Program Integrity
2021 Annual Report

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Table of Contents

Introduction

The Ohio Department of Medicaid (ODM) remains focused on increasing accountability and transparency in its administration of the Medicaid program, and this commitment shapes our program integrity work. ODM started 2020 working to improve collaborations with program integrity partners, to identify and prevent fraud in the program, and to improve its eligibility determination process through additional monitoring and active remediation of audit findings. In March, as the threat of a global health crisis emerged due to coronavirus, Governor Mike DeWine declared a public health emergency (PHE) for the state of Ohio. That declaration required ODM to adjust its work to maintain access to services while mitigating the risk of COVID exposure or spread among Medicaid members and providers. It also foreshadowed a spike in Medicaid enrollment as access to employer-sponsored health coverage decreased with the state's growing unemployment rates and federal financial supports were conditioned upon maintaining pre-COVID eligibility criteria and foregoing annual eligibility redeterminations.

Between March and June, ODM's agencywide priorities shifted from business as usual to focus on ensuring Ohioans could access essential health services amid an unprecedented global health crisis. During this time, standard program integrity practices such as monthly on-site facility visits were either modified or postponed as a precautionary measure against COVID. In June, ODM responsibly resumed program integrity activities, continuing to strive for accountability and transparency in the operation of the state's Medicaid program.

Overview

ODM created the Bureau of Program Integrity (BPI) in late 2014. BPI coordinates activities across ODM business units and external stakeholders in order to better detect fraud, waste, and abuse. BPI also supports internal and external fraud, waste, and abuse preventions efforts, including cost containment, compliance, and quality of care. We are all responsible for ensuring program integrity as part of our everyday work, and we each have a role in the fight against fraud, waste, and abuse.

Therefore, while BPI is a functioning business unit within ODM, program integrity is also the continuum of activities carried out to ensure Ohioans receive the care they need and safeguard Ohio's Medicaid program from fraud, waste, and abuse. These activities include provider enrollment and support, automated system controls, law-enforcement coordination, pre-payment review, post-payment review, managed care oversight, participant eligibility reviews, sub-recipient monitoring, staff training, and more. ODM monitors its providers, sub-recipient network, and managed care plans to better regulate program integrity risk, promote compliance, and provide technical assistance and training throughout Ohio's Medicaid system.

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

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

- Determining whether providers are billing properly;
- Conducting unannounced pre- and post-enrollment provider site visits;
- Performing onsite provider reviews and audits;
- Monitoring the program integrity activities of managed care organizations (MCO);
- Suspending and/or terminating providers for program violations;
- Reimbursing providers in accordance with established policies;
- Conducting provider post-payment reviews and audits to identify and collect overpayments and identify possible utilization issues;
- Screening and enrolling providers and consumers into the program promptly and accurately;
- Ensuring the reliability of databases used for determining reimbursement rates;
- Educating providers and individuals on their responsibilities and rights;
- Responding to provider and individual questions effectively and promptly;
- Maintaining appropriate documentation of policies, procedures, and systems;
- Identifying and analyzing possible cases of fraud, waste, and abuse;
- Monitoring the utilization and quality of care by providers and individuals;
- Coordinating and tracking the submission of fraud, waste, and abuse referrals;
- Conducting deconfliction with MCOs to eliminate interference with law enforcement activities;
- Providing education and training to managed care organizations.

Provider Network Management & 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 utilizes a variety of methods to promote program integrity. ODM's provider network management work supports program integrity for both fee-for-service and managed care payments.

42 CFR 455 Subpart E outlines federal requirements for provider screening and enrollment. ODM contracts with over 163,755 active providers and screens each of these providers 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. Per 42 CFR 455.434, Ohio requires fingerprint and background checks for owners and managing employees of high- and moderate-risk provider organizations. 42 CFR 455.432 requires that state Medicaid agencies conduct 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 unannounced site visits on behalf of the department. In calendar year 2020, PCG completed 130 unannounced site inspections on behalf of Ohio Medicaid.

Based on the results of the site visits, further action may include provider sanctioning, corrective action, or referral to the Ohio Attorney General's Office in cases of suspected fraud. As a result of these site visits, ODM denied four provider applicants because of non-compliance or Plan of Correction issues.

Provider Enrollment

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

ODM Provider Enrollment built system interfaces with various federal databases (e.g., System for Award Management Exclusion Database, Medicare Exclusion Database, the Social Security Administration Death Master File, State of Ohio exclusion and source databases (Department of Developmental Disabilities Abuser Registry, Ohio Professional License Boards through DAS e-license) and the National Plan and Provider Enumeration System). ODM then screens applicants, disclosed owners, and/or individuals with controlling interest and managing employees against these resources upon submission of the application to determine if they are excluded from receiving federal funding for various program integrity reasons.

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

As an additional program integrity effort, compliance staff in the Network Management Bureau review monthly actions taken by professional licensing boards (as available on public resources such as their respective websites) to determine if any Ohio Medicaid providers have been disciplined by their professional licensing boards. ODM also implements a manual review and update of all license statuses for out-of-state providers enrolled with Ohio Medicaid.

Suspensions for Credible Allegations of Fraud

Ohio Revised Code 5164.36 requires ODM to suspend payments and the provider agreement when it determines that a credible allegation of fraud exists against the provider. In 2020, Ohio Medicaid suspended 20 providers due to credible allegations of fraud. The Bureau of Network Management collaborates with the Ohio Attorney General's Office, Medicaid Fraud Control Unit, and ODM's Bureau of Program Integrity to determine when it should suspend providers for credible allegations of fraud.

Provider Education and Resources

In 2020, ODM led provider consultations, presented at seminars and association meetings, and conducted provider training for federally qualified health centers (FQHCs) and pharmacists. Consultations are one-on-one meetings to address each provider's unique issues. These activities enhance communication, minimize billing discrepancies, and strengthen provider relations. If ODM identifies a provider or group of providers having difficulty meeting ODM requirements, it works with sister agencies, including ODA, DODD, and MHAS, to provide consistent education and training. In addition to provider training, ODM includes resources for providers on its website, such as billing instructions, Medicaid rules, and enrollment information.

MITS Web Portal

ODM's web portal supports Medicaid providers in a variety of ways. Providers utilize the portal to view reader-friendly versions of remittance advice. Providers also can submit claims via the web portal. Claims submitted through the portal are adjudicated more quickly, and providers may search the portal for the status of submitted claims. Approximately 1.5 million claims were submitted through the web portal between Jan. 1, 2020, and Dec. 31, 2020, resulting in payments of nearly $1 billion.

Providers also can research Medicaid beneficiary eligibility via the portal and will know immediately whether an individual is enrolled in Medicaid and whether they have any third-party insurance in addition to Medicaid or the Medicaid program category they participate in. Between Jan. 1, 2020, and Dec. 31, 2020, providers submitted over 18 million eligibility inquiries through the web portal.

Automated System Controls

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

Medicaid Information Technology System (MITS)

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

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

Pre-Payment Review

The ideal time to discover an inappropriate Medicaid claim is before payment is made. Therefore, pre-payment screenings are performed on claims submitted by providers. This section describes ODM's pre-payment review procedures that apply to fee-for-service payments.

Limit Parameters within MITS

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

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

Pharmacy Point-of-Sale

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

ODM uses COB3 methodology for the processing of claims submitted with primary Cost Avoidable coverage on the date of service. Prescription pricing through Change Healthcare's point-of-sale system utilize Other Payer Amount Paid and Other Payer Patient Responsibility Amount to determine the ODM payment for the claim.

Third-Party Liability Cost Avoidance and Collection

Healthcare providers are prohibited from billing ODM for services when third-party resources are responsible for payment. Third-party resources may include private insurance companies, Medicare, or court-ordered coverage. With a few exceptions, ODM is generally the payer of last resort under state and federal law. Ohio Medicaid staff aggressively monitor payments and update its systems to ensure that claims pay properly.

Through the work of ODM's Cost Avoidance staff, the state of Ohio avoided more than $824 million in billed charges for healthcare services during calendar year 2020. Changes in insurance or other events can affect the payment responsibility after ODM has paid a claim. ODM contracts with the company HMS to collect payment on behalf of the department. HMS specializes in recovering medical expenses paid by the state when a legally obligated third-party source is later identified. In SFY20, HMS's activities resulted in more than $77 million being returned to Ohio Medicaid.

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. Prior authorization is required for certain medical-surgical, behavioral health, state plan home health, and other services considered to be experimental. It also includes services with limitations established by rule. Prior authorization reviews determine whether the requested service is medically necessary, and the setting is medically appropriate. ODM contracts with Permedion to conduct fee-for-service prior authorization reviews. In 2020, Permedion completed 3,811 reviews that resulted in 63 denials for an estimated savings of $538,460. Additionally, Permedion conducted pre-certification reviews for psychiatric inpatient hospital admissions. In 2020, Permedion completed 4,028 reviews resulted in 109 denials for an estimated savings of $536,607.

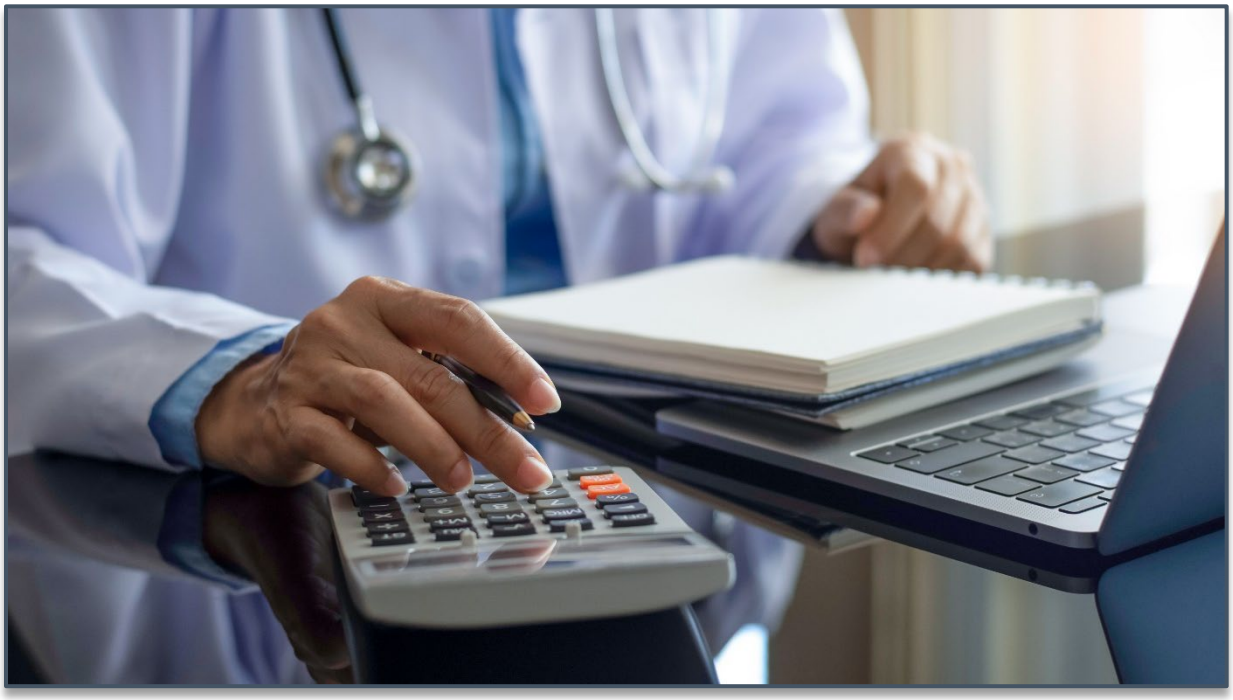
Post-Payment Review

If ODM identifies waste or abuse, it takes action to ensure compliance and recoup inappropriate payments through audits and reviews in accordance with rule 5160:1-27 or 5160:26-06 of the Ohio Administrative Code. Where fraud is suspected, ODM refers the case to the Ohio Attorney General's Medicaid Fraud Control Unit (AGO MFCU or MFCU) for further investigation. ODM conducts the post-payment review work described below on fee-for-service payments.

ODM-Administered Waivers

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

ODM contracts with the Public Consulting Group (PCG) to complete incident investigations, provider enrollment, provider oversight through structural reviews, and provider site visits. Site visits are a federal requirement for screening all moderate- and high-risk provider types at initial enrollment and 3-5 years later at provider agreement revalidation. These are short visits in nature focused on verifying the provider information on the application, such as service location address and the basic tenets of the Medicaid provider agreement such as HIPAA compliance and screening employees against exclusion databases. Structural reviews are an annual monitoring activity for home- and community-based service waiver providers. These reviews are more in depth and include a review of claims activity, daily activity sheets, the members' person-centered service plans, and any other relevant information. PCG conducted 1,281 structural reviews and 128 on-site visits in calendar year 2020. These reviews were used to identify issues that violated program rules and to educate providers about rule requirements. PCG and ODM worked with providers to address identified issues.



Issues that continued after being addressed resulted in further action, which could include provider sanctions and/or termination. Reviews are also used to uncover evidence of possible overpayments. For routine overpayments associated with billing errors, PCG referred information to ODM for potential collection. These efforts led to the referral of 131 potential overpayments, totaling just over $166,000, to Ohio Medicaid for recovery.

As of Nov. 13, 2018, ODM does not require non-agency waiver providers to submit an annual background check. Instead, ODM transitioned to utilization of the Ohio Attorney General's Bureau of Criminal Investigation's Retained Applicant Fingerprint Database continuous criminal record monitoring service ("Rapback Service") to obtain criminal record checks. Upon initial application, the applicant must submit an initial background check. Once ODM screens, approves, and enrolls the provider, he or she is enrolled into the rapback system. The provider remains in the system unless ODM terminates the provider agreement for one of the following reasons: voluntary termination, inactivity, non-compliance, or disqualifying convictions. The rapback system is a continued check of a person's background. If an individual is arrested and fingerprinted, ODM receives a report within 48 hours, allowing it to monitor the criminal case and take needed actions against a provider sooner. Since the utilization of rapback, ODM has suspended or terminated 18 providers for their criminal background. The rapback system allows ODM to act faster for the safety of ODM consumers; relying on annual BCI reports, depending on the court and crime, may have allowed 12-24 months to pass before ODM received notice of the conviction. The rapback system also eliminated an administrative burden for providers, who were previously required to annually submit a background check to ODM. Previously, ODM terminated hundreds of provider agreements annually for failing to comply with that requirement.

Surveillance and Utilization Review Section

The Surveillance and Utilization Review Section (SURS) is charged with helping the agency detect Medicaid fraud, waste, and abuse. SURS performs a majority of the data analysis for Program Integrity and combines clinical, audit, and data staff to meet its mission and goals.

In 2020, SURS completed 128 provider reviews and identified overpayments totaling more than $3.3 million and issued 26 reconsideration decisions that reconsider, or review, previous ODM overpayment findings. During normal operations, Medicaid providers sometimes discover instances when they were overpaid by the Medicaid program. When this occurs, providers contact the department with the overpayment information and remit payment. Providers conducted seven self-reviews in 2020 to remit approximately $510,000 in overpayments.

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 a provider committed fraud in the Medicaid program, SURS refers the case to the MFCU. As needed, SURS supports MFCU by providing copies of records and access to computerized data and provider information it has collected, while protecting the privacy rights of individuals receiving Medicaid benefits. SURS also accepts referrals from MFCU to initiate any available administrative action to recover improper payments made to providers.

Inpatient Hospital Reviews

ODM contracts with Permedion to conduct retrospective reviews primarily focused on inpatient hospital care. These reviews assist the agency in determining whether care rendered to a beneficiary meets

medical necessity and quality of care standards. Any hospital that is subject to a review may appeal its findings to Permedion. Should the finding be upheld at that level, the provider may request a Surveillance and Utilization Review. In 2020 Permedion reviewed 11,283 inpatient cases that resulted in 5,066 denials and/or adjustments to 4,707 claims for a savings of $32,600,252. Permedion also completed 772 outpatient reviews resulting in 354 cases being denied for a savings of $706,551.

Long-Term Care Facilities

The Long-Term Care and State Agency Audits Section focuses, in part, on post-payment reviews (PPR) of payments made to long-term care (LTC) providers. This section's PPR of LTC facilities' claims activity identified overpayment totaling $8,748,642 in calendar year 2020. These recoupments affected nearly all of Ohio's 1,500 LTC providers and resulted in nearly 2,500 individual payments received by ODM. BPI settled more than 2,100 overpayments with Ohio's long-term care providers.

Cost Report Audits

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

- Developmental Centers: associated DODD;
- PASSPORT: associated with ODA;
- Nursing Facilities (NFs); and
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID).

In compliance with state rule, ODM utilizes a risk-based approach to audit Developmental Center and PASSPORT agency cost reports at least once every three years. ODM contracts annually with the Ohio Auditor of State (AOS) to perform certain cost report audits. During calendar year 2020, the AOS cost-report work included:

	Started	Completed
Passport Agencies	**5**	**5**
ICF-IIDs	**11**	**11**

ODM delayed any cost report audits of Developmental Centers in calendar year 2020 due to the PHE but will still meet its goal of auditing each Developmental Center at least once every three years. ODM coordinates with DODD on the risk-based selection of ICF-IIDs for cost report review purposes. Additionally, ODM coordinates with DODD to determine the final disposition and related follow-up actions for all entries listed on the AOS' reports detailing the results of these reviews.

Medicaid Provider Incentive Payment (MPIP) Reviews

The American Reinvestment and Recovery Act (ARRA) was enacted on Feb. 17, 2009, and included measures to modernize our nation's infrastructure. One of these measures is the "Health Information

Technology for Economic and Clinical Health (HITECH) Act." The principle goals of the HITECH Act are to promote coordination and improve the continuity of healthcare among providers; reduce medical errors; improve population health; reduce health disparities; reduce chronic disease; and advance research and education. The HITECH Act established Medicare and Medicaid Electronic Health Record (EHRs) incentive programs to promote the adoption of EHRs. State Medicaid programs had the option of receiving 100% of their expenditures from the federal government for incentive payments to certain providers; the state agency then monitored and paid the EHR incentive payments.

BPI conducts two types of reviews of these incentive payments:

1. eHospitals.
2. eProfessionals (e.g., doctors, dentists, nurse practitioners, etc.)

In 2020, BPI completed 27 eHospitals and 339 eProfessionals reviews and identified approximately $6,553,537 in overpayments and $1,127,124 in underpayments.

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. To do this, ODM operates a clearinghouse of five 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 sister agencies, and ODM contractors submit fraud referrals to the clearinghouse. If the referrals provide a 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 that are home health and/or waiver related to the MFCU at a bimonthly home health and waiver fraud referral meeting

designed to share knowledge of home health and waiver fraud schemes. All other referrals are sent to the MFCU weekly by ODM and not presented at a meeting. In calendar year 2020, ODM submitted 452 fraud referrals to the MFCU, and the MFCU accepted 280 of these referrals for investigation.

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 2019, the most recent statistics available. The unit processed 826 complaints in calendar year 2020, posting 143 indictments, 115 convictions, and 21 civil settlements. Recoveries totaled $40.9 million.

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.

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 also meets monthly for education and information sharing and promotes collaboration among Ohio's program integrity partners.

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 ODM, the AOS issued 12 reports with findings and interest totaling approximately $3.5 million in calendar year 2020. 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 on field audits and auditing best practices.

Managed Care

ODM ensures program integrity in its managed care program through its own oversight and monitoring of its MCOs and through the program integrity work required of the MCOs. Managed care and MyCare Ohio MCOs 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 additional cooperation with law enforcement.

As discussed above, ODM continues to build a collaborative relationship with the MCOs' Special Investigative Units through its MCPIG meetings. These meetings are held at least eight times a year to educate and train managed care plan special investigative unit and program integrity staff, and share information concerning fraud, waste and abuse among law enforcement, the Ohio AOS, and the MCOs. The MFCU, ODM, and the MCOs' special investigative unit lead representatives also meet regularly to discuss Medicaid provider fraud investigations and coordination. These meetings assist the MCOs in

proactively identifying and addressing potential provider fraud and abuse issues and ensure coordination with law enforcement and ODM.

ODM produces an annual managed care fraud, waste, and abuse report that details all of the MCOs' program integrity activities accomplished during the previous calendar year. ODM supplements the provision of training, coordination meetings, and quarterly technical advice with a regular newsletter, the MCPIG Messenger, to address any gaps or MCO questions. Our program integrity partners, AGO MFCU, and the AOS, regularly contribute to each newsletter.

ODM staff, including BPI members, also participated in multiple managed care procurements throughout 2020. BPI assisted in designing requests for applications and scoring submitted bids for a managed care organization procurement, a single pharmacy benefit manager procurement, and the new OhioRISE procurement, which is a specialized managed care program for youth with complex behavioral health and multi-system needs

Managed Care and Provider Audit Section

ODM's Managed Care and Provider Audits section reviews the MCOs' program integrity activities and conducts its own reviews of ODM payments to the MCOs and payments the MCOs make to providers. The section works collaboratively with ODM business areas to identify reviews of payments with higher risks of errors, reviews suggested by other business areas as potential concerns, or reviews that support or monitor other ODM work. In calendar year 2020, it received and reviewed four quarterly inventory reports from each of the MCOs. MCOs are required under the provider agreement to submit a quarterly report to ODM of audits and investigations performed, overpayments identified and recovered, fraud, waste, or abuse (FWA) referrals made, other program integrity actions taken, list of involuntary terminations and denied credentialing applications, and recipient fraud referrals. The auditors reviewed each plan's program integrity-related activities and held four quarterly meetings with each MCO to provide feedback regarding their quarterly performances.

The team reviewed capitation payments made to the plans for individuals who received nursing facility level of care in calendar year 2017 plans. ODM pays the MyCare MCOs an increased capitation payment when a member enters a nursing facility. This increased payment is intended to compensate the MCO for the increased cost of care when a member is receiving nursing home services. The team identified an overpayment of $385,047.03 for payments not supported by proper billing and documentations and a draft report were sent to the plans.

The Managed Care and Provider Audit section also completed a review of a sample of paid and denied high-dollar inpatient hospital claims for all the managed care plans, excluding Aetna. This project was a request from ODM's Office of Managed Care and assessed the MCP's hospital payment methodologies, which could result in slow payment or no payment at all. The auditors reviewed samples of paid and denied claims and BPI issued reports with recommended changes in some cases.

The section also includes a clinical audit team, with nurse reviewers that support that section and increase its ability to conduct meaningful reviews of managed care-related payments. This team evaluated SFY 2017 delivery kick payments that reimburse MCOs for certain members' childbirth deliveries. This review identified and recovered over $7 million in overpayments from the MCOs. The clinical audit team also collaborated with ODM's Clinical Operations Bureau to conduct a chart review of a sample of Ohio Home Care Waiver enrollees in order to determine if services and durable medical

equipment were appropriately sorted and authorized to the correct payor, and to identify areas for future training, education, and/or guidance to the case management agencies.

Electronic Visit Verification

Section 12006(a) of the 21st Century Cures Act mandates that states implement Electronic Visit Verification (EVV) for all Medicaid personal care services and home health services that require an in-home visit by a provider. This applies to PCS provided under sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), and Section 1115; and HHCS provided under 1905(a)(7) of the Social Security Act or a waiver.

EVV requires home care providers that furnish PCS and HHCS services outlined by the Cures Act to electronically verify the services they deliver. Caregivers must record the visit date and time, visit location, individual receiving services, caregiver who is providing services, and the service provided.

ODM has contracted with Sandata Technologies to provide an EVV system to all impacted Medicaid providers at no cost. A mobile, GPS-enabled solution using a device provided by Sandata or an app on a device owned by the provider or caregiver is the preferred method of visit entry. Telephony and manual visit entry are available alternatives for those circumstances when the mobile solution is not available. All visit data collected with the Sandata system is stored in the aggregator and is available to substantiate information on claims.

Agency providers can choose to use an alternative data collection system that has satisfied business and technical requirements. Alternate data-collection systems must send all visit information to the Sandata Aggregator within 24 hours of data capture.

All payers (ODA, DODD, and MCOs) are required to use the same EVV solution and approach that is used by ODM.

During 2020, Ohio Medicaid completed implementation of EVV for the state. Below is a summary of the phased approach Ohio adopted in implementation of EVV:

- Phase 1: Implemented 01/18/2018
  - State Plan and Ohio Home Care Waiver Services
- Phase 2: Implemented 08/05/2019
  - Passport ODA services
  - IO and Level 1 Waiver DODD services
  - Comparable services accessed through traditional managed care and MyCare Ohio
- Phase 3: Implemented 09/04/2020
  - Participant Directed services
  - Home Health therapy services

Moving forward, ODM will continue to engage in program integrity efforts related to home- and community-based services using EVV to reduce fraud and abuse within the system and to improve 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 for them. The eligibility program integrity work described below applies to all individuals receiving Medicaid benefits, whether they are assigned to an MCO or in fee-for-service Medicaid.

Medicaid Eligibility Quality Control Reviews

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

The MEQC pilot reviews conducted by ODM focus on the 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.

In 2019, the MEQC unit completed a pilot review as required by CMS. The MEQC Unit reviewed 198 active Medicaid cases, 202 active Children's Health Insurance Program (CHIP) cases, 207 negative Medicaid cases, and 193 negative CHIP cases, for a total of 800 cases reviewed. The months under review were January to December 2019. At the conclusion of the pilot review, a case-level report on the findings of the reviews and a corrective action plan identifying all errors and deficiencies was submitted to CMS on Oct. 30, 2020. To ensure these corrective actions are improving the accuracy of county eligibility determinations, ODM increased the number of reviews that MEQC reviewers conduct outside of the CMS-required pilot and improved its tracking of the results.

To improve its tracking of these reviews, the MEQC unit worked with ODM ITS to build an online application, the Eligibility Quality Control (EQC) application, that will allow reviewers to more effectively identify and report eligibility error trends internally and to county partners. The MEQC unit began assisting with Medicaid application processing at the start of the PHE, but in October the unit initiated an eligibility case review project. The MEQC reviewers are evaluating the accuracy of the eligibility determinations for randomly selected Medicaid beneficiaries under multiple eligibility categories. This process includes reviewing caseworker actions, system actions, and documentation in the case file to determine the accuracy of the eligibility determination.

The project streamlined the MEQC's case review process and aligned the processes with CMS and the Department of Health and Human Services Office of Inspector General (HHS-OIG) eligibility-related audits. When a MEQC reviewer determines that a case contains an error or technical deficiency, the reviewer no longer redetermines the beneficiary's eligibility by gathering the month of review household information. The elimination of this step requires the reviewers to determine the individual's eligibility using only the actions and documentation in the case. At the conclusion of the case review, reviewers determine if the case is correct, an error, or a technical deficiency.

The MEQC unit is now able to use the EQC application for comprehensive case review reporting. ODM's IT department deployed two enhancements in the application to date. The EQC application captures the review findings in real time and allows users to identify current error and technical deficiency trends. The reporting capability assists in determining the root cause of errors and/or technical deficiencies, as well as categorizing these findings into areas of focus. The report shows the number of cases reviewed, the number of errors or technical deficiencies assigned, and the breakdown of the specific findings. The MEQC unit manager distributes the captured data on all the error/technical deficiency findings to ODM Technical Assistance (TA) and Operational staff on a monthly basis and to the county contact personnel at a county's request.

The MEQC unit developed a plan to share the error and technical deficiency findings with the county contact personnel by using a communicator form. This ensures that the counties are advised when errors and technical deficiencies are discovered. The counties must respond to the form and findings by a specific deadline, closing the loop to validate the issue is addressed. The MEQC manager unit tracks these notices to substantiate that the county was notified of the errors and the county addressed the error finding(s).

The MEQC unit coordinator also meets quarterly with ODM Technical Assistance and Compliance to share the information found during the reviews. Findings that are forwarded to the County Job and Family Services are also sent to ODM Compliance as a means to improve training focus as well improvements for Ohio Benefits.

Public Assistance Reporting Information System (PARIS)

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

The PARIS matching process is managed by the 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 (TANF), 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 42 USC 1320b-7(b). IEVS is a computerized system that matches the Social Security numbers of individuals receiving public assistance to other provider databases, including those of the Social Security Administration, Internal Revenue Service, State Wage Information Collection Agency, and Unemployment Compensation. When a match with any of these databases occurs, the information is returned to the state, which generates an electronic alert to the county eligibility worker responsible for the case. The county 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

County Eligibility Technical Assistance (TA) staff provide training support to county agencies to improve eligibility determinations. During calendar year 2020, TA presented numerous statewide Technical Assistance and Compliance Video Conferences and webinars. These sessions include discussions of recent Ohio administrative code policy changes and clarifications, eligibility system processing tips, and updates on current eligibility compliance activities. In addition, every other month ODM Technical Assistance and ODJFS provide joint sessions to cover topics affecting cash, food, and Medicaid programs.

TA offered a total of 35 targeted trainings on a variety of Medicaid policy and system topics throughout 2020. ODM recorded almost all of these sessions and the recordings are available for viewing by county staff at any time on the Medicaid innerweb page. New in 2020, ODM and ODJFS launched a combined new worker training that provides basic training to new workers on both system and policy for cash, SNAP, and Medicaid. In addition, attendees learn Ohio Benefits basics and wrap it all up with a Case Maintenance class. The entire course is 12 weeks and includes web-based prerequisite courses followed by instructor-led, virtual class work, and small-group session. To date, ODM and ODJFS have conducted three full classes.

ODM also developed a one-week long-term care worker training focused on training workers who may be experienced but are new to long-term care. Like the new worker training for all programs, long-term care training includes a week of web-based prerequisite courses followed by a week of instructor-led virtual training. This course also covers policy and system considerations for long-term care case processing. The pilot class concluded in October 2020 and ODM continued these courses in 2021.

Published materials include the Medicaid Matters newsletter, which is issued monthly and provides case processing tips, policy highlights, and questions and answers. County eligibility workers can also contact TA staff with eligibility policy questions through a shared email box.

Eligibility Compliance staff provide a variety of eligibility support to counties. Starting in CY 2019 and continuing through CY 2020, compliance staff engaged counties to reduce pending Medicaid applications and Medicaid renewal backlogs. Through three phases, staff sent weekly spreadsheets to counties with information on applications pending greater than 45 days and conducted weekly telephone calls with counties identified to have the highest backlogs. This work resulted in the reduction of pending applications statewide. Compliance staff monitor various reports for eligibility issues and reach out to county administrators to assist in resolution.

The County Engagement unit was formed in February 2020 and consists of five county engagement managers. Each are assigned 17 to 18 counties, including two metropolitan counties. Engagement managers are responsible for meeting with each county in their region once per quarter. The meetings address any questions the agency may have on eligibility policy or the Ohio Benefits system, identify training needs, review reports on county pending application and renewal backlog numbers, provide hypercare 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.

During CY 2019, ODM created a Central Processing Team. This work unit was designed to provide ongoing in-house support to enable ODM to understand fallout issues from system releases, process and fix errors to cases that are no fault of the counties, and to develop in-house expertise for requesting system enhancements suggested by the counties and identifying defects. This team will work with system vendors to enhance ODM's reporting capabilities and support county eligibility workers on presumptive eligibility issues.

Sub-Recipient Monitoring

Monitoring sub-recipients is required under 2 CFR 200 and includes review of current work performed by sub-recipients and the resolution of any required audits. When ODM passes on a portion of a federal award to another entity for the purpose of carrying out a portion of that federal award, as opposed to the purpose of obtaining goods or services, it creates a subrecipient relationship.[1]

County Monitoring

ODM continues to leverage its partnership with ODJFS to assist in monitoring county activities related to the Medicaid program. While ODM performs quality reviews of county-based eligibility determinations, ODJFS monitors the related administrative claiming and county-based non-emergency transportation services. ODJFS reviews of counties are risk-based and generally cover compliance testing and internal control. A Monitoring Review Final Summary report, summarizing the areas monitored and the significant observations identified (if any) and a copy of the county completed continuous improvement plans (CIP) for each significant observation is issued after each review. These CIPs are intended to help improve processes and internal controls and correct the significant observations moving forward for each CDJFS.

As part of this testing, the ODM protocol includes review of cost allocation for administrative costs claimed to Medicaid, consideration and possible review of direct charge Medicaid claims, and a review of the county NET program for procurement, accounting, and program compliance.

ODM coordinates with ODJFS for review and resolution of any Medicaid-related audit findings arising from federal compliance testing during the county single audits. The AOS or other independent public accountants perform these audits under 2 CFR 200 and ODM's Executive Audit Committee resolves any findings. Any open AOS County Single Audit findings related to Medicaid receive follow-up to determine

[1] ODM identified the Board of Pharmacy, CareStar Inc, the county departments of job and family services, National Church Residences, the Ohio Colleges of Medicine Government Resource Center, the Ohio departments of Aging, Developmental Disabilities, Education, Health, Mental Health and Addiction Services, and the PASSPORT administrative agencies as sub-recipients in CY 2020.

if the issues have been resolved as part of the planning and risk assessment process used by the ODJFS auditors reviewing counties.

Partner State Agency Monitoring

State agencies receiving Medicaid funding passed through from ODM are classified as sub-recipients, and are therefore subject to monitoring reviews. These agencies include DODD, ODA, ODE, ODH, and MHAS. BPI conducts these reviews using a risk-based approach. Monitoring reviews help provide reasonable assurance that sub-recipient state agencies are compliant with key federal and state regulations governing Ohio's Medicaid program. The overall objective is to ensure Medicaid program and fiscal operations across the Medicaid network are operating efficiently and effectively through program integrity processes and controls. Monitoring represents a host of activities including the provision of technical assistance in coordination with fiscal, policy and operations stakeholders.

For 2020, BPI staff participated in regularly occurring activities that help ODM monitor and support partner state agency activities such as performing a risk assessment and review of claimed costs, supporting provider enrollments and suspensions, managing fraud and abuse referrals, joint-coordination of AOS audit work performed for DODD and with ODA for ODM reviews on local Areas on Aging, and coordinating and reviewing AOS audits of Medicaid providers operating in the partner state agency portion of the network. BPI works collaboratively with ODM Policy staff who support the partner state agencies.

BPI efforts related to partner state agencies are designed to not only monitor compliance but also to prevent and detect FWA and promote quality of care for individuals receiving Medicaid benefits.

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 demonstrating ODM's compliance with the regulation or requirement the auditors are testing. 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 calendar year 2020, the AOS, HHS-OIG, and the Ohio Office of Budget and Management completed audits of ODM. ODM also developed and implemented corrective action plans for audits completed by CMS and the Internal Revenue Service during calendar year 2020. This work includes:

- The AOS completed a public interest audit focused on Medicaid eligibility determinations, and identified systems deficiencies with Ohio Benefits, Ohio's statewide eligibility system, and caseworker errors, and provided recommendations to improve the accuracy of eligibility determinations and reduce the risk of improper payments. ODM responded to these recommendations, identifying the steps it was taking to fix and improve the Ohio Benefits system and to work with counties to reduce caseworker errors.
- HHS-OIG completed a review of eligibility for a sample of Group VIII members, individuals who were newly eligible for Medicaid through the Affordable Care Act and received Medicaid-covered services from October 2014 through March 2015. HHS-OIG identified deficiencies in Ohio's eligibility determinations in this sample because the Ohio Benefits system lacked the necessary system functionality and eligibility caseworkers made errors. ODM responded to the

audit and identified the system changes, caseworker training, and additional eligibility determination oversight that it was implementing to respond to these errors.

- HHS-OIG also completed a review of individuals receiving Medicaid benefits in Ohio and concurrently receiving benefits in another state from July 1, 2018, through Sept. 30, 2018. HHS-OIG identified capitation payments that ODM made to MCOs for individuals also receiving benefits and residing in another state. In response to the audit, ODM identified system enhancements and caseworker training to prevent these errors in the future.
- In November 2019, ODM received CMS' Payment Error Rate Measurement (PERM) audit results that estimated ODM made $6 billion in improper payments during fiscal year 2018. In February 2020, ODM provided CMS with its corrective action plans for Medicaid and CHIP improper payments and continued to implement the system improvements and caseworker training to address this serious issue. The PHE required adjusting the timing of some of these changes, but ODM remained focused on these improvements throughout the year.