

**Department of Health and Human Services
Centers for Medicare & Medicaid Services**

**Medicaid Integrity Program
Ohio Comprehensive Program Integrity Review
Final Report
February 2011**

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Ohio Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Ohio Department of Job and Family Services (ODJFS). The review team also conducted an interview with the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Office of Fiscal and Monitoring Services (OFMS) and the Office of Ohio Health Plans (OHP). Both are components of ODJFS which work together on Medicaid program integrity efforts. This report describes three effective practices, five regulatory compliance issues, and six vulnerabilities in Ohio's program integrity operations.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Ohio improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Ohio's Medicaid Program

The ODJFS administers the State Medicaid program. In the State fiscal year (SFY) ending September 30, 2009, the program served 1,860,000 beneficiaries, with Medicaid expenditures totaling \$13,384,831,780. Of that total, 1,290,577 beneficiaries were enrolled in 7 managed care organizations (MCOs). The remaining 569,423 beneficiaries were served on a fee-for-service (FFS) basis. The State had 47,086 participating FFS providers and 42,321 MCO providers. During Federal fiscal year (FFY) 2009, the Federal medical assistance percentage (FMAP) for Ohio was 62.14 percent. Following the passage of the American Recovery and Reinvestment Act of 2009, the actual FMAP for Ohio during FFY 2009 increased to 70.25 percent in the first and second quarters and 72.34 percent in the third and fourth quarters.

Program Integrity Section

The OFMS Surveillance and Utilization Review Subsystem (SURS) unit in ODJFS is the organizational component dedicated to the prevention and detection of provider fraud and abuse. At the time of the review, OFMS SURS had 62 authorized full-time equivalent staff. The authorized positions included 40 auditors, 3 data analysts, 6 nurses, and 1 clerk. From SFYs 2006 through 2009, SURS staff conducted an annual average of 2,131 preliminary and 179 full audits and/or reviews. The table below presents the number of audits/reviews and overpayment amounts identified and collected as a result of program integrity activities. These audits or reviews correspond to preliminary and full investigations as defined in Federal regulations.

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Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Overpayments Identified	Overpayments Collected ***
2006	673	201	\$1,832,499	\$ 915,840
2007	2460	208	\$12,484,392	\$6,418,129
2008	2864	167	\$16,190,692	\$6,579,128
2009	2528	179	\$ 5,657,225	\$4,740,620

* Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation. Ohio reported the audits OFMS performed from SFY 2006 through SFY 2009 in this column.

** Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition. Ohio reported the cases that resulted in MFCU referrals from SFY 2006 through SFY 2009.

***The figures on overpayments collected through program integrity activities are based on CMS-64 reports for the period covering Ohio's SFY 2006 through SFY 2009.

Methodology of the Review

In advance of the onsite visit, the review team requested that the State complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosure, managed care, and the MFCU. A five-person review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of December 7, 2009 the MIG review team visited the offices of OFMS and OHP. The team conducted interviews with numerous OFMS and OHP officials and staff. In order to determine if the State waiver programs were complying with Federal regulations relating to program integrity, the team met with the director of ODJFS' Bureau of Community Services (BCS). Finally, to determine whether the MCOs were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team interviewed OHP staff responsible for managed care oversight. The team also reviewed the managed care contract provisions and gathered information through interviews with representatives of four MCOs. In addition, the team conducted sampling of provider enrollment applications, case files, selected claims, and other primary data to validate Ohio's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the OFMS and OHP, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment and managed care. The State's Children's Health Insurance Program (CHIP) operates as a Medicaid expansion program under Title XIX of the Social Security Act. The State's CHIP operates under the same billing and provider enrollment policies as the State's Title XIX program. The same findings, vulnerabilities, and effective practices discussed in relation to the Medicaid program also apply to the expansion CHIP.

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Unless otherwise noted, the State provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that ODJFS provided.

RESULTS OF THE REVIEW

Effective Practices

The State has highlighted one practice that demonstrates its commitment to program integrity. The ODJFS web-based exclusion database provides increased provider screening prior to enrollment.

Web-based exclusion database

The ODJFS maintains a web-based database, called the Sanctioned Provider List, of individuals and entities that have been excluded from Medicaid and waiver programs in Ohio. The database contains the last known address of the provider, the date of the termination/exclusion and the reason for the termination. When applicable, the reinstatement date is also indicated. The ODJFS also maintains a web-based Suspension Log of waiver providers which includes the indictment date, the indictment code and the date of final disposition. At the time of the review, the waiver suspension log listed 101 waiver providers and the sanctioned provider list identified 848 providers. All provider applications are run against these files prior to enrollment. The ODJFS does not track recoveries as the result of provider terminations or suspensions.

Additionally, the MIG review team identified two practices that are particularly noteworthy. The CMS recognizes Ohio's policy of requiring all personal care assistants (PCAs) and home health aides to be enrolled in Medicaid under the same terms as FFS providers. The CMS also recognizes the Medicaid agency's efforts to establish collaborative relationships and effective program integrity communications with a broad range of internal and external partners.

Enhanced enrollment measures for PCAs and home health aides

The BCS contracts with a provider management agency to assure that PCAs and home health aides are enrolled in Ohio Medicaid in compliance with State regulations. This agency reviews PCA and home health aide contract agreements and determines whether the agreements contain appropriate documentation and provisions for training and performance monitoring.

All PCAs and home health aides are considered contractors of the State of Ohio, but as non-licensed providers they must meet application criteria and complete background checks. The background investigations are conducted by the Attorney General's office and forwarded directly to BCS for review. In addition, BCS checks the U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE) to determine if any individuals are subject to a national exclusion from Federal health care programs.

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In the State's personal care services programs, nurses are also checked quarterly for current licensing. The BCS maintains a "high roller" list; any registered nurse who bills more than \$100,000 in a 365 day period or any PCA who bills more than \$50,000 in a 365 day period is placed on the high roller list and monitored. The high roller list is also shared with the SURS unit and the MFCU. Between July 1, 2009 and September 30, 2009, BCS referred \$317,586 in questionable reimbursement for PCAs alone to the SURS Alleged Overpayments Referrals Report.

Collaborative relationships and effective communications with external and internal partners

The ODJFS has established a close relationship with the MFCU and the Ohio Auditor of State. To improve communications on program integrity issues throughout the State agency, ODJFS has also established program integrity workgroups which bring managed care and home and community-based waiver staff together regularly with State program integrity, auditing and MFCU personnel.

- ***Bureau of Community Services and MFCU interagency meeting***
The BCS within ODJFS facilitates an interagency meeting with the MFCU every other week, to refer cases of suspected fraud, waste, and abuse in home and community-based waiver programs to the MFCU. The meeting includes ODJFS' Office of Legal Services, the BCS provider management contractor, the Office of Mental Retardation and Developmental Disabilities (OMRDD), the Long Term Care Ombudsman, the Ohio Department of Aging (ODA) and SURS. According to the ODJFS, the attendance of sister agencies, such as OMRDD and ODA, at these meetings gives these agencies the opportunity to learn from the MFCU about emerging trends in fraud and abuse. According to documentation provided by ODJFS, from July 1, 2009 through September 30, 2009, 179 alleged waiver program overpayments totaling \$345,235 came to light from these biweekly meetings.
- ***State and MFCU relationship***
Ohio's program integrity operation has a cooperative and strong relationship with the MFCU. The MFCU actively communicates with, and conducts training for, a range of State programs. Both agencies meet regularly on FFS provider issues, with MCOs, and with sister agencies serving clients in home and community-based waiver programs. These close relationships have resulted in a high volume of good quality case referrals to the MFCU. In the previous 4 complete SFYs, ODJFS made 624 referrals to the MFCU, of which 604, or 97 percent, were accepted. The ODJFS referral process follows the *Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit* document published by CMS in September 2008. The training efforts of the MFCU have helped to increase the number and quality of managed care referrals as well.

- ***Signed service agreement with Auditor of State***

The State Medicaid Agency has a signed service agreement with the State's auditing agency, called the Auditor of State (AOS). The agreement provides that the AOS will help carry out the department's Medicaid program integrity function by performing audit services, while acknowledging that ODJFS has final authority for policy decisions and administration of the Ohio Medicaid program.

According to ODJFS, the AOS has audited Medicaid providers for over 20 years. An interagency agreement has existed since 1996. However, beginning in 2009, a Letter of Arrangement between ODJFS and the AOS has provided a formal structure to the agreement, defined how much audit work AOS would undertake, and specified how much it would charge for the work. Between SFY 2006 and SFY 2009, AOS performed an average of nine audits per year which resulted in the identification of an average of \$1,994,376 per year in potential overpayments.

The AOS audits are supplemental to State agency audit activities. According to review guide responses and onsite interviews, OHP postpayment review activities are conducted by the SURS unit-Bureau of Audit and Consulting, which is a separate component within the OHP. Audit staff conducted a yearly average of 2,115 desk and 15 full audits, resulting in an average of \$9,000,000 in overpayments being identified per year for the past four SFYs.

- ***Program integrity workgroups***

Ohio has established a Program Integrity Group (PIG) consisting of participants from the SURS unit, the OHP, the AOS, the MFCU and the State's Medicare-Medicaid data match program partners. The PIG meets on a monthly basis and brainstorms on how to approach high risk areas of Medicaid as identified by a collaborative risk assessment. The combination of program policy, surveillance and utilization review, and MFCU staff allows the workgroup to develop system edits when patterns of fraud, waste and abuse are identified.

In addition to the PIG, Ohio has formed another workgroup which focuses on program integrity within Medicaid managed care. The ODJFS established the Medicaid Managed Care Program Integrity Group (MMCPIG) in December 2008 upon a suggestion from the MFCU special agent-in-charge and Ohio's MFCU director. In addition to ODJFS staff and a representative from the Ohio MFCU, investigators and other fraud and abuse staff from all Medicaid MCOs attend the group meetings either in person or by conference call.

The MMCPIG meets quarterly. Meetings usually include a presentation on a specific fraud issue. The group also confidentially processes information related to specific fraud and abuse cases and includes a round robin discussion to identify new issues. The meetings also include training by staff from Ohio's Office of the Attorney General on the difference between fraud and abuse. The ODJFS

indicated that since the inception of this group, the MCOs are submitting better quality and more complete MFCU referrals.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations regarding the referral of suspected recipient fraud cases to law enforcement as well as certain required disclosures and payment withhold notification.

The ODJFS does not refer cases of suspected recipient fraud to law enforcement.

The Federal regulation at 42 CFR § 455.15(b) requires State Medicaid agencies to refer suspected cases of recipient fraud to an appropriate law enforcement agency.

The ODJFS does not refer cases of suspected recipient fraud directly to law enforcement agencies. For cases of suspected recipient fraud, the ODJFS fraud unit follows protocol by contacting county Job and Family Services offices. The county offices investigate and refer to local law enforcement and prosecutors as appropriate. The ODJFS indicated that suspected recipient fraud cases are only investigated and referred to the MFCU when there is evidence of collusion with providers.

Recommendation: Develop and implement policies and procedures for referring suspected recipient fraud cases to an appropriate law enforcement agency.

Ohio's notice of payment withholding does not include all required information.

The regulation at 42 CFR § 455.23(b) stipulates that the Medicaid agency's notice of withholding state that payments are being withheld in accordance with the Federal regulation.

When Medicaid payments are suspended for Ohio providers suspected of fraud, the State agency notice informing providers that payments are being withheld does not specify that the payments are withheld in accordance with 42 CFR §455.23. Ohio's withhold letter refers to the Ohio Administrative Code (OAC) 5101:3A3-1-27.1 and OAC 5101:3A3-1-27.2. Neither section of the OAC contains a reference to the Federal regulation. In addition, ODJFS program integrity staff does not send the withhold letter within 5 days of payment suspension.

Recommendations: Modify withholding letters to include language that references §455.23 as required by the regulation. Modify policies and procedures to include sending withholding letters within the required timeframe.

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The ODJFS does not capture all required ownership, control, and relationship information from FFS providers and MCOs. (Uncorrected Repeat Finding)

Under 42 CFR § 455.104(a)(1), a provider, or “disclosing entity,” that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

The 2002 CMS Medicaid Alliance for Program Safeguards review report noted that Ohio did not meet the requirements of 42 CFR §455.104. The 2010 MIG review noted that the ODJFS uses a single Organizational Provider application for institutional and group providers. The Disclosure and Ownership/Control Interest Statement contained in this package does not request the name and address of every person or disclosing entity with an ownership or control interest in any subcontractor in which the provider has an ownership interest of 5 percent or more as required by 42 CFR § 455.104(a)(1). It also does not solicit relationship information among persons with ownership or control interests as required by 455.104(a)(2), or the names of other disclosing entities in which persons with ownership or control interests have similar ownership or control interests as required by 455.104(a)(3). At a minimum, this information should be solicited from institutional providers because they are considered disclosing entities under the regulation.

Additionally, Ohio provided no evidence that it gathers the complete ownership, control and relationship disclosures from MCOs as required by this regulation. Specific language is not present in the ODJFS MCO contract requiring disclosure of each person with an ownership or controlling interest in the entity or in any subcontractor in which the MCO has direct or indirect ownership of 5 percent or more. Likewise there are no requirements to disclose spouse, parent, child, and sibling relationships. Although the ODJFS Managed Care Plan cost report, which is completed annually by each MCO, requires disclosures of the name, address and percentage of interest for each person or entity with an ownership or control interest in the MCO, it does not address relationship disclosures or disclosures relating to the ownership of subcontractors or other disclosing entities. It also does not include the requirement to submit these disclosures within 35 days of a written request by the Secretary or Medicaid agency.

Recommendations: Modify the FFS provider enrollment application and instructions to capture appropriate ownership, control and relationship information required under 42 CFR § 455.104.

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Modify the MCO contracts and Request for Proposal documents to require the pre-contract submission of all required ownership and control information.

Ohio does not require disclosure of business transactions in its FFS operations and from MCOs.

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or the U.S. Department of Health and Human Services information about certain business transactions with wholly owned suppliers or any subcontractors.

The ODJFS FFS provider agreements do not require providers to report business transactions upon request in accordance with the regulation. They also contain no reference to a 35-day timeframe, although the regulation further states that providers must submit business transaction information within 35 days of the date on a request by the Secretary or the Medicaid agency.

Although Ohio's managed care contracts require the disclosure of service and rate-related financial information, they also do not contain a reference to the regulation or language requiring that MCOs furnish business transaction information within 35 days of a request from the Secretary or the State Medicaid agency.

Recommendation: Modify provider agreements, credentialing forms and MCO contracts to require disclosure upon request of the information identified in 42 CFR § 455.105(b).

The State does not collect health care-related criminal conviction information from MCOs.

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made. Pursuant to 42 CFR § 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

Although the State contract with MCOs requires each MCO to certify that it and its principals (directors, officers, partners or persons with ownership of 5 percent or more) are not presently debarred, suspended, ineligible or otherwise excluded from participation in Federal programs, the contract does not contain specific language requiring the disclosure of health care-related criminal convictions. Further, ODJFS provided no evidence that prior to entering into contracts with the MCOs, it solicits the required criminal conviction disclosures from persons with ownership and control interest in the MCO or its agents or managing employees. The ODJFS' Managed Care Plan cost report, which each MCO completes annually, does require the disclosure of conviction information about all MCO affiliated owners, principal officers, board members or trustees. However, this report is filed after the contract has been executed, and these disclosures are not required from all parties specified in the regulation. This prevents the State from being able to disclose such information to HHS-OIG within 20 working days as required.

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Recommendations: Modify the MCO contracts and Request for Proposal documents to require the health care-related criminal conviction disclosures from all the parties specified in 42 CFR § 455.106, including agents and managing employees. Monitor MCO compliance and timely reporting of such disclosures to ODJFS. Refer any such disclosures to HHS-OIG within the timeframe specified in the regulation.

Vulnerabilities

The review team identified six areas of vulnerability in the State's program integrity practices. These relate to incomplete exclusion search procedures, verification of receipt of managed care services, managed care disclosures, and reporting of adverse actions to HHS-OIG.

Not conducting complete searches for individuals and entities excluded from participation in Medicaid.

On June 12, 2008, CMS issued a State Medicaid Director Letter (SMDL #08-003) providing guidance to States on checking providers and contractors for excluded individuals. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers to screen their own staff and subcontractors for excluded parties.

During the walk-through of the provider enrollment process, the MIG team observed that the exclusion checks performed on institutional and group FFS provider applications were done for the entity name only. Although the names of related parties are collected, no managing employees, agents or individual providers are checked against the LEIE or the U.S. General Services Administration's Excluded Parties List System, as is the practice of ODJFS for individual provider applications. Additionally, while the names of managing employees and agents are collected, they are not stored in the Ohio Medicaid Management Information System (MMIS) or an equivalent data repository where they can be searched on an ongoing basis for exclusions. Thus, the State would have no way of knowing if excluded providers are working for health care entities in such positions as billing managers, department heads or health care providers.

Although all four of the MCOs interviewed indicated they checked their network providers for exclusions on a monthly basis, two of the four MCOs told the MIG interviewers that exclusion checks for owners and managing employees were only completed upon application and annually.

This contradicts the CMS directives in both SMDLs, which directed States to conduct or require monthly exclusion checks on providers, owners and managing employees within all FFS, managed care, and other waiver programs.

Recommendations: Develop and implement policies and procedures for expanding FFS exclusion searches to include the managing employees, agents and individual providers of disclosing entities. Ensure that the identities of providers and all related parties are stored in the MMIS or an equivalent repository to facilitate ongoing automated exclusion searches. Require contracted MCOs to conduct monthly exclusion searches on providers and all affiliated parties. For guidance, refer to SMDLs #08-003 and #09-001, which can be found on the CMS website.

Not having methods of verifying with managed care enrollees whether services billed by MCO network providers were received.

While Ohio meets the requirements of 42 CFR § 455.20 by sending explanations of medical benefits to 6,800 FFS beneficiaries monthly, Medicaid managed care enrollees are not asked to confirm the receipt of managed care services by either the State or any of the four MCOs interviewed. The MCOs indicated that they only attempted to verify services when conducting a specific provider investigation.

Recommendation: Develop and implement policies and procedures to monitor MCO compliance with contract provisions requiring verification with beneficiaries that services billed by network providers were actually received.

Not collecting all required ownership and disclosure information from MCO network providers.

The MCO applications do not collect the ownership and control disclosures from MCO network providers that Federal regulations at 42 CFR § 455.104 would otherwise require from FFS providers.

In their internal credentialing process, the MCOs use the Council for Affordable Quality Healthcare (CAQH) provider application form. One plan uses an additional application for ancillary providers. None of these forms gather complete information on persons with ownership and control interests in the provider, family relationships among such persons, and interlocking relationships of ownership and control with subcontractors.

Recommendations: Revise MCO network provider applications to collect the same information on persons with ownership and control interests in the provider that is required in the FFS system. This should include information on family relationships among persons with ownership and control interests and the interlocking relationships of ownership and control with subcontractors. Modify the MCO contracts to require that plans collect all required ownership and control information from network providers.

Not requiring MCO network providers to disclose business transaction information, upon request.

The network provider agreements and Medicaid addenda for the four MCOs reviewed do not require providers to supply, upon request, the business transaction information that would otherwise be required from FFS providers under 42 CFR § 455.105.

Recommendation: Modify the MCO network provider agreements to require timely disclosure of business transaction information, upon request.

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Not capturing criminal conviction information on owners and managing employees of MCO network providers.

Although Section 8 of the CAQH application for MCO network providers asks for health care-related criminal conviction disclosures from the applying provider, all four of the MCOs interviewed did not solicit the health care-related criminal conviction information from owners, agents, and managing employees of MCO network providers that would otherwise be required from FFS providers under 42 CFR § 455.106. The failure to collect this information prevents ODJFS from sending timely notifications of such disclosures to the HHS-OIG as the regulation requires.

Recommendation: Modify MCO contracts to require the collection and reporting of health care-related criminal conviction disclosure information from all MCO network providers and affiliated parties as specified in 42 CFR § 455.106.

Not reporting adverse actions taken on MCO provider applications for participation in the program.

The regulation at 42 CFR § 1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

Based on MCO review guide responses and interviews with MCO representatives, two of the four MCOs interviewed do not notify the State agency when network provider applicants are denied enrollment for reasons relating to program integrity. This prevents the State from being able to report such actions to HHS-OIG within 20 working days, as required by this regulation.

Recommendations: Require contracted MCOs to notify the State when they deny providers credentialing for program integrity-related reasons. Develop and implement policies and procedures for reporting these actions to HHS-OIG.

CONCLUSION

The State of Ohio applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. These effective practices include:

- maintenance of a web-based exclusion database for expanded exclusion checks during provider enrollment,
- enhanced enrollment measures for PCAs and home health aides, and
- good communication and collaborative relationships with strategically important external and internal partners.

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of five areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, six areas of vulnerability were identified. The CMS encourages ODJFS to closely examine the vulnerabilities that were identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require ODJFS to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Ohio will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If the State has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Ohio on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.