

**Department of Health and Human Services**  
**Centers for Medicare & Medicaid Services**  
**Center for Program Integrity**  
**Ohio Focused Program Integrity Review**  
**Oversight of Medicaid Personal Care Services**  
**April 2026**  
**Final Report**

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## I. Executive Summary

### Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a focused program integrity review of Ohio's Medicaid Personal Care Services (PCS) program to assess the state's program integrity oversight efforts for Fiscal Years (FY) 2021 – 2023. This focused review specifically assessed the state's compliance with CMS regulatory PCS requirements within 42 CFR Parts 440, 441, and 455. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in the delivery of these services.

To meet the objectives of this focused review, CMS reviewed information and documents provided in response to the CMS PCS review tool provided at the initiation of the review, CMS also conducted in-depth interviews with the state Medicaid agency (SMA) and evaluated program integrity activities performed by selected agencies and PCS managed care entities, under contract to provide PCS to Medicaid beneficiaries.

This report includes CMS' observations that were identified during the focused review.

### Findings and Recommendations

Findings and/or recommendations represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified no findings that create risk to the Ohio Medicaid program related to PCS program integrity oversight.

### Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid PCS program. CMS identified **seven** observations related to Ohio's PCS program integrity oversight. While observations do not represent areas of non-compliance with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of leading practices. The observations identified during this review include the following:

#### *State Oversight of PCS Program Integrity Activities and Expenditures*

**Observation #1:** CMS encourages Ohio to be more proactive in tracking overpayments identified and recovered due to PCS fraud. This is especially important because the state relies on the MFCU to determine credible allegations of fraud, creating delays in authorizing payment suspensions until the provider has been indicted or convicted of a credible allegation of fraud by the MFCU. CMS acknowledges that ODM tracks all overpayments identified in its Surveillance and Utilization Review Section (SURS) system. However, due

to the high-risk for fraud for PCS, CMS encourages a proactive approach to PCS overpayment tracking.

**Observation #2:** CMS encourages Ohio to establish program integrity policies and procedures for conducting post-payment reviews of PCS claims with a focus on identifying and investigating providers who may have an unusually high number of PCS visits that are manually entered or adjusted within the Electronic Visit Verification (EVV) system. Furthermore, CMS encourages Ohio to leverage EVV data when performing data analytics to identify outliers and patterns in post-payment reviews, enhancing the detection of potential program abuses.

### Provider Enrollment and Screening

**Observation #3:** CMS encourages Ohio to require annual training for all PCS providers and require a program integrity component to the initial and annual training. Annual training could include updates to PCS program rules and/or guidance, PCS billing requirements, and prevention, detection, investigation, referral, and reporting of fraud, waste, and abuse. In addition, CMS encourages Ohio to provide additional training and/or guidance to PCS providers on state and federal regulations when performing required background checks.

### State Oversight of Self-Directed and Agency-Based Services

**Observation #4:** CMS encourages Ohio to update their system to allow tracking of MCO imposed sanctions and corrective actions on self-directed providers, to ensure the enforcement of the terms of the providers' agreement.

**Observation #5:** CMS encourages Ohio to ensure that Medicaid Management Information System (MMIS) edits are active to detect overlapping claims with institutional care, which will strengthen program integrity and increase the identification and referral of potential fraud, waste, and abuse within PCS.

**Observation #6:** CMS encourages Ohio to implement additional program integrity measures to ensure the state and MCOs can determine the number of beneficiary verifications issued and returned for PCS by provider agencies, individual providers, and providers of self-directed care.

**Observation #7:** CMS encourages Ohio to establish policies and procedures and provide additional training and/or guidance to ensure PCS providers are properly reporting instances of possible fraud, waste, or abuse of PCAs. In addition, CMS encourages Ohio to develop procedures to ensure the SMA promptly acknowledges its receipt of referrals from PCS agencies.

## **II. Background**

### **Focused Program Integrity Reviews**

In the Comprehensive Medicaid Integrity Plan for FYs 2019-2023, CMS set forth its strategy to safeguard the integrity of the Medicaid program.<sup>1</sup> This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring strategies that meet federal standards.

As a part of these efforts, CMS conducts focused program integrity reviews on high-risk areas in the Medicaid program, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, telehealth, and PCS. These reviews assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

### **Medicaid Personal Care Services**

Medicaid PCS are services provided to eligible beneficiaries that help them to stay in their own homes and communities rather than live in institutional settings, such as nursing facilities. The PCS benefit is provided according to a state's approved plan, waiver, or demonstration and are optional Medicaid services, except when medically necessary for children eligible for early and periodic screening, diagnostic, and treatment (EPSDT) services. PCS are categorized as a range of assistance provided to persons with disabilities and chronic conditions to enable them to accomplish activities of daily living (ADLs) or instrumental activities of daily living (IADLs). An independent or agency-based personal care attendant (PCA) may provide ADL services, which include eating, bathing, dressing, ambulation, and transfers from one position to another, and IADL services, which include day-to-day tasks that allow an individual to live independently but are not considered necessary for fundamental daily functioning, such as meal preparation, hygiene, light housework, and shopping for food and clothing.

States administer their Medicaid programs within broad federal rules and according to requirements of the specific authority approved by CMS. Pursuant to 42 CFR Part 440, states can choose to provide PCS for eligible beneficiaries through their state plan, a waiver, or a Section 1115 demonstration. Because PCS are typically an optional benefit, they can vary greatly by state and within states, depending on the Medicaid authority used to cover the benefit. Under federal statute and regulations, PCS must be approved by a physician or through some other authority recognized by the state. Beneficiaries receiving PCS cannot be inpatients or residents of a hospital, nursing facility, intermediate care facility for the developmentally disabled, or institution for mental disease. Services can only be rendered by qualified individuals who have met certain training and enrollment requirements, as designated by each state.

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<sup>1</sup> <https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf>

## **Overview of the Ohio Personal Care Services Program and the Focused Program Integrity Review**

The Ohio Department of Medicaid (ODM) is the agency that is responsible for the administration of the Ohio Medicaid program. Within ODM, the Bureau of Program Integrity (BPI) is the organizational unit primarily tasked with oversight of program integrity-related functions, including those related to PCS. The PCS program is administered and monitored by the ODM in conjunction with its sister agencies the Department of Developmental Disabilities (DODD) and the Ohio Department of Aging (ODA) through interagency agreements.

While PCS is not a covered benefit under Ohio's state plan, Ohio administers Medicaid PCS to eligible beneficiaries under six Section 1915(c) Home and Community-Based Services (HCBS) waivers, which are person-centered care delivered in the home and community. Detailed descriptions of the Ohio Medicaid PCS programs and their applications can be found in Appendix C.

In FY 2023, Ohio's total Medicaid expenditures were approximately \$32 billion, providing coverage to approximately 3.7 million beneficiaries. Ohio's Medicaid expenditures for PCS totaled approximately \$3.7 billion<sup>2</sup>, and 79,079 beneficiaries received PCS. The ODM offers both agency-based and self-directed PCS options. Appendix C provides enrollment and expenditure data for the PCS population in Ohio.

In August 2024, CMS conducted a focused program integrity review of Ohio's PCS program. This focused review assessed the state's compliance with regulatory requirements at 42 CFR Parts 440, 441, 455, and 456, as well as Sections 1905(a), 1915(c), and 1915(j) of the Social Security Act (the Act). As a part of this review, CMS conducted interviews with SMA staff involved in the administration of PCS to validate the state's program integrity practices, as well as with key personnel within three managed care organizations (MCOs) and three PCS agencies. CMS also evaluated the status of Ohio's previous corrective action plan developed by the state in response to a managed care focused review conducted by CMS in 2019, the results of which can be found in Appendix A.

During this review, CMS identified a total of seven observations. CMS also included technical assistance and educational resources for the state, which can be found in Appendix B. The state's response to the CMS' draft report, can be found in Appendix D, and the final report reflects changes CMS made based on the state's response.

This review encompasses the three following areas:

- A. State Oversight of PCS Program Integrity Activities and Expenditures** – States share responsibility with CMS for ensuring that state and federal dollars are used to deliver health care services consistent with efficiency, economy, and quality to eligible individuals and are not misused for fraud, waste, or abuse. States must meet various

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<sup>2</sup> \$2.6 billion in direct payments and \$1.1 billion in capitation payments to MCOs

statutory and regulatory requirements, such as program integrity safeguards in 42 CFR Parts 455 and 456, to maintain effective oversight of their Medicaid programs. In addition, pursuant to Section 12006(a) of the 21<sup>st</sup> Century Cures Act, all states were required to implement an Electronic Visit Verification (EVV) system for PCS by January 1, 2020. Failure to meet this requirement results in incremental Federal Medical Assistance Percentage (FMAP) reductions of up to 1 percent, unless the state has both made a “good faith effort” to comply and has encountered “unavoidable delays.”

- B. Provider Enrollment and Screening** – As defined by § 440.167, PCS must be provided by an individual who is qualified to provide such services, unless defined differently by a state agency for purposes of a waiver granted under part 441, subpart G.<sup>3</sup> In accordance with these standards, state law often requires PCS agency staff and attendants to be subject to enhanced screening and credentialing procedures at the date of hire and annually thereafter. CMS regulations at § 455.436 require that the SMA conduct database checks to determine the exclusion status of providers, persons with an ownership or control interest, and agents and managing employees on the Department of Health and Human Services Office of Inspector General’s (HHS-OIG) List of Excluded Individuals and Entities (LEIE), the System for Award Management (SAM), the Social Security Administration’s Death Master File (SSA-DMF), and the National Plan and Provider Enumeration System (NPPES) upon enrollment and reenrollment, and check the LEIE and SAM no less frequently than monthly. In accordance with § 455.434, PCS agencies or attendants that enroll in Medicaid as providers are also subject to federal screening requirements found at § 455.410.
- C. State Oversight of Self-Directed and Agency-Based Services** – States may elect to offer self-directed PCS through several pathways, including the state plan, Section 1915(c) waivers, and specific provisions under Sections 1915(j) and 1915(k). These options allow participants, or their authorized representatives, to exercise choice and control over the planning, budgeting, and purchase of self-directed PCS. CMS regulations at 42 CFR 441 Subpart J govern the use of self-direction under these options, outlining the requirements for oversight and support of participants’ control in managing their care. Self-directed PCS under the state plan and Section 1915(c) waivers enable beneficiaries to tailor their care according to their specific needs and preferences while maintaining autonomy. Alternatively, beneficiaries may receive agency-based PCS, where a personal care agency provides oversight, management, and supervision of their services. Agency-based PCS are available through either state plan or waiver authority. In accordance with §§ 441.302 and 441.570, the SMA must ensure that adequate safeguards are in place to protect the health and welfare of individuals receiving PCS through these options and maintain financial accountability for all funds expended on PCS through waiver or state plan authority to uphold program integrity and compliance with federal standards.

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<sup>3</sup> The conditions of participation for home health aides participating in PCS programs are further detailed at § 484.80.

### **III. Results of the Review**

#### **A. State Oversight of PCS Program Integrity Activities and Expenditures**

States share responsibility with CMS for ensuring that state and federal dollars are used to deliver health care services consistent with efficiency, economy, and quality to eligible individuals and are not misused for fraud, waste, or abuse. States must meet various statutory and regulatory requirements, such as program integrity safeguards in 42 CFR Parts 455 and 456, to maintain effective oversight of their Medicaid programs.

As required by §§ 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and beneficiaries. In addition, Section 1902(a)(30) of the Act and federal regulations at 42 CFR Part 456 require the state plan to provide for the establishment and implementation of a statewide surveillance and utilization control program that provides methods and procedures to safeguard against unnecessary or inappropriate utilization of care, services, and excess payments. States often meet these requirements through implementation of a surveillance and utilization review subsystem within the Medicaid Management Information System (MMIS) and/or discrete surveillance and utilization review subsystem units that are a part of larger program integrity efforts.

In Ohio, the ODM BPI is primarily responsible for Medicaid program integrity activities. The ODM BPI identifies fraud and abuse within the Medicaid program by delegating specific administrative and monitoring functions, as follows:

- For all waivers, ODM utilizes the Data Support unit within the Surveillance and Utilization Review Section (SURS) to perform data analytics with sophisticated analytic tools. In addition, the SURS utilizes profile reports that identify instances of possible fraud, waste, and abuse by comparing provider peer groups.
- For Level One, Individuals Options, and SELF waivers, the DODD conducts compliance monitoring on an annual basis.
- For the PASSPORT waiver, ODA delegates provider oversight to the PASSPORT Administrative Agencies (PAAs).
- Additionally, each MyCare Ohio MCO has a special investigations unit (SIU) which conducts pre- and post-payment reviews of claims, prior authorizations, and reviews and processes referrals for fraud, waste, and abuse activities.
- The BPI Partner State Agency Audits Section reviews monitoring reports completed by DODD, ODA, and ODJFS to ensure compliance with regulations and the interagency agreements between the different agencies.

The ODM has established PCS program participation and reporting requirements through state policy specific to each HCBS waiver and ODM provider agreements. During the review period, Ohio contracted with five MCOs to provide health services to the Medicaid population under the MyCare Ohio program. As part of this review, three of these MCOs were interviewed, including Aetna Better Health of Ohio, Buckeye Health Plan, and CareSource. The ODM and MCO

responsibilities are outlined in the Ohio Administrative Code (OAC) Chapters 5160-26, 5160-58, a memorandum of understanding (MOU) between ODM and each MCO, and a three-way agreement between CMS, ODM, and each MCO. CMS noted that the general contract between Ohio and each MCO was available online, as required by § 438.602(g)(1). Pursuant to OAC Rule 5160-26-06(A)(2), the MCOs are required to annually submit a report to ODM that summarizes the MCO's fraud, waste, and abuse activities for the previous year and identifies any proposed changes for the coming year. In addition, MCOs are contractually required to provide ODM with a quarterly inventory report on fraud, waste, and abuse activities, including any planned activities for the upcoming quarter. The ODM BPI completes assessments of these reports and communicates any questions or concerns, if applicable, during quarterly inventory meetings with the MCOs. The ODM staff, MCOs, sister state agencies, and ODM contractors submit fraud, waste, and abuse referrals to the Fraud Referral Clearinghouse. The ODM uses this clearinghouse for referral and deconfliction information allowing for real-time monitoring and data reporting, increased opportunities for collaboration, and the elimination of duplicate workstreams.

The ODM has a MOU with the Ohio Attorney General's Medicaid Fraud Control Unit (MFCU). Under this MOU, ODM is required to conduct a preliminary review of fraud, waste, and abuse referrals and promptly forward any cases of potential fraud to the MFCU. In accordance with § 455.23, ODM must suspend Medicaid payments to a provider when there is a credible allegation of fraud under investigation, unless a good cause exception is applied. Additionally, per OAC Rule 5160-1-17.5, ODM must suspend a provider agreement if there is a credible allegation of fraud without a good cause exception or upon receiving notice of an indictment against a non-institutional provider or related officer.

ODM refers all cases of suspected fraud to the MFCU and returns abuse and waste cases to the MCOs for further investigation and potential recovery. The Ohio MFCU is responsible for investigating fraud referrals and determining credible allegations of fraud. When the MFCU establishes a credible allegation of fraud, ODM will suspend payments to the PCS provider. Also, CMS has identified that ODM performs oversight and works with the MFCU to track and recover overpayments due to PCS fraud.

In addition, the state must request a certification from the MFCU that any case accepted on the basis of a referral continues to be under investigation in accordance with § 455.23(d)(3)(ii). The MOU requires the MFCU and ODM to perform quarterly and annual reconciliations of program activities (e.g., case referrals, cases accepted/refused, convictions, recoveries). CMS noted that the MFCU and ODM meet the quarterly certification requirement through daily file updates regarding ongoing cases. Additionally, ODM report their process for meeting bi-weekly and getting almost daily updates from MFCU in their clearinghouse system.

The ODM attends monthly Program Integrity Group meetings that consist of the MFCU, the Auditor of State, ODM policy unit, and ODM BPI to discuss Medicaid fraud, waste, and abuse, potential areas of risk, and other relevant investigatory information. The group meets monthly for educational presentations and information sharing. The group discusses data mining projects with a focus on fraudulent schemes. The ODM replicated the successful elements of these

meetings by creating the Managed Care Program Integrity Group. 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 meets regularly throughout the year for education and information sharing which promotes collaboration among Ohio's program integrity partners. In addition, ODM facilitates MCO SIU meetings to serve as a forum for regular exchanges of information between the MFCU, MCOs, and ODM.

The ODM, in conjunction with the DODD, ODA, and other delegated entities, conducts programmatic audits to ensure compliance with established program guidelines. Each PCS agency is subject to an audit that includes, but is not limited to reviews of personnel files, client records, and service billing records. The PCS agencies are subject to recoupments and corrective actions plans if programmatic deficiencies are discovered during the audit. Detailed information on post-payment actions taken as a result of PCS provider audits can be found in Appendix C.

States are also required to implement an EVV system to help oversee PCS providers. EVV is used to verify that PCS visits occurred and can be performed through a number of methods, including telephonic or GPS-enabled mobile applications. Pursuant to Section 12006(a) of the 21<sup>st</sup> Century Cures Act, all states were required to implement an EVV system for PCS by January 1, 2020. Failure to meet this requirement results in incremental FMAP reductions of up to one percent, unless the state has both made a "good faith effort" to comply and has encountered "unavoidable delays."

Currently, Ohio utilizes an EVV system for in-home scheduling, tracking, and billing for PCS providers. The ODM contracted with Sandata Technologies LLC, the vendor chosen for the Ohio EVV system. Agency providers can choose to use a certified alternate EVV system, as long as the alternative EVV can send new and edited visits in a verified status to the Sandata Aggregator within 24 hours of entry. The ODA, DODD, and MCOs are required to utilize the same EVV solution and approach that is used by ODM. All visit data collected within the Sandata system is stored in the Aggregator and is available to substantiate information on claims. All PCS agencies interviewed reported the use of Sandata. Ohio implemented their current EVV in 2018 and is in compliance with Section 12006(a) of the 21<sup>st</sup> Century Cures Act. Manual visit entry is only permissible in the event verification through a device with an application or telephony is not available or appropriate based on the immediate needs of the individual.

CMS determined that Ohio met the appropriate oversight and monitoring requirements for PCS for the review period. CMS did not identify any findings related to these requirements, however two observations to take into account going forward.

**Observation #1:** CMS encourages Ohio to be more proactive in tracking improper payments and specifically overpayments identified and recovered, due to PCS fraud. Also, the state should consider implementing robust tracking tools, to assist with prompt identification and recovery of overpayments and improper payments. This is especially important because the state relies on the MFCU to determine credible allegations of fraud, creating delays in authorizing payment suspensions until the provider has been indicted or convicted of a

credible allegation of fraud by the MFCU.

**Observation #2:** CMS encourages Ohio to establish program integrity policies and procedures for conducting post-payment reviews of PCS claims with a focus on identifying and investigating providers who may have an unusually high number of PCS visits that are manually entered or adjusted within the EVV system. Furthermore, CMS encourages Ohio to leverage EVV data when performing data analytics to identify outliers and patterns in post-payment reviews, enhancing the detection of potential program abuses.

## **B. Provider Enrollment and Screening**

CMS regulations at § 455.436 require that the SMA conduct database checks to verify the exclusion status of the provider, persons with an ownership or control interest, and agents and managing employees on the HHS-OIG's LEIE, SAM, SSA-DMF, and NPPES upon enrollment and reenrollment, and check the LEIE and SAM no less frequently than monthly.

For agency directed services available under Section 1915(c) waiver authorities, responsibility for compliance with § 455.436 is delegated to the agency. Compliance requirements for this regulation apply only to providers who are enrolled in traditional Medicaid and are issued a Medicaid provider ID. CMS confirmed that the ODM has a state policy in place addressing this requirement. For PCAs not enrolled with the state, federal database checks (e.g., LEIE or SAM) are not required under federal law for either traditional or managed care Medicaid, though states may impose their own requirements. According to the OAC 5160-1-17, all eligible providers, including MyCare Ohio providers, are required to enroll in the Medicaid program, have a signed provider agreement, and obtain an Ohio Medicaid provider number. The ODM, ODA, or DODD completes initial federal database checks for all PCS providers as part of their enrollment in Ohio Medicaid and then on an on-going basis (i.e., at least every five years for PCS agencies and annually for all ODM-approved non-agency providers). Background checks are conducted for all providers having direct contact with waiver beneficiaries as required by Ohio Revised Code, Section 5123.081 and ORC 5164.341, which include background screening against relevant abuse and fraud databases and criminal record checks with the Ohio Bureau of Criminal Identification and Investigation (BCII). The PCS provider must consent to Fingerprint-based Criminal Background Checks (FCBCs) as part of the criminal records check. An applicant must have a criminal record check conducted by the Federal Bureau of Investigation if the person does not present proof of Ohio residency during the five-year period immediately prior to the date the BCII criminal record check is requested. All PCAs hired by employers are automatically enrolled in criminal record rap back monitoring. In addition, MCOs check PCS providers enrolled in MyCare Ohio waivers including people with ownership or controlling interests or management employees of the provider agency against applicable federal databases each month.

Under all waivers in which services are subject to EVV, agency-based and self-directed PCS providers are required to obtain mandatory EVV training by Sandata Technologies prior to the provider accessing the EVV system. In addition, MCOs and the ODM Provider Oversight Contractor offer ongoing waiver service provider training. While the state requires Medicaid agency providers, independent providers, and PCAs receive initial and annual training, PCS

providers are not required to participate in fraud prevention training. The DODD PCS providers are responsible for ensuring that their employees are properly trained in accordance with OAC 5123-2-08, Appendix C.

For self-directed services available under the Section 1915(c) waiver authority, the Financial Management Services Agency (FMSA) performs the provider screenings and provides fiscal intermediary and other support services to beneficiaries who choose to self-direct their service. The ODM requires an annual background check for self-directed providers. The ODM also requires that self-directed providers, as part of the Medicaid application process, must consent to FCBCs as part of the criminal records check with BCII. The ODM also transitioned from annual background checks to mandatory use of BCII's rap back monitoring.

In accordance with § 455.410, PCS agencies or attendants that enroll in Medicaid as providers are subject to federal screening requirements found at § 455.450. SMAs must require providers, as a condition of enrollment in Medicaid, to consent to FCBCs when required to do so under state law, or by the level of screening based on fraud, waste, and abuse risk as determined for that category of provider, in accordance with § 455.434. High risk and moderate risk providers are subject to enhanced screening. As described in OAC 160-1-17, providers enrolled in Ohio Medicaid are screened based on their categorical risk. Screening is conducted during provider enrollment to determine the provider's categorical risk level. Ohio requires fingerprinting and background checks for owners and managing employees of moderate and high-risk provider organizations and conducts 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. ODM, ODA, DODD and their delegates perform provider enrollment and oversight activities, including conducting site visits. In accordance with state regulations, PCS agency staff and attendants are subject to these enhanced screening and credentialing procedures at the date of hire and periodically thereafter.

As part of this review, CMS interviewed three PCS agencies to determine if they are exercising appropriate oversight of the quality and integrity of services provided to beneficiaries under the care of their agency, in accordance with state standards. Ohio does not require PCAs providing agency-directed services to be licensed or enrolled in the Ohio Medicaid program, therefore it is the responsibility of the employing agency to perform the appropriate background checks according to the specific waiver requirements. The SMA encourages providers to use the Automated Registry Check System (ARCS) for conducting background investigations. Potential employees who clear the screening are required to consent to FCBCs and submit to a criminal record check with BCII. The agency can conditionally employ the person on a time-limited basis pending the results of the criminal record check; however, the person is only permitted to provide services under supervision. If the results indicate the person has been convicted of, or pleaded guilty to, a disqualifying offense, then employment must be terminated. The PCS agency is responsible for ensuring that employees are subject to the database screening and criminal records recheck procedures every five years and maintain documentation of the screening and records recheck for all employees.

As part of this review, CMS interviewed three provider agencies: Alpha Home Health Agency,

Cap City Supported Living and Home Care Services, and Graceworks Enhanced Living. Each of the agencies reported compliance with these requirements. Each agency utilized the ARCS or their own designated system to perform the required database checks. CMS noted that during the review period, the ODA contracted with PASSPORT PAAs to complete onsite visits and structural compliance reviews of personal care providers which identified 3,670 non-compliance issues, of which 979 issues noted were due to non-compliance with required criminal records checks.

CMS determined that Ohio has met federal screening requirements; however, ODM may benefit from providing additional training and/or guidance to ensure providers receive annual fraud prevention training and understand state and federal regulations for performing required background checks.

**Observation #3:** CMS encourages Ohio to require annual training for all PCS providers and require a program integrity component to the initial and annual training. Annual training could include updates to PCS program rules and/or guidance, PCS billing requirements, and prevention, detection, investigation, referral, and reporting of fraud, waste, and abuse. In addition, CMS encourages Ohio to provide additional training and/or guidance to PCS providers on state and federal regulations when performing required background checks.

### **C. State Oversight of Self-Directed and Agency-Based Services**

A self-directed PCS state option allows beneficiaries or their representatives, if applicable, to exercise decision-making authority in identifying, accessing, managing, and purchasing their PCS. A state offering a self-directed option must assure that certain necessary safeguards have been taken to protect the health and welfare of individuals furnishing services under the program and assure the financial accountability for funds expended for self-directed services in accordance with § 441.464. These safeguards must include prevention against the premature depletion of the beneficiary directed budget, as well as identification of potential service delivery problems that might be associated with budget underutilization.

Ohio ensures these requirements are met through the FMSA and other delegated entities (e.g., County Boards of Developmental Disabilities, PASSPORT PAAs, CareStar, CareSource) which provides each beneficiary receiving self-directed PCS with a case manager to monitor the beneficiary's expenditures. This case manager is tasked with advising the beneficiary on care choices and reporting significant budget variances that may indicate potential fraud or abuse to the ODM. Additionally, the FMSA conducts regular monitoring of self-directed beneficiary records to identify any potential outliers, such as reviewing timesheets and documentation submissions prior to approving payment or submitting claims.

During the review period, Ohio contracted with GT Independence as the FMSA for Level One, Individual Options, and SELF waivers, and Public Partnerships, LLC for PASSPORT and My Care waivers. County Boards of Developmental Disabilities provide ongoing individual service plan monitoring to ensure services and supports are provided in accordance with the individual

service plan and to the benefit and satisfaction of the individual. The state provides oversight of interactions of the FMSA with beneficiaries and PCS providers through regularly occurring meetings with the contractor. The SMA monitors the effectiveness of the FMSA's established protocols for customer service, reporting, payroll processing, and employer related activities as defined in the FMSA contract and operational protocols. The FMSA provides monthly, quarterly, and semiannual program reports to the SMA that are used to assess the FMSA performance. The SMA oversees the employee payroll process and reviews the monthly FMSA invoices prior to payment to ensure the invoice remittance only includes the authorized services, scope, duration, and frequency and timely resolution of identified issues. In addition, the DODD monitors and assesses the performance of the FMSA by performing annual reviews of a representative sample of beneficiary files, including expenditures, to identify inconsistencies based on information including utilization, individual budgets, expenditures, dates of service, waiver enrollment date, and follow up with FMSA staff to ensure correction of errors.

For the MyCare Ohio waiver, the MCOs work in conjunction with the FMSA and PASSPORT PAAs to monitor PCS provider compliance and utilization management. The MCOs submit encounter data to the SMA which is reviewed annually by a contracted external quality review organization. However, ODM does not track MCO sanctions or corrective actions imposed on self-directed PCS providers to ensure enforcement of the terms of the provider contracts.

Beneficiaries can also elect to have their care overseen, managed, and supervised by a personal care agency. Agency-based PCS in Ohio is available under waiver authority. In accordance with §§ 441.302 and 441.570, the SMA must assure that certain safeguards have been taken to protect the health and welfare of individuals furnishing services under the program and to assure the financial accountability for funds expended for agency-based PCS. Ohio ensures that these requirements are met through use of prior authorization of PCS which is based on the individual beneficiary's needs identified through the person-centered service planning process. The care plan is updated as required by ongoing assessment of progress and needs.

ODM has implemented MMIS claim edits that prevent inaccurate and double billing of PCS claims, with the exception of institutional overlapping claims edits, that were inactive for the review period. In addition, Ohio requires all MyCare plans to employ edits in accordance with OAC 5160-58-01.1, OAC 5160-26-06, and the ODM 1915(c) and 1915(b) CMS-approved waiver requirements. Edits include, but are not limited to, verifying the contracted provider type to prevent out of scope services, EVV to ensure services are provided to an individual in their home at the date, time, and duration submitted in the claim, duplicated claims, billing for HCBS when an individual is temporarily residing in a nursing facility, billing in excess of 24 hours, deceased individuals etc. However, as stated previously, there were no pre-payment MMIS edits in place to detect overlapping claims with institutional care claims.

ODM has a Data Support unit within SURS which uses sophisticated analytic tools to create, modify, and run complex algorithms of all paid waiver claims as well as utilize profile reports to identify instances of possible fraud, waste, and abuse by comparing provider peer groups. Each MyCare plan has an SIU which conducts pre- and post-reviews of claims, prior authorizations, and reviews and processes referrals for fraud, waste, and abuse activities. Additionally, ODA

delegates provider oversight to the PASSPORT PAAs to complete onsite visits initially and ongoing to complete structural compliance reviews. The case managers at the PAAs ensure authorizations are accurately reflected on the service plan prior to the claim being processed and paid.

In accordance with § 455.20, the SMA must have a method for verifying with beneficiaries whether services billed by providers were received. The ODM sends approximately 6,400 explanations of medical benefits (EOMBs) per month to fee-for-service recipients that had a paid claim from the prior month. The notices are sent to randomly selected recipients (including agency directed and self-directed services) and includes all services paid for the individual in the prior month. In addition, MCOs are contractually required to conduct a random sample of EOMBs of their beneficiaries. Alternatively, the MCO may meet this requirement by targeting specific services or areas of concern as long as the number of mailed EOMBs is not less than the number generated by the random sample described above. If the MCO opts to use a targeted mailing, it must submit the proposed strategy in writing to ODM and receive written prior approval. CMS noted that all three MCOs interviewed had a method in place and conducted mailings of EOMBs during the review period. However, CMS noted the state's tracking system does not allow the state and MCOs to determine the number of beneficiary verifications issued and returned for PCS by provider agencies, individual providers, and self-directed care.

Lastly, CMS identified that the current reporting process for overpayments and instances of PCS fraud, waste, and abuse may be unclear for agencies. One PCS agency reported that they had not received any guidance from the state on how or where to report such issues. Another agency shared that after submitting a fraud referral to the SMA, they never received any response, confirmation, or update on the referral's status.

CMS determined that Ohio has met federal monitoring requirements; however, CMS encourages Ohio to increase program integrity activities to protect the health and welfare of individuals furnishing services under the program and ensure the financial accountability for funds expended for self-directed and agency-based PCS.

**Observation #4:** CMS encourages Ohio to update their system to allow tracking of MCO imposed sanctions and corrective actions on self-directed providers, to ensure the enforcement of the terms of the providers' agreement.

**Observation #5:** CMS encourages Ohio to ensure that MMIS edits are active to detect overlapping claims with institutional care, which will strengthen program integrity and increase the identification and referral of potential fraud, waste, and abuse within PCS.

**Observation #6:** CMS encourages Ohio to implement additional program integrity measures to ensure the state and MCOs can determine the number of beneficiary verifications issued and returned for PCS by provider agencies, individual providers, and providers of self-directed care.

**Observation #7:** CMS encourages Ohio to establish policies and procedures and provide additional training and/or guidance to ensure PCS providers are properly reporting instances of possible fraud, waste, or abuse of PCAs. In addition, CMS encourages Ohio to develop procedures to ensure the SMA promptly acknowledges its receipt of referrals from PCS agencies.

#### **IV. Conclusion**

CMS supports Ohio's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified seven observations that require the state's attention.

The state is not required to develop a corrective action plan for any observations included in this report. However, CMS encourages the state to take the observations into account when evaluating its program integrity operations going forward.

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

## V. Appendices

### Appendix A: Results of the Prior Review

Ohio's last CMS program integrity review was in May 2019, and the report for that review was issued in October 2019. The report contained nine recommendations. During the virtual review in August 2024, CMS conducted a thorough review of the corrective actions taken by Ohio to address all recommendations reported in calendar year 2019. The findings from the 2019 Ohio focused PI review report have all been satisfied by the state.

### Findings

- 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.*

Status at time of the review: Corrected
- 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.*

Status at time of the review: Corrected
- 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.*

Status at time of the review: Corrected
- 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.*

Status at time of the review: Corrected
- 5. The state should amend its policies and procedures 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.*

Status at time of the review: Corrected

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.*

Status at time of the review: Corrected

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

Status at time of the review: Corrected

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

Status at time of the review: Corrected

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 at time of the review: Corrected

## Appendix B: Technical Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance and educational resources for the SMA.

- Access the Resources for State Medicaid Agencies website at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs> to address techniques for collaborating with MFCUs.
- Access the CMS frequently asked questions document, Allowability of Using National Provider Identifiers (NPIs) for Medicaid Personal Care Attendants (PCAs), at <https://www.cms.gov/medicare-medicicaid-coordination/fraud-prevention/fraudabuseforprofs/downloads/faqs-using-npis-for-medicaid-pcas.pdf>
- Access Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services at <https://www.cms.gov/medicare-medicicaid-coordination/fraud-prevention/fraudabuseforprofs/downloads/vulnerabilities-mitigation-strategies.pdf>
- Access the Preventing Medicaid Improper Payments for Personal Care Services fact sheet and booklet at <https://www.cms.gov/medicare-medicicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/pcs-prevent-improperpayment-factsheet.pdf> and <https://www.cms.gov/medicare-medicicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/pcs-prevent-improperpayment-booklet.pdf>
- Access the Medicaid Payment Suspension Toolkit at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf>, to address overpayment and recoveries.
- 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. <https://www.riss.net/>
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at <https://www.cms.gov/medicaid-integrity-institute>
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at <https://www.cms.gov/hfpp>.

**Appendix C: Program Information**

Table C-1 provides detailed information on the PCS programs available in Ohio.

**Table C-1. Ohio Medicaid PCS Programs**

<b>Program Name/Federal Authority</b>	<b>Administered By</b>	<b>Description of the Program</b>
<i>Section 1915(c) HCBS Waiver Authorities</i>		
Home Care Waiver	ODM	Provides personal care aide services, home care attendant, and other services to individuals with physical disabilities ages zero to 59 years who meet a hospital or nursing facility level of care.
Individual Options Waiver	Administered by ODM  Operated by DODD	Provides homemaker/personal care, homemaker/personal care - daily billing unit, self-directed homemaker/personal care, and other services to individuals with intellectual disabilities or developmental disabilities who meet an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care.
Integrated Care Delivery System Waiver (MyCare Ohio)	ODM	Provides personal care, choices - home care attendant service, home care attendant, and other services to individuals ages 65 or older and individuals with physical disabilities ages 18 to 64 years who meet a hospital or nursing facility level of care. This waiver operates with a concurrent 1915(b)(1) and 1915(b)(4) authority.
Level One Waiver	Administered by ODM  Operated by DODD	Provides homemaker/personal care, self-directed homemaker/personal care, and other services to individuals with intellectual disabilities and developmental disabilities who meet an ICF/IID level of care.
PASSPORT Waiver	Administered by ODM  Operated by ODA	Provides personal care, choices - home care attendant service, home care attendant and other services to individuals ages 65 or older and individuals with physical disabilities ages 60 to 64 years who meet a nursing facility level of care.
Self-Empowered Life Funding (SELF) Waiver	Administered by ODM  Operated by DODD	Provides self-directed homemaker/personal care and other services to individuals with intellectual disabilities or developmental disabilities ages zero or older who meet an ICF/IID level of care.

**Table C-2. Ohio PCS Enrollment by Authority**

	<b>FY 2021</b>	<b>FY 2022</b>	<b>FY 2023</b>
<b>1915(c) HCBS Waiver Authority</b>	57,113	55,924	56,195

**Table C-3. Summary of Ohio PCS Expenditures by Authority**

	<b>FY 2021</b>	<b>FY 2022</b>	<b>FY 2023</b>
<b>1915(c) HCBS Waiver Authority</b>	\$2,463,886,824	\$2,538,292,619	\$2,685,161,477

**Table C-4. Waiver Authority Expenditures by Type**

<b>1915(c) HCBS Waiver Authority</b>	<b>FY 2021</b>	<b>FY 2022</b>	<b>FY 2023</b>
Home Care Waiver	\$108,478,547	\$115,638,033	\$120,086,604
Individual Options Waiver	\$1,692,940,338	\$1,740,393,539	\$1,835,142,862
Integrated Care Delivery System Waiver (MyCare Ohio)***	\$391,009,177	\$395,141,094	\$403,142,381
Level One Waiver	\$32,321,832	\$44,401,985	\$69,595,854
PASSPORT Waiver	\$215,416,261	\$218,778,222	\$234,623,567
SELF Waiver	\$23,720,669	\$23,939,746	\$22,570,209

**Table C-5. Program Integrity Post Payment Actions Taken – PCS Providers**

<b>Agency-Directed and Self-Directed Combined</b>	<b>FY 2021</b>	<b>FY 2022</b>	<b>FY 2023</b>
Identified Overpayments - FFS	\$337,687	\$274,462	\$279,964
Identified Overpayments - MyCare	\$254,750	\$1,961,615	\$754,459
Recovered Overpayments - FFS	\$165,717	\$62,227	\$17,767
Recovered Overpayments - MyCare	\$1,849	\$123,542	\$139,089
Terminated Providers	1,806	3,951	1,558
Suspected Fraud Referrals	266**	352**	409
Number of Fraud Referrals Made to MFCU	266	225	228

\*\* For calendar year 2020 and 2021, there was no ODM Clearinghouse. All referrals submitted to ODM were also sent to the MFCU.

\*\*\* Since the MyCare program is a dual program for individuals with both Medicare and Medicaid, the MyCare waiver operates on Calendar Year instead of Fiscal Year to align with the Medicare Advantage plan year. Numbers in Table C-4 are by CY 2021, 2022, and 2023 respectively.

**Appendix D: State Program Integrity Review Response**

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an “X” in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
N/A	No recommendations are included in report.		

Acknowledged by: (Please do not sign and date draft report. Only the final report)

*Jeffrey S. Corzine*, Chief, Bureau of Program Integrity

\_\_\_\_\_  
 [Name], [Title]

April 16, 2026

\_\_\_\_\_  
 Date (MM/DD/YYYY)