on-site visits of provider types identified as being at a heightened level of risk for fraud, waste, and abuse. These visits take place both before and after enrollment into the Medicaid program. Ohio Medicaid contracts with Public Consulting Group (PCG) to conduct site visits (conducted virtually due to the public health emergency (PHE)) on behalf of the department. In CY 2022, PCG completed 668 virtual site visits. As a result of these site visits, PCG was able to identify one hundred fifty-eight potential fraud cases and forty-nine PCG fraud referrals were accepted by the MFCU for further investigation.

Provider Enrollment

In October 2022, as part of its Next Generation of Medicaid Managed Care, ODM implemented the Provider Network Management (PNM) module, a component of the Ohio Medicaid Enterprise System (OMES). The PNM module is a single-entry point for provider enrollment/revalidation, and credentialing and reduces the administrative burden. The PNM manages credentials for all MCOs, OhioRISE, and fee-for-service Medicaid provider enrollments and increases self-service capabilities.

Having one "source of truth" for provider credentials allows ODM insight into all providers rendering services to recipients enrolled in Ohio Medicaid. This provides the department with better program oversight and allows for quicker ODM action to disenroll providers for cause.

Minimum Dataset Exception Reviews (MDS) of Nursing Facilities

The MDS is a set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. ODM conducts an MDS exception

review program on skilled nursing facilities' (SNF) use of CMS' Resident Assessment Instrument, the accuracy of MDS data transmitted from SNFs to ODM for use in calculating direct care rates, and overall SNF recipient care. ODM oversees the completion of up to 100 exception reviews annually. SNFs receiving unfavorable exception review results could be subjected to reduced direct care rates for a subsequent six-month period. In calendar year 2022, ODM completed 62 MDS reviews, which led to reduced rates for 18 SNFs.

Provider Compliance Reviews

The Provider Audit and Compliance Review (PACR) unit conducts limited, on-site and virtual provider reviews. The reviews entail in-depth claims and supporting documentation examination. The PACR unit conducts these reviews for the purpose of offering guidance in the form of education and technical assistance. When issues are identified, PACR notifies the provider, connects the provider to educational resources when needed and conducts a follow-up review after six months to ensure corrective action has been taken.

In 2022, the PACR unit completed 130 reviews of behavioral health providers, dentists, optometrists, occupational therapists, chiropractors, registered dieticians, and home health agencies. Reviews resulting in the detection of patterns of fraud, waste or abuse are referred to the MFCU for further investigation. In 2022 the PACR unit submitted 20 referrals to the MFCU.

By conducting these reviews and providing guidance, ODM is working to foster a stronger network of educated, compliant providers to better serve its Medicaid beneficiaries.

Collaboration with Program Integrity Partners

Fraud Referral Clearinghouse

Federal regulations require ODM, as the single state Medicaid agency, to have procedures for referring suspected fraud cases to law enforcement. ODM accomplishes this by operating a clearinghouse of subject matter experts from the Bureaus of Program Integrity and Provider Network Management to review fraud referrals and determine if the referrals provide probable evidence of fraud. ODM staff, MCOs, state agencies, and ODM contractors submit fraud referrals to the clearinghouse. If the referrals provide reasonable and explainable evidence of fraud, ODM submits them to the MFCU for a full investigation. ODM and its program integrity partners present fraud referrals associated with home health and/or home- and community-based waiver to the MFCU at bi-monthly meetings that are designed to share knowledge of home health and waiver fraud schemes. ODM submits all other referrals after the weekly ODM clearinghouse review. In 2022, ODM submitted 247 fraud referrals to the MFCU, and the MFCU accepted 177 of these referrals for investigation.

In 2022, ODM refined the Fraud Referral and Coordination (FRC) system to support investigating and reporting fraud, waste, or abuse, and if warranted, referring appropriate cases to the MFCU for potential criminal investigation. The FRC is used as a portal to submit referrals and deconfliction requests allowing ODM to monitor, review, and conduct preliminary investigations on all referrals to determine whether a conflict with law enforcement or a collaboration opportunity exists. ODM then permits the MCO to investigate, review, recoup payment, or involuntary terminate a provider. Using a system that houses all referral and deconfliction information allows for real-time monitoring and data reporting, increases opportunities for collaboration, and eliminates duplicate workstreams.

Office of the Ohio Attorney General Medicaid Fraud Control Unit

Attorney General Dave Yost's MFCU is responsible for the investigation and prosecution of healthcare providers accused of defrauding the state's Medicaid program. It ranked first in indictments and convictions among all units nationwide in federal fiscal year 2022.

The unit processed 957 complaints in calendar year 2022, posting 155 indictments, 169 convictions, and 41 civil settlements. **Recoveries totaled $19.3 million**.

Additionally, in early 2022, the Health and Human Services Office of the Inspector General (HHS-OIG) awarded the MFCU the Inspector General's Award for Excellence in Fighting Fraud, Waste, and Abuse. The Ohio MFCU received this award for its high number of case outcomes across a mix of case types, excellent partnership with HHS-OIG and other federal and state partners, and its regular contributions to the larger MFCU community.

Program Integrity Group

The Ohio Medicaid Program Integrity Group (PIG) brings together representatives from ODM, the Auditor of State's Office, and the MFCU to discuss Medicaid fraud, waste, and abuse, potential areas of risk, and other relevant investigatory information. The PIG meets monthly for educational presentations and information sharing. The group discusses data mining projects with a focus on fraudulent schemes.

Managed Care Program Integrity Group

ODM replicated the successful elements of the PIG with the Managed Care Program Integrity Group (MCPIG.) This group brings together ODM's MCOs with representatives from ODM, the MFCU, and the Auditor of State to address program integrity issues related to managed care. This group meets regularly for education and information sharing which promotes collaboration among Ohio's program integrity

partners. Eight meetings were held in 2022 with relevant education and guidance provided during each meeting.

The Ohio Auditor of State

The Auditor of State (AOS) audits Medicaid providers under Section 117.10 of the Ohio Revised Code (ORC). Under a letter of arrangement with ODM, the AOS released 46 reports with findings and interest totaling approximately $1.4 million in calendar year 2022. The AOS reviews both fee-for-service and managed care payments to providers. The AOS also participates in the PIG and MCPIG meetings and provides training at these meetings related to field audits and auditing best practices.

Managed Care

ODM ensures program integrity in its managed care program through its own oversight and monitoring of MCOs and through the program integrity work required of the MCOs. Managed care and MyCare Ohio MCOs, as well as the newly implemented OhioRISE plan and Single Pharmacy Benefit Manager (SPBM) must comply with all applicable state and federal program integrity requirements in addition to requirements contained in their provider agreements. These requirements focus on risk-based plans, employee education, monitoring of services and payments, fraud reporting, and cooperation with law enforcement.

ODM continues to build a collaborative relationship with the MCOs' SIUs through its MCPIG and SIU Lead meetings. The MCPIG meetings, described above, are an opportunity to educate MCO SIU and ODM staff, and share information concerning fraud, waste, and abuse among law enforcement and the Ohio AOS. The MFCU, ODM, and the MCOs' SIU Lead representatives also hold SIU Lead meetings regularly to discuss Medicaid provider fraud investigations, provide policy and technical guidance and information, and to increase coordination among program integrity partners. These meetings assist the MCOs in proactively identifying and addressing potential provider fraud and abuse issues and ensure coordination with law enforcement and ODM on active fraud cases.

Program Integrity work completed by Ohio Medicaid's MCOs

Planning

ODM monitors the MCOs' required program integrity plans to ensure MCO compliance with all state and federal program integrity requirements. MCOs must develop and submit to ODM:

1. An Ohio-specific compliance plan that describes the MCO's compliance program and includes the MCO's monitoring and auditing work plan for the upcoming year.
2. An Ohio-specific fraud, waste, and abuse plan (FWA plan).

The FWA plan must include a risk-based assessment, designated staff responsible for administering the plan, clear goals, milestones, or objectives, key dates for achieving identified outcomes, and an explanation of how the MCO will determine the effectiveness of the plan. The MCOs submit the Ohio-specific FWA plan annually on January 15 for ODM review and approval. In 2022, most MCOs updated their FWA plans to include high-risk provider types or services such as behavioral health, telehealth services, home health services, transportation, labs, and outlier prescribers.

The MCOs' FWA plans helped to further define their program integrity work for the upcoming year based on Ohio-centric data analytics that resulted in identifying patterns, risks, and trends.

The PHE continued to impact MCOs, their FWA plans, and their program integrity processes. All MCOs adhered to ODM guidance to eliminate prior authorization for skilled nursing facilities, long-term acute care facilities, and inpatient rehabilitation facilities until this requirement was rescinded on April 13, 2022. ODM also advised MCOs to continue the hold on field audits and to consider resuming them in 2023. MCOs altered their FWA plans based on utilization and ODM recommendations to investigate telehealth, COVID 19 testing, and other relevant schemes resulting from the PHE.

Utilization Management

All MCOs conducted a variety of pre-payment activities to decrease risk of fraud, waste, and abuse by educating providers, monitoring utilization and access, as well as, reviewing provider appeals following an MCO's denial of a prior authorization request. MCOs monitored utilization by conducting quarterly audits and reviewing monthly trend reports, and daily adjudication and timing reports.

All the MCOs conducted annual prior authorization (PA) reviews to determine if they unreasonably limited a member's access to Medicaid-covered services through the prior authorization process. None found that their PA processes limited member access to services. All MCOs annually review their appeals process for providers following an MCOs denial of a prior authorization request for a determination as to whether the appeals process unreasonably limits access to covered services. Unreasonable limitations were not discovered.

Pre-payment Activities

The MCOs employed a variety of pre-payment and cost avoidance strategies during calendar year 2022. Examples of pre-payment program integrity activities include, preventing enrollment of fraudulent providers, claim edits, claim flags for additional review, and medical record reviews. All MCOs use information intelligence, such as a decision support system, to address risks and identify outliers, and other aberrancies prior to claims payment.

Post-Payment Review and Recoveries

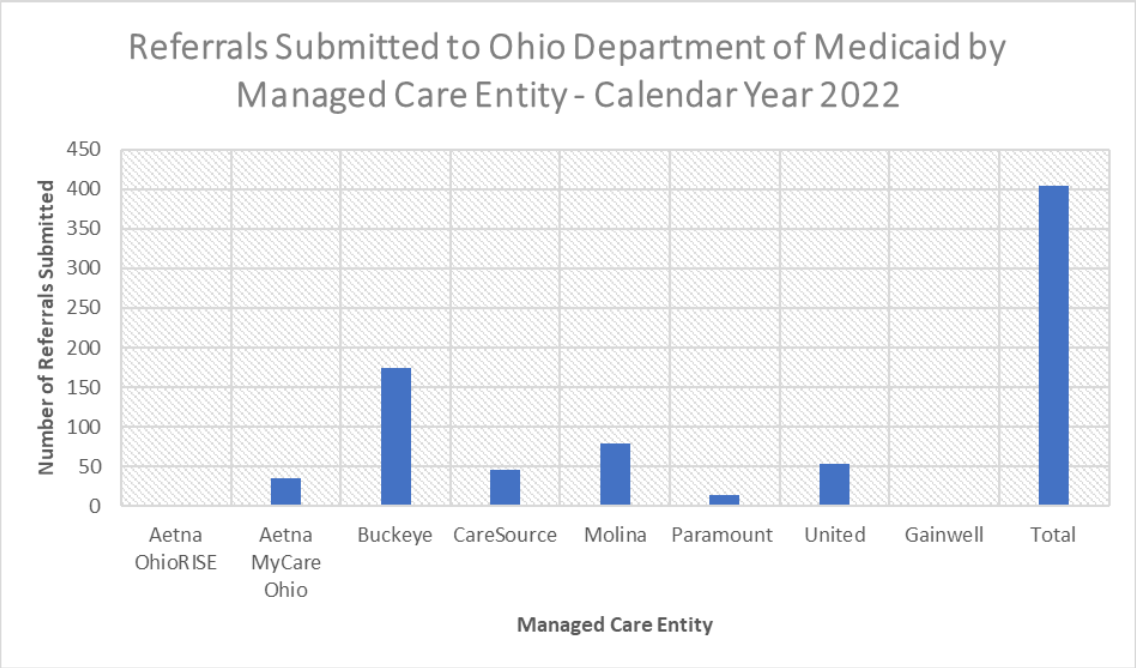
Post-payment reviews are an established tool use to ensure program integrity. Post-payment activities and review occurs after providers submit claims and receive payment from the MCO. MCOs review records to examine whether the goods and services claimed were medically necessary and were rendered to an eligible beneficiary.

The MCOs report to ODM the overpayments identified and recovered. In calendar year 2022, the MCOs conducted a total of 1,066 audits, reviews and investigations and recovered $1,673,279.86 in overpayments.

Referrals and Enforcement Action by the MFCU

ODM receives and reviews all fraud, waste, and abuse referrals submitted by MCOs and reviews these through its fraud clearinghouse before submitting the fraud referrals to the MFCU. ODM also monitors whether MCOs promptly refer any potential fraud, waste, and abuse to ODM. MCOs also submit member fraud referrals to ODM which are tracked and sent to CDJFS agencies to investigate. The MCOs submitted a total of 420 provider fraud referrals and 27-member fraud referrals during 2022. Not all fraud referrals are accepted by the MFCU.

Many referrals submitted by the MCOs to ODM were based on incidents submitted in ODM's Incident Management System (IMS). The IMS serves to meet CMS health and safety assurance requirements as specified in the CMS 1915(c) waiver application. The IMS system launched July 1, 2019, to manage, report, and track critical incidents, reportable incidents, and provider occurrences that occur with individuals involved in the following waiver programs: Ohio Home Care Waiver (OHCW), Specialized Recovery Services Program (SRSP) and the MyCare Ohio Waiver. Medicaid fraud is a sub-category of incident within the provider occurrences category.



Home health and waiver services comprise the majority of referrals submitted to ODM. Many of these referrals incorporated visit data from ODM's Electronic Visit Verification system (EVV), which electronically records certain home-health and personal care services provided.

Electronic Visit Verification

The 21st Century Cures Act (Cures Act) mandates that states implement Electronic Visit Verification (EVV) for all Medicaid personal care services (PCS) and home healthcare services (HHCS) that require an in-home visit by a provider. EVV requires home care providers that furnish PCS and HHCS services outlined by the Cures Act to electronically verify the services they deliver. Providers record the visit date and time, visit location, individual receiving services, caregiver who is providing services, and the service provided.

The EVV solution utilizes current technology to provide near real time validation of service delivery in home- and community-based settings, supporting the following policy and program integrity objectives:

- Ensure the health and welfare of individuals choosing to receive long-term services and supports where they live or otherwise receive services timely.
- Improve payment accuracy by using technology to match data on claims with data in visit documentation.
- Reduce fraud and abuse by requiring verification of service delivery before claims are adjudicated and paid.

ODM provides an EVV system for use by providers at no cost. Providers should capture visits via a mobile app on a device, however, alternate visit capture methods include telephony and manual visit entry for those circumstances when the mobile solution is not available. ODM stores all visit data collected in a uniform database called the Aggregator and uses this data to substantiate information on claims. All payers (ODA, DODD, and MCOs) are required to use the same EVV solution and approach prescribed by ODM.

In 2022, ODM worked to procure a new EVV contract. The new contract language shows ODM learned from our EVV experience and is seeking to enhance the system and implement new EVV concepts in Ohio. ODM incorporated stakeholder feedback in the request for proposals and looks forward to creating an enhanced EVV solution to assist with our program integrity efforts, reducing fraud and abuse within the system and improving provider compliance with the EVV system.

Eligibility and Program Integrity

Determining an individual's Medicaid eligibility is the first step toward connecting prospective beneficiaries to coordinated healthcare coverage. In many ways, successful program integrity begins by ensuring that ODM only provides benefits to those individuals who qualify. The eligibility program

integrity work described below applies to all individuals receiving Medicaid benefits, whether they are enrolled in an MCO or receive services through fee-for-service Medicaid.

Medicaid Eligibility Quality Control Reviews

Federal regulations require states to conduct Medicaid Eligibility Quality Control (MEQC) reviews every three years. The MEQC pilot includes review of active Medicaid cases each month to determine if beneficiaries were eligible for services during the month under review. The pilot also requires states to sample and review negative actions, such as case denials or terminations, to determine whether the reason for the action was correct. Through these reviews Ohio can evaluate the implementation of improvements and monitor the effectiveness of corrective actions that address audit findings including PERM eligibility errors. MEQC review outcomes are shared with the CDJFS agencies and ODM County Compliance Team for follow-up, training, and technical assistance to prevent future eligibility errors.

In March of 2022, the MEQC unit began the federally required pilot review project. The MEQC pilot reviews conducted by ODM focused on caseworker actions, system actions, case file verifications, and other factors of eligibility to ensure the accuracy of eligibility determinations. The MEQC unit reports the error and deficiency findings from these reviews to each CDJFS as they are identified.

The 2022 pilot included the review of 400 active cases, 400 negative cases including denials and terminations, and a payment review when errors are identified. At the conclusion of the pilot review, Ohio must report results on a case level report and provide a corrective action plan for identified errors or technical deficiencies due to CMS.

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 and to identify people receiving concurrent benefits from multiple states.

The PARIS matching process is managed by the U.S. Department of Health and Human Services' 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, Food Assistance and Medicaid programs), and Workers' Compensation data from participating states. The PARIS match information is added to Ohio's eligibility system and generates an electronic alert for caseworkers to verify potential concurrent eligibility for an individual receiving Ohio Medicaid benefits.

Income and Eligibility Verification System (IEVS)

Ohio operates the IEVS as required by federal law. 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 caseworker 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.

County Support and Monitoring

County Eligibility Technical Assistance (TA) staff continued to provide training and support to county agencies to improve eligibility determinations. During calendar year 2022, TA presented statewide Technical Assistance and Compliance video conferences and webinars including discussions of recent Ohio administrative code policy changes and clarifications, eligibility system processing tips, and updates on current eligibility compliance activities. TA offered targeted trainings on a variety of Medicaid policy and system topics throughout 2022. ODM recorded most of the sessions and the recordings are available for viewing by county staff at any time on the Medicaid innerweb page. In collaboration with the Ohio Department of Job and Family Services (ODJFS), TA continued the 12-week new worker training series first implemented in 2020.

Eligibility Compliance staff provide a variety of eligibility support to counties. Starting in CY 2019 and continuing through CY 2022, compliance staff engaged counties to reduce pending Medicaid applications and Medicaid renewal backlogs. Compliance staff sent weekly reports to counties with information on all pending applications, and all current and past due renewals. Statistics from these reports were compiled and shared with County Engagement staff to support ongoing conversations with counties related to application and renewal processing. In CY2022, Compliance staff increased monitoring of PARIS alerts and began outreach to counties struggling to make significant reductions in pending PARIS alerts. Compliance staff also monitor various reports for eligibility issues, reach out to county administrators to assist in resolution of issues, and continue to work with the data team to ensure reports are updated when necessary to provide the best output for county use.

The County Engagement unit consists of five county engagement managers assigned to 17 or 18 counties each. Engagement managers are responsible for meeting with each county in their region at least once per quarter. The meetings address any questions the agency may have on eligibility policy or the Medicaid eligibility system, identify training needs, review reports on county pending application and renewal backlog numbers, provide county-specific support following policy or system training, and cover county business processes and best practices. The engagement managers also serve as the county agency's ODM contact to ensure all questions and concerns are being responded to timely and escalated appropriately, when necessary. County engagement managers build rapport with county agencies to open lines of communication and ensure counties receive prompt assistance.

Audit Coordination

Audit Coordination

Federal and state auditors and oversight agencies regularly audit ODM. ODM's Audit Coordination unit works to ensure ODM provides auditors with complete and accurate information. If the auditors identify an area of non-compliance, the Audit Coordination unit works internally with ODM staff to develop a corrective action plan to address the non-compliance, and monitors ODM's remediation of that non-compliance. In 2022, the AOS, Centers for Medicare and Medicaid Services (CMS), the Internal Revenue Service (IRS), HHS-OIG, and Ohio Office of Budget and Management (OBM-OIA) entered into or completed audits or reviews of ODM. CMS concluded the review year 2022 Payment Error Rate

Measurement (PERM) audit that occurs every three years and ODM began developing the corrective action plan to address identified errors. ODM also developed and implemented corrective action plans for audits completed by AOS and the IRS during calendar year 2022.

- The AOS completed the annual SFY 2021 Single State audit. It made findings related to eligibility determinations and identified systems deficiencies within Ohio Benefits (OB) – Ohio's statewide eligibility system, and caseworker errors. ODM provided a corrective action plan to CMS in response. Additionally, the AOS began the annual SFY 2022 Single State audit during CY 2022.
- The AOS completed a public interest audit on Public Assistance Reporting Information System (PARIS) alerts. AOS cited issues relating to system errors, human errors, and communication difficulties. ODM continues to make improvements to alert functionality within the system, and provides assistance, monitoring, and training to counties on alert processing.
- OBM-OIA completed an assurance engagement on the Department of Rehabilitation and Correction (DRC) Bot and Ex Parte project. This engagement evaluated the DRC Bot and Ex Parte processes used by the agency to identify and confirm Medicaid eligibility of recipients in preparation for the PHE unwinding.
- OBM-OIA began a consulting engagement on Information Technology Contingency Planning. This engagement is the develop a Business Continuity and Disaster Plan for ODM.
- In 2022, CMS' PERM review concluded. There are three reviews that are part of PERM: Medicaid Records Review, Data Processing Review, Eligibility Review. ODM began the corrective action plan process to remediate all findings.

Closing

Medicaid plays a unique and necessary role for our state. There are opportunities to positively change the trajectory of many young Ohioans' lives. There are also opportunities to lower barriers to employment for working age adults, and to ensure the full range of service options and choice for Ohioans who are elderly or have a disability.

In addition to the health of 3.5 million Ohioans, ODM also takes very seriously the responsibility for the financial stewardship of the program. The program integrity efforts described in this report encompass some of the important strategies to ensure that individuals are eligible, and that they receive appropriate services from credible, quality providers. Assuring the integrity of the program is essential for the trust and support of those served by the program, the General Assembly, and all Ohioans.