# Annual Report
# Program Integrity
# 2023


**Governor Mike DeWine • Lt. Governor Jon Husted • Director Maureen Corcoran**

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## Introduction

During calendar year (CY) 2023, the Ohio Department of Medicaid (ODM) resumed routine operations at the end of the public health emergency and launched its Next Generation of Medicaid Managed Care program. The Next Generation of Medicaid Managed Care promotes transparency and accountability, and ODM's program integrity work is integral to this vision. In 2022, ODM implemented OhioRISE (Resilience through Integrated Systems and Excellence), which is a specialized Medicaid managed care plan with tailored services to meet the needs of youth with complex needs, the Single Pharmacy Benefit Manager (SPBM), centralized credentialing, and Provider Network Management (PNM).

ODM continues to improve its monitoring of Ohio's managed care organizations (MCO) while working cooperatively with them and other program integrity partners to prevent and identify fraud, waste, and abuse in the Medicaid program. Through regular meetings with MCO special investigative unit (SIU) staff, including the Ohio Attorney General's Medicaid Fraud Control Unit (MFCU) and ODM experts, ODM's program integrity efforts continue to evolve. This collaboration continues to produce strong results. ODM made several changes to the managed care provider agreement, effective January 1, 2024, to further program integrity monitoring.

During the year, ODM continued to focus on improving its response to external audits and eligibility determination oversight. ODM focused on improving responses to audits to ensure federal and state partners received accurate and complete information. The department also prioritized corrective action plan monitoring and remediation efforts. ODMs Medicaid Eligibility Quality Control (MEQC) unit conducts a variety of Medicaid eligibility reviews throughout the year to focus on specific areas, identified by the Payment Error Rate Measurement (PERM) review and other audits. These reviews assist the county eligibility staff in correctly determining eligibility while PERM is not being conducted, to improve performance during the PERM cycle. Through these reviews, ODM can also evaluate the implementation of improvements and monitor the effectiveness of corrective actions that address audit findings.

## Overview

ODM's Bureau of Program Integrity (BPI) coordinates activities across ODM business units and external stakeholders to effectively prevent and detect fraud, waste, and abuse.

BPI, other ODM businesses units, and our program integrity partners conduct a variety of activities to ensure Ohioans receive the care they need from qualified providers, and that ODM correctly pays for these services. These activities include provider enrollment and support, automated system controls, law-enforcement coordination, pre-payment and post-payment review, managed care oversight, participant eligibility reviews, monitoring of other state agencies, staff training, and more. ODM monitors its providers, partner agencies, and MCOs to regulate program integrity risk, promote compliance, and provide technical assistance and training throughout Ohio's Medicaid program.

Key stakeholders in ODM's program integrity continuum include ODM business units and staff, Ohio's Attorney General and Auditor of State, several state agencies including the Ohio Departments of Aging, Developmental Disabilities, Education and Workforce, Health, and Mental Health and Addiction Services, Office of Budget and Management, healthcare-related boards, MCOs, County Departments of Job and Family Services (CDJFS), and the federal government. ODM also coordinates with other states. It is through building relationships with these stakeholders and partners that ODM is implementing a thorough, well-rounded program integrity approach.

# Provider Network Management and Support

ODM employs a multifaceted approach to ensure it pays Medicaid providers correctly and appropriately. Beginning with provider enrollment and continuing through post-payment reviews, ODM uses a variety of methods to promote program integrity for both fee-for-service and managed care payments.

State and federal laws require provider screening and enrollment. ODM contracts with approximately 207,000 providers and screens each at initial enrollment and then monthly against various federal exclusion databases that identify individuals and organizations prohibited from receiving payment from or participating in the Medicaid program. Ohio also requires fingerprinting and background checks for owners and managing employees of high and moderate-risk provider organizations and conducts on-site visits of provider types identified as being at a heightened level of risk for fraud, waste, and abuse. These visits take place both before and after enrollment into the Medicaid program. Ohio Medicaid contracts with Public Consulting Group (PCG) to conduct site visits on behalf of the Department. In CY 2023, PCG completed 1,062 virtual and in person onsite visits. As a result of these site visits, PCG was able to identify 158 potential fraud cases and 49 PCG fraud referrals were accepted by the MFCU for further investigation. The referrals that are not accepted for a criminal investigation are evaluated by SURS to determine if there is a recoverable overpayment.

## Provider Enrollment

In February 2023, as part of its Next Generation of Medicaid Managed Care, ODM implemented the Fiscal Intermediary (FI) module, a component of the Ohio Medicaid Enterprise System (OMES). The FI module is a single point for provider claims adjudication and reduces the administrative burden. The FI will manage claims for all MCOs, OhioRISE, and fee-for-service Medicaid provider providers.

## Minimum Data Set Exception Reviews of Nursing Facilities

The Minimum Data Set (MDS) is a set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. ODM conducts an MDS exception review program on skilled nursing facilities' (SNF) use of CMS' Resident Assessment Instrument, the accuracy of MDS data transmitted from SNFs to ODM for use in calculating direct care rates, and overall SNF recipient care. ODM oversees the completion of up to 100 exception reviews annually, utilizing an outside vendor to assure objectivity. SNFs receiving unfavorable exception review results could be subjected to reduced direct care rates for a subsequent six-month period. In calendar year 2023, ODM completed 89 MDS reviews. Twenty-six out of 89 NFs received unfavorable results and ODM reduced their direct care rates for a future six-month period by a total of $3.4M respectively.

ODM is currently analyzing the transition from Resource Utilization Group (RUG) to Patient Driven Payment Model (PDPM) as the case mix reimbursement system for all Medicaid recipients. ODM aims to fully transition from RUGs to PDPM by January 1, 2026.

## Post Payment Reviews

Post-payment reviews (PPRs) occur after providers submit claims and receive payment. ODM's Long-Term Care (LTC) Section conducts post-payment reviews of claims submitted by Nursing Facilities (NFs) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IIDs). LTC reviews records to validate eligibility and level of care and ensure patient liability and days were billed correctly.

For calendar year 2023, ODM conducted a total of 1,024 PPRs and issued approximately $1.8M in overpayment findings.

### Provider Compliance Reviews

The Provider Audit and Compliance Review (PACR) Section conducts limited, on-site, and virtual provider reviews. The reviews entail in-depth claims and supporting documentation examination. The PACR Section conducts these reviews for the purpose of offering guidance in the form of education and technical assistance. When issues are identified, PACR notifies the provider, connects the provider to educational resources when needed and conducts a follow-up review after six months to ensure corrective action has been taken.

In 2023, the PACR Section completed 112 reviews of behavioral health providers, dentists, optometrists, occupational therapists, chiropractors, registered dieticians, acupuncturists, and home health agencies. Reviews resulting in the detection of patterns of fraud, waste or abuse are referred to the MFCU for further investigation. In 2023 the PACR Section submitted 17 referrals to the MFCU.

By conducting these reviews and providing guidance, ODM is working to foster a stronger network of educated, compliant providers to better serve its Medicaid beneficiaries.

### Surveillance and Utilization Review Section

The Surveillance and Utilization Review Section (SURS) is charged with helping the agency detect Medicaid fraud, waste, and abuse. SURS performs a majority of the data analysis for the Bureau of Program Integrity and combines clinical, audit, and data staff to meet its mission and goals.

In 2023, SURS completed 105 provider reviews and identified overpayments totaling more than $525,000 and issued 8 reconsideration decisions that reconsider, or review, previous ODM overpayment findings. During normal operations, Medicaid providers sometimes discover instances when they were overpaid by the Medicaid program. When this occurs, providers contact SURS with the overpayment information and remit payment. SURS then works with the provider to complete documentation of the overpayment and its repayment to ODM. In 2023, approximately $37,000 in overpayments were remitted to ODM via provider self-initiated review.

When SURS receives a complaint regarding potential Medicaid fraud or identifies any questionable practices, it conducts a preliminary review to determine the appropriate course of action. If the results of the review give SURS reason to believe that a provider committed fraud in the Medicaid program, SURS refers the case to the MFCU. As needed, SURS supports MFCU by providing copies of records and access to computerized data and provides information it has collected. SURS also accepts referrals from MFCU to initiate any available administrative action to recover improper payments made to providers.

### Inpatient Hospital Reviews

ODM contracts with Permedion to conduct retrospective reviews primarily focused on inpatient hospital care. These reviews assist the agency in determining whether care rendered to a beneficiary meets medical necessity and quality of care standards. Any hospital that is subject to a review may appeal its findings to Permedion. Should the finding be upheld at that level, the provider may request an appeal from the Surveillance and Utilization Review Section. In 2023, Permedion reviewed 18,072 inpatient cases that resulted in 4,447 denials that total $47,716,062 before the provider rebilled using the correct codes or the appropriate level of care. Permedion also completed 2,328 outpatient reviews resulting in 547 cases being denied that total $1,830,282 before rebills.

## Collaboration with Program Integrity Partners

### Fraud Referral Clearinghouse

Federal regulations require ODM, as the single state Medicaid agency, to have procedures for referring suspected fraud cases to law enforcement. ODM accomplishes this by operating a clearinghouse of subject matter experts from the Bureaus of Program Integrity and Provider Network Management to review fraud referrals and determine if the referrals provide probable evidence of fraud. ODM staff, MCOs, state agencies, and ODM contractors submit fraud referrals to the clearinghouse. If the referrals provide reasonable and explainable evidence of fraud, ODM submits them to the MFCU for a full investigation. ODM and its program integrity partners present fraud referrals associated with home health and/or home- and community-based waiver to the MFCU at bi-monthly meetings that are designed to share knowledge of home health and waiver fraud schemes. ODM submits all other referrals after the weekly ODM clearinghouse review. In 2023, ODM received a total of 766 potential fraud referrals from the MCOs, Sister-State agencies and ODM's vendors. ODM submitted 502 fraud referrals to the MFCU, and the MFCU accepted 425 of these referrals for investigation. Those referrals not sent to the MFCU or declined by the MFCU, were went back to the referring entity for an administrative action i.e. recoupment.

In 2023, ODM continued to refine the Fraud Referral and Coordination (FRC) system to support investigating and reporting fraud, waste, or abuse, and if warranted, referring appropriate cases to the MFCU for potential criminal investigation. The FRC is used as a portal to submit referrals and deconfliction requests allowing ODM to monitor, review, and conduct preliminary investigations on all referrals to determine whether a conflict with law enforcement or a collaboration opportunity exists. ODM then permits the MCO to investigate, review, recoup payment, or involuntarily terminate a provider. Using a system that houses all referral and deconfliction information allows for real-time monitoring and data reporting, increases opportunities for collaboration, and eliminates duplicate workstreams. BPI conducted training for all MCOs regarding the FRC system and expectations.

### Office of the Ohio Attorney General Medicaid Fraud Control Unit

Attorney General Dave Yost's MFCU is responsible for the investigation and prosecution of healthcare providers accused of defrauding the state's Medicaid program. It ranked first in indictments and convictions among all units nationwide in federal fiscal year 2022.

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The unit processed 1,131 allegations of fraud and abuse in calendar year 2023, posting 120 indictments, 184 criminal convictions, and 37 civil settlements. **Recoveries totaled $23 million in restitution and penalties**.

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### Program Integrity Group

The Ohio Medicaid Program Integrity Group (PIG) brings together representatives from ODM, the Auditor of State's Office, and the MFCU to discuss Medicaid fraud, waste, and abuse, potential areas of risk, and other relevant investigatory information. The PIG meets monthly for educational presentations and information sharing. The group discusses data mining projects with a focus on fraudulent schemes. This group continued to meet virtually during the pandemic.

### Managed Care Program Integrity Group

ODM replicated the successful elements of the PIG with the Managed Care Program Integrity Group (MCPIG.) This group brings together ODM's MCOs with representatives from ODM, the MFCU, and the Auditor of State to address program integrity issues related to managed care. This group meets regularly for education and information sharing which promotes collaboration among Ohio's program integrity partners. Nine meetings were held in 2023 with relevant education and guidance provided during each meeting. The training and information provided at the MCPIG meetings served as a catalyst for FWA referrals on the subject matter.

Below is the list of topics discussed at the MCPIG meetings in calendar year 2023:

| Meeting Dates | Topics |
|---|---|
| 1/24/2023 | Fraud Referral & Coordination System Training - Referrals, Access, Deconflictions and SIU Lead Meetings |
| 2/28/2023 | Next Generation - Introduction to Program Integrity, Staff, Goals |
| 3/28/2023 | Telehealth challenges, policy, and schemes |
| 5/23/2023 | Office of Managed Care Compliance & Policy Sections Provider Agreements Update |
| 6/20/2023 | Referral and SIU Overview |
| 7/25/2023 | OhioRISE Update |
| 9/19/2023 | Ohio Attorney General's Office Medicaid Fraud Control Unit |
| 10/24/2023 | Hospice - Policy and MFCU Challenges |
| 12/12/2023 | 2023 Year End Successes, Opportunities and Calendar for 2024 |

### The Ohio Auditor of State

The Auditor of State (AOS) audits Medicaid providers under Section 117.10 of the Ohio Revised Code (ORC). Under a letter of arrangement with ODM, the AOS released 43 reports with findings and interest totaling approximately $2,200,000 in calendar year 2023. The AOS reviews both fee-for-service and managed care payments to providers. The AOS also participates in the PIG and MCPIG meetings and provides training at these meetings related to field audits and auditing best practices.

ODM contracts with AOS to audit cost reports of non-state operated Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IIDs) and cost reports of the Ohio Department of Aging (ODA) Area Agencies on Aging (AAA) related to the PASSPORT and Independent Living program. AOS issued 13 ICF-IID cost report audits and four PAA cost report audits during calendar year 2023.

## Managed Care

ODM ensures program integrity in its managed care program through its own oversight and monitoring of MCOs and through the program integrity work required of the MCOs. Managed Care Organizations and MyCare Ohio Plans, as well as the OhioRISE plan and Single Pharmacy Benefit Manager (SPBM), must comply with all applicable state and federal program integrity requirements in addition to requirements contained in their provider agreements. These

requirements focus on risk-based plans, employee education, monitoring of services and payments, fraud reporting, and cooperation with law enforcement.

ODM continues to build a collaborative relationship with the MCOs' SIUs through its MCPIG and SIU Lead meetings. The MCPIG meetings, described above, are an opportunity to educate MCO SIU and ODM staff, and share information concerning fraud, waste, and abuse among law enforcement and the Ohio AOS. The MFCU, ODM, and the MCOs' SIU Lead representatives also hold SIU Lead meetings regularly to discuss Medicaid provider fraud investigations, provide policy and technical guidance and information, and to increase coordination among program integrity partners. These meetings assist the MCOs in proactively identifying and addressing potential provider fraud and abuse issues and ensure coordination with law enforcement and ODM on active fraud cases.

## Program Integrity work completed by Ohio Medicaid's MCOs

### Planning

ODM monitors the MCOs' required program integrity plans and related activities to ensure MCO compliance with all state and federal program integrity requirements. MCOs must develop and submit to ODM:

1. An Ohio-specific compliance plan that describes the MCO's compliance program and includes the MCO's monitoring and auditing work plan for the upcoming year.
2. An Ohio-specific fraud, waste, and abuse plan (FWA plan).

The FWA plan must include a risk-based assessment, designated staff responsible for administering the plan, clear goals, milestones, or objectives, key dates for achieving identified outcomes, and an explanation of how the MCO will determine the effectiveness of the plan. The MCOs submit the Ohio-specific FWA plan annually on January 15 for ODM review and approval. In 2023, most MCOs updated their FWA plans to include high-risk provider types or services such as behavioral health, telehealth services, home health services, transportation, labs, and outlier prescribers.

The MCOs' FWA plans helped to further define their program integrity work for the upcoming year based on Ohio-centric data analytics that resulted in identifying patterns, risks, and trends.

The Public Health Emergency (PHE) continued to impact MCOs, their FWA plans, and their program integrity processes. All MCOs adhered to ODM guidance to eliminate prior authorization for skilled nursing facilities, long-term acute care facilities, and inpatient rehabilitation facilities until this requirement was rescinded on May 11, 2023. MCOs altered their FWA plans based on utilization and ODM recommendations to investigate telehealth, COVID 19 testing, and other relevant schemes resulting from the PHE.

### Utilization Management

All MCOs conducted a variety of pre-payment activities to decrease risk of fraud, waste, and abuse by educating providers, monitoring utilization and access, as well as, reviewing provider appeals following an MCO's denial of a prior authorization request. MCOs monitored utilization by conducting quarterly audits and reviewing monthly trend reports, and daily adjudication and timing reports.

All the MCOs conducted annual prior authorization (PA) reviews to determine if they unreasonably limited a member's access to Medicaid-covered services through the prior authorization process. None found that their PA processes limited member access to services. All MCOs annually review their appeals process for providers following an MCOs denial of a prior authorization request for a determination as to whether the appeals process unreasonably limits access to covered services. No unreasonable limitations were discovered.

## Pre-payment Activities

The MCOs employed a variety of pre-payment and cost avoidance strategies during calendar year 2023. Examples of pre-payment program integrity activities include, preventing enrollment of fraudulent providers, claim edits, claim flags for additional review, and medical record reviews. All MCOs use information intelligence, such as a decision support system, to address risks and identify outliers, and other aberrancies prior to claims payment.

## Post-Payment Review and Recoveries

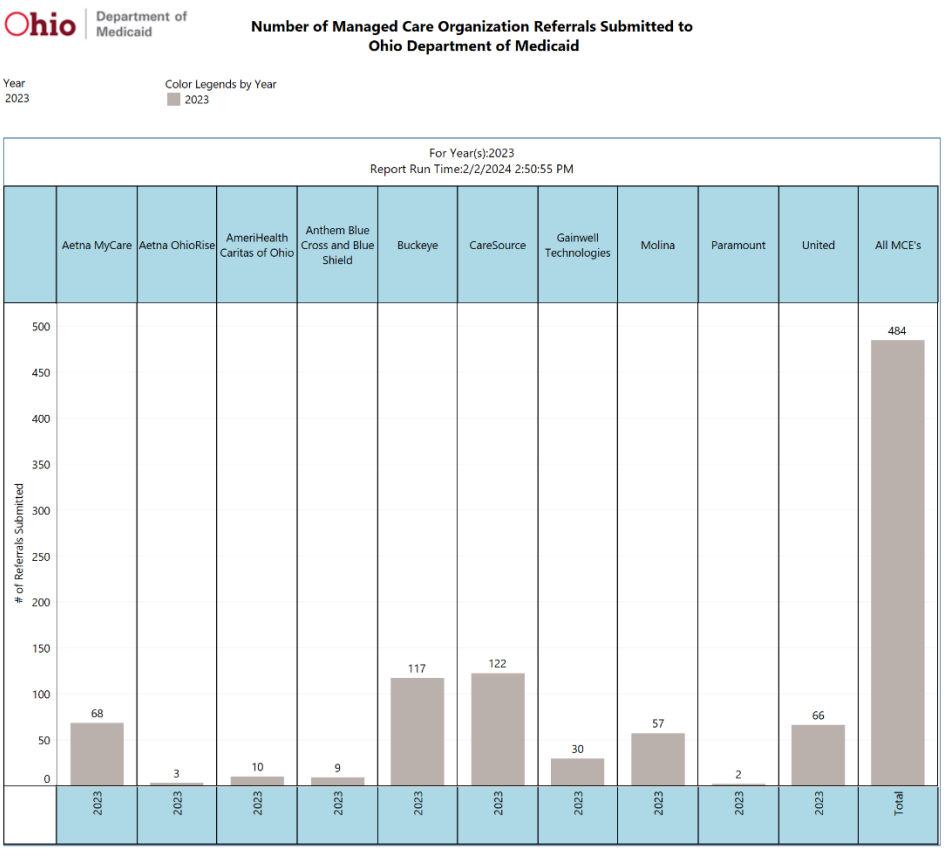
Post-payment reviews are an established tool used to ensure program integrity. Post-payment activities and review occurs after providers submit claims and receive payment from the MCO. MCOs review records to examine whether the goods and services claimed were medically necessary and were rendered to an eligible beneficiary.

The MCOs report to ODM the overpayments identified and recovered. In calendar year 2023, the MCOs conducted a total of 1,428 audits, reviews, and investigations and recovered $1,832,859.13 in overpayments.

## Referrals and Enforcement Action by the MFCU

ODM receives and reviews all fraud, waste, and abuse referrals submitted by MCOs and reviews these through its fraud clearinghouse before submitting the fraud referrals to the MFCU. ODM also monitors whether MCOs promptly refer any potential fraud, waste, and abuse to ODM. MCOs also submit member fraud referrals to ODM which are tracked and sent to CDJFS agencies to investigate. The MCOs submitted a total of 484 provider fraud referrals to ODM, and ODM forwarded 313 referrals to MFCU, and the remaining referrals were sent back to the MCOs for an administrative action i.e. recoupment. The MCOs also forwarded to ODM 237-member fraud referrals during 2023. Not all fraud referrals are accepted by the MFCU.

Many referrals submitted by the MCOs to ODM were based on incidents submitted in ODM's Incident Management System (IMS). The IMS serves to meet CMS health and safety assurance requirements as specified in the CMS 1915(c) waiver application. The IMS system launched July 1, 2019, to manage, report, and track critical incidents, reportable incidents, and provider occurrences that occur with individuals involved in the following waiver programs: Ohio Home Care Waiver (OHCW), Specialized Recovery Services Program (SRSP) and the MyCare Ohio Waiver. Medicaid fraud is a sub-category of incident within the provider occurrences category.




Home health and waiver services comprise the majority of referrals submitted to ODM. Many of these referrals incorporated visit data from ODM's Electronic Visit Verification system (EVV), which electronically records certain home-health and personal care services provided.

## Electronic Visit Verification

The 21st Century Cures Act (Cures Act) mandates that states implement Electronic Visit Verification (EVV) for all Medicaid personal care services (PCS) and home healthcare services (HHCS) that require an in-home visit by a provider. EVV requires home care providers that furnish PCS and HHCS services outlined by the Cures Act to electronically verify the services they deliver. Providers record the visit date and time, visit location, individual receiving services, the caregiver who is providing services, and the service provided.

Ohio was the first state to implement an EVV system. Phase 1 of initial implementation was on July 8, 2018, for home health nursing and aide services, private duty nursing and Ohio Home Care Waiver nursing aide and home care attendant services and RN assessments.

The EVV solution utilizes current technology to provide near real time validation of service delivery in home- and community-based settings, supporting the following policy and program integrity objectives:

- Ensure the health and welfare of individuals choosing to receive long-term services and supports where they live or otherwise receive services timely.
- Improve payment accuracy by using technology to match data on claims with data in visit documentation.
- Reduce fraud and abuse by requiring verification of service delivery.

ODM provides an EVV system for use by providers at no cost. Providers capture visits via a mobile app on a device, however, alternate visit capture methods include telephony and manual visit entry for those circumstances when the mobile solution is not available or does not meet the needs of the individual. In certain cases, an alternate EVV entity may be used to collect visit data to send to ODM. ODM stores all visit data collected in a uniform database called the Aggregator and uses this data to substantiate information on claims. All payers (ODA, DODD, and MCOs) are required to use the same EVV solution and approach prescribed by ODM.

In 2023, ODM procured an EVV solution through a request for proposal process as the current contract was expiring. ODM awarded the new contract to Sandata (the current vendor) and collaborated with partner agencies, ODM contractors, and the EVV vendor to outline business rules, technical specifications, and changes to the program in preparation for the enhanced system to go live in 2024. This work directly reflects stakeholder feedback into the enhanced system.

In addition to the enhanced system work completed in 2023, ODM has collaborated internally to revise the Ohio Administrative Code EVV rule to ensure the rule and system are in full alignment. ODM also conducted significant outreach to payers and providers, which resulted in an improvement in claim validation responses across all payers. ODM collaborated with our EVV vendor to complete three stakeholder webinars and two Managed Care Surveillance, Investigation, Utilization (SIU) specific webinars.

In 2023, the EVV vendor conducted over 100 personalized training sessions with providers. ODM also received over 2,500 provider referrals from our contractor, Public Consulting Group, which resulted in ten direct outreach campaigns to providers assisting them with EVV requirements and compliance. ODM's EVV work in 2023 has positively impacted our program integrity efforts, reducing fraud and abuse within the system, and improving provider compliance with the EVV system.

## Eligibility and Program Integrity

Determining an individual's Medicaid eligibility is the first step toward connecting prospective beneficiaries to coordinated healthcare coverage. In many ways, successful program integrity begins by ensuring that ODM only provides benefits to those individuals who qualify. The eligibility program integrity work described below applies to all individuals receiving Medicaid benefits, whether they are enrolled in an MCO or receive services through fee-for-service Medicaid.

### Medicaid Eligibility Quality Control Reviews

Federal regulations require states to conduct Medicaid Eligibility Quality Control (MEQC) reviews every three years. The MEQC pilot includes review of active Medicaid cases each month to determine if beneficiaries were eligible for services during the month under review. The pilot also requires states to sample and review negative actions, such as case denials or terminations, to determine whether the reason for the action was correct. Through these reviews, Ohio can evaluate the implementation of improvements and monitor the effectiveness of corrective actions that

address audit findings including from PERM. MEQC review outcomes are shared with the CDJFS agencies and ODM County Compliance Team for follow-up, training, and technical assistance to improve future eligibility processing and determinations.

In March 2023, the reporting year (RY) 2022 federally required pilot review project concluded. The MEQC pilot reviews conducted by ODM focused on caseworker actions, system actions, case file verifications, and other factors of eligibility to ensure the accuracy of eligibility determinations. The MEQC unit reports the error and deficiency findings from all reviews to each CDJFS as they are identified.

The MEQC Pilot Corrective Action Plan (CAP) was submitted to CMS in July 2023. Out of the 800 cases reviewed, 124 technical deficiencies and 84 errors were found. Most of the findings were related to case worker training and all the trainings have either been conducted or scheduled by the eligibility training team.

After concluding the pilot review and CAP work, the MEQC unit transitioned to reviewing Medicaid and CHIP renewals processed during the Return to Routine Operations for accuracy and timeliness. This work continues, to date.

ODM MEQC leadership meets monthly with the Eligibility and County Compliance areas to discuss statistics, trends, updates, and future projects. A dashboard is currently being created for counties to view their monthly MEQC statistics and pull reports.

### Public Assistance Reporting Information System

Public Assistance Reporting Information System (PARIS) is a computer matching system through which Social Security numbers of public assistance beneficiaries are matched against various federal income and state agency public assistance databases. Matching is done to identify individuals receiving public assistance who may not have reported income accurately during eligibility determinations and to identify people receiving concurrent benefits from multiple states.

The PARIS matching process is managed by the U.S. Department of Health and Human Services' Administration for Children and Families (ACF). The ACF provides states participating in PARIS with pension and compensation information from the U.S. Department of Veteran Affairs, income information for civilian and military employees from the U.S. Department of Defense and Office of Personnel Management, information on interstate public assistance benefit payments (e.g., Temporary Assistance to Needy Families, Food Assistance and Medicaid programs), and Workers' Compensation data from participating states. The PARIS match information is added to Ohio's eligibility system and generates an electronic alert for caseworkers to verify potential concurrent eligibility for an individual receiving Ohio Medicaid benefits.

### Income and Eligibility Verification System (IEVS)

Ohio operates the IEVS as required by federal law. IEVS is a computerized system that matches the Social Security numbers of individuals receiving public assistance to other provider databases, including those of the Social Security Administration, Internal Revenue Service, State Wage Information Collection Agency, and Unemployment Compensation. When a match with any of these databases occurs, the information is returned to the state, which generates an electronic alert to the county eligibility worker responsible for the case. The county caseworker is required to determine whether the new match information affects the amount of benefits the individual or family is receiving and adjust the benefits accordingly.

### County Support and Monitoring

County Eligibility Technical Assistance (TA) staff continued to provide training and support to county agencies to improve eligibility determinations. During calendar year 2023, TA presented statewide Technical Assistance and Compliance video conferences and webinars including discussions of recent Ohio Administrative Code policy changes

and clarifications, eligibility system processing tips, and updates on current eligibility compliance activities. TA offered targeted training on a variety of Medicaid policy and system topics throughout 2023. ODM recorded most of the sessions and the recordings are available for viewing by county staff at any time on the Medicaid innerweb page. In collaboration with the Ohio Department of Job and Family Services (ODJFS), TA continued the 12-week new worker training series first implemented in 2020.

Eligibility Compliance staff provide a variety of eligibility support to counties. Starting in CY 2019 and continuing through CY 2024, compliance staff engaged counties to reduce pending Medicaid applications and Medicaid renewal backlogs. Compliance staff sent weekly reports to counties with information on all pending applications, and all current and past due renewals. Statistics from these reports were compiled and shared with County Engagement staff to support ongoing conversations with counties related to application and renewal processing. In CY 2022 and continuing through CY 2024, Compliance staff increased monitoring of PARIS alerts and began outreach to counties struggling to make significant reductions in pending PARIS interstate alerts. Compliance staff also monitor various reports for eligibility issues, reach out to county administrators to assist in resolution of issues, and continue to work with the data team to ensure reports are updated when necessary to provide the best output for county use.

The County Engagement unit consists of five county engagement managers assigned to 17 or 18 counties each. Engagement managers are responsible for meeting with each county in their region at least once per quarter. The meetings address any questions the agency may have on eligibility policy or the Medicaid eligibility system, identify training needs, review reports on county pending application and renewal backlog numbers, provide county-specific support following policy or system training, and cover county business processes and best practices. The engagement managers also serve as the county agency's ODM contact to ensure all questions and concerns are being responded to timely and escalated appropriately, when necessary. County engagement managers build rapport with county agencies to open lines of communication and ensure counties receive prompt assistance.

# Audit Coordination

### Audit Coordination

Federal and state auditors and oversight agencies regularly audit ODM. ODM's Audit Coordination unit works to ensure ODM provides auditors with complete and accurate information. If the auditors identify an area of non-compliance, the Audit Coordination unit works internally with ODM staff to develop a corrective action plan to address the noncompliance, and monitors ODM's remediation of that noncompliance. In 2023, the AOS, Centers for Medicare and Medicaid Services (CMS), the Internal Revenue Service (IRS), HHS-OIG, and Ohio Office of Budget and Management (OBM-OIA) entered into or completed audits or reviews of ODM. CMS initiated the review year (RY) 2025 Payment Error Rate Measurement (PERM) audit that occurs every three years. ODM also worked with IT to develop a PERM tracking system to be used for RY 2025. This system was built and tested in 2023 and will help the agency track PERM work.

- The AOS completed the annual SFY 2022 Single State audit. It made findings related to eligibility determinations and identified systems deficiencies within Ohio Benefits– Ohio's statewide eligibility system, and caseworker errors. ODM provided a corrective action plan to CMS in response. Additionally, the AOS began the annual SFY 2023 Single State audit during CY 2023.
- The AOS conducted a public interest audit on concurrent eligibility; to determine whether Ohio made capitation payments for enrollees who were also enrolled in a Medicaid or CHIP program in another State.
- OBM-OIA completed an assurance engagement on the Department of Rehabilitation and Correction (DRC) bot and ex parte project. This engagement evaluated the DRC bot and ex parte processes used by the agency to

identify and confirm Medicaid eligibility of recipients in preparation for the PHE unwinding. DRC bot enhancements helped to speed up the processing of alerts saving about 1.5 minutes for each of them, and the enhancements were deployed November 1, 2023.

- OBM-OIA began a consulting engagement on Information Technology Contingency Planning in CY 2022. This engagement aims to develop a Business Continuity and Disaster Plan for ODM. OBM-OIA and ODM have been meeting every two months to monitor ODM's progress on developing contingency planning controls.
- OBM-OIA performed an assurance engagement related to the controls over the ODM's third-party liability fiscal processes. Both the revenue collection process and refund process were found to be well controlled, and no findings were reported.
- HHS OIG conducted an audit to determine whether the Ohio Department of Health complied with applicable Federal, State, and local regulations and standards for ensuring the health and safety of the persons in care of providers providing adult day health care services. ODM participated in the audit as requested by HHS OIG. This audit has concluded and ODM is waiting on the draft report from HHS OIG.
- HHS OIG conducted an audit on eligibility actions following the conclusion of the COVID-19 public health emergency. This audit is concluded, and HHS OIG found that ODM generally completed medicaid eligibility actions during the unwinding period in accordance with federal and state requirements.
- CMS audited ODM's Managed Care Medical Loss Ratio reporting to determine if annual reporting and calculations were reasonably represented by MCOs and payments made back to ODM were appropriate. This audit is concluding and is expected to be closed at the start of CY 2024.
- In 2023, CMS' RY 2025 PERM review initiated. There are three reviews that are part of PERM: Medicaid Records Review, Data Processing Review, Eligibility Review. ODM has been engaged with CMS contractors for the various parts of PERM this year.
- CMS requested RY 2022 PERM CAP updates bimonthly. ODM provided its first bimonthly update on the CAP in December 2023.
- ODM has been engaged in audit remediation efforts with the IRS. After four CAP submissions, the IRS has determined there are five total open findings still needing to be remediated by ODM and/or DAS. ODM/DAS is required to submit a corrective action plan (CAP) worksheet semi-annually on the CAP due date of August 31, 2023.
- OBM's Vulnerability and Patching audit was conducted from April 2023 through June 2023. A Final Audit Report was received in July 2023 and no high-risk findings were noted .

## Closing

Medicaid plays a unique and necessary role for our state. There are opportunities to positively change the trajectory of many young Ohioans' lives. There are also opportunities to lower barriers to employment for working age adults, and to ensure the full range of service options and choice for Ohioans who are elderly or have a disability.

In addition to the health of 3.5 million Ohioans, ODM recognizes its legal and ethical duty to steward the public tax dollars that enable Ohio's Medicaid program. The program integrity efforts described in this report encompass some of the important strategies deployed to ensure that individuals are eligible, and that they receive appropriate services from credible, quality providers. Assuring the integrity of the program is essential for the trust and support of those served by the program, the General Assembly, and all Ohioans.