# Department of Health and Human Services

# Centers for Medicare & Medicaid Services

# Center for Program Integrity

# Ohio Focused Program Integrity Review

# Final Report

# October 2019

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Ohio Focused Program Integrity Review Final Report
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## Executive Summary

The Centers for Medicare & Medicaid Services (CMS) is committed to performing program integrity reviews with states in order to identify risks and vulnerabilities to the Medicaid program and assist states with strengthen program integrity operations. The significance/value of performing onsite program integrity reviews include: (1) assess the effectiveness of the state's PI efforts, including compliance with certain Federal statutory and regulatory requirements, (2) identify risks and vulnerabilities to the Medicaid program and assist states to strengthen PI operations, (3) help inform CMS in developing future guidance to states and (4) help prepare states with the tools to improve PI operations and performance.

The CMS conducted a focused review of Ohio to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency.

During the week of May 21, 2019, the CMS review team visited the offices of Ohio's single state Medicaid agency, the Ohio Department of Medicaid (ODM). The onsite review was conducted with the Bureau of Program Integrity (BPI) and involved conducting interviews with numerous ODM officials as well as with staff from ODM's Bureau of Managed Care and four contracted MCOs. In addition, the CMS review team conducted sampling of program integrity cases referred by the MCOs special investigations units (SIUs), as well as other primary data in order to validate the state and the selected MCOs' program integrity practices.

### Summary of Recommendations

The CMS review team identified a total of nine recommendations based upon the completed focused review modules and supporting documentation, as well as discussions and interviews with key stakeholders. The recommendations were in the following areas: State Oversight of Managed Care Program Integrity Activities, MCO Investigations of Fraud, Waste, and Abuse, Encounter Data, Payment Suspensions, Terminated Providers and Adverse Action Reporting. The recommendations will be detailed further in the next section of the report.

### Objective of the Review

- The ODM is the single state agency charged with overseeing the Medical Assistance Plans in Ohio.
- The ODM BPI is the organizational unit responsible for the overall program integrity operations, although other units within the organization maintain certain delegated program integrity related responsibilities.
- In 2018, Ohio's total Medicaid program expenditures were approximately $24 billion. The Federal Medical Assistance Percentage matching rate was 67.89 percent.
- The Medicaid enrollment increased to approximately 3 million beneficiaries in federal fiscal years (FFY) 2016 to 2018.

### Overview of Managed Care in Ohio

- In 2018, Ohio's Managed Care Medicaid expenditures exceeded $15.5 billion.
- Ohio has approximately 3 million beneficiaries or approximately 90 percent of the Medicaid population, were enrolled in six MCOs during FFY 2018; however, approximately 10 percent of the Medicaid beneficiaries are enrolled in the state's fee-for-service (FFS) program.

- During the onsite review, four of the six MCOs were interviewed; Molina, Paramount Advantage, Buckeye Health Plan and CareSource. Table 1 and Table 2 below provide enrollment, SIU and expenditure data for each MCO.

**Table 1.**

| | **Molina** | **Paramount Advantage** | **Buckeye Health Plan** | **CareSource** |
|---|---|---|---|---|
| Beneficiary enrollment total | 292,141 | 239,281 | 304,893 | 1,290,737 |
| Provider enrollment total* | 75,357 | 22,288 | 77,181 | 34,017 |
| Year originally contracted | 2005 | 1993 | 2004 | 1989 |
| Size and composition of SIU | 31 | 5 | 7 | 31 |
| National/local plan | National | Local | Local | National |

*Based solely on providers providing services to the Medicaid program only

**Table 2.**

| **MCOs** | **FFY 2016** | **FFY 2017** | **FFY 2018** |
|---|---|---|---|
| Molina | $1,972,071,520 | $2,072,102,561 | $2,082,360,436 |
| Paramount Advantage | $1,024,579,890 | $1,128,527,552 | $1,276,795,528 |
| Buckeye Health Plan | $1,809,146,218 | $1,941,849,064 | $2,056,291,340 |
| CareSource | $6,516,907,006 | $7,156,415,236 | $7,358,371,550 |

*Expenditure amounts depicted were provided by the state

## Results of the Review

The CMS review team identified areas of concern with the state's managed care program integrity oversight, thereby creating risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible. These issues and CMS' recommendations for improvement are described in detail in this report.

### *State Oversight of Managed Care Program Integrity Activities*

All Ohio providers who seek participation in the Ohio Medicaid managed care program must first enroll in Medicaid through a provider portal. The state performs all of the required provider enrollment activities in accordance with the requirements of 42 CFR 455, subparts B and E. Upon ODM's approval of the application, the providers should secure contracts with participating MCOs.

The MCOs comply with the minimum requirements relative to 42 CFR 438.608 in regards to having a general compliance plan. Moreover, CareSource and Molina were able to provide the review team with a customized and detailed statewide fraud, waste, and abuse plan that addresses the fluid nature of the state's program integrity environment. In addition, the MCOs appeared to have inconsistent program integrity direction based upon the responses to the managed care documents requested by the CMS review team. Variation was noted amongst the MCOs related to compliance with some of the

requirements of the general contract, including but not limited to, tracking of MCO investigations, fraud referrals, payment suspensions, overpayments and provider adverse actions, including program integrity related terminations. The CMS review team was unable to determine the reason for the inconsistencies by the MCOs in accomplishing the program integrity requirements of the general contract.

The CMS review team identified a lack of concise program integrity contract language that allows the state to maintain the necessary program integrity controls and oversight capabilities, while maintaining the flexibility to govern its managed care program effectively. The current contract with the MCOs has a limited fraud, waste, and abuse section, Appendix I (Program Integrity), with generally outlined program integrity requirements. The state should consider enhancing/improving the program integrity contract language (including its associated guidance policies and procedures) in order to help the state eliminate any impediments to its MCOs program integrity contract performance and deliverables.

In connection to the lack of concise program integrity contract language, ODM should enhance the monitoring of MCOs compliance with meeting the program integrity requirements outlined in the general contract. The improved oversight would include verifying and validating the quality and accuracy of the program integrity information being provided by MCOs. The state should consider developing, compiling, implementing and updating as necessary, written policies and procedures addressing all program integrity functions. For example, the state might develop a comprehensive case referral policy aimed at improving the quality and quantity of investigations referred annually. The state should also consider developing a monitoring tool that is linked to the program integrity related contract requirements, as well as revising the program integrity section of the contract as needed.

**Recommendation #1:** The state should improve its oversight of MCOs through improved communications and tracking of MCO investigations, fraud referrals, payment suspensions, overpayments and provider adverse actions, including program integrity related terminations. The improved oversight measures may consist of, but are not limited to, making appropriate revisions to the program integrity section of the contract as needed.

**Recommendation#2 -** The state should consider implementing an annual review, at minimum, of each MCO in order to assess compliance with meeting all program integrity related contract requirements, including credentialing requirements, since, there is currently no process where the state audits the MCO credentialing process.

***MCO Investigations of Fraud, Waste, and Abuse***

As required by 42 CFR 455.13 , 455.14, 455.15, 455.16, and 455.17, the state does have an established process for the identification, investigation, referral and reporting of suspected fraud, waste, and abuse by providers and MCOs.

There are currently 69 of the 83 positions filled in BPI. The workload is predominately FFS, with approximately a 60/40 split between FFS and managed care; however, the managed care workload is increasing. There is a team of 14 FTEs devoted specifically to auditing MCOs. Ohio's MCOs are required to submit a *Suspected Fraud and/or Abuse Reporting Form* to ODM upon completion of a preliminary investigation. Some of the preliminary investigations may develop into a more extensive or full investigation being conducted by the MCO (see Table 4); however, all preliminary investigations are accepted by the BPI for a determination of whether they rise to the level of a credible allegation of fraud. The BPI will either request more information from the MCO or it may refer the case to the Medicaid Fraud Control Unit (MFCU). The BPI may also independently conduct an investigation upon

receiving managed care fraud referrals. In situations where the suspected fraud cases are substantiated by the BPI, the BPI meets regularly with all MCOs, so that both the FFS program and other MCOs are notified and can follow-up on a suspect provider.

Ohio's MCO contract states that the MCOs program integrity program, "shall comply with all applicable state and federal program integrity requirements, including, but not limited to, those specified in Ohio Administrative Code (OAC) rule 5160-26-06, 42 CFR Part 455, 42 CFR Part 1002 and 42 CFR Part 438 Subpart H." The MCOs do not conduct routine unannounced site visits as a proactive program integrity activity commonly used to pursue and develop cases. CareSource stated they have contracts with providers that provides a three-day's notice. Buckeye Health Plan claimed they lacked the resources to perform unannounced site visits, while they relied solely on data analytics. None of the other plans were conducting routine unannounced site visits, while Paramount Advantage added they had no plans to start doing unannounced provider site visits.

The state should review its contract language in regards to the minimum ratio for MCO SIUs. Some of the MCOs expressed using a 1 FTE per 100,000 Medicaid beneficiary minimum ratio in order to staff its SIU. Other states in the region may be utilizing ratios that would increase the size of the SIU staff in Ohio. Therefore, ODM may want to research common industry trends for their particular state Medicaid population and unique dynamics and determine if changes to the ratio are warranted. Although, Paramount Advantage reported having no investigators assigned to its SIU, the state maintains the MCO has four analysts who perform investigations on a regular basis. Therefore, ODM may want to consider reviewing the SIU positions and determine whether each MCO has the appropriate skills required to perform the required program integrity activities as outlined in the general managed care contract.

**Recommendation#3 -** The state should ensure MCOs develop work plans for conducting both announced and unannounced site visits to ensure services are rendered and billed correctly and develop potential cases. The state should also analyze potential opportunities to partner with the MCOs in conducting joint unannounced visits during the investigation process.

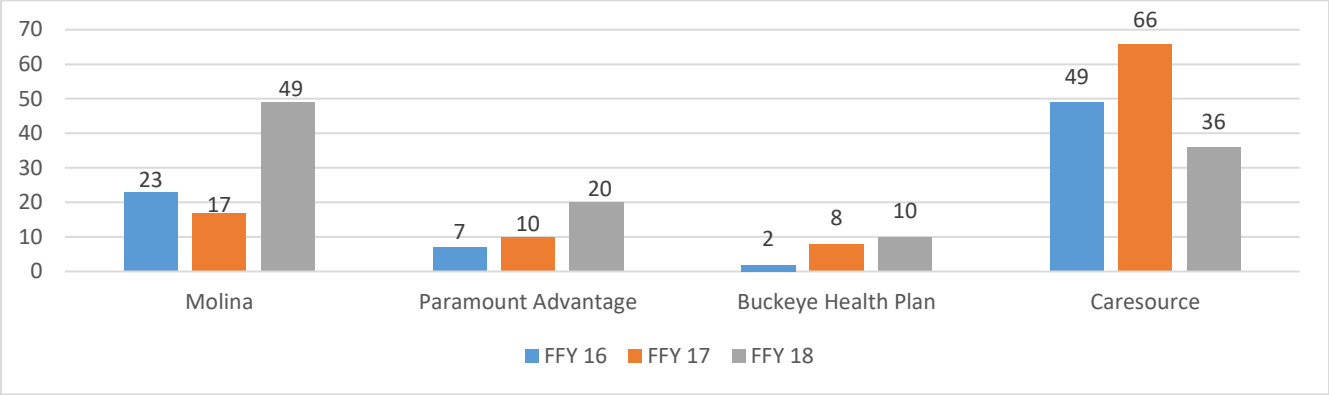
The ODM maintains programmatic control of all the managed care fraud referrals from the MCOs. The MCO makes referrals of possible credible allegations of fraud to the ODM. The MCOs do not make referrals directly to the MFCU according to its contract with ODM and in turn, the ODM determines if cases warrant a referral to the MFCU. The contract states that the MCOs shall submit fraud, waste and abuse referrals to ODM using the ODM Referral form. Each referral submitted to ODM will be distributed to all MCOs. Upon receipt of a fraud, waste, and abuse referral from ODM, the MCO shall respond by submitting the ODM Attestation form within 90 calendar days. A failure to file an attestation timely, completely, and accurately may result in the MCO waiving its right to participate in any MFCU recoveries. This de-confliction process ensures that the MCOs, MFCU, and ODM work cooperatively, do not duplicate work, and avoid actions that may impact the MFCU investigation.

The ODM stated they are very quick to refer even the preliminary investigation cases to the MFCU that have an element of credible fraudulent activity associated to it. Table 3 lists the number of referrals that Molina's SIU, Paramount Advantage's SIU, Buckeye Health Plan's SIU and CareSource's SIU made to the state in the last three FFYs. During interviews with the state, the PI director mentioned the FFS program integrity activity was much greater than what was being referred in the managed care program. Across each fiscal year, the number of Medicaid provider investigations and referrals by each of the MCOs is low, compared to the size of the health plans as well as comparatively to the FFS delivery system. The few exceptions are the Molina referrals in FFY18 and the CareSource totals for FFY16

and FFY17. Although these are two of the larger health plans in Ohio, these referrals are more moderate in comparison to the program integrity activity experienced in Ohio's FFS delivery system.

Over the three-year review period, CareSource referred 49 cases to the ODM on average, while Molina averaged 30. Paramount Advantage and Buckeye Health Plan referrals were much lower with 12 and 7, respectively. The level of investigative activity is trending upward for all of the MCOs, with the exception CareSource in FFY18.

**Table 3.**




As illustrated above, the MCOs were actively engaged in referring cases of suspected fraud during the review period. The volume of MCO provider case referrals was of particular concern to the CMS review team, particularly with Paramount Advantage and Buckeye Health Plan; however, the CMS review team recognized the plans showed progress each year. This was also a concern in the state's previous 2014 program integrity review report. As depicted in table 3 above, CareSource had the most referrals, however, the number of referrals dropped substantially in FFY18 and are particularly low for a plan with the size and experience of CareSource. Paramount Advantage just started tracking case referrals, while Buckeye Health Plan expressed having success with utilizing pre-pay review as their preferred method of handling problematic or suspicious provider billing activity. The ODM should incorporate a specific referral policy and procedure that provides a description of the MCOs internal procedures for the SIU to identify and report possible acts of fraud, waste, and abuse by providers to ODM.

**Recommendation#4 -** Given the limited number of provider investigations and history of low referrals by the MCOs, the state should ensure that MCOs are allocating sufficient resources to the prevention, detection, investigation, and referral of suspected provider fraud. The state should ensure that MCOs have adequate training opportunities related to fraud prevention, detection, investigation and referral of suspected provider fraud at least annually.

Although the ODM performs capitation payment reconciliation to account for the overpayments that Medicaid has paid to the MCOs, the ODM does not perform their own case analysis of MCO investigations in order to verify and validate the MCOs' overpayment figures. Since overpayments are not audited by the BPI, there is no way of assessing the appropriateness or accuracy of the overpayment amounts claimed by the MCOs. The overpayments identified and recovered by the MCOs (see Table 4) are consistently low, particularly with Molina and Buckeye Health Plan. Notably, Paramount Advantage, the smallest of the MCOs in terms of expenditures, total providers, and SIU staffing,

conducts as many full investigations as Molina and Buckeye Health Plans and identifies and collects more overpayments.

This concern over the low referrals from Ohio MCOs was also mentioned in the previous 2014 review report, where the review team referenced there appeared to be a great deal of MCO scrutiny to identify improper payments, almost none of which is classified officially as fraud and abuse detection. In that report, the review team wrote, "From an oversight perspective, it is difficult to identify the efficacy of plan efforts given the various ways in which the MCOs conduct and define savings from prepayment and post-payment review and cost avoidance activities. Whether the results of this activity were being reported--and if so, to what components within the state agency--was not made clear to the team during its 4-day onsite review. This is a question that merits follow-up." The current review team experienced many of the same difficulties in looking across the MCOs to compare recovery of overpayments activity and considers this to be an area of particular concern.

The ODM should ensure it maintains information on all types of recoveries to ensure the accurate figures are being factored into the rate-setting process and that all Medicaid improper payments are accounted for appropriately. It should review the audit activity of the MCOs in particular to ensure that potential cases of fraud and abuse are identified and addressed appropriately. Furthermore, since MCOs are allowed to negotiate the overpayment amount with providers, recoveries may be further lowered. Paramount Advantage was not currently tracking excess capitation or other contract overpayments. The state is relying on the MCOs to report accurate overpayments and recoveries. The state should consider the feasibility of developing MCO overpayment metrics.

**Recommendation#5 -** The state should amend its policies and procedures to in order to increase the reliability and accountability regarding MCO overpayment and recovery activities. Enhanced oversight is required in order for the state to have better visibility and a comprehensive understanding regarding the complete Medicaid overpayment and recovery activities taking place within its managed care program.

**Table 4-A.**

| FFY | Preliminary Investigations | Full Investigations | Total Overpayments Identified | Total Overpayments Recovered |
|---|---|---|---|---|
| 2016 | 41 | 13 | $71,756.00 | $106,072.00 |
| 2017 | 56 | 13 | $7,946.00 | $44,173.00 |
| 2018 | 186 | 14 | $399,285.00 | $78,053.00 |

**Table 4-B.**

| FFY | Preliminary Investigations | Full Investigations | Total Overpayments Identified | Total Overpayments Recovered |
|---|---|---|---|---|
| 2016 | 33 | 09 | $514,864.56 | $277,765.28 |
| 2017 | 27 | 12 | $1,002,346.00 | $359,056.22 |
| 2018 | 101 | 24 | $1,627,429.00 | $403,728.45 |

**Table 4-C.**

| FFY | Preliminary Investigations | Full Investigations | Total Overpayments Identified | Total Overpayments Recovered |
|---|---|---|---|---|
| 2016 | 161 | 41 | $156,108.67 | $156,108.67 |
| 2017 | 136 | 19 | $189,240.44 | $11,117.21 |
| 2018 | 110 | 36 | $116,820.48 | $85,403.77 |

**Table 4-D:**

| FFY | Preliminary Investigations | Full Investigations | Total Overpayments Identified | Total Overpayments Recovered |
|---|---|---|---|---|
| 2016 | 237 | 77 | $20,662,431.58 | $17,581,313.89 |
| 2017 | 160 | 27 | $1,326,272.49 | $7,113,642.07 |
| 2018 | 44 | 7 | $4,053,000.33 | $669.88 |

The ODM contract with its MCOs requests the prompt reporting of all instances of suspected provider fraud, waste and abuse to ODM's BPI. The primary reporting information in the program integrity section of the contract is as follows: "Pursuant to OAC rule 5160-26-06, the MCP shall report annually to ODM a summary of the MCP's monitoring of credible allegations of fraud, waste and abuse, underutilization of member services, limits to Medicaid-covered services and suspicious claims submission and billing. The MCP's report shall also identify any proposed changes to the MCP's compliance plan for the coming year."

In addition, the MCOs submit quarterly reports of fraud, waste, and abuse activity to ODM for review, and that is also in accordance with the language within the contract with the MCOs. The contract does include language that requires the MCOs to submit reports of suspected provider fraud, waste, or abuse on a quarterly basis. The review team discussed the need for more frequent reporting time frames for the identification, investigation, referral and reporting of suspected fraud waste and abuse. Monthly or 60-day reports would allow the ODM to oversee program integrity in the managed care program more effectively.

**Recommendation#6 -** The state should enhance its general contract language in regards to MCO reporting requirements, as well as training to ensure the MCOs understand all newly developed program integrity reporting expectations.

***Encounter Data***

The ODM collects encounter data from each of the MCOs electronically on a weekly basis as the encounter data requirements are specified in Appendix L of the general managed care contract. Ohio's submitted managed care encounter data, must comply with HIPAA standards and meet several submission measures monthly and quarterly that are focused on completeness, accuracy, and comparison between data sources. Although the ODM ensures the timely submission of the encounter data, the BPI acknowledged that their efforts are limited by the quality of the MCO encounter data that it uses.

The ODM analyzes the validated encounter data for aberrant practices or trends and may refer that information back to the MCO in order for the MCO to conduct further analysis and/or investigation. The encounter data is getting better according to BPI; however, having access to the MCO system claims data system would allow for enhanced data mining efforts to be achieved by the BPI. Each of the MCOs reported that the ODM has never requested system access to the managed care claims data. Having access to the actual system claims data could then be utilized by the ODM to proactively identify improper claims that may have been paid inappropriately to manage care providers, as well as aid in conducting any internal audits of the encounter data. Furthermore, the ODM should research and develop comprehensive policies and procedures for reviewing encounter data currently submitted by the MCO, in order to enable state staff or designated contractors to mine MCO data for provider aberrancies, which may potentially lead to other program integrity benefits like improved state capacity to audit problem network providers directly.

**Recommendation#7 -** Given the limitations of the encounter data, the ODM should seek system access to the complete actual claims data.

***Payment Suspensions***

In Ohio, Medicaid MCOs are contractually required to suspend payments to providers at the state's request. The state confirmed that there is contract language that directs the MCO on referring suspected cases of provider fraud. The contract then states, "If a credible allegation of fraud exists, at the direction of ODM, the MCP shall immediately suspend all payments to the provider and shall suspend the provider in accordance with ORC section 5164.36. This language is in accordance with the regulation at 42 CFR 455.23.

The regulation at 42 CFR 455.23(a) requires that when the State Medicaid agency determines that there is credible allegation of fraud, it must suspend all Medicaid payments to a provider, unless the agency has good cause not to suspend payments or to suspend payment only in part. The BPI informed the review team that they are more prone to accept fraud cases from the MCOs at the earliest signs of suspicious provider activity. Once a case has been referred by the MCO, the BPI will determine whether there is a credible allegation of fraud prior to initially sending a case to the MFCU. The BPI consequently relies on the MFCU to conduct the full investigation and decide whether or not to accept the case for further actions.

As a result of the interviews with the MCOs, the actual payment suspension process appears to be operational, but inconsistent. A unique process that was evidenced in Ohio, is that when Molina receives a provider payment suspension notification from the state, they take immediate action to terminate the provider's participation agreement altogether. The MCO places the provider in a "no pay" status which ultimately concludes with the provider being terminated with no program integrity reason associated to the termination. Therefore, the provider is no longer contracted with the MCO once that termination action is processed. The CMS review team was unable to ascertain whether other MCOs contracted with ODM followed the same procedure. Although, one of the MCOs reported that while it does not formally suspend payments, it will put claims on hold or in pending status. A second MCO reported that it does not suspend payments, but stated they would if directed, and the third MCO reported that it has not issued any payment suspensions, but instead conducts pre-payment reviews to deny improper claims.

**Recommendation#8 -** The state should ensure that all MCOs are operationalizing its payment suspension policy in a consistent manner.

***Terminated Providers and Adverse Action Reporting***

The MCO contract does address terminated providers and adverse action reporting and requires the reporting of terminated providers directly to the ODM when the termination is for program integrity reasons. With the Program Integrity reporting section of the contract it specifically states, "The MCP shall notify ODM when there is a change in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including when a provider panel application is denied or a panel provider agreement is terminated for program integrity reasons. The MCP shall provide the reason for the denial or termination."

The team found that all "reported" for-cause program integrity terminations by the MCOs to the state are being reported in turn to the HHS-OIG. The state also uploads the for-cause terminations to the DEX (formerly Tibco) managed file transfer server.

**Table 5:**

| MCOs | Total # of Providers Dis-enrolled or Terminated in Last 3 Completed FFYs | Total # of Providers Terminated For Cause in Last 3 Completed FFYs |
|---|---|---|
| Molina | 2018-230<br>2017-203<br>2016-369 | 2018-0<br>2017-0<br>2016-0 |
| Paramount Advantage | 2018-2250<br>2017-1870<br>2016-1686 | 2018-0<br>2017-2<br>2016-0 |
| Buckeye Health Plan | 2018-5372<br>2017-7731<br>2016-5688 | 2018-136<br>2017-517<br>2016-200 |
| CareSource | 2018-230<br>2017-203<br>2016-369 | 2018-0<br>2017-0<br>2016-0 |

* Some of the MCOs revised their figures several times in order to complete the data represented.
** The state was unable to substantiate the information provided by the MCOs.

While Buckeye and CareSource appear to be taking appropriate action to remove providers from participating in the Medicaid program for-cause, Molina and Paramount Advantage are not taking equivalent action. As depicted in Table 5, Molina has not terminated a provider for cause over the three-year review period, while Paramount Advantage has terminated only two providers during the review period. Molina and Paramount Advantage have consistently provided the state with fraud referrals, but have not terminated providers for cause other than the two by Paramount Advantage in 2017. A key element to Medicaid program integrity is to ensure the accurate removal of bad actors from the program. This is a major program integrity concern for these two MCOs, not only for their lack of activity in this area, but also when comparing the number of providers enrolled with the MCOs, and when compared to the number of providers dis-enrolled or terminated for any reason. For Molina, this is largely due to the "no-pay" payment suspension procedure described earlier. This creates a problem where providers may not be accurately terminated "for cause" when their actions constitute an appropriate program integrity related termination action.

In addition, the MCOs do not appear to have a clear understanding of what constitutes a for-cause action versus a not for-cause action. The for-cause termination totals for the majority of the MCOs appear to be the result of definition and terminology differences. The bulk of these cases do not involve issues of integrity, quality or fraud. Accordingly, the CMS review team determined that additional education is warranted in order to ensure provider adverse actions are handled appropriately.

**Recommendation#9-** The state should develop a comprehensive termination policy and monitor MCO program integrity related adverse actions in order to consistently account for all MCO program integrity related terminations due to fraud, integrity or quality.

**Status of the Corrective Action Plan from the 2014 Review Report**

Ohio's last CMS program integrity review was in September 2013, and the report for that review was issued in December 2014. The CMS conducted a Program Integrity CAP desk review in 2017, in which all of Ohio's 2014 Program Integrity Report CAP issues were satisfied by the state.

**Technical Assistance Resources**

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Ohio to consider utilizing:

- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to Ohio are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the Regional Information Sharing Systems (RISS) as tool to identify effective program integrity practices.
- Access the Toolkits to Address Frequent Findings: 42 CFR 455.436 Federal Database Checks website at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf.
- Access the Toolkits to Address Frequent Findings: Payment Suspension Toolkit website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance.html.

**Conclusion**

The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas 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 CAP should identify those corrections as well.

CMS looks forward to working with Ohio to build an effective and strengthened program integrity function.