Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Ohio Focused Program Integrity Review

Final Report

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Objective of the Review

The Centers for Medicare and Medicaid Services (CMS) conducted a focused review to determine whether Ohio's program integrity procedures satisfy the requirements of federal regulations that implemented the enhanced provider screening and enrollment provisions of the Affordable Care Act. Another purpose of the review was to determine the extent of program integrity oversight of the managed care program at the state level and assess the program integrity activities performed by selected managed care entities (MCEs) under contract with the state.

Background: State Medicaid Program Overview

Ohio's Medicaid program is administered by the Department of Medicaid (DOM). In Ohio, program integrity functions are handled by a combination of DOM units principally organized under the Operations Division of the State Medicaid Agency (ODM). The DOM reported that it has a total of 78 authorized full time equivalents (FTEs) assigned to program integrity functions. These include two liaisons in the Operations Division as well as staff in the Surveillance and Utilization Review Subsystem (SURS) unit and the DOM components that handle provider enrollment, screening, and outreach and compliance functions. Program integrity-related staff is also in the Managed Care Contract Management Bureau and the Bureau of Long Term Care Services & Support. At the time of the review, 10 positions were vacant. The state indicated that it 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.

In September 2014, Ohio did not have a division or department dedicated to program integrity activities and functions. Ohio reported that program integrity activities and functions occur across the agency. However, in response to a 2013 CMS review and recommendation, a new Bureau of Program Integrity will be created. The new bureau will have 30 FTEs dedicated to program integrity activities and functions. At the time of the review, ODM said it was attempting to realign multiple program integrity functions and was in the process of creating the new Bureau of Program Integrity in order to better coordinate and monitor Ohio Medicaid's efforts around fraud, waste, and abuse. ODM identified a few initial tasks of the new bureau, such as developing a tracking/reporting system for all fraud referrals and standardizing the referral sheet sent to the Medicaid Fraud Control Unit (MFCU). This work would be followed by a realignment of staff and functions to focus on efforts to improve system edits, provider surveillance, and data mining.

Ohio is one of 28 Medicaid jurisdictions (including 27 states and the District of Columbia) that implemented a Medicaid expansion under the ACA. The state reported 360,252 enrollees in what it called the Medicaid Extension (Group VIII) as of August 23, 2014. Per state officials, this expansion population will primarily be in managed care, but state policy allows approximately 60 days for an enrollee to select a plan, so there will also be months of fee-for-service (FFS) enrollment. In January 2014, Ohio's Medicaid program served 2,350,000 beneficiaries. Of that total, 1,711,201 beneficiaries were enrolled in managed care plans. The state had 93,248 enrolled FFS providers in June 2014 and estimated that 90 percent of managed care network providers were also enrolled in the FFS program. During FFY 2013, Ohio's

Medicaid expenditures totaled approximately $17.6 billion. The federal share of these expenditures was approximately $11.3 billion.

Methodology of the Review

In advance of the onsite visit, CMS requested that Ohio and the MCEs selected for the focused review complete a review guide that provided detailed insight into the operational activities subject to review. A four-person team reviewed the responses and additional materials submitted prior to the onsite visit.

During the week of September 8, 2014, the CMS review team visited ODM and interviewed staff from the Special Investigation Units (SIUs) and/or Compliance Departments of three of the state's six managed care plans: CareSource, Molina, and United HealthCare. As part of the onsite review, the team also conducted interviews with numerous agency staff involved in program integrity, provider enrollment, and managed care, along with staff from two sister agencies that provide specialty services: the Ohio Department of Aging (ODA) and Ohio Department of Developmental Disabilities (DODD). In addition, the team reviewed a sample of provider enrollment applications, MCE investigations, and actions taken against providers along with other primary data to validate Ohio's and the selected MCEs' program integrity practices.

Results of the Review

The focused review covering Ohio's implementation of the ACA regulations and managed care operations found the state to be in compliance with many program integrity requirements. However, the review team identified some areas of concern and instances of regulatory non-compliance which reflect vulnerabilities in the Ohio Medicaid program. CMS will work closely with the state to ensure that all issues, particularly those that remain from earlier reviews, are satisfactorily resolved as soon as possible. These issues and CMS' recommendations for improvement are described in detail in this report.

Section 1: Affordable Care Act Provider Screening and Enrollment

Overview of the State's Provider Enrollment Process

In Ohio, FFS provider enrollment and screening is handled by the state Medicaid agency, the ODM, and its sister agencies, the ODA and the DODD. The ODA and DODD are responsible for screening and certifying a subset of providers who participate in waiver programs. The ODM is responsible and has final authority for ensuring that all provider types are properly screened and enrolled in the Medicaid program. On June 27, 2012, a CMS-approved State Plan Amendment took effect in Ohio which attested to the state's compliance with the provider screening and enrollment requirements as outlined under Section 6401(a) of the ACA and 42 CFR 455 Subpart E (as discussed below). The ODM does not require all managed care network providers to be enrolled in the Medicaid program. Managed care network providers are enrolled by individual MCEs. The applicability of the ACA provider screening and enrollment requirements to managed care will be discussed later in the report.

42 CFR 455.410: Enrollment and screening of providers

The regulation at 42 CFR 455.410 requires that the State Medicaid agency: (a) screen all enrolled providers; and (b) enroll all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan as participating providers; and (c) the State Medicaid agency may rely on the results of the provider screening performed by any of the following:
 	
  (1) Medicare contractors.
  (2) Medicaid agencies or Children's Health Insurance Programs of other states.

The state is not in compliance with this regulation.
The ODM and its delegated sister agencies, DOA and DODD, require that all ordering, referring physicians or other professionals providing services under the State plan, or under a waiver of the plan, be enrolled as participating providers. In 2013, ODM estimated that approximately 8,200 physicians or other professionals involved in the generation of services billable to Medicaid were not currently enrolled with the Ohio Department of Medicaid. ODM created an online application tool for medical professionals to enroll as ordering, prescribing, and referring (OPR) providers only. The on-line application process reduced the state's workload and provided a streamlined enrollment process for providers that can be completed in less time than the traditional application process.   However, as of July 21, 2014, ODM indicated that only a fraction (214) of the universe of OPR-only providers had been enrolled.
Recommendation: Develop and implement policies and procedures requiring all OPR providers to be enrolled to ensure that information about such professionals is being captured during the provider enrollment process.

42 CFR 455.412: Verification of provider licenses
The regulation at 42 CFR 455.412 requires that the State Medicaid agency: (a) have a method for verifying that any provider purporting to be licensed in accordance with the laws of any state is licensed by such state; and (b) confirm that the provider's license has not expired and that there are no current limitations on the provider's license.
The state is in compliance with this regulation.

ODM officials explained they perform license verifications for all in-state providers by utilizing the licensing board's online verification database. ODM and sister agencies verify the license of each applicant provider and upon revalidation with individual licensing boards. State provider enrollment staff makes use of a system-generated report (PRV-0002M) that lists all licensed providers by provider type. This report indicates when a provider's license is about to expire. ODM further explained that it checks the license reports of various state boards, such as the Ohio State Medical Board, the Ohio Board of Nursing, and the Ohio State Dental Board, on a monthly basis to confirm expired licenses. If providers with expired licenses are enrolled in Medicaid, their Medicaid provider agreement is terminated. The provider applicant is notified by letter and can request a re-consideration from the Director of ODM. If a provider license has any limitations on it, the application is denied.

For out-of-state providers, ODM checks the CMS provider terminations database (on the Tibco managed file transfer server) on a bi-monthly basis to identify providers that have lost their license. Ohio likewise cooperates with and exchanges licensure information with the five contiguous states of Michigan, Pennsylvania, West Virginia, Kentucky, and Indiana in a collaborative effort to identify out of state providers whose licenses have been pulled or have restrictions. Most of its out-of-state license checks involve these five states. Where the status of licenses in other states cannot be verified through online checks, ODM staff will call someone directly at the Medicaid agency to determine if the out-of-state provider is in "good standing" or has licensure limitations.

Recommendation: None

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42 CFR 455.414: Revalidation of enrollment

The regulation at 42 CFR 455.414 requires that the State Medicaid agency revalidate the enrollment of all providers regardless of provider type at least every five years.

The deadline has been revised according to *Sub Regulatory Guidance for SMAs: Revalidation (2016-001)*. The purpose of this guidance is to align Medicare and Medicaid revalidation activities to the greatest extent possible. The new requirement is now a two-step deadline under which states must notify all affected providers of the revalidation requirement by the original March 24, 2016 deadline, and must have completed the revalidation process by a new deadline of September 25, 2016.

The state is potentially at risk of non-compliance with this regulation for both the March 25, 2016 and September 25, 2016 deadlines.

The ODM has a plan and process in effect for revalidating all Medicaid providers every five years. However, the volume of work that remains to be done and the current revalidation schedule call into question whether the state can comply with the regulation in a timely manner.

The ODM revalidation procedures involve sending providers a 90-day notice prior to the deadline for the requested revalidation. The state uses an online revalidation application which is the same as the form for new applicants, except certain fields are already prepopulated. All provider types are targeted as part of the process, except for waiver providers in programs operated by sister agencies. ODM sends providers who have not responded within 60 days of the date of the original notice an additional 30 day reminder. At the time of the review, there were 13,580 providers who sought revalidation. ODM had revalidated a total of 8,835 providers, and an additional 216 were in the work queue for processing. Of the total number of providers seeking revalidation, ODM also terminated 4,745, or 35 percent, for failure to submit revalidation information. The state reported that there were still 31,130 Medicaid providers in Ohio whose provider agreements date back at least five years or longer. While Ohio said it expected to complete 20,504 revalidations before Dec. 31, 2015, this left a balance of more than 10,000 providers who would have to be revalidated in the first quarter of calendar year 2016. According to ODM officials, most of these were home and community based services (HCBS) waiver providers who were being screened by ODA and DODD on shorter one- and three-year revalidation cycles, respectively. Thereafter, ODM would have to finalize all enrollments and assign Medicaid ID numbers. Despite the identified progress made to date, it was not clear that ODM was on target to complete the first round revalidation process by the September 25, 2016 deadline.

Recommendation: Develop and implement a process that will meet the revalidation requirements for all eligible providers by the stipulated deadline of September 25, 2016.

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42 CFR 455.416: Termination or denial of enrollment

The regulation at 42 CFR 455.416 describes several conditions under which a State Medicaid agency must terminate or deny enrollment to any provider. These include situations in which the Medicare program, or another state Medicaid or Children's Health Insurance Program, has terminated a provider for-cause on or after January 1, 2011, unless the State Medicaid agency determines that denial or termination of enrollment is not in the best interests of the Medicaid program and documents that determination in writing.

The state is in compliance with this regulation.

The ODM reviews the CMS terminations database for Medicare and other state terminations and submits Ohio's for-cause provider terminations regularly. A staff member is assigned to these tasks and downloads reports as they become available on the server every two weeks. The submission of for-cause terminations in Ohio takes place once a week. Agency spokespersons reported that since July 1, 2012, ODM and the delegated sister agencies have terminated or excluded a total of 24,212 providers for various reasons, and as of September 11, 2014, the state had uploaded approximately 400 program integrity-related termination entries in the federal provider termination database.

Recommendation: None

42 CFR 455.420: Reactivation of provider enrollment
The regulation at 42 CFR 455.420 requires that the State Medicaid agency, after denial or termination of a provider for any reason, require the provider to undergo rescreening and pay the associated application fees pursuant to 42 CFR 455.460.
The state is in compliance with this regulation.
The ODM will deactivate a provider's number if that provider has not actively billed the Medicaid program for 24 consecutive months or if mail to the provider's listed address cannot be delivered. The state documented that when the deactivation process occurs, providers go through a complete enrollment and screening process before they can start billing, just like any new applicant. The process includes the payment of Medicaid application fees where relevant.
Recommendation: None

42 CFR 455.422: Appeal rights
The regulation at 42 CFR 455.422 requires that the State Medicaid agency give providers terminated or denied pursuant to 42 CFR 455.416 any appeal rights available under State law or regulations.
The state is in compliance with this regulation.
The ODM and its delegated sister agencies afford appeal rights to a provider when they take adverse action against a provider's participation in the Medicaid program. This is consistent with provisions in the Ohio Administrative Code that address the state's administrative review and the appeal process. The team reviewed a sample termination letter and confirmed that appeal rights were referenced in the body of the letter.
Recommendations: None

42 CFR 455.432: Site visits
The regulation at 42 CFR 455.432 requires that the State Medicaid agency conduct pre-enrollment and post-enrollment site visits of providers who are designated as ''moderate'' or ''high'' categorical risks to the Medicaid program.
The state is not fully in compliance with this regulation.

For Medicare-enrolled providers, the state Medicaid agency and its delegated sister agencies rely on site visits conducted by Medicare. However, they do not always check the Medicare Provider Enrollment, Chain, and Ownership System for related documents or the date of the site visit to ensure that it occurred within the preceding twelve months.[1]

For other Medicaid providers the state is currently using two approaches to meet the site visit requirement. The ODM has contracted with an outside vendor to conduct pre-enrollment site visits for moderate and high risk provider types. These include non-emergency medical transportation (NEMT) providers, durable medical equipment businesses, home health agencies, laboratories, community mental health centers, adult medical day health centers, ambulance service providers and comprehensive outpatient rehabilitation facilities. The contractor uses a pre-formatted survey tool in conducting a provider interview as part of the contracted site visits, after which it forwards the results of the visit to ODM via an upload into the state's Medicaid Management Technology System (MITS).[2] State staff has gone out to oversee site visits and provided feedback.

The contractor also conducts site visits for out-of-state providers located in contiguous states within an established perimeter of a 60 minute drive from the Ohio state line. Ohio requests assistance from other state's Medicaid agencies for non-Medicare providers located beyond this perimeter. While Ohio clearly makes a good faith effort to meet the site visit requirement of all out-of-state providers, it was not clear if the state is able to ensure that the site visit requirement is met for all moderate- and high-risk out-of-state providers.

Besides the work done by the site visit contractor, ODA conducts site visits on all HCBS providers and on all assisted living facilities prior to completing the certification process and recommending the provider for Medicaid enrollment. However, these are not done on an unannounced basis. The other sister agency, DODD, does not conduct pre-enrollment site visits as part of the certification process. Instead, the site visit is conducted within a few months after the certification process is complete. At the time of the review, the contractor had not begun conducting pre-enrollment site visits for DODD providers. Ohio indicated that it anticipated bringing the sister agencies into compliance no earlier than July 1, 2015.

Recommendation: Ensure that pre-enrollment site visits are performed on all moderate- and high-risk out of state providers. Develop and implement policies and procedures specifying how sister agencies will perform site visits and report on these to ODM as part of the provider enrollment and screening process.

42 CFR 455.436: Federal database checks

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[1] Note: The stipulation that states could rely on Medicare site visits and other screening procedures in the Medicaid provider enrollment process if done within the preceding 12 months was part of CMS guidance on this subject at the time of the Ohio focused review. However, the 12-month time frame was dropped after the onsite visit to Ohio was completed.

[2] In Ohio, MITS is the name of the CMS-required management information system which replaced the state's traditional Medicaid Management Information System.

The regulation at 42 CFR 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE), the Excluded Parties List System (EPLS) on the System for Award Management (SAM), the Social Security Administration Death Master File (DMF), the National Plan and the Provider Enumeration System (NPPES) upon enrollment and reenrollment; and check the LEIE and EPLS no less frequently than monthly.

The state is not fully in compliance with this regulation.

Upon enrollment and re-enrollment or revalidation, ODM confirms the identity of provider applicants, persons with ownership or control interests in the provider, and agents and managing employees of the provider by checking all the databases listed in the regulation as well as Social Security cards, W-9 Forms and driver licenses. The state Medicaid agency also checks in-state registries, such as the Ohio Department of Developmental Disabilities Abuser Registry and the Ohio Auditor of State's Fraud Reporting Database. The EPLS (on SAM), Medicare Exclusion Database (used as an approved substitute for the LEIE), DMF and the latter two state registries are also checked on a monthly basis.

However, Ohio is not fully in compliance because one of the sister agencies does not solicit the full range of affiliated party information which must be checked at the time of enrollment and on an ongoing basis. The DODD does not collect or confirm the identity of persons with ownership or control interests in the provider or agents and managing employees. Without the full range of required disclosures, it is not possible for ODM to perform all the mandated database checks on these waiver providers.

Recommendation: Ensure that all agencies involved in the provider screening and enrollment process collect the required disclosures and have access to and the ability to screen all appropriate persons and entities against the databases listed in the regulation. Consideration should be given to centralizing the provider enrollment data collection process and database and/or having similar information technology systems across the agencies to ensure the consistency and quality of data collection and database checks.

42 CFR 455.440: National Provider Identifier

The regulation at 42 CFR 455.440 requires that the State Medicaid agency require all claims for payment for items and services that were ordered or referred to contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services.

The state is not fully in compliance with this regulation.

The ODM provided a printout of its on-line professional claim form, which showed a specific field calling for an OPR provider's NPI. At the time of the review, there was no edit in place to reject or kick-out a claim that was submitted by an OPR provider without an NPI. According to ODM officials, in January 2014, the state began to take actions on Medicaid claims missing the NPI. At that time, Ohio began posting warning messages on the remittance advice sent to billing providers. This informed them that the medical professional listed on their claim form as an OPR provider was not enrolled with the Ohio Medicaid program. Although the state said it plans to reject claims after an initial grace period in which the warning messages are used, at the time of the review, Ohio had not yet begun rejecting claims that were out of compliance. ODM anticipated that this process would begin in January 2015.

Recommendation: Establish an edit for capturing and rejecting claims that are submitted without the NPI of OPRs.

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42 CFR 455.450: Screening levels for Medicaid providers

The regulation at 42 CFR 455.450 requires that the State Medicaid agency must screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation of enrollment request based on a categorical risk level of ''limited,'' ''moderate,'' or ''high.''

The state is not fully in compliance with this regulation.

The ODM and ODA conduct extra screening measures, such as site visits and background checks for regular Medicaid and HCBS waiver providers who are considered moderate or high risk. State staff indicated that they use ACA and Ohio Administrative Code criteria in defining moderate and high risk. As per the regulation, the ODM will also adjust categorical risk levels upward for providers who meet specific sanction-related conditions, such as:

- Have been excluded by the HHS-OIG or another state Medicaid agency within the past 10 years;
- Have an outstanding overpayment;
- Have had a payment suspension imposed based on a credible allegation of fraud; and
- Applied for enrollment within 6 months of being affected by a temporary moratorium.

The DODD does not conduct pre-enrollment screenings as part of its certification process prior to recommending providers for enrollment in Medicaid. This issue was previously identified in the discussion of 42 CFR 455.432.

Recommendation: Develop and implement policies and procedures specifying how sister agencies will perform site visits and report on these to ODM as part of the provider enrollment, screening and certification process.

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42 CFR 455.460: Application fee

The regulation at 42 CFR 455.460 requires the State Medicaid agency to collect applicable application fees prior to executing a provider agreement from certain prospective or re-enrolling Medicaid-only providers as stipulated in the regulation.

The state is in compliance with this regulation.

The state Medicaid agency has a method of determining when providers owe Medicaid application fees and had in fact collected fees from 648 providers at the time of the review. Forty-two of the fees came from Medicaid-only institutional providers, such as Intermediate Care Facilities for Individuals with Intellectual Disabilities. The ODM also has a procedure for determining exemptions from the fee requirement when imposition of the fee would have an adverse impact on beneficiaries' access to care.
Recommendation: None

42 CFR 455.470. Temporary moratoria
The regulation at 42 CFR 455.470 requires the State Medicaid agency to impose temporary moratoria on enrollment of new providers or provider types identified by the Secretary as posing an increased risk to the Medicaid program unless the State Medicaid agency determines that imposition of a temporary moratorium would adversely affect beneficiaries' access to medical assistance.
The state is in compliance with this regulation.
During interviews, ODM representatives indicated that neither they nor their delegated sister agencies have ever imposed moratoria on any provider types. At this point in time, the state does not have policies and procedures or legislative or regulatory tools to address moratoria. However, ODM officials maintained that if the HHS Secretary were to impose a Medicare moratorium on the enrollment of specific provider types in the State, they would be able to comply with the requirement.
Recommendations: None

Provider Enrollment and Screening in Managed Care

During the interview with state managed care staff, the CMS review team asked whether there are provisions in the Ohio Medicaid managed care contract that direct the MCEs to conduct enhanced provider enrollment and screening activities similar to the activities the state is required to conduct by the regulations at 42 CFR 455 Subpart E. The CMS review team was particularly interested in whether managed care contracts require the reporting of for-cause terminations and the checking of federal databases for excluded parties. Likewise, CMS asked if different provider types are assigned different risk levels and subject to greater screening and site visits during the credentialing process when categorized at a higher risk.

Ohio does not require managed care providers to be enrolled in the state FFS Medicaid program in order to serve Medicaid beneficiaries through an MCE. While the state's model contract addresses the managed care provider credentialing process, it does not currently include any provisions directing the plans to conform to the provider enrollment and screening regulations at 42 CFR 455 Subpart E. Nor does it require the collection of complete ownership and control disclosure information from network providers pursuant to the regulation at 42 CFR 455.104. The Ohio Revised Code at section 3963.05, in fact, prohibits contracting plans from soliciting information that goes beyond what is required by a standard credentialing and application form

issued by the State Department of Insurance (DOI).[3] As the DOI form is not in compliance with 42 CFR 455.104, the state Medicaid agency cannot require managed care contractors to collect information on persons with ownership and control interests in network providers or agents and managing employees of those providers. This impacts the ability of plans to perform complete federal database checks for excluded and debarred parties, as discussed in greater detail below.

The state's model contract makes clear that plans may suspend or terminate providers for-cause on their own initiative and not solely in response to a prior Medicaid or Medicare action. The plans are required to notify ODM when they terminate a provider. The MCE must notify contracted providers at least 55 days prior to the effective date of termination. The provider notification must be approved by ODM prior to distribution. Additionally, in accordance with 42 CFR 1002.3(b), MCEs must notify ODM when the MCEs deny credentialing to providers for program integrity reasons. The CMS team found evidence that plans are reporting terminations for-cause.

The team conducted onsite interviews with three of the state contracted MCEs. The interviews contained some questions about enrollment and screening procedures to determine if actual MCE provider enrollment and screening practices were aligned with current regulations that apply to the FFS Medicaid program. Below are the team's observations:

- *Credentialing, Risk Levels and Site visits*
  All of the MCEs reviewed had initial enrollment or credentialing processes that adequately handled licensure checks on providers. Further, the plans required all providers to go through re-credentialing every three years. However, all providers were reviewed in the same manner as part of credentialing and re-credentialing process. None of the MCEs assigned risk levels to provider types or individuals that might be higher risks for fraud and abuse. Also, none of the plans conducted site visits to moderate or high risk providers as part of their enrollment or revalidation process.

- *Database Checks*
  The MCEs do search for excluded parties. However, because they do not solicit the same breadth of disclosure information that is required in the FFS Medicaid program, the database checks they conduct are not as extensive as in FFS practice. For example, CareSource checks the LEIE, SAM, NPPES, and DMF databases at the time of credentialing and re-credentialing for providers and organizations. It also searches the LEIE and EPLS on a monthly basis for participating and non-participating providers. But persons with ownership and control interests, agents and managing employees are not systematically checked, even though it would be a violation of another federal regulation (42 CFR 438.610) if anyone in a plan's ownership or management structure were found to be excluded or debarred from federal contracting.

  Likewise, Molina searches the LEIE, EPLS, NPPES and DMF at credentialing and re-credentialing for providers and all other names disclosed on the application, but the full range of mandated FFS disclosures is not solicited. This plan also checks the LEIE,

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[3] "No contracting entity shall require a provider to provide any information in addition to the information required by the applicable standard credentialing form provided by the department of insurance (DOI)."

MED, and EPLS on a monthly basis but only for providers and not the other required affiliated parties.

United Health Care has a contractor which performs automated searches of network providers against the LEIE, EPLS, National Provider Data Bank, Ohio Department of Job and Family Services Excluded Provider Listing, and state licensing agency data. Affiliated parties, however, do not appear to be scrutinized. Moreover, the DMF and NPPES are not checked at initial credentialing or re-credentialing. United indicated that the responsibility for checking the latter two databases remained with the state; and in interviews, ODM representatives confirmed this. Although the state noted that it ran these checks against most network providers, there were some plan-affiliated providers who did not undergo these checks because they only went through a "limited" enrollment by the state in order to gain a provider number for payment purposes.

- *Provider terminations*

All of the interviewed plans had procedures in place to comply with contractual requirements for the prompt reporting of providers terminated for-cause to the state. The team found evidence that program integrity-related actions were being reported within a week or less.

Section 2: Managed Care Program Integrity

Overview of the State's Managed Care Program

The total number of Medicaid beneficiaries in the managed care program as of June 2014 was 2,747,608. The number of new enrollees as a result of ACA's Medicaid expansion was 360,252 (as of August 23, 2014) and ODM estimated that the number of newly eligible Medicaid enrollees would reach 377,140 by the end of its current fiscal year. Based on data provided by the state, the plans received $15,056,474,284 in SFY 2013 and $20,859,067,354 in SFY 2014, for a total of $35,915,541,638 in Medicaid managed care expenditures during the last two completed SFYs. All managed care entities are paid a pre-determined capitation rate to manage all enrolled beneficiary healthcare services, with the exception of NEMT which is paid for on a FFS basis by the state.

The ODM's Bureau of Managed Care (BMC) oversees the state's Medicaid managed care program. Within the BMC, direct oversight of program integrity activities for managed care is the responsibility of the Managed Care Contract Administration section, which is comprised of 12 FTEs. The state established a Managed Care Program Integrity Group (MCPIG) in support of its oversight responsibilities. The MCPIG is comprised of BMC staff as well as staff from the MCEs and MFCU. Its members meet on a quarterly basis to discuss matters related to fraud. All MCE SIU program integrity leads attend these meetings during which the participants discuss fraud schemes and specific provider fraud cases. Information about high risk providers is also shared within the group to help prevent further fraud and abuse. From time to time, the MFCU will conduct fraud training.

Within the BMC, a specific Contract Administrator (CA) has been assigned to each MCE. MCEs contact their designated CA for questions/assistance related to Medicaid and/or the MCE's contractual obligations and responsibilities. However, even though MCE contracts on paper comply with BMC requirements, BMC admitted that it does not actively check whether plans are following all contract requirements in practice. Oversight of program integrity activities in managed care could be improved with a more active stance to monitor compliance with contract requirements.

The Managed Care Contract Administration section also contracts with an External Quality Review Organization (EQRO) to conduct an administrative review focused on processes in place related to 42 CFR 438.608 and 438.610 (compliance plans and certifications/assurances regarding excluded affiliations). The EQRO uses the *Ohio DOM Comprehensive Administrative Review* tool to assist in determining if review elements were "met" or "not met" on such topics as False Claims Act education, safeguards against fraud and abuse, and the reporting of fraud and any actions taken against providers. However, the review by the EQRO is limited from a program integrity perspective. It does not specifically look at fraud case files, fraud investigations, or other key program integrity activities, such as data mining and audits. Nor does it consider the overall effectiveness of MCE program integrity and provider enrollment and screening policies.

The BMC does not conduct audits of the plans or perform any data mining on providers, despite the fact that 90 percent of beneficiaries are enrolled in managed care. The State relies on its SURS unit to audit FFS activity and reaches out to MCEs when providers participating in both programs are suspected of fraud. In general, the state expects the MCEs to conduct their own data mining and audit activity and to investigate and report suspected fraud.

Summary Information on the Plans Reviewed

The CMS review team interviewed three MCEs: CareSource, Molina, and United. All of the plans were sizeable contractors. CareSource had the largest enrollment at one million-plus members, while Molina had just over 300,000 and United slightly over 244,000. United and Molina are affiliated with national managed care companies, while CareSource has a major regional presence in Ohio and Kentucky. While United's program integrity and audit activities are directed and largely supported from the plan's corporate headquarters in Minneapolis, Molina had both a corporate SIU headquartered in Long Beach, California and a local Compliance Department based in Columbus. In contrast, the CareSource SIU was locally based in Dayton. In Ohio, all three of these MCEs served mainly Medicaid clients at the time of the review. United's enrollment consisted solely of Medicaid beneficiaries. The CareSource clientele was 95 percent Medicaid and that of Molina 94 percent.

MCE Program Integrity Activities

Investigations of Fraud, Waste, and Abuse

Ohio's MCEs are required to submit a *Suspected Fraud and/or Abuse Reporting Form* to the BMC upon completion of a preliminary investigation. Case information is also summarized in

an annual report to the BMC. The BMC is responsible for immediately referring suspected fraud cases to the Ohio Department of Justice for a determination of whether they rise to the level of a credible allegation of fraud. The BMC does not take an independent look or conduct an investigation upon receiving managed care fraud referrals. However, BMC does notify ODM units and all MCEs when suspected fraud cases are referred so that both the FFS program and other MCEs can follow-up on a suspect provider.
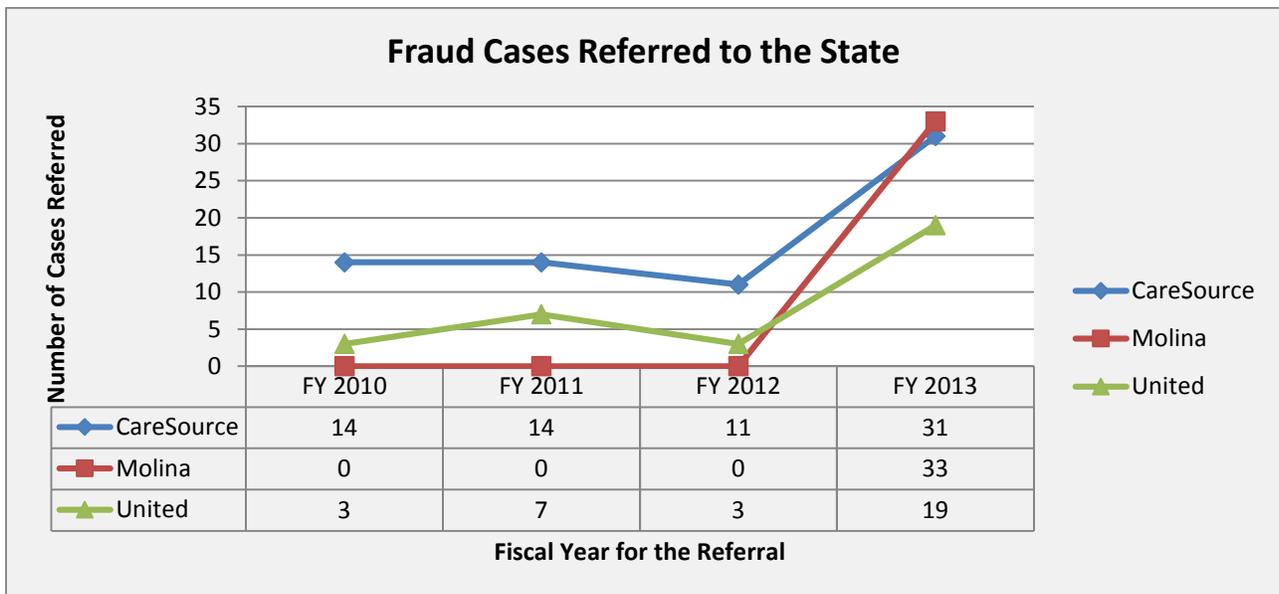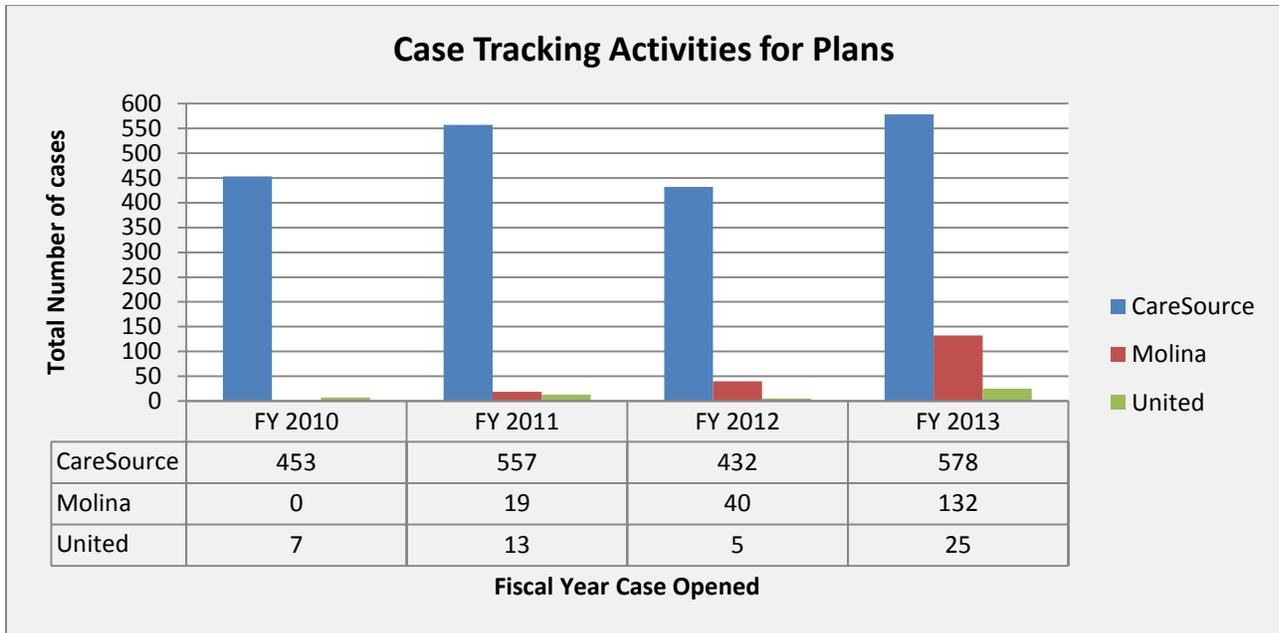
As noted, all three of the MCEs selected for interviews have SIUs, one based in Ohio, one based at a parent company out-of-state, and one situated both with an out-of-state parent company and a small local unit. The level of investigative and case referral activity reported by these plans varied significantly and was not necessarily commensurate with the number of staff assigned to SIU functions. CareSource had a total of 16 FTEs in its Dayton-based SIU. The in-house staff conducted provider surveillance when necessary as well as data mining, network provider audits, and claims review for improper payments. CareSource, serving the largest number of Medicaid beneficiaries, tracked (i.e., triaged and/or investigated) a total of 2,200 cases over the period SFY 2010-2013 and made 73 referrals to the state, as seen in the two tables below.

Molina did not provide specific figures on how its California-based SIU was staffed, but its Compliance Department in Columbus had four FTEs, including a director and manager. The compliance manager was responsible for conducting fraud investigations, and .17 FTE was assigned to data mining activities with some unspecified level of vendor support (but less than one FTE). In total, Molina's "local" SIU tracked 191 cases from SFY 2010 through 2013, with 33 referrals to the state. The plan did not have any in-house or vendor FTEs dedicated to conducting proactive audit activities. Any audits it conducted were done on an as needed basis as part of an existing investigation. The recoupment of overpayments or improper payments was handled outside the compliance department at the parent company level through an outside vendor.

United on paper had the largest SIU operation. It reported having a total of 48 individuals of diverse skill sets at its corporate SIU, including a Business Operations team which performed data mining and a Network Audit team. United also had contracts with outside vendors-some national in scope such as Optum-for advanced data analytics as well as a variety of program integrity activities in specialized areas such as pharmacy and behavioral health. All told, the program integrity vendors brought many more FTEs to bear on program integrity tasks, as much as two or three times the number housed in United's corporate SIU office. Yet the volume of fraud and abuse cases worked in Ohio was relatively modest. Over the period SFY 2010-2013, United tracked a total of 50 cases and made 32 referrals to the state.

The two charts below summarize the case tracking and fraud referral activity of each of the interviewed plans:

Case Tracking Activities for Plans

Fiscal Year Case Opened	FY 2010	FY 2011	FY 2012	FY 2013
CareSource	453	557	432	578
Molina	0	19	40	132
United	7	13	5	25

Total Number of cases (y-axis); Fiscal Year Case Opened (x-axis)

Fraud Cases Referred to the State

Fiscal Year for the Referral	FY 2010	FY 2011	FY 2012	FY 2013
CareSource	14	14	11	31
Molina	0	0	0	33
United	3	7	3	19

Number of Cases Referred (y-axis); Fiscal Year for the Referral (x-axis)

Even though United and Molina serve many fewer beneficiaries than CareSource in Ohio (approximately 25 and 30 percent of CareSource's total enrollment, respectively), the volume of their activity appears to be disproportionately less than that of CareSource. That said, the protocols for targeting providers for both audits and/or investigations are highly varied across plans and make it difficult to render comparisons with respect to the effectiveness of plan investigation and audit units.

Overpayment Recoveries
Ohio's model managed care contract contains few prescriptions on the handling of fraud and abuse recoveries by managed care plans. The state does not have contractual language or language in its administrative code requiring the MCEs to return overpayments to the state. From interviews, however, it was made clear that plans recoup overpayments directly and such

recoupments could be subject to appropriate adjustments in the rate-setting/reconciliation budget process with ODM. Ohio has established an incentive program for MCEs to report fraud. Per the Administrative Code [Rule 5160:26-9.1(B)], in order for the MCEs to participate in the fraud recovery process, they must promptly report to ODM all cases of fraud and abuse. If a plan does not report the fraud and the state finds it, the plan will not receive any of the overpayment recoveries. These will instead go to the state. If these circumstances do not apply, the plans may keep any improper payments they recoup.

The table below shows the overpayments collected by the three MCEs interviewed for the period SFY 2010-2013. Again, there are significant variations across plans. While CareSource averaged over $650,000 in annual recoveries, Molina collected only $1,180 in SFY 2013, and nothing in the three preceding fiscal years. United averaged $3,100 per year in recoveries, but recouped only $301 in SFY 2013 and nothing in SFY 2011.

Selected MCE	Overpayments Recovered SFY 2010	Overpayments Recovered SFY 2011	Overpayments Recovered SFY 2012	Overpayments Recovered SFY 2013
CareSource	$353,928	$369,998	$1,499,321	$404,201
Molina	0	0	0	$1,180
United	$9,546	0	$2,551	$301

The reported recovery figures seem quite low--even the CareSource figures--for managed care plans that are each receiving well over a billion dollars per year in capitation payments. However, they do not tell the full story of what the plans are doing to prevent and detect improper payments. All of the plans perform various types of claims adjudication, post-payment review, and audit activities which provide a combination of actual recoveries and cost savings that are not reported as fraud-related actions. In SFY 2013, for example, CareSource reported $569,559 in savings through such activities as well as $2,587,083 in prevented losses. These cost avoidance figures were in addition to the $404,201 in recoveries. Likewise, Molina reported cost savings through the activities of two separate vendors totaling $637,745 and $932,000, respectively.

United's prospective claims review, post-payment review, and audit activities were the largest in scope. During the period SFY 2010-2013, the plan reported an average of just over $13 million a year in savings based on prepayment claims review and providers flagged for sanctions or exclusions. In addition, it recovered nearly $16 million per year from post-payment reviews nationwide, including close to $2 million annually for Ohio.

The Medicaid Budget and Expenditure System[4], is the financial reporting database used by CMS to track state Medicaid outlays and claims for matching federal funds. Data from this system

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[4] More detailed information about the Medicaid Budget and Expenditure System and the various reports it generates can be found at: http://medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/mbes/medicaid-budget-and-expenditure-system-mbes.html

was used to compare the reporting of fraud, waste, and abuse recoveries in FFS and managed care programs. The sum total of managed care fraud, waste, and abuse recoveries in SFY 2013 was $405,682, while Ohio's FFS program reported analogous recoveries of $1.5 million. In terms of fraud-related recoveries, then, the managed care program in Ohio recovered little more than a quarter of the FFS total, even though it covers 90 percent of all Medicaid beneficiaries.

In general, it appears that there is a great deal of MCE scrutiny to identify improper payments, almost none of which is classified officially as fraud and abuse detection. It is also very difficult to look across plans and to compare activity. From an oversight perspective, it is difficult to identify the efficacy of plan efforts given the various ways in which the MCEs 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 ODM should ensure that it has a complete overview of such activity taking place at the MCE level. It should have information on all types of recoveries to ensure that these are factored into the rate-setting process where appropriate. It should review the audit activity of the MCEs in particular to ensure that potential cases of fraud and abuse are identified and addressed appropriately, for example through MFCU referrals. In addition, the ODM should continue to develop comprehensive policies and procedures for the review and analysis of encounter data, as this will enable state staff or designated contractors to mine MCE data for provider aberrancies and should lead to improved state capacity to audit problem network providers directly. The envisioned Bureau of Program Integrity should consider addressing these issues as it becomes the agency's focal point for program integrity.

Terminated Providers and Adverse Action Reporting
The state's contract with the MCEs requires the reporting of terminated providers directly to the BMC. As noted, the MCEs have been doing this in a timely manner and rely on BMC to share this information across plans. The MCEs themselves will not share termination information with other plans outside the quarterly meetings attended by all MCEs and the state. For this reason, the quarterly meetings have taken on added importance as forums for the sharing of important information and expertise. The MCEs are required to notify ODM as well when they deny credentialing to providers for program integrity reasons. The team found that all for-cause program integrity terminations reported by MCEs to the state have been reported in turn to the HHS-OIG. They have also been uploaded to the Tibco managed file transfer server.

MCE Compliance Plans
According to the Ohio Administrative Code (Rule 5160-26-06), MCEs must have a program that includes administrative and management arrangements or procedures, including a mandatory compliance plan, to guard against fraud and abuse. The MCE contract also requires plans to have a compliance plan that meets the requirements of 42 CFR 438.608, and all of the MCEs interviewed had such plans. However, consistent with its limited oversight activities, the state was not actively monitoring these plans to ensure that they were in compliance with all elements of the regulation.

Payment Suspensions
In Ohio, MCEs are required to promptly report all instances of provider fraud and abuse to ODM and member fraud to the Ohio Department of Jobs and Family Services. Once a plan substantiates provider fraud, the plan then makes a referral to BMC. The BMC does not conduct a full investigation but relies on the MFCU to conduct the investigation and determine whether the case involves a credible allegation of fraud. Before referrals are made to MFCU, the BMC meets with the MCPIG to discuss the proposed referral. Payment suspensions are also discussed at this time, specifically whether to suspend payment or issue a good cause exception. However, the managed care contract does not require the plans to suspend payments. Interviews with the plans confirmed that the use of payment suspensions as a tool varied across plans but that this sanction in general was seldom used. One of the MCEs reported that while it does not formally suspend payments, it will put claims on hold or in pending status. A second MCE reported that it does not suspend payments, and the third MCE reported that it has not issued any payment suspensions, but instead conducts pre-payment reviews to deny improper claims.

CMS recommends that Ohio contractually require MCEs to suspend payment to providers against whom an MCE or the state can document a credible allegation of fraud. The payment suspension requirements in the federal regulation at 42 CFR 455.23 should be consulted in designing this provision. The state should provide training to its contracted MCEs on the circumstances in which payment suspensions are appropriate pursuant to 42 CFR 455.23 and should further require the reporting of plan-initiated payment suspensions based on credible allegations of fraud.

Meetings and Training
All the MCEs attend the quarterly meetings of the Ohio MCPIG and another group called the Ohio Healthcare Investigator's Organization. The plans also send representatives to a variety of other relevant statewide and national conferences, such as the Ohio State Auditor's annual fraud conference and meetings of the National Association of Drug Diversion Investigators. The plans also send new investigators to the National Health Care Anti-fraud Association boot camp and other staff to other National Health Care Anti-Fraud Association trainings either in person or via webinar. Managed care plans also were represented at the Health Care Compliance Association's basic compliance academy, sent staff to the Association of Certified Fraud Examiners conference, and participated in training seminars of the American Association of Professional Coders. In general, the plans selected for interviews were well acquainted with the important program integrity meetings and conferences held locally and nationally and demonstrated a commitment to ensuring that their staff received relevant core training.

Summary Recommendations:

- Schedule more frequent one-on-one meetings with plans to review the status of program integrity activities and conformance with contract requirements. In particular, the state should develop some benchmarks to support more active SIU activity for those plans that report very low numbers of audits, investigations, and referrals proportional to their number of enrolled beneficiaries.
- Develop the capacity to conduct audits of the MCEs and potentially aberrant network providers. Develop an enhanced ability to identify provider aberrancies through the

analysis of encounter data as well as data from other available sources. Strive for greater integration of FFS and managed care activity when auditing providers, as 90 percent of the state's providers cross over between FFS and managed care network participation.

- Collect information on all types of MCE improper payment recovery and cost avoidance activities, not only those relating to cases defined as fraud. Ensure that appropriate recovery and cost avoidance data is reported for future managed care rate-setting purposes.
- Contractually require MCEs to suspend payment to providers against whom an MCE or the state can document a credible allegation of fraud. The payment suspension requirements in the federal regulation at 42 CFR 455.23 should be consulted in designing this provision. The state should provide training to its contracted MCEs on the circumstances in which payment suspensions are appropriate pursuant to 42 CFR 455.23 and should further require the reporting of plan-initiated payment suspensions based on credible allegations of fraud.

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 as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in Regional Information Sharing Systems for information provided by other states including best practices and managed care contracts.
- Consult the managed care plan compliance toolkit developed for CMS by a private contractor. This is available at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Provider-Education-Toolkits/managedcare-toolkit.html.
- 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. CMS can also refer Ohio to states that are further along in the process of addressing any of the risks identified in Section 2.
- 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 based on its identified risks include those related to provider enrollment and oversight of managed care. More information can be found at http://www.justice.gov/usao/training/mii/training.html.
- 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.
- Access the annual program integrity review summary reports on the CMS's website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html. These reports contain information on noteworthy and effective program integrity practices in states.

- Regarding the development of viable encounter data systems, consult the Encounter Data Toolkit developed for CMS by a private contractor in November 2013. This is available on the CMS website at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/Medicaid-Encounter-Data-toolkit.pdf.
- Consult CMS's Medicaid Payment Suspension Toolkit at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance.html to develop a payment suspension process for MCEs that is consistent with federal regulations and guidance.

Conclusion

The CMS focused review identified some 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 plan should identify those corrections as well.

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

Ohio
Department of Medicaid
John R. Kasich, Governor
John B. McCarthy, Director

May 4, 2016

Laurie Battaglia
Acting Director – Division of State Program Integrity
Department of Health and Human Services
Centers of Medicare and Medicaid Services
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Baltimore, MD 21244-1850

Re: Ohio Focused Program Integrity Review Final Report – February 2016

Dear Ms. Battaglia,

Thank you for the opportunity to respond to the final report issued by CMS regarding their focused review of Ohio's Medicaid Program Integrity procedures and processes. The Ohio Department of Medicaid appreciates CMS's comprehensive review of Ohio's implementation of the federal regulations that implemented the enhanced provider screening and enrollment provisions of the Affordable Care Act (42 CFR 455 Subpart E0. Furthermore, the department recognizes the value of the assessment and review of ODM's oversight of program integrity activities related to the managed care program as well as the activities performed by selected managed care entities under contract with Ohio.

In the attached response to the final report, ODM has provided a corrective action plan for each recommendation made by CMS in regards to this review.

If you have any questions or would like to discuss our corrective action plans further, please contact Angela Houck at (614) 752-3250 or angela.houck@medicaid.ohio.gov.

Sincerely,

John Maynard
Director Program Integrity
Ohio Department of Medicaid