# Department of Health and Human Services

# Centers for Medicare & Medicaid Services

# Medicaid Integrity Program

# Ohio Comprehensive Program Integrity Review

# Final Report

# August 2014

**Reviewers:**
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# Executive Summary and Introduction

The Centers for Medicare & Medicaid Services (CMS) regularly conducts reviews of each state's Medicaid program integrity activities to assess the state's effectiveness in combating Medicaid fraud, waste, and abuse. Through state comprehensive program integrity reviews, CMS identifies program integrity related risks in state operations and, in turn, helps states improve program integrity efforts. In addition, CMS uses these reviews to identify noteworthy program integrity practices worthy of being emulated by other states. Each year, CMS prepares and publishes a compendium of findings, vulnerabilities, and noteworthy practices culled from the state comprehensive review reports issued during the previous year in the *Annual Summary Report of Comprehensive Program Integrity Reviews*.

The purpose of this review was to determine whether Ohio's program integrity procedures satisfy the requirements of federal regulations and applicable provisions of the Social Security Act. A related purpose of the review was to learn how the State Medicaid agency receives and uses information about potential fraud and abuse involving Medicaid providers and how the state works with the Medicaid Fraud Control Unit (MFCU) in coordinating efforts related to fraud and abuse issues. Other major focuses of the review include but are not limited to: provider enrollment, disclosures, and reporting; pre-payment and post-payment review; methods for identifying, investigating, and referring fraud; appropriate use of payment suspensions; False Claims Act education and monitoring; managed care; non-emergency medical transportation (NEMT) and waiver program oversight; and program integrity activities conducted by managed care entities (MCEs).

In January 2013, Ohio's Medicaid program served 2,230,000 beneficiaries. Of that total, 1,676,893 beneficiaries were enrolled in managed care plans. The state had 104,228 enrolled fee-for-service (FFS) providers and estimated that 90% of managed care network providers were also enrolled in the FFS program. During federal fiscal year 2012, Ohio's Medicaid expenditures totaled approximately $17.3 billion.

The review of Ohio's program integrity activities found the state to be in compliance with many of the program integrity requirements. However, the review team identified a number of vulnerabilities and instances of regulatory non-compliance in its program integrity activities, thereby creating risks to the Medicaid program. The areas of risk include those related to oversight of program integrity operations, and provider enrollment practices and reporting.

Several of the issues described in this review were also identified in CMS's 2010 review and are still uncorrected. CMS will work closely with the state to ensure that all issues, particularly those that remain from the earlier review are satisfactorily resolved as soon as possible. These issues and CMS's recommendations for improvement are described in detail in this report.

# Methodology of the Review

In advance of the onsite visit, the review team requested that Ohio complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosures, managed care, and relationship with the MFCU. A four-person team reviewed the responses and materials that the state provided in advance of the onsite visit. The review team also conducted in-depth telephone interviews with representatives from the MFCU and three MCEs.

During the week of August 12, 2013, the CMS review team visited the Ohio Department of Medicaid (ODM), recently established as a separate agency from the Ohio Department of Jobs and Family Services. The team conducted interviews with numerous ODM staff involved in program integrity. In addition, the team conducted sampling of provider enrollment applications, program integrity cases, 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 ODM but also considered the work of other components and contractors responsible for a range of program integrity functions, such as managed care and NEMT services. Ohio operates its Children's Health Insurance Program (CHIP) as both a Title XXI Medicaid expansion program and a stand-alone Title XXI program. The same effective practices and risks discussed in relation to the Medicaid program also apply to the expansion program. The stand-alone CHIP program operates under the authority of Title XXI and is beyond the scope of this review. Unless otherwise noted, Ohio 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 the ODM provided.

## Medicaid Program Integrity Unit

In Ohio, Medicaid program integrity is generally overseen by the office of the Chief of Staff within ODM. However, day-to-day program integrity functions are handled by a combination of ODM units principally organized under the Operations Division of the State Medicaid agency. The ODM reported that it has a total of 78 authorized full time equivalents (FTEs) assigned to program integrity functions which include two liaisons in the Operations Division as well as staff in each of the following: the Surveillance and Utilization Review Subsystem (SURS) unit; provider services and network management; provider enrollment, outreach and compliance functions; Managed Care Contract Management; and the Bureau of Long Term Care Services & Support. At the time of the review, 10 positions were vacant. The state indicated that they had 103 authorized FTEs in State Fiscal Year (SFY) 2010, which indicates a reduction of 25 FTEs between 2010 and 2013, most notably in the auditor and data analyst areas.

The table below presents the total number of preliminary and full investigations, and the amount of identified and recovered overpayments related to program integrity activities in the last four complete SFYs.

**Table 1**

| SFY | Number of Preliminary Investigations Initiated* | Number of Cases Referred to MFCU** | Amount of Overpayments Identified*** | Amount of Overpayments Collected*** |
|---|---|---|---|---|
| 2009 | 2528 | 179 | $39,113,789 | $5,594,173 |
| 2010 | 1724 | 183 | $41,035,135 | $8,332,184 |
| 2011 | 1644 | 243 | $31,927,519 | $3,410,647 |
| 2012 | 921 | 192 | $25,152,548 | $3,006,072 |

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a referral to the MFCU or administrative sanction. The ODM conducts desk and field audits and reviews for its preliminary investigations. The reduction and likely inaccurate number of preliminary investigations is caused by a decentralized case tracking system, which is further discussed in Risk Area 1.
**The ODM refers cases to the MFCU for full investigation.
***The Amount of Overpayments Identified and Collected columns includes the following global settlement amounts for each of the past 4 SFYs: $509,756 (SFY09); $480,121 (SFY10); $605,179 (SFY11); $65,000 (SFY12).

## Results of the Review

The CMS review team found regulatory compliance issues and vulnerabilities related to program integrity in the Ohio Medicaid program. Several of these issues represent risks to the integrity of the state's Medicaid program. These issues fall into two areas of risk and are outlined below. To address them, Ohio should improve oversight and build more robust program safeguards.

### Risk Area 1: Risks were identified in the state's oversight of program integrity operations.

#### State Infrastructure

As described above, program integrity activities, though overseen by a central office in ODM, are divided among multiple units. The benefits of this approach are that program integrity becomes part of the core operations of many program units. However, while there is broad communication across the agency, there is no central repository and no integration of case files including audit reports, case investigations and case progress reports. Decentralized records, incomplete case files and limited tracking systems made it difficult for the state to provide CMS with a clear picture of its activity with respect to investigations and case follow-up. Not maintaining a centralized database or tracking system to capture milestones for FFS, managed care, and waiver program cases across the state agency and the MFCU has the potential to create inefficiencies. In sum, a more integrated system in support of multiple units would improve internal controls and decision support for managing cases, referrals and payment suspensions.

#### Written Policies and Procedures

The state has SURS policies and procedures for referrals made to an agency or entity, an audit manual and a Provider Enrollment Manual. These policies, however, do not comprehensively address the identification, investigation, and referral of fraud, waste and abuse under the regulations at 42 CFR 455.13 through 455.23, nor do they encompass the complete scope of current program integrity functions and practices at the ODM. The absence of written policies and procedures leaves the state vulnerable to inconsistent operations and ineffective functioning in the event the state loses experienced program integrity staff.

## Payment Suspension

Ohio's procedures do not appear to reflect the referral process described in the Memorandum of Understanding (MOU) between the state and the MFCU. In Article IV.H of the MOU, the state procedure for referrals reflects a process whereby the ODM would notify the MFCU when suspending payments and the MFCU will notify the ODM when there is good cause not to suspend. However, the review team found that in practice, the state rarely takes action to suspend Medicaid payments under its own authority; it will only suspend payments when there is evidence of patient harm or immediate jeopardy. Primarily, the state relies on the MFCU to determine if an allegation of fraud is credible and suspends payments only when directed to do so by the MFCU. The MFCU asks the state to exercise good cause not to suspend payments in almost all cases for an indeterminate amount of time.

The state suspended payment in only ten cases in the last three SFYs and, more recently in SFY12, the number of payment suspensions was quite low (4 cases) given the number of referrals for the same period.[1] During case sampling, the review team also noted that the time frame from when the MFCU determines that a credible allegation of fraud exists on a particular case to the time when a payment suspension is made varies significantly—from one week to 5 months.

Further, according to 42 CFR 455.23(d), the State Medicaid agency must make a fraud referral to the MFCU in writing and it must conform to the fraud referral performance standards issued by the Secretary. In the MOU, the ODM is instructed to make referrals to the MFCU after preliminary review using the CMS Fraud Referral Performance Standards as a reference. This was not being done in the cases sampled. The state does not use a standard summary or referral form for most cases, which identifies in one place both the rationale for a referral, the conduct at issue, estimated dollar exposure, and referral milestones. The state reported that much case discussion is done face to face and may never make it onto paper or written files, as the MFCU is meeting with state staff multiple times a month.

## Oversight of NEMT

In the county-administered NEMT system, the state expended approximately $50 million in federal fiscal year 2012, but its oversight is limited. The state has not provided guidance on obtaining provider ownership and control disclosures, criminal conviction disclosures, exclusion checks of various private transportation vendors or drivers or verifying services with beneficiaries. State staff were unaware of whether ownership and control disclosures were being captured by Ohio counties that enroll providers and contractors. The state shared a sample of county interagency agreements currently in force between the State Medicaid agency and Ohio counties, but none of these documents were the same. Most agreements were transportation plans and would not be considered contracts; many agreements were without signature and the review team did not find language requiring assurances and accountability related to program integrity, fraud or abuse. The CMS review team concluded that the NEMT program does not

[1] The State Medicaid Agency reported making 192 referrals for SFY12.

incorporate the program integrity framework employed elsewhere in the ODM. Oversight of NEMT was also an issue in the CMS review of 2010.

### False Claims Act Education

The state is not following its compliance review protocol in accordance with its State Plan on False Claims Act education requirements. Chiefly, the State Plan requires the state, beginning in 2007, to annually determine what providers are covered entities following Section 1902(a) (68) of the Social Security Act [42 U.S.C. 1396a(a)(68)] and to verify that providers are meeting the requirements of the federal rule during compliance audits, record reviews and policy reviews. The CMS review team was informed that the Bureau of Audit Performance[2] was to perform the review of provider false claims education policies during on-site field audits. However, due to a reduction in staffing levels, the state postponed on-site monitoring and has not implemented its reviews to ensure compliance.

***Recommendations***:

- Develop and implement integrative mechanisms to further coordinate program integrity activity across the ODM and further develop written policies and procedures addressing all program integrity functions and practices.
- Refine current payment suspension practices to ensure that the ODM fully considers each case referred to the MFCU on its own merits in order that the state agency identify where it can safely suspend Medicaid payments to problem providers without jeopardizing further investigation of those providers. Ensure that in the absence of a written good cause exception, provider payments are suspended after determination of a credible allegation of fraud in accordance with the requirements at 42 CFR 455.23. Develop and implement a form that complies with CMS Fraud Referral Performance Standards[3] when preparing preliminary investigations for referral to the MFCU. Work with the MFCU to lift good cause exceptions as soon as possible and suspend payments on a consistent, timely basis.
- Develop policies and procedures to conduct program integrity oversight of the county-based NEMT programs by providing guidance to Ohio counties that enroll providers and contractors. Develop a standard county interagency agreement that incorporates the necessary program integrity accountabilities.
- Implement the compliance review protocol associated with the state's False Claims Act education requirements which is outlined in Ohio's approved State Plan.

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## Risk Area 2: Risks were identified in the state and MCE's provider enrollment practices and reporting.

### Ownership and Control Disclosures in FFS

[2] The Bureau of Audit Performance is a division of the Ohio Department of Medicaid that conducts internal audits.
[3] http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/downloads/fraudreferralperformancestandardsstateagencytomfcu.pdf

Ohio has redesigned its enrollment process and web-portal, the Medicaid Information Technology System, as part of its new Medicaid Management Information System (MMIS), and there are several unintended gaps in information that the state is in the process of correcting. For example, the CMS review team observed that technical issues related to the design of portal screens caused gaps in the collection of clear provider ownership, control, and managing employee information for on-line provider applications for pharmacies. Although the enrollment process includes collection of all required information, the CMS review team noted on several applications that the Social Security Number (SSN) and date of birth (DOB) were not always filled in for individuals. The state reported that the system has been configured so that the applicant cannot advance with certain fields left blank; but from the forms reviewed, the review team was not able to confirm this.

**Inadequate Safeguards in Place to Ensure Payments Are Not Made to Excluded or Debarred Individuals or Entities**

In managed care, the state is not capturing complete disclosures from MCEs as required by 42 CFR 455.104 (ownership and control) and 455.106 (criminal history) at the point of contracting or renewal and is not capturing this information in a searchable database. Five MCEs were placed under contract in Ohio as of July 1, 2013. Although the ODM requires MCEs to provide ownership and disclosure information during the procurement process, the information provided is not complete. Four of the five MCEs did not provide managing employee information. One MCE provided a list of names and addresses for its managing employees but did not provide SSNs and DOBs for these individuals. Several MCEs listed as corporations did not provide tax identification numbers.

Although Ohio reports that more than 90 percent of managed care providers are enrolled as FFS providers by the state, a small percentage of non-Medicaid providers remain outside this enrollment process. The federal managed care regulations at 42 CFR 438.610 prohibit MCEs from knowingly having a director, officer, partner, or person with a beneficial ownership of more than 5 percent of the entity's equity who is debarred, suspended, or excluded, or from having an employment, consulting, or other agreement with an individual or entity for the provision of items and services that are significant and material to the entity's obligations under its contract with the state where the individual or entity is debarred, suspended, or excluded. CMS issued guidance to states through a series of State Medicaid Director Letters and a best practices document on this topic that provided states direction on screening for excluded individuals and entities.[4] The guidance also communicated the important point that while states may delegate many provider enrollment or credentialing functions to MCEs for managed care network providers, the state remains responsible for ensuring that excluded or debarred parties do not receive Medicaid funds.

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[4] CMS, State Medicaid Director Letter, SMDL #08-003 (June 12, 2008), available at: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd061208.pdf.
CMS, State Medicaid Director Letter, SMDL #09-001 (January 16, 2009), available at: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD011609.pdf.
CMS, *Best Practices for Medicaid Program Integrity Units' Collection of Disclosures in Provider Enrollment*, available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/bppedisclosure.pdf.

Since federal regulations prohibit payment for items or services furnished by excluded individuals and entities, it is imperative that this first line of defense in combating fraud and abuse be conducted accurately, thoroughly, and routinely. The ODM and its MCEs could not demonstrate that they had a process in place that was thorough or frequent enough to verify that they do not have a relationship with an individual or entity that has been debarred, suspended, or otherwise excluded from participating in a contract paid with federal funds at the MCE or network provider level. Without conducting routine searches of federal exclusion and debarment databases for providers, as well as those with an ownership or control interest, or who are agents or managing employees of the provider at both the MCE level and of the network providers they enroll, the ODM cannot ensure that excluded or debarred parties did not receive federal health care funds through Medicaid managed care contracts.

Ownership, control and criminal history disclosures are also not captured for NEMT providers working with or on contract with counties or county brokers/vendors and exclusion checking is also not being properly completed for county-based transportation brokers/vendors/providers (see Oversight of NEMT in Risk Area 1), which was also identified during the 2010 CMS review.

**Exclusion Searches**

As noted above, the ODM's enrollment process has an unintended gap that does not always require a provider to list complete ownership and control information and associated identifying information such as the SSN or DOB on their enrollment application. For this reason, the state cannot check all of the appropriate affiliated parties against the federal databases that must be checked at the time of provider enrollment, reenrollment, or monthly according to the regulation at 42 CFR 455.436 including: the U.S. Department of Health and Human Services' Office of Inspector General (HHS-OIG) List of Excluded Individuals and Entities (LEIE) and the Excluded Parties List System (EPLS) on the System for Award Management (SAM)[5], the Social Security Administration Death Master File (DMF), and the National Plan and Provider Enumeration System (NPPES).

**Site Visits**

The state is not currently conducting pre and post-enrollment site visits on all their identified moderate and high risk providers with the exception of certain provider types for whom Ohio has historically conducted site visits.[6] The state has hired a contractor to conduct site visits but has not finalized its strategy and approach. The state estimates that it will implement its site visit program by January 2014.

[5] In July 2012, the EPLS was migrated into the new System for Award Management (SAM).
[6] Traditionally Ohio has performed pre-enrollment site visits on assisted living facilities, waiver contractors, and home health agencies. The state also has conducted post-enrollment site visits on community mental health centers and adult medical day health centers.

### National Provider Identifier

The state does not require that all claims contain the National Provider Identifier (NPI) of the ordering and referring provider. The ODM claim forms and claims processing system has not been updated to incorporate the NPI of the ordering or referring physician or other professional as required by the regulation at 42 CFR 455.440.

### Notifications to HHS-OIG

The state stopped reporting all fraud and abuse-related adverse actions to the HHS-OIG as required by the regulation at 42 CFR 1002.3 when it started reporting to the Medicaid and Children's Health Insurance Program State Information Sharing System (MCSIS).[7] The state indicated that it would resume OIG reporting of adverse actions immediately and reach out to the regional office of the Special Agent-in-Charge.

***Recommendations:***

- Resolve the defects in the Medicaid Information Technology System to capture all required information at enrollment of FFS providers. Develop and implement a process to ensure that any person with an ownership or control interest or who is an agent or managing employee of the provider is checked against all of the databases required by the regulation at 42 CFR 455.436.
- Develop and implement a process to ensure that neither the state nor its MCEs are affiliated with any individual or entity prohibited from receiving federal funds. At a minimum, either the state or the MCEs should search managed care network providers and any person with an ownership or control interest or who is an agent or managing employee of the provider against HHS-OIG's LEIE, the EPLS, NPPES, and the DMF during the enrollment process and against the LEIE and EPLS monthly thereafter. The ODM should also conduct these same searches of all of the parties disclosed by the MCE itself.
- Perform pre and post-enrollment site visits on moderate and high-risk provider types.
- Require all claims for items and services that were ordered or referred to contain the NPI of the physician or other professional who ordered or referred such item or service.
- Ensure that the state reports all program integrity-related adverse actions taken on a provider's participation to the HHS-OIG.

## Effective Practices

As part of its comprehensive review process, CMS also invites each state to self-report practices that it believes are effective and demonstrate its commitment to program integrity. CMS does not conduct a detailed assessment of each state-reported effective practice.

[7] In November 2013, the MCSIS database was replaced by a new system of reporting terminations known as Termination Notification. Under the new system, terminations are reported and shared across states using CMS's TIBCO Managed File Transfer internet server.

### Collaborative Relationships and Communication with External and Internal Partners

The ODM created the Program Integrity Group, which meets monthly, and consists of participants across and beyond the State Medicaid agency, e.g., program integrity unit, the SURS unit, managed care unit, provider services (which houses a provider network management group and a provider compliance unit), the Auditor of State[8], and the MFCU. The Program Integrity Group discusses both policy issues, such as how to identify and approach high risk areas and develop a collaborative risk assessment process, as well as specific cases.

Additionally, the ODM has created a separate Managed Care Program Integrity Group, which meets quarterly, and consists of ODM staff, a representative from the MFCU, as well as investigators and other fraud and abuse staff from all MCEs who attend in person or by conference call. This group confidentially processes information related to specific fraud and abuse cases and includes a round robin discussion to identify new issues. The state has facilitated an increasingly transparent process for fraud referrals by encouraging information sharing among health plans. Ohio's Managed Care Unit distributes all suspect fraud referrals received from any plan to all plans, other units of the State Medicaid agency, and the MFCU in order to coordinate efforts and investigative approaches to specific providers or patterns of abuse.

This combination of multiple meetings and several groups has enabled the state to focus on fraud, waste and abuse in an effective way, share state data mining analytics in a timely manner, and identify system edits and changes in policy to support law enforcement.

## 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 RISS for information provided by other states including best practices and managed care contracts.
- 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 assistance as needed to conduct exclusion searches and training of managed care staff in program integrity issues.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. 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.

[8] The Ohio Auditor of State is an independent state agency that is responsible for auditing all public offices in Ohio.

- Access the annual program integrity review summary reports on CMS's website. These reports contain information on noteworthy and effective program integrity practices in states. We recommend that Ohio review the effective practices related to provider screening and enrollment to address the issues outlined in Risk Area 2.

## Summary

The instances of non-compliance with federal regulations are of concern and should be addressed immediately. CMS is also concerned about uncorrected, repeat risks that remain from the time of the agency's last comprehensive program integrity review in 2010.

We require the state to provide a corrective action plan (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. Please 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 plan should identify those corrections as well.

CMS looks forward to working with Ohio to strengthen the effectiveness of its program integrity function.

**Official Response from Ohio**
**October 2014**

# Ohio | Department of Medicaid

John R. Kasich, Governor
John B. McCarthy, Director

October 3, 2014

Peter Leonis
Director, Division of Field Operations
Centers for Medicare and Medicaid Services
233 N. Michigan Avenue, Suite 600
Chicago, IL 60601

Dear Mr. Leonis:

In response to the August 2014 Ohio Comprehensive Program Integrity Review Final Report, the Ohio Department of Medicaid would like to express its appreciation for the recognition CMS gave to Ohio's effective program integrity practices. Effective practices cited in the report included the collaborative relationships and communication with external and internal partners. ODM values its partnerships and strives to continue and build upon existing collaborations.

The report also identifies regulatory issues and vulnerabilities related to Ohio Medicaid program integrity. ODM has already implemented changes to address some findings, and the corrective action plan outlines ODM's approach to addressing the remaining areas of non-compliance and vulnerability.

Thank you for the opportunity to respond to the Ohio Comprehensive Program Integrity Review Final Report. Please let me know if you have questions regarding this response or the accompanying corrective action plan.

Sincerely

John B. McCarthy
Director

Attachment