



**Department of
Job and Family Services**

**Medicaid Program Integrity Report
For Calendar Year 2009**

To Governor Strickland 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) 2009 (October 1, 2008 – September 30, 2009), Ohio Medicaid provided health care coverage to approximately 2.3 million eligible Ohioans. Ohio's total Medicaid expenditures were \$14.3 billion (state and federal funds) during FFY 2009. Of that total, Ohio contributed about 31 percent, or \$4.4 billion, and drew down about \$9.9 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, system controls, pre-payment review, post-payment review, contract management, participant eligibility testing and subrecipient monitoring to detect fraud, waste and abuse. Included within subrecipient monitoring is an examination to determine whether entities receiving funding through ODJFS are conducting adequate monitoring of their subrecipients and of any Medicaid disbursements to further strengthen the system of internal control.

In achieving coverage, the continuum includes efforts of those in many state agencies (e.g., ODJFS, the Ohio Department of Aging (ODA), the Ohio Department of Alcohol and Drug Addiction Services, the Ohio Department of Mental Health, the Ohio Department of Developmental Disabilities (ODD), the Ohio Department of Health, the Ohio Department of Education, the Auditor of State (AOS), the Attorney General (AG), and the Executive Medicaid Management Administration (EMMA), county departments, 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 identify 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 integrates a multifaceted approach to ensure that Medicaid providers are paid correctly and appropriately. Beginning with provider enrollment and continuing through to payment, Ohio Medicaid 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 by creating a provider file within the Medicaid Management Information System (MMIS).

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

Approximately 840 Medicaid provider applications are received each month. (This number includes new and resubmitted applications that were returned to the applicant for incomplete information). In July 2009, 93,856 active providers were enrolled in the system.

The department is commencing its third purge of the Provider Master File in six years, since given permissive authority in H.B.66 to terminate providers who have not billed the department in a 24-month period. The last purge was in July 2008, when a little over 22,000 providers were identified as not having billed the department in a 24-month period. When these providers were notified of their pending termination, about 5,000 requested and were permitted to remain on the provider rolls. Notice of the upcoming purge will be mailed to approximately 16,000 providers who have not billed the department in 24 months. These providers will also have the opportunity to request to remain on the provider rolls.

During the last biennium, the legislature approved the ODJFS plan to implement seven-year time-limited agreements for providers enrolling in the Medicaid program. So far the department has enrolled in excess of 20,000 providers with time-limited agreements since the time-limited provision of HB 119 was implemented on January 1, 2008. ODJFS is using a phased-in approach to convert the remaining 73,000 providers who were enrolled prior to the January 1, 2008, implementation date for time-limited agreements. These providers, currently operating under an open-ended agreement, are, according to the five-year phase-in schedule, now beginning to receive notice from the department that their open-ended agreement has been officially closed and that they will be further notified of when their re-enrollment application must be submitted to the department for review and approval. The phase-in will be completed by December 31, 2015, and, at that time, all applicable Medicaid providers will be enrolled under time-limited agreements.

Provider terminations for 2009 totaled 1,720. Of these, 1,128 providers had been enrolled as service providers under Medicaid's various waiver programs. Reasons for termination included non-compliance with waiver program rules, failure to renew their annual background checks, and health care fraud and abuse. The remaining provider terminations were of physicians, osteopaths, dentists, ambulettes, chiropractors and certified nurse anesthetists. Reasons for termination included a failure to renew licensure, license revocation and health care fraud.

Provider Education and Resources

In 2009, Ohio Medicaid provided 19 training sessions to a variety of provider types. More than 400 providers attended the sessions, which were focused on educating providers on how to properly bill the Medicaid program. These training sessions increased communication, helped to minimize billing issues, and strengthened provider relationships.

In addition to provider training, Ohio Medicaid includes on its Web site information targeted to providers. Providers can find links to information related to enrollment, billing, remittance advice, manuals and other provider-related topics.

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, whereas paper claims may require 30 days for processing), and providers may search the portal for the status of submitted claims. In 2009, 542,276 claims were submitted through the Web portal, resulting in payments of \$272,969,913.

Providers are also able to verify Medicaid recipient 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 2009, providers submitted 4,886,584 eligibility inquiries through the Web portal.

CyberAccess

ODJFS has contracted with its pharmacy vendor to provide the CyberAccess system. CyberAccess is a user-friendly Internet portal for providers to access important clinical information regarding their patients. Prescribers can also use the tool to verify a drug's prior authorization status and to send "e-prescriptions" to pharmacies. The CyberAccess tool is a Web-based, Health Insurance Portability and Accountability Act (HIPAA)-compliant portal that provides prescribers and/or their authorized staff with the ability to review two years of patients' prescribed drug history paid by Medicaid. This enables providers to identify care management concerns, including potential overuse, abuse or "doctor shopping" behavior.

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. Without these systems, it would be virtually impossible to process all that is required. 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.

PARIS

The Public Assistance Reporting Information System (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 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, and interstate public assistance benefit payments for the Temporary Assistance for Needy Families (TANF), Food Assistance and Medicaid programs. In August 2007, the PARIS database began to collect Child Care (in Ohio this is a mix of TANF, Title XX, Food Assistance, and Child Care Development Grant funding) 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.

IEVS

Ohio is operating an income and eligibility verification system (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. 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 (UR) 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 is too soon, or if the drug duplicates therapy for the consumer. In calendar year 2009, edits were added to limit some drugs to certain ages, limit the quantity of certain drugs allowed per day, and add/refine prior authorization criteria.

Third-Party Liability (TPL) 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. By checking Medicare and health insurance eligibility rolls before processing claims (“cost avoiding”), Ohio saved \$758,761,867 in calendar year 2009, an increase of \$200 million over calendar year 2006.

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 2009, 52,473 prior authorization requests were received. Of those requests, 37,144 were approved. Of the approved requests, \$79,829,781 was requested in reimbursement, and \$48,670,629 was approved, a savings of \$31,159,152.

Post-payment Review

ODJFS has in effect a program to prevent and detect fraud, waste and abuse in the Medicaid program. Where cases of suspected fraud to obtain payment from the Medicaid program are detected, providers will be subject to a review or an audit by ODJFS. 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.

CareStar

Consumers enrolled in Ohio Medicaid's Home Care Waiver and Transitions Waiver benefit packages receive a variety of home care services through a contracted case management agency, CareStar. These services include needs assessment, service planning, care coordination and quality assurance.

As part of its contract responsibilities, CareStar conducts structural reviews of non-agency providers of waiver services and, as a result, may discover evidence of possible overpayments. For routine overpayments associated with billing errors, CareStar refers information to ODJFS for potential collection. CareStar also forwards to ODJFS information related to suspected provider fraud. If further investigation confirms the suspicion of fraud, ODJFS makes a referral to the AG.

As a result of CareStar's efforts, \$1.3 million in potential overpayments were referred to ODJFS for recovery in SFY 2009.

Third-Party Liability (TPL)

In addition to the cost avoidance activities that Ohio Medicaid conducts prior to paying a claim, it also “pays and chases” claims. Pay and chase occurs when the Ohio Medicaid program pays the claim and then attempts to later recover the amount paid from a liable third party. The Ohio Medicaid program uses a contracted vendor to conduct pay and chase activities. In calendar year 2009, Ohio Medicaid recovered \$79,023,389 as a result of its TPL pay and chase efforts.

Surveillance and Utilization Review

The Office of Fiscal and Monitoring Services 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 the period of this report, 2,398 provider reviews were conducted, with total identified overpayments of \$6,019,090.

Audits are a formal post-payment examination, made in accordance with generally accepted auditing standards, of a Medicaid provider’s records and documentation to determine program compliance, the extent and validity of services paid for under the Medicaid program, and to identify any inappropriate payments. The department has the authority to use statistical methods to conduct audits and to determine the amount of overpayment. An audit may result in a final adjudication order by the department.

A review is a post-payment limited scope investigation; special project and/or special analysis; and/or an examination or monitoring of a Medicaid provider’s records, claims and/or supporting

documentation to determine quality of care, compliance with accepted standards of care, program compliance, and/or validity of services rendered, billed or paid for under the Medicaid program. A review may result in the denial of invalid services or claims and/or the collection of overpayments.

During the course of normal of operations, Medicaid providers sometimes discover instances when they were overpaid by the Medicaid program. When this occurs, providers contact the department with the overpayment information and remit payment. Providers who utilize the self-reporting vehicle are not charged interest on overpayments, in accordance with Ohio Administrative Code. During calendar year 2009, providers conducted 21 self-reviews, for a total overpayment of \$533,317.

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. SURS refers all cases of suspected provider fraud to the MFCU, as mandated by 42 CFR 455.21(a)(1). As needed, SURS then performs a support function to MFCU by providing access to and/or copies of any records or information, access to computerized data, and access to provider information, while protecting the privacy rights of Medicaid consumers. 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. The Health Care Fraud section is recognized as a leader among similar units across the country.

SURS accepts referrals from the 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 Program Safeguard Contractor (PSC), to discuss procedures, potential areas of risk and other relevant investigatory information.

Medi-Medi

In 2001, the Centers for Medicare and Medicaid Services (CMS) established the Medicare-Medicaid (Medi-Medi) match program, which analyzes claims data from both programs to detect patterns that may not be evident when billings for either program are viewed in isolation. In 2004, the state of Ohio elected to participate in this program. 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.

This program targets areas of potential fraud and/or abuse through input by the Medi-Medi Steering Committee or other internal/external sources. To accomplish this task, 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.

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, the HHS, the United States Department of Labor, the Medicaid Fraud Control Unit of the AG's Office, 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 governmental organization to combat fraud and abuse.

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 their actual Medicaid costs incurred to run the program (administrative costs, direct services costs or both types of costs). Based on the federal requirement, ODJFS currently monitors the following cost report types as submitted by Medicaid providers:

- Developmental Centers - Associated with ODD;
- Pre-Admission Screening System Providing Options & Resources Today (PASSPORT) - Associated with the ODA;
- 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 the Developmental Center and PASSPORT agency cost reports at least once every three years. The majority of Medicaid audit resources for calendar year 2009 were used for the SURS monitoring of Medicaid providers and for monitoring of NFs and ICFs-MR. The department issued 280 proposed adjudication orders (PAOs) totaling \$6,972,222 for cost report adjustments of NFs and ICFs-MR for calendar 2009.

Payment Error Rate Measurement (PERM) – Medical Records and Claims Processing

The Office of Health Plans (OHP) participates in two facets of the PERM audits: the data processing review of claims and the medical review of claims. In 2009, OHP worked with CMS on the FFY09 PERM audit. As of January 21, 2010, no errors were identified in the 592 claims selected for the data processing review, and 5 errors were identified in the 202 claims selected for the medical review.

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.

Permedion

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. Permedion reviews more than 1,000 claims per month. 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. Permedion also performs pre-certifications for certain inpatient medical procedures. Precertification is an approval a hospital must obtain for certain procedures to be performed in an inpatient hospital setting. (These procedures would normally be performed in an outpatient setting.) Permedion receives about 264 requests per month. For SFY 2009, Permedion completed 1,454 reviews, which resulted in 19 denials.

Permedion also provides technical assistance to policy and operational units within ODJFS. A minimum of 200 hours of technical assistance in each SFY is provided, including expertise and guidance, as needed, in support of policy and operational functions.

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. SURS monitors the deliverables on a monthly basis.

The Ohio Auditor of State

The AOS audits Medicaid providers under Section 117.10, Ohio Revised Code. In order to reimburse the AOS for its Medicaid audit services, ODJFS enters into a formal agreement (letter of arrangement). This letter of arrangement outlines the services that will be provided by the AOS, responsibilities of the AOS and ODJFS under the arrangement, and the deliverables that will be provided as a final product. During calendar year 2009, the AOS issued 21 reports with findings and interest totaling approximately \$4.1 million.

The Medicaid Fraud Control Unit

Each year, the United States Department of Health and Human Services / Office of the Inspector General publishes a statistical comparison of the fifty (50) Medicaid Fraud Control Units (MFCU) around the country.

For FFY 2008 (10/01/07 – 09/30/08), the most recent period for which statistics are available:

- The Ohio MFCU ranked fifth in terms of gross dollar recoveries;
- The Ohio MFCU ranked fourth in terms of gross numbers of convictions; and
- The Ohio MFCU ranked first in the nation, when jointly comparing convictions-per-professional-staff and recoveries-per-grant-dollar.

In 2009, the MFCU Unit achieved:

- 82 indictments;
- 114 convictions; and

- \$87.9 million in recoveries.

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, along with the Ohio AG's Office, a program integrity group that meets quarterly. 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. Testing is done to monitor the work done in relation to eligibility determination as this eligibility is truly the source that moves further claims toward payment.

Medicaid Review

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 the consumers were eligible for services during the month under review. The MEQC review consists of a review of the case record at the county department of job and family services (CDJFS) and a field investigation to verify income, resources and other factors of 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 to each CDJFS and OHP. The total case findings for the year are reported to the CMS. The report to HHS 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 county departments of job and family services to address error findings over the review year.

Payment Error Rate Measurement (PERM) - Eligibility

42 CFR 431.978 and 431.980 require states to conduct monthly Payment Error Rate Measurement (PERM) eligibility reviews of a sample of Medicaid and Children's Health Insurance Program (CHIP) cases to determine whether these cases were correctly determined to be eligible, denied or terminated. The regulations require states to conduct these reviews and provide case review findings data to HHS for purposes of estimating improper payments in the Medicaid and CHIP programs as required by the Improper Payments Information Act of 2002. After each sampled Medicaid and CHIP case is reviewed, states are required to determine the amount of any claims paid for services rendered in the review month and during each of the four months following the review month. This information is reported to HHS for the purposes of determining a state and national dollar error rate. This review is required to be conducted during one year out of every three-year cycle. Ohio conducted the PERM eligibility review in FFY 2009.

County Support

Training is offered to county agency staff through statewide videoconferences to all county departments of job and family services. Agenda items are based on review findings from various review activities (MEQC reviews, PERM 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 county departments of job and family services 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. County departments of job and family services may also request individualized videoconference training to meet their specific training needs. In 2009, 22 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 2009, OHP staff responded to 4,793 technical assistance questions.

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

Subrecipient Monitoring

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

County Monitoring

These monitoring reviews focus on evaluating internal controls related to determining eligibility by county agency staff. To support this effort, county monitors from the ODJFS Bureau of Monitoring and Consulting Services (BMCS) utilize a Guided Self-Assessment (GSA), which consists of a two-step method for introducing the need for functioning internal controls and capturing information about county activities.

Within each major GSA area, applicable federal and state requirements are outlined. This is followed by series of questions to elicit responses about the processes in place within the county agency and the related internal controls to provide reasonable assurance the agency is complying with these federal and state requirements. The document provides examples of possible internal controls that may be effective at limiting errors and ensuring program objectives are met. For example, the use of supervisory reviews and quality control checks is encouraged, as well as controls to ensure eligibility redeterminations are processed timely. Program eligibility is one major area for review.

GSA completion includes direct contact with BMCS county monitoring staff, who interview county agency staff to assist in the completion of the GSA document and to gather background information for the review. A completed GSA, along with supporting documentation, is reviewed by BMCS county monitoring staff to determine whether internal controls are reasonably designed to ensure program compliance. This may include a testing of the related internal controls. A Technical Assistance Report is issued 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 may be reviewed. This review is generally designed to answer three questions:

- Are the consumers receiving Medicaid-eligible services;
- Is there documentation of costs claimed; and
- Has the county implemented procurement processes and contract management processes designed to ensure the most cost-effective service delivery model and accurate provider payments?

County monitors may also review county agency cost allocation processes to ensure internal controls provide reasonable assurance that administrative costs were 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 BMCS 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. Through the utilization of risk assessments and dollar magnitude of expenditures, the typical compliance areas encompassed within the review scope include, but are not limited to, activities allowed or unallowed, allowable costs, cash management, matching, period of availability, and subrecipient monitoring.

As a result, testing performed provides assurance as to the allowability of administrative costs incurred by the subrecipient state departments and provides for the assessment of their monitoring of secondary level or local level subrecipient activities. The results of monitoring review engagements completed by BMCS personnel are communicated to subrecipient management, OHP and to the ODJFS Resolution Section for corrective action, if appropriate.

Executive Medicaid Management Administration (EMMA)

EMMA's Legal and Program Integrity Subcommittee (LPI) has focused its efforts on analyzing and evaluating Ohio Medicaid program integrity methods with the goals to eliminate duplication of effort, reduce administrative burden on agencies and providers, and prioritize activities based on risks.

In 2009, the LPI conducted a SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis of Ohio Medicaid activities. A summary of the findings showed that the present system activities are effective in protecting the integrity of the Medicaid program despite the fact that they are performed in a decentralized manner. The similarities and differences identified through this analysis form the baseline for the ongoing work of the subcommittee and its efforts to ensure that critical program integrity issues are adequately addressed in accordance with their risks and that coordination and accountability across state agencies is clear.

The SWOT analysis resulted in the LPI identifying three issues for continued focus: 1) the integration and expansion of the SURS function into Medicaid partner agencies, 2) the fiscal and program integrity goal that claims payment for behavioral health services be elevated to the state level, and 3) development of a process that changes the current agency practice of modifying program integrity provisions in isolation to provide that initiatives/changes be shared and approved by the LPI prior to implementation.

In addition to the three issues above, the LPI is also working on developing a consistent policy for provider background checks for application across all Medicaid programs, with the goal of increasing the system's effectiveness in barring individuals with prohibited offenses from employment as direct care Medicaid providers.

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. Courses are designed to meet the training and education needs of state Medicaid program integrity employees. The MII provides a unique opportunity for CMS to offer substantive training, technical assistance and support to the states in a structured learning environment.

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. ODJFS has sent several employees for training at the MII.

INITIALISMS

ACF	Administration for Children and Families (Agency of HHS)
AG	Ohio Attorney General
AOS	Ohio Auditor of State
BIC	Business Intelligence Channel
BMCS	Bureau of Monitoring and Consulting Services
CDJFS	County Department of Job and Family Services
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CRIS-E	Client Registry Information System-Enhanced
EMMA	Executive Medicaid Management Administration
FFY	Federal Fiscal Year
GSA	Guided Self Assessment
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
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
MMIS	Medicaid Management Information System
NFs	Nursing Facilities
ODA	Ohio Department of Aging
ODD	Ohio Department of Developmental Disabilities
ODJFS	Ohio Department of Job and Family Services
OMB	U.S. Office of Management and Budget
PAO	Proposed Adjudication Order
PARIS	Public Assistance Reporting Information System
PASSPORT	Pre-Admission Screening Providing Options & Resources Today
PDD	Procedure, Drug and Diagnostic (MMIS file)
PERM	Payment Error Rate Measurement
SURS	Surveillance and Utilization Review Section
SWOT	Strengths, Weaknesses, Opportunities and Threats
TANF	Temporary Assistance to Needy Families
TPL	Third-Party Liability