



**Department of
Job and Family Services**

**Medicaid Program Integrity Report
For Calendar Year 2010**

To Governor John R. Kasich and the Ohio General Assembly
As required by Section 5111.092, Ohio Revised Code

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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 federal fiscal year (FFY) 2010 (October 1, 2009 - September 30, 2010), Ohio Medicaid provided health care coverage to approximately 2.4 million eligible Ohioans. Ohio's total Medicaid expenditures were \$15.5 billion (state and federal funds) during FFY 2010. Of that total, Ohio contributed about 27 percent, or \$4.2 billion, and drew down about \$11.3 billion in federal funds.

The Ohio Department of Job and Family Services (ODJFS) is the single state agency charged with administering Ohio's Medicaid program. Within ODJFS, the Offices of Ohio Health Plans (OHP) and Fiscal and Monitoring Services (OFMS) have 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 42 CFR Part 455. The basic requirements include the following:

- 42 CFR 455.12, which sets forth the state plan requirement;
- 42 CFR 455.13, 455.23 and 455.1, which set forth requirements for a state fraud detection and investigation program;
- 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 ODJFS to comply with the requirements of OMB Circular A-133, Audits of States, Local Governments and Non-Profit Organizations, including monitoring of subrecipients 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 subgrant 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.

Am. Sub. H. B. No. 1 of the 128th Ohio General Assembly enacted Section 5111.092, Ohio Revised Code, which requires that ODJFS 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, subrecipient monitoring, and staff training to detect fraud, waste and abuse. Included within subrecipient monitoring are examinations to determine whether entities receiving funding through ODJFS are conducting adequate monitoring of their subrecipients and of any Medicaid disbursements.

The continuum includes efforts individually as well as collectively of those in many state agencies (ODJFS, the Ohio Departments of Aging, Alcohol and Drug Addiction Services, Mental Health, Developmental Disabilities, Health, and Education), the Auditor of State (AOS), the Attorney General (AG), the Executive Medicaid Management Administration (EMMA), 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;
- 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 overpayments; and
- Referring possible cases of fraud to the proper authorities to investigate and prosecute when deemed appropriate.

Provider Enrollment and 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, OHP utilizes a variety of methods to promote program integrity.

Provider Enrollment

ODJFS is responsible for receiving, reviewing and verifying licensure certification and accreditation for Ohio Medicaid provider enrollment applications. Provider enrollment applications are reviewed for the appropriate support documentation to ensure accuracy and completeness and to determine whether the provider meets all applicable requirements. If an application is incomplete, the provider is contacted to obtain the missing information or supporting documentation. Once the provider meets all applicable licensure requirements, the provider is enrolled into the Medicaid program through the creation of a provider file within the Medicaid Management Information System (MMIS).

A management quality check is completed every week on a random sampling of twenty applications prior to an enrollment notification letter being mailed to the provider. This includes a review of the notification letter, provider application, provider agreement, MMIS provider file and all required support documentation to ensure provider eligibility was accurately determined and entered into MMIS.

Approximately 1,243 Medicaid provider applications are received each month. This number includes new and resubmitted applications that were returned to the applicant for incomplete information.

As of December 2010 there were 88,948 active providers in MMIS, with 10,491 of those providers enrolled in 2010. This enrollment number includes 3,431 service providers under Medicaid's various waiver programs.

The time-limited provision of HB 119 was implemented on January 1, 2008. This provision required a three-year time-limited provider agreement. From January 1, 2008 to December 31, 2008 there were 2,039 providers enrolled with the three-year provision. In mid-2009, HB 1 changed the three-year time-limited provision to a seven-year time-limited provision. To address the 2,039 providers enrolled with the three-year provision, the department notified them about a re-enrollment process to renew their provider agreement to the new seven-year period. As of December 31, 2010, 1,331 providers responded with their re-enrollment materials and 708 provider agreements are pending providers' response. It is anticipated that the 2010 re-enrollment process will be completed by spring 2011.

For providers enrolled prior to January 1, 2008, OHP is using a five-year phase-in schedule to convert the provider agreements to seven-year time-limited agreements. In 2010, 16,453 providers were notified by mail about the conversion of their provider agreement. The phase-in schedule will be completed by January 1, 2015, and at that time all applicable Medicaid providers will be enrolled under time-limited agreements.

The department is given permissive authority in HB 66 to terminate providers who have not billed the department in a 24-month period. This authority allows the department to purge the Provider Master File within MMIS of these provider agreements. During March 2010 and August 2010, 17,503 providers were notified by mail about their 24-month no billing status and were given an opportunity to terminate or keep their provider agreement. A total of 1,335 providers chose to keep their agreement, and 16,168 provider agreements were terminated.

Other provider terminations for 2010 totaled 1,670. Reasons for termination included, but were not limited to, non-compliance with waiver program rules, failure to renew annual background checks, failure to renew licensure, license revocation and health care fraud.

Provider Education and Resources

In 2010, Ohio Medicaid conducted 30 association and large provider presentations, 15 basic billing classes, 46 provider consultations and 31 MITS (Medicaid Information Technology System) training sessions. Basic billing sessions were used to train various provider types on provider enrollment requirements, program rules and federal regulations, and how to submit claims, among other topics. Consultations were one-on-one provider meetings intended to assist with each provider's unique issues, predominantly claims submission. MITS training was conducted to prepare providers for the implementation of the new Medicaid claims payment

system, to ensure providers are aware of MITS, how it will affect them and changes they can expect to see. All of these activities along with the approximately 60 providers that get individual attention daily via email and phone calls to Medicaid ombudsmen served to enhance communication, minimize billing issues, and strengthen provider relations. It is estimated that over 11,000 providers availed themselves of Medicaid training opportunities in 2010.

In addition to provider training, Ohio Medicaid includes information targeted to providers on its Web site, including links related to enrollment, billing, remittance advices and provider manuals.

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 online. Providers are also able to submit claims via the Web portal. This not only gives providers an alternative to submitting paper claims, but it also strengthens program integrity through the increase in claims accuracy gained via decreased keying errors. Claims submitted through the portal are adjudicated more quickly (within one week, while paper claims may require 30 days for processing), and providers may search the portal for the status of submitted claims. In 2010, approximately 613,000 claims (or 2.7% of all fee-for-service claims) were submitted through the Web portal, resulting in payments of nearly \$339 million.

Providers are also able to verify Medicaid consumer eligibility via the portal. The application incorporates eligibility information from multiple sources, and providers may search eligibility for the past three years. 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 information regarding the consumer's Medicaid program category. This enhances Ohio Medicaid's program integrity efforts by providing information that increases providers' ability to submit accurate and viable claims. In 2010, providers submitted 8.2 million eligibility inquiries through the Web portal.

CyberAccess

ODJFS has entered into a contract with Affiliated Computer Services (ACS) 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, allows prescribers to generate an electronic prescription, after verifying Medicaid coverage. The Ohio Board of Pharmacy has approved the system for both electronic faxing of prescriptions to pharmacies and true "e-prescribing" through SureScripts. There are over 200 medical practices registered to use the system, in addition to the Medicaid-contracting managed care plans and the Medicaid-contracted case management company CareStar. An initiative to enroll hospitals in Southeastern Ohio has resulted in 16 hospitals registered to use the system, which assists emergency department staff with identifying pertinent medical conditions and/or signs of abuse, and assists with medication reconciliation when patients are admitted.

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 Management Information System (MMIS)

MMIS is Ohio's claims processing system. 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 services.

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 or conflict edits are used for unique situations in which Medicaid may permit payment of two claims to 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, interstate public assistance benefit payments for the Temporary Assistance for Needy Families (TANF), Food Assistance and Medicaid programs and Workers' Compensation data from participating states.

Many levels of government and taxpayers benefit from matching data: Cases are closed that should no longer be open, benefits are sometimes redirected for payment to the proper payer, and benefits are reduced for those with income higher than the appropriate budget standard. Consumers can also benefit by having their benefits increased, as income is sometimes over-reported during eligibility determination. In 2010, ODJFS received 15,766 PARIS matches which were passed on to CDJFS for review for impact on consumers' eligibility for public assistance benefits.

Income and Eligibility Verification System (IEVS)

Ohio operates IEVS as required by 42 USC 1320b-7(b). IEVS is a computerized system that matches the social security numbers of Food Assistance, Cash Assistance (TANF) and Medicaid consumers 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, this information is returned to the state, which generates an electronic alert to the county eligibility worker responsible for the case in which the match occurred. 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. In 2010, 2.4 million IEVS alerts were generated and sent to CDJFS. The OFMS Bureau of Program Integrity conducts IEVS monitoring reviews triennially to determine whether counties are timely and accurately responding to IEVS match alerts.

Pre-payment Review

The optimum time to discover an inappropriate Medicaid claim is before payment is made; therefore, certain pre-payment screenings are performed on claims submitted by providers.

Limit Parameters within MMIS

MMIS has a Procedure, Drug and Diagnostic (PDD) file that contains the reimbursable amounts for all procedure, drug and diagnostic codes. When a claim is submitted by a provider for reimbursement, MMIS automatically references the PDD file and calculates the allowed amount for each claim. MMIS has system edits that help prohibit billed amounts from exceeding the allowed reimbursable amounts.

There are also additional utilization and review edits programmed into MMIS. These edits include quantity or dollar limits that are 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 point-of-sale vendor performs prospective drug utilization review, including screening for therapeutic duplication, overuse and drug interactions. Claims may be denied if the refill was given before it should have been, or if the drug duplicates therapy for the consumer.

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 ODJFS Office of Ohio Health Plans updates records to reflect Medicare and health insurance coverage in the Medicaid payment system so that liable third parties are billed first. This activity resulted in \$640.4 million in savings in calendar year 2010.

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 correct insurance carrier. In these instances, the third party insurance information is not available until post-payment. For these claims, the Ohio Medicaid program uses a contracted vendor to conduct third-party liability (TPL) collection activities.

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 2010, 41,082 prior authorization requests were received. Of those requests, 28,499 were approved. Of the approved requests, \$78.5 million was requested in reimbursement, and \$45.5 million was approved, a savings of \$33 million.

Post-payment Review

ODJFS has in effect a program to prevent and detect fraud, waste and abuse in the Medicaid program. If waste and abuse are suspected or apparent, ODJFS takes action to gain compliance and recoup inappropriate payments through audits and reviews in accordance with rule 5101:3-1-27 or 5101:3-26-06 of the Ohio Administrative Code. Where cases of suspected fraud to obtain payment from the Medicaid program are detected, ODJFS refers the case to the AG's Medicaid Fraud Control Unit (MFCU) for further investigation.

ODJFS-Administered Waivers

Consumers enrolled in ODJFS-administered waiver programs (Ohio Home Care Waiver, Transitions Developmental Disabilities Waiver, and the Transitions Carve out Waiver) receive a variety of home care services that are managed through a contracted case management agency, CareStar. These services include needs assessment, service planning, care coordination, provider management, and quality assurance.

As part of its contract responsibilities, CareStar conducted 3,822 reviews of non-agency providers of waiver services between October 2009 and September 2010. These reviews were used to identify issues which violated program rules and to educate providers about rule requirements. Both CareStar and ODJFS work with providers to address identified issues, and issues that continue after they have been addressed with providers may result in provider sanctions and/or termination.

During its reviews, CareStar may discover evidence of possible overpayments. For routine overpayments associated with billing errors, CareStar refers information to ODJFS for potential collection. As a result of these efforts, 866 potential overpayments totaling \$2.3 million were referred to ODJFS for recovery in SFY 2010. ODJFS also holds bi-weekly meetings with CareStar, the AG's Office and other stakeholders to review potential issues of fraud related to ODJFS-administered waivers.

In addition, ODJFS requires all non-agency waiver providers to submit an annual criminal history report completed by the Bureau of Criminal Identification and Investigation. In 2010, 630 providers were terminated for non-compliance with this requirement, and 19 providers were terminated because of disqualifying criminal history.

Third-Party Liability 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 SFY 2010, Ohio Medicaid recovered \$76.3 million through its TPL contract.

Surveillance and Utilization Review

The ODJFS OFMS Surveillance and Utilization Review Section (SURS) is the foundation for the agency's efforts to detect Medicaid fraud, waste and abuse. Various methods of audit and

review are utilized in cases of suspected waste and abuse. During 2010, 1,860 provider reviews were conducted, which identified overpayments of \$5.7 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 2010, providers conducted 32 self-reviews, for total overpayments of \$940,000.

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 the Medicaid Fraud Control Unit (MFCU), which is housed in the AG's Office. The 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 the MFCU, as mandated by 42 CFR 455.21(a)(1). 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. Regular meetings are held between SURS, MFCU, the Auditor of State (AOS) and AdvanceMed, a Center for Medicare and Medicaid Services (CMS) Program Safeguard Contractor, to discuss procedures, potential areas of risk and other relevant investigatory information.

SURS also participates in the U.S. Department of Justice's Northern and Southern District of Ohio Health Care Fraud Task Forces. Meetings are held on a quarterly basis with representatives from the following government organizations: U.S. Attorney's Office Northern and Southern Districts of Ohio, the Drug Enforcement Administration, the Federal Bureau of Investigation, the Internal Revenue Service, the United States Department of Defense, HHS, the United States Department of Labor, MFCU, the Ohio Board of Pharmacy, the Ohio Bureau of Workers' Compensation, the Ohio State Chiropractic Board, the Ohio State Medical Board, the County Prosecuting Attorneys, the AOS, Medicare Carriers, Intermediaries and Peer Review Organizations, and several insurance companies. The Health Care Task Force Meetings build partnerships and cooperative efforts among the above mentioned organizations to combat fraud and abuse.

The Medicaid Fraud Control Unit of the Office of the Ohio Attorney General (MFCU)

It is worth noting here that MFCU's Health Care Fraud section is recognized as a leader among similar units across the country. Each year, the HHS Office of the Inspector General publishes a statistical comparison of the fifty Medicaid Fraud Control Units around the country.

For FFY 2009 (10/01/08 – 09/30/09), the most recent period for which statistics are available, the Ohio MFCU:

- Ranked 5th in terms of gross dollar recoveries;
- Ranked 7th in terms of gross numbers of convictions; and
- Ranked 2nd in the nation, when jointly comparing convictions-per-professional-staff and recoveries-per-grant-dollar.

In 2010, the MFCU Unit achieved:

- 146 indictments;
- 104 convictions; and
- \$77.6 million in recoveries.

Medicare-Medicaid Data Match Program (Medi-Medi)

Since 2004, the state of Ohio has participated in the CMS Medicare-Medicaid Data Match Program (Medi-Medi) which analyzes claims data from both programs to detect patterns that may not be evident when billings for either program are viewed in isolation. The Medi-Medi program is a partnership between ODJFS, AdvanceMed and CMS to investigate providers for fraud and/or abuse. This project 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 that produce potential outcomes, such as: investigation of providers for fraud and/or abuse, identification of a vulnerability with one or both programs, identification and collection of overpayments, or system changes to avoid future payments for fraudulent or abusive activities.

Cost Report Audits

ODJFS, 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. ODJFS currently monitors the following cost report types as submitted by Medicaid providers:

- Developmental Centers – associated with the Ohio Department of Developmental Disabilities;
- Pre-Admission Screening System Providing Options & Resources Today (PASSPORT) - associated with the Ohio Department of Aging;
- Clinics;
- Nursing Facilities (NFs); and
- Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)

Based on state rule, ODJFS 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 2010 were used for the SURS monitoring of Medicaid providers and for monitoring of NFs and ICFs-MR. During 2010, ODJFS issued 912 final adjudication orders (FAOs) to NFs and ICFs-MR for overpayments due the state. These FAOs resulted in recoveries of \$31.3 million due the state.

The Ohio Auditor of State

The AOS audits Medicaid providers under Section 117.10 of the Ohio Revised Code. Under a letter of arrangement with ODJFS, during calendar year 2010, the AOS issued 7 reports with findings and interest totaling approximately \$3.1 million.

Contract Management

Proper contract management ensures that deliverables are met for the contracts let by ODJFS. 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 ODJFS contractor that performs retrospective reviews primarily focused on hospital inpatient 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 and, if the finding is upheld at that level, may request a review by SURS. In SFY 2010, Permedion reviewed 12,060 inpatient cases which resulted in denials and/or adjustments to 5,674 claims for a savings of \$35.4 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 99 pre-certification requests per month. In SFY 2010, Permedion completed 1,181 reviews which resulted in 21 denials and a cost savings of \$115,000.

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

Each Managed Care Plan (MCP) that contracts with Ohio Medicaid is required to promptly report all instances of provider fraud and abuse to ODJFS. ODJFS shares this information with other MCPs to assist the plans in proactively identifying and dealing with potential provider fraud and abuse issues.

In addition to provider reporting requirements, each MCP must have a compliance plan to guard against fraud and abuse. The compliance plan must designate staff responsibility for administering the plan and must include clear goals, objectives, measurements, key dates for identified outcomes, and an explanation as to how the MCP will determine the effectiveness of the compliance plan. By the end of each January, MCPs are required to submit an annual report to ODJFS that summarizes fraud and abuse activities for the previous year.

ODJFS and MCPs have gone beyond contract requirements regarding fraud and abuse to form a program integrity group that meets quarterly with the Ohio AG's Office. This partnership facilitates discussion between the MCPs, ODJFS and the AG, and encourages the sharing of best practices and emerging issues.

Participant Eligibility Testing

Determining eligibility for a Medicaid participant is the first step toward accessing the system of health care needed by many Ohioans. Ensuring that program eligibility is correctly determined is the first step in ensuring the integrity of the Medicaid program.

Medicaid Eligibility Quality Control Reviews

42 CFR 431.810 and 812 requires 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. The MEQC review is conducted by ODJFS OFMS Bureau of Program Integrity staff and consists of a review of the CDJFS case record and a field investigation to verify income, resources and other factors of participant eligibility. States are also required to sample and review negative actions (case denials or terminations by the CDJFS) each month to determine whether the reason for the denial or termination was correct. The error findings from these case reviews, along with a brief analysis of the top five most frequently occurring errors, are reported monthly to each CDJFS and OHP. The total case findings for the year are reported to CMS. The report to CMS also identifies the top five most frequently identified types of errors and the corrective actions taken by OHP (e.g., training and technical assistance to CDJFS) to address error findings over the review year.

County Support

OHP offers training to county agency staff through statewide videoconferences to all CDJFS. 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 OHP component units. Also discussed in the videoconferences are updates to administrative rules for Medicaid eligibility, as well as changes to specific CRIS-E screens impacted as a result of the changes. CDJFS may also request individualized videoconference training to meet their specific training needs. In 2010, 32 training sessions were provided to counties.

In addition, OHP publishes 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 the CRIS-E system. In 2010, OHP staff responded to 5,363 technical assistance questions.

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

Subrecipient Monitoring

Monitoring subrecipients is required under OMB Circular A-133. This monitoring includes review of current work performed by subrecipients and the resolution of any required audits.

County Monitoring

These monitoring reviews focus on evaluating internal controls related to determining eligibility by county agency staff. A Technical Assistance Report is issued to the CDJFS after each review. These reports are provided to help improve processes and internal controls.

In some cases, Medicaid transportation services provided directly by county staff or via a third-party contractor are reviewed by ODJFS county monitoring staff to determine: consumer eligibility for provided services; whether the services provided are covered by Medicaid; whether

providers can document the costs they claim; and whether the CDJFS has implemented procurement and contract management processes designed to ensure cost effective service delivery and accurate provider payments.

County monitors may also review county agency cost allocation processes to ensure internal controls provide reasonable assurance that administrative costs are properly computed, documented and claimed.

Sister State Agency Monitoring

Subrecipient state departments receiving Medicaid funding passed-through from ODJFS are subject to monitoring reviews conducted by ODJFS personnel. The monitoring reviews are aimed at providing assurance as to subrecipient state departments' compliance with federal and state regulations governing the state of Ohio's Medicaid program and to satisfy oversight responsibilities established by federal law. Although specific testing is tailored to each subrecipient department, the strategy of the reviews entails using the material compliance areas outlined within the Code of Federal Regulations, as well as Ohio Revised and Administrative Code provisions, as a basis to identify compliance areas to be included within the scope of testing. The typical compliance areas within the review scope include activities allowed or unallowed, allowable costs, cash management, the use of matching funds, period of availability, and subrecipient monitoring.

The reviews provide assurance as to the allowability of administrative costs incurred by the subrecipient state departments and assess their monitoring of secondary level or local level subrecipient activities. The results of monitoring review engagements completed by BMCS personnel are communicated to subrecipient agency management, OHP and to the ODJFS Audit Resolution Section for corrective action, if appropriate.

Executive Medicaid Management Administration (EMMA)

EMMA's Legal and Program Integrity Subcommittee (LPI) focused its efforts on analyzing and evaluating Ohio Medicaid program integrity methods with the goals to eliminate duplication of effort, reduce administrative burdens on agencies and providers, and prioritize activities based on risks. The agencies participating in the LPI meetings included the Departments of Mental Health, Developmental Disabilities, Alcohol and Drug Addiction Services, Health, Aging and ODJFS. The Office of Budget and Management's Internal Audit Division also attended the meetings.

In 2010, the LPI examined the processes and controls in place in each agency to ensure utilization review efforts were being conducted consistently across agencies. The group also discussed controls over the accountability of federal stimulus (ARRA) funds to ensure the proper tracking and reporting of expenditures and established a uniform format for the reporting of Medicaid overpayments identified by each agency.

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. The training needs of employees from Medicaid program integrity units are primarily addressed; however, employees from other Medicaid components may also participate depending on the course objectives. In 2010 ODJFS sent ten employees for training at the MII to enhance their skills in data mining, fraud detection, and medical coding.

Conclusion

As indicated throughout this report, ODJFS 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 Used in This Report

ACF	Administration for Children and Families
AG	Ohio Attorney General
AOS	Ohio Auditor of State
CAU	Cost Avoidance Unit
CDJFS	County Department of Job and Family Services
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
CRIS-E	Client Registry Information System-Enhanced
EMMA	Executive Medicaid Management Administration
FAO	Final Adjudication Order
FFY	Federal Fiscal Year
HHS	U.S. Department of Health and Human Services
ICFs-MR	Intermediate Care Facilities for the Mentally Retarded
IEVS	Income Eligibility and Verification System
LPI	Legal and Program Integrity Subcommittee
MCP	Managed Care Plan
MEQC	Medicaid Eligibility Quality Control
MFCU	Medicaid Fraud Control Unit
MII	Medicaid Integrity Institute
MITS	Medicaid Information Technology System
MMIS	Medicaid Management Information System
NFs	Nursing Facilities
ODJFS	Ohio Department of Job and Family Services
OMB	U.S. Office of Management and Budget
PARIS	Public Assistance Reporting Information System
PASSPORT	Pre-Admission Screening Providing Options & Resources Today
PDD	Procedure, Drug and Diagnostic (MMIS file)
SURS	Surveillance and Utilization Review Section
TANF	Temporary Assistance to Needy Families
TPL	Third-Party Liability