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OHIO MEDICAID PROGRAM FOLLOW - UP PERFORMANCE AUDIT

DECEMBER 18, 2008

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Auditor of State

To the General Assembly, Governor's Office, Participating Medicaid Agencies, and Interested Citizens:

As a State Legislator, I advocated for the General Assembly to provide legislative direction to the Auditor of State to examine the Medicaid Program through a performance audit and make recommendations for improvements in the Program. This authority was included in Amended Substitute House Bill 66. In December 2006, the Auditor of State's Office (AOS) released a performance audit of the Medicaid Program. The performance audit's intent was to determine ways of reducing or eliminating fraud, waste, and abuse in the Program, making the Program more efficient, and enhancing the Program's results.

As Auditor of State, I recommended the inclusion of several recommendations into Amended Substitute House Bill 119, the State's 2008-2009 biennial budget bill. I also directed the AOS to initiate this follow-up audit to provide decision makers with information that would be beneficial in the development of the State's next biennium budget. Because of the complexity of the Medicaid Program and the historical difficulty in implementing change in its administration, the follow-up audit is intended to ensure that consideration and implementation of the 2006 recommendations is occurring. The large scale of the Program and the high cost to the State necessitate continual scrutiny to ensure effective use of taxpayer resources.

As the State faces a difficult fiscal outlook in the current economic climate, the financial resources used by the Program must be aggressively managed. At the same time, the population accessing Medicaid is growing, increasing the financial outlay required for the Program. Therefore, the Program components require continual oversight to ensure effective application of taxpayer resources. Finally, lower tax revenues and increased Medicaid cost may require the State to make significant cuts in other program areas to meet balanced budget requirements. As a result, improved management is imperative to lessen the impact of the costs of Medicaid in Ohio on the State budget and its other programs.

Ohio's Medicaid Program remains a complex and unwieldy system that involves multiple State agencies. The audit found that while the recommendations from the 2006 performance audit have been used by these agencies, the vast majority have not been fully implemented. Ohio has not implemented recommendations that potentially could have yielded over $300 million in savings. It is reported that many of the recommendations will be addressed with the implementation of the Medicaid Information Technology System (MITS) and the work being undertaken by the new Executive Medicaid Management Administration (EMMA). A great deal of work remains to fully implement the audit recommendations.

A report has been prepared which includes the project overview and history; objectives, scope and methodology; summary of results; and implementation status for each of the 109 recommendations issued in the 2006 performance audit.

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Sincerely,

Mary Taylor, CPA
Auditor of State

December 18, 2008

MEDICAID FOLLOW-UP

Ohio Medicaid Follow-Up Audit

Project Overview and History

The Medicaid Program is a federal entitlement program, administered by the states, that pays for medical assistance for certain individuals and families with low incomes and limited resources. Since its adoption and implementation, Medicaid has evolved into a program of immense size, significance, and impact. Medicaid is the largest source of funding for medical and health-related services for America's poorest people, serving nearly 59 million people (or 1 in 6 Americans) in federal fiscal year 2005. In 2005, approximately 2 million Ohioans were enrolled in the Medicaid Program and from State fiscal years (SFY) 2000 to 2004, Ohio's Medicaid spending grew by an average of 11.8 percent per year while the growth in State revenue was between 3 and 4 percent. In SFY 2006-07, actual Medicaid spending in State-only General Revenue Funds (GRF) for all agencies was $4.3 billion and the Medicaid Program accounted for 22 percent of Ohio's total State-only GRF spending.

The Auditor of State (AOS) was originally authorized to undertake a performance audit of the Ohio Medicaid Program (Program) in Amended Substitute House Bill 66, passed by the General Assembly on June 21, 2005 and signed by the Governor on June 30, 2005. The performance audit was released on December 19, 2006 and included a total of 109 recommendations in the areas of organizational issues, service provision, managed care and care management, program integrity, and technology. The recommendations were intended to reduce or eliminate fraud, waste, and abuse in the Program, improve its efficiency, and enhance the Program's results. Thirteen of the recommendations contained quantified cost savings totaling up to $403.5 million.

The 2006 performance audit found that the Ohio Medicaid Program exhibited excessive complexity, inconsistency in its implementation at the State and county level, inadequate information and program systems, and fragmented and redundant monitoring and oversight functions. Many of the legal requirements of the Program at both the State and federal level were difficult to interpret due to the length of the laws and the arcane language used. The audit described the complexities of the Program as a primary factor in the State Medicaid Agency's general inability to be proactive. Other problems, such as frequent breakdowns in communication with sub-recipient agencies and other external stakeholders, and an often negative perception regarding the administration of the Program, added to difficulties in managing the Program. Despite these challenges, Ohio Medicaid was found to be a vital program which provides an irreplaceable service to some of the State's most vulnerable populations.

In accordance with Government Auditing Standards, AOS initiated this follow-up performance audit to provide decision makers with information that would be beneficial in the development of

the State's next biennium budget. Because of the complexity of the Program and the historical difficulty in implementing change in its administration, the follow-up audit is intended to ensure that consideration and implementation of recommendations is occurring.

Subsequent Events

Since completion of fieldwork for this audit, the following changes have occurred in the Ohio Medicaid Program:

On September 22, 2008 a meeting was held between ODJFS, the Ohio Rehabilitation Services Commission, and representatives of county departments of job and family services and a model for a single disability determination process was selected. Subgroups were formed to assist with the development of the detailed model.

ODJFS reported that it implemented a reorganization of the Office of Ohio Health Plans (OHP) on October 1, 2008. The new structure is reportedly based on a functional model and was described as allowing OHP to evolve with the implementation of the Medicaid Information Technology System (MITS) and the integration of business process re-engineering approaches.

Also in October, 2008, ODJFS launched the HOME Choice initiative, in which persons who have received institutional long-term care for at least six months are eligible for additional services and supports to help them move to a community setting. Additionally, ODJFS indicated it is developing a State Profile Tool to measure the success of efforts to balance long-term care.

ODJFS stated that OHP has identified the knowledge, skills, and abilities of its existing employees and developed a process to capture the essential knowledge of departing employees.

ODJFS indicated that it is currently conducting a full evaluation of the managed care program and the results will be available in 2009. According to ODJFS, the results will be used to revise the Quality Strategy which is used to set performance expectations and to monitor managed care plans.

The target "go-live" date to provide on-line pharmacy information to providers through ACS State Healthcare was delayed from August 2008 to February 2009.

Objectives, Scope, and Methodology

Performance audits are defined as engagements that provide assurance or conclusions based on an evaluation of sufficient, appropriate evidence against stated criteria, such as specific requirements, measures, or defined business practices. Performance audits provide objective analysis so that management and those charged with governance and oversight can use the information to improve program performance and operations, reduce costs, facilitate decision making by parties with responsibility to oversee or initiate corrective action, and contribute to public accountability. The goals of the Ohio Medicaid Program follow-up performance audit were as follows:

- Determine the implementation status and actions taken to address recommendations from the initial Ohio Medicaid Program performance audit;
- Research other states' initiatives related to the areas of Medicaid covered in the initial audit, as well as innovative health care programs for the uninsured;
- Examine any federal changes that have occurred since the initial audit which impact the Ohio Medicaid Program; and
- Identify any additional changes Ohio has made to its Medicaid Program or health care programs for the uninsured since the completion of the initial performance audit.

This follow-up performance audit was conducted in accordance with Generally Accepted Government Auditing Standards. Those standards require that AOS plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for findings and conclusions based on audit objectives. AOS believes that the evidence obtained provides a reasonable basis for the audit findings and conclusions based on the audit objectives.

The Ohio Medicaid Program follow-up performance audit's primary purpose is to identify changes made within the Ohio Medicaid Program which address the recommendations from the 2006 performance audit. There were no new assessments, comparisons, or analyses completed within the scope of this audit. However, auditors examined practices in other states that are similar to those recommended in the 2006 performance audit or represent innovative approaches to managing state Medicaid programs. Audit field work was conducted between May 2008 and August 2008. Although the audit work reflects the status of the program during this time frame, information was updated based on feedback from ODJFS as of December 1, 2008. Furthermore, several areas that were identified to the auditors by agencies as being implemented were still in the discussion phase or being planned for future implementation.

To complete this report, the auditors gathered data, researched changes in the Medicaid Program and Ohio law, conducted interviews with relevant staff members of the ODJFS, including the OHP, the Ohio Department of Alcohol and Drug Addiction Services (ODADAS), the Ohio Department of Mental Health (ODMH), the Ohio Department of Aging (ODA), the Ohio

Department of Health (ODH), the Ohio Department of Mental Retardation and Developmental Disability (ODMRDD), Ohio General Assembly, and the Executive Medicaid Management Administration (EMMA).

The performance audit process involved information sharing with ODJFS, ODADAS, ODMH, ODA, ODH, and ODMRDD, including a preliminary draft of the report. The agencies provided comments in response to the draft report, which were taken into consideration during the reporting process. Where warranted, the report was modified based on the agencies' comments. As the audit involves a State-wide program and no specific agency, no official client response was solicited for this report.

The Auditor of State and staff express their appreciation to the Ohio General Assembly staff, EMMA, the Office of Ohio Health Plans and the Medicaid sub-recipient State agencies for their cooperation and assistance throughout this follow-up audit.

Summary of Results

The General Assembly, Governor's Office and the State Medicaid Agency have fully implemented 15 (or 14 percent) of the recommendations from the 2006 Medicaid Performance audit. Amended Substitute House Bill 119 (Am. Sub. HB 119),[1] the State operating budget bill for SFYs 2008 and 2009 that was signed by the Governor on June 30, 2007, incorporated eight Medicaid law changes resulting from the 2006 audit,[2] as well as the Governor's Turnaround Ohio initiatives.[3] Ohio has not implemented initial audit recommendations that potentially could have yielded $302.8 million in savings (75.0 percent of the total financial implications identified). Ohio has either implemented or partially implemented recommendations that potentially could have yielded $100.7 million in savings (25.0 percent of the total financial implications identified); however, actual savings could not be quantified due to the various stages of implementation, as well as the time needed to realize savings to the Program.

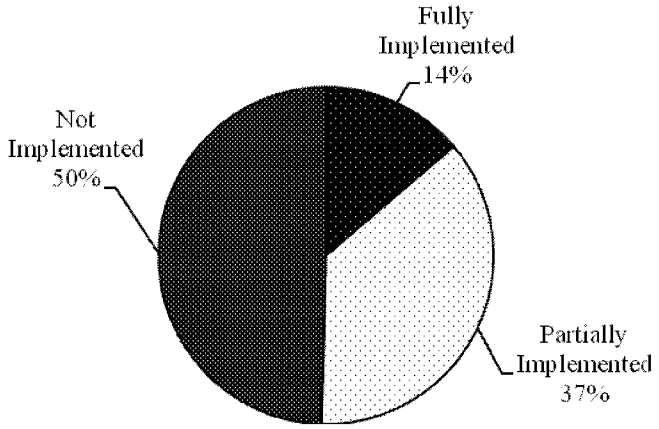
Chart 1-1 displays the status of the 109 recommendations by category of implementation: fully implemented, partially implemented, or not implemented.

[1] Am. Sub. HB 119 has been the primary source of State law changes to the Medicaid program since the release of the 2006 performance audit and, as such, is referenced throughout this report.

[2] The Auditor of State testified before the Senate Finance and Financial Institutions Committee on May 17, 2007 and encouraged adoption of the 2006 Medicaid Program performance audit recommendations.

[3] Turnaround Ohio refers to a package of policy initiatives proposed by the Governor that encompasses a broad range of issues, including economic development, education, and Medicaid reform. A number of the specific elements of the plan were enacted in Am. Sub. HB 119.

Chart 1-1: Medicaid Follow-Up Implementation Status by Category[1]



Source: AOS
[1] Percentages do not equal 100 percent due to rounding.

As the State has implemented only 15 (or 14 percent) of the 2006 recommendations, there are 94 recommendations (or 86 percent) partially or not implemented. Many of these recommendations reportedly will be addressed with the implementation of the MITS and the work being undertaken by EMMA. MITS, which is expected to be functional and replace the Medicaid Management Information System (MMIS) in October 2009, will have a major impact on Ohio Medicaid technology. The system will allow flexibility and opportunity for evolving technology within the Medicaid Program. EMMA was created by Executive Order in December 2007 to serve as the central coordinating body to manage the Ohio Medicaid Program across all State agencies. EMMA brings together cabinet-level leadership, as well as staff from the various State agencies with responsibility for Medicaid-funded programs, and has formed five subcommittees – Budget and Finance; Clinical; Legal and Program Integrity; Strategy and Policy; and the Consolidation Exploration Team. Although EMMA has established subcommittees, there has not been sufficient time for it to produce any tangible results.

During the audit, sub-recipient agencies and members of the General Assembly noted increased cooperation and improved communication with the State Medicaid Agency. Furthermore, the State has taken steps to increase community-based care through the Unified Long Term Care Budget (ULTCB); however, the recommendations from the ULTCB report were submitted to the

Joint Committee on Medicaid Technology and Reform and it remains to be seen if the recommendations will be implemented.

Most importantly, few of the recommendations have been ignored or wholly rejected. As recommended in the 2006 audit, a long term perspective of the Program is required as it is difficult to make dramatic changes to a program as large and complex as Ohio Medicaid. However, a substantial amount of work remains in order to achieve full implementation of the audit recommendations and leading practices being used in other states.

Table 1-1 summarizes the status of the 2006 performance audit recommendations by report section. A full description of the implementation status of recommendations follows.

Table 1-1: Implementation Status of 2006 Audit Recommendations

	Report Section											
	Organizational Issues		**Service Provision**		**Managed Care/ Care Mgt.**		**Technology**		**Program Integrity**		**Total**	
Status	No.	%	No.	%	No.	%	No.	%	No.	%	**No.**	**%**
Fully Implemented	3	14.3%	2	8.7%	2	7.1%	3	15.8%	5	27.8%	**15**	**13.8%**
Partially Implemented	7	33.3%	9	39.1%	13	46.4%	9	47.4%	2	11.1%	**40**	**36.7%**
Not Implemented	11	52.4%	12	52.2%	13	46.4%	7	36.8%	11	61.1%	**54**	**49.5%**

Source: Performance Audit Sections

Less than two years have passed since the release of the first performance audit and Ohio's Medicaid Program remains a complex and unwieldy system involving multiple State agencies. While most of the sub-recipient agencies remarked on the benefits of increased communication and cooperation in addressing Medicaid issues, much of the work proposed to implement the recommendations or resolve outstanding issues is still in the planning stages. Also, the durability of the recent level of cooperation is uncertain, and the strength of newly-formed working relationships between the State Medicaid Agency and sub-recipients will be challenged when the EMMA subcommittees begin to tackle extensive system changes.

Since the 2006 performance audit, other states have implemented recommended and novel practices that Ohio has not yet incorporated into its program. ODJFS indicated that implementation of a significant number of recommendations and more recent leading practices are contingent upon the successful implementation of MITS. Since the implementation of complex information systems has proven to be difficult in Ohio and other states, it is critical that the MITS implementation process be carefully monitored and that the State Medicaid Agency considers alternative methods for implementing cost-saving recommendations in the event the system requires rework. Likewise, alternatives should be considered in the event federal support for modifications to the system, which are proposed to implement some of the performance audit

recommendations, is not forthcoming. Regardless of recent progress, the size, complexity, and cost of the Ohio Medicaid Program requires continued executive and legislative scrutiny as well as an undiminished focus on reform through the implementation of established, innovative, and sometimes even revolutionary practices.

Implementation Status

Organizational Issues

In 2006, the General Assembly created the Medicaid Administrative Study Council to study, among other things, the administration of Medicaid under a new standalone Medicaid Agency. It was assumed that the Legislature would enact a law by July 1, 2007 establishing such an agency. However, in Am. Sub. HB 119, the General Assembly required the Governor to create a new administration for Medicaid. EMMA was intended to "manage all Medicaid policies and functions and promote the efficient and effective delivery of health care," and was required, in its enabling statutory language, to implement the recommendations of the Medicaid Administrative Study Council, except the recommendation for the creation of a standalone Medicaid Agency.

Partially in response to the expectation that the General Assembly would create a standalone Medicaid Agency, or at least require a structural overhaul of the existing State Medicaid Agency (ODJFS), the 2006 Ohio Medicaid Performance Audit recommended a number of steps related to long-term planning and organizational structure, to be initiated by the State Medicaid Agency or the General Assembly. Specifically, the audit recommended the creation of a broad, long-term vision for the Medicaid Program in Ohio, the development of specific goals and priorities for the Program, the selection of an appropriate organizational structure based on the role of Medicaid within the overall public health system in Ohio, and steps to provide a higher level of stability within the Program.

Very little has been done to implement these longer-term recommendations. Neither the General Assembly nor the Governor's Administration has engaged in discussions about a long-term vision or specific priorities for Medicaid. No dedicated efforts have been undertaken to define the role of Medicaid relative to Ohio's overall public health system. As illustrated in the initial performance audit, without these efforts at long-term planning, there is no foundation for selecting an appropriate organizational structure or imposing a level of stability in terms of statutory and rule changes.

Beyond the long-term recommendations, the various Medicaid agencies have taken numerous steps to address the findings in the 2006 performance audit, largely through two specific initiatives. Through EMMA, the various Medicaid agencies work toward solutions to common problems including consistency across the Medicaid system, consolidation of business services where appropriate, and improvement of the oversight function of the State Medicaid Agency. Virtually all of the Medicaid agencies cited the framework of EMMA – as well as efforts of leadership within OHP and ODJFS to improve transparency, outreach, and oversight – as leading to increased levels of communication and collaboration within the Medicaid Program. Although the sustainability of these improved relationships will be tested over time, EMMA does provide a formal structure for addressing Medicaid issues across the entire Program.

The second major initiative affecting organizational issues is the implementation of the Medicaid Information Technology System (MITS), which is scheduled to be operational in October 2009. Issues related to the functionality and implementation of MITS is described in more detail in the technology section of this report, but the system is expected to have both an internal and external function. Specifically relevant to the recommendations of the organizational issues section, MITS is expected to collect and report important data about the Medicaid Program as a whole. In the past, oversight agencies such as the General Assembly or the Office of Budget and Management (OBM) have been unable to obtain reliable Medicaid information upon which to base policy decisions.

In addition to its reporting functions, MITS is expected to enhance the functions of OHP. For example, MITS will help OHP to better track individual employee performance as well as the status of specific initiatives, including budget and caseload tracking. OHP is in the process of an internal reorganization, and the functionality of MITS is a key component of its business transformation plan. As recommended by the 2006 performance audit, OHP is seeking to implement a more function-based organizational structure that will allow it to be more flexible and responsive to the demands and requirements of the Program. Although the timing of the reorganization is not aligned with the MITS implementation, the functionality of MITS is a key consideration. For example, OHP has administered a knowledge, skills, and abilities assessment of nearly all its employees to ensure that their skills match the future needs of the organization and identify any necessary training.

Table 1-2 illustrates the 2006 performance audit recommendations from the **organizational issues** section as well as the actions taken in response to the recommendations and the implementation status. The status of the recommendations is indicated by: I (fully implemented), P (partially implemented), or N (not implemented).

Table 1-2: Implementation Status of Organizational Issues Recommendations

2006 Recommendation	Actions Taken	Status
R3.1 Develop a long-term perspective: The General Assembly should establish a long term perspective for the program.	There is no process in place for the Legislative and Executive branches to work together to develop a long-term vision of the Medicaid program. However, some service-specific plans that include long-term strategies have been developed for portions of the Medicaid Program (e.g. the ULTCB and the MRDD Futures Committee).	N
R3.2 Use service strategies: The State Medicaid Agency should use service provision strategies to help stabilize the program and reduce market and environmental effects on the program.	The Medicaid Program has implemented managed care and limited co-pays, which were mandated by the General Assembly. However, it has not considered a comprehensive consumer-driven approach to addressing the market failures inherent in Medicaid.	P
R3.3 Improve state-level relationships: The State Medicaid agencies should develop transparent, positive, and proactive relationships.	Collaboration across Medicaid agencies is reported to have improved with the advent of EMMA workgroups and through other formal initiatives to improve oversight and communication. However, much of the improved cooperation is attributed to an increased emphasis in this area by Agency leadership and has not been tested over time. An example of increased cooperation is the behavioral health collaborative, which includes ODJFS, ODMH, ODADAS, managed care plans, and other stakeholders that meets to address ongoing issues related to coordination of care between the different systems.	P
R3.4 Use an intermediary reporting agency: The State Medicaid Agency should provide access to the Decision Support System.	Access and training to the Decision Support System (DSS) has been provided to the Attorney General, AOS, ODH, ODADAS, OBM, Legislative Service Commission, ODMH, ODMRDD, and ODA.	I
R3.5 Establish an intermediary oversight body: The General Assembly should evaluate if a second tier of reporting structures or processes, would help future elected officials maintain an appropriate scope of decision-making.	No formal reporting structures or independent sources of Medicaid information for the General Assembly have been established.	N
R3.6 Prioritize program goals: The General Assembly and the Governor's Office should devise a process to prioritize the goals of Medicaid to provide guidance and direction.	No formal priorities for the Medicaid Program have been developed or articulated by the General Assembly or the Administration.	N

2006 Recommendation	Actions Taken	Status
R3.7 Centralize claims: The General Assembly should provide the State Medicaid Agency authority to centralize claims processing.	There is a general consensus about the value of centralizing claims processing functions. However, the agencies have not determined how to implement this process, although it would likely be among various business processes that could be integrated within MITS. No legislation has been enacted to require such a measure	N
R3.8 Revise interagency agreements: the State Medicaid Agency should revise its interagency agreements to strengthen its ability to oversee Medicaid.	Interagency agreements (IAA) have been bolstered to strengthen the oversight provided by the State Medicaid Agency, and the IAA process has reportedly been more collaborative. However, priorities and program outcomes remain largely unaddressed though some additional work is being completed through EMMA in this area.	P
R3.9 Improve relationships with sub-recipients: The State Medicaid Agency should improve its relationships with sub-recipient and stakeholder organizations and seek to broaden collaborative opportunities.	Collaboration across Medicaid agencies is reported to have improved through EMMA. The sustainability of these improvements will be tested over time.[1]	P
R3.10 Capture all program costs: The State should improve its information management practices to better capture health care and Medicaid costs.	Better identifying sources of local match has become more of a priority, and has improved in specific areas. However, the General Assembly has not enacted a new local reporting requirement, nor has Medicaid taken a formal Program-wide approach to tracking local match dollars.	P
R3.11 Grant information access to independent bodies: The Legislative Service Commission (LSC) and Office of Budget and Management (OBM) should be granted access to the Decision Support System.	Access and training to the DSS have been provided to LSC and OBM as recommended. The State Medicaid Agency should ensure that LSC and OBM also be granted access to any additional program outcome measures that are developed in the future.	I
R3.12 Reorganize based on a clear purpose for the program: The General Assembly should base Medicaid reorganization decisions on a clear purpose for the State's publicly funded health care system and social safety net programs.	Neither a standalone Medicaid Agency nor any of the alternatives presented in the 2006 report have been implemented. Instead, the General Assembly instructed the Governor to create EMMA, which has assumed the role of managing issues that run across the Medicaid Program.	N
R3.13 Permit the program to stabilize without additional near-term changes: Once a structure for publicly funded health care is implemented, the General Assembly should cease Medicaid redesign efforts for an extended period of time	Both the Administration and General Assembly continue to pursue significant Medicaid legislative changes. Moreover, the biennial budget cycle and periodic issues of contention between the legislative and executive branches make a moratorium unlikely.	N
R3.14 Centralize contract management within the State Medicaid Agency: The General Assembly should centralize the core functions of Medicaid contract management within the State Medicaid Agency.	Centralization of Medicaid contract management functions has not been enacted in statute nor implemented independently by the State Medicaid Agency. The Legal and Program Integrity subcommittee of EMMA is considering this issue.	N

2006 Recommendation	Actions Taken	Status
R3.15 Decentralize authority within State Medicaid Agency: The State Medicaid Agency should decentralize internal authority so that it is sufficiently flexible to respond to its operating environment.	OHP is in the process of reorganizing into a more flexible organizational model based on functional tasks. However, this reorganization has not yet been completed.	N
R3.16 Involve program participants and stakeholders in planning: The State Medicaid Agency should seek feedback when revising (or developing) its strategic plan.	OHP's 2007 strategic planning process did not seek input from other Medicaid participants or external stakeholders. However, external stakeholders were involved in developing many of the initiatives (through the Governor's Turnaround Ohio initiatives and the legislative process). These were then considered in the strategic planning process. In addition, ODMRDD included stakeholders and ODJFS in its strategic planning development which was done through the MRDD Futures Committee.	N
R3.17 Involve internal staff in planning: The State Medicaid Agency should involve internal staff in strategic planning.	OHP's 2007 strategic planning process featured five open forums to solicit input from all levels of staff within its organization.	I
R3.18 Select an appropriate strategic management approach: The State Medicaid Agency should revise its approach to strategic management.	ODJFS's 2007 process of updating its strategic plan did not use any across-the-board management approach.	N
R3.19 Implement appropriate information technology to measure program outcomes: The State Medicaid Agency should manage its information needs based on its desired end goals, outcomes, and clinical measures.	Although ODJFS does continue to implement the HEDIS measurement system and is in the process of initiating a pilot program to collect and use data to improve health outcomes in the area of neonatal care, the Medicaid Program has not implemented any Program-wide initiatives to manage its information needs based on outcomes. ODJFS noted it is implementing MITS and making improvements to the existing Decision Support System and Data Warehouse to improve its ability to track program outcomes.	N
R3.20 and **R3.21.Manage employee skills within participating agencies, and improve human resources support:** The State Medicaid Agency should actively engage in skill set management and succession planning and should strengthen its human resources support structures.	OHP has initiated processes to identify the knowledge and skills of its existing employees, and to capture the essential knowledge of departing employees. These processes are still in progress. In addition, OHP expects the implementation of MITS to transform the organization's ability to track Program performance measures, achievement of goals, and status of Program initiatives.	P

Source: AOS 2006 Medicaid Performance Audit, ODJFS, ODMRDD, ODA, ODMH, ODADAS, ODH

[1] Due to the limited scope of this follow-up audit, Medicaid Program stakeholders were not interviewed. The analysis of the implementation of this recommendation is based exclusively on information provided by ODJFS and the sub-recipient State agencies.

Service Provision

Within the Ohio Medicaid Program, a number of changes have impacted Medicaid service provision. These changes include the implementation of a Medicaid buy-in premium assistance program.[4] Additionally, the State Medicaid Agency, as part of the 2005 Deficit Reduction Act, designed and implemented a Money Follows the Person (MFP) program. The program is aimed at relocating elderly persons and persons with disabilities from institutions to home and community-based settings and balancing the long-term services and support system. ODJFS estimates the program will enable about 2,200 seniors and persons with disabilities to relocate from institutions to home and community-based settings. Ohio may receive up to $100 million in federal matching funds over a five-year period for this program.

In March 2008, the State Medicaid Agency awarded the University of Cincinnati's College of Pharmacy a grant to conduct research on Medicaid prescription drug use. Partial funding for the research came from the Medicaid Technical Assistance and Policy Program (MEDTAPP). This research will provide data analysis and clinical/research services in support of the drug utilization review (DUR) program. ODJFS also contracted with a pharmacist to serve as the DUR Program Coordinator, whose role includes reviewing and analyzing consumer medical history profiles for specific drug therapy problems, reporting retrospective DUR activities to the DUR Board on a quarterly basis, and preparing and annually updating therapeutic exception criteria.

There have been some statutory changes that impact Medicaid service provision. These changes include:

- Ohio Administrative Code (OAC) § 5101:1-38-10 (E) requires that notice be given to the Ohio Attorney General's Office (AG) upon the death of anyone who was age 55 or older, or who was permanently institutionalized at the time of death by the person responsible for the estate. After death, whenever adjustment or recovery is sought by ODJFS or its designee, a claim for recovery must be presented by the AG's Office.

- Ohio Revised Code (ORC) § 2117.061 requires that a properly completed Medicaid estate recovery reporting form, listing all of the person's real and personal property and other assets that are part of the estate, be submitted to the section administrator of the Medicaid estate recovery program.

- Am. Sub. HB 119 required ODJFS to undertake and submit an analysis of the effect of Medicare Part D and the care management system by June 30, 2008. The analysis found a steady and significant increase in the collection of manufacturer drug rebates as a percent

[4] Beginning April 1, 2008, workers with disabilities earning up to 250 percent ($26,000 in 2008) of the federal poverty level were eligible to pay a monthly premium to continue Medicaid coverage.

of total Medicaid spending and an increase in the use of generic drugs (as opposed to name brand drugs).

- Am. Sub. HB 119 required that all child support orders include provisions for health insurance coverage. ODFJS has begun drafting administrative rules to require obligators of child support orders whose children are also on Medicaid to contribute toward their children's Medicaid expenses.

In addition, Am. Sub. HB 119 charged the Director of the Department of Aging to lead an inclusive workgroup to develop a Unified Long-term Care Budget (ULTCB). The ULTCB report, released May 30, 2008, examined the costs associated with both nursing home care and home and community-based services. The report calculated that a year in an Ohio nursing home costs, on average, $60,000. Comparable services provided through the PASSPORT waiver cost roughly $20,000. Moreover, the Miami University Scripps Gerontology Center estimates the number of individuals needing long-term care will peak as baby boomers age. By 2020, Ohio will have more than 220,000 older people with severe disabilities, an increase of more than 25 percent compared to 2005. ODA supports the use of home and community-based services as an alternative to institutional care and believes consumers prefer home and community-based services. Consequently, the ULTCB report emphasized a better balance between home and community-based services and institutional care.

The ULTCB report also made recommendations about long term care services. For instance, the report recommends the current number of beds serve as a cap for the total number of nursing facility beds and that Ohio maintain the certificate of need (CON). The ULTCB report further suggests that a stakeholder group, initiated by the Director of ODH, be convened to review existing CON criteria, identify an appropriate bed need formula, and discuss the need for and impact of the movement of beds between counties, a practice which is currently prohibited. This stakeholder group met for approximately two months. It was suspended on August 1, 2008 pending further review of issues impacting long-term care by the Administration. Furthermore, the report recommends that Ohio determine the feasibility and appropriateness of implementing a nursing facility bed buyback or conversion program.

Since the 2006 Ohio Medicaid performance audit was conducted, several states have implemented changes similar to the recommendations made within the audit. The following changes have been incorporated into other state Medicaid programs:

- In 2007, the District of Columbia, Georgia, Pennsylvania, Rhode Island, South Carolina, and Utah joined multi-state purchasing pools for prescription drugs.

- Maryland implemented a Money Follows the Person (MFP) program to improve the transition process from living in an institution to a community setting by increasing outreach and decreasing barriers to transition. Efforts resulting from MFP include peer

mentoring, enhanced transition assistance, improved information technology, housing assistance, flexible transition funds, and the addition of services to existing waivers. For instance, MFP augmented Maryland's existing Living at Home Waiver by providing access to environmental assessments, nutritionist/dietician services, and home delivered meals.

Table 1-3 illustrates the 2006 performance audit recommendations from the **service provision** section as well as the actions taken in response to the recommendations and the implementation status. The status of the recommendations is indicated by: I (fully implemented), P (partially implemented), or N (not implemented).

Table 1-3: Implementation Status of Service Provision Recommendations

2006 Recommendation	Actions Taken	Status
R4.1 Align eligibility with program goals: Ohio should review its eligibility coverage for all recipients in relation to Program goals.	Although ODJFS did make some changes to items such as the limit of disregard for families, increased asset levels for beneficiaries and changes the federal poverty level requirement, ODJFS has not reviewed eligibility in relation to Program goals.	N
R4.2 Reshape coverage using Deficit Reduction Act flexibility: The State Medicaid Agency should use the flexibility of the Deficit Reduction Act to reshape the Ohio Medicaid Program coverage.	According to ODJFS, it does not have the technology to redesign its covered services; however, once MITS is fully operational, it should be able to separate out Medicaid covered services to make them specific to certain populations. ODJFS also noted that most of the flexibility provided by the Deficit Reduction Act is directed toward non-mandatory groups.	N
R4.3 Implement the Disability Determination Consolidation Study Council recommendations: The State Medicaid Agency should implement the Disability Determination Consolidation Study Council's recommendation.	Am. Sub. HB 119 authorized ODJFS to work with the Rehabilitation Services Commission to reduce the duplication of eligibility activities performed by each agency. In June 2007, ODJFS requested electronic access to Social Security determinations and medical information. The Social Security Administration (SSA) denied the request for access to the SSA electronic case folder. ODJFS is still pursuing this issue.	N
R4.4 Opt to implement an employer-sponsored premium assistance program by using Section 1906 of the Social Security Act or Health Insurance Flexibility and Accountability (HIFA) Section 1115 waivers: Medicaid Agency should opt to implement an employer-sponsored premium assistance program and use Medicaid funds to purchase employer-sponsored group health insurance.	Although the report issued by the State Coverage Initiative Team, which was a Governor appointed group charged with developing health care coverage strategies to cover the uninsured, supported the implementation of a premium assistance program, one has not been established.	N

2006 Recommendation	Actions Taken	Status
R4.5 Develop a Medicaid Buy-In (MBI) premium assistance program.	A Medicaid Buy-In premium assistance program was implemented. Beginning April 1, 2008, workers with disabilities earning up to 250 % of the federal poverty level were eligible to pay a monthly premium to continue Medicaid coverage.	I
R4.6 Improve consistency and process for Medicaid spend-down: The State Medicaid Agency should implement a review of CDJFS spend-down eligibility.	ODJFS has provided spend down training to county JFS agenices, however training to providers and recipients has not occurred. ODJFS has a fact sheet and brochure regarding spend-down that is available on its web page and at the county departments of job and family services. In addition, ODJFS consumer hotline staff have been trained on spend-down to better address consumers' questions.	P
R4.7 Expand community-based long-term care services to enhance long-term care rebalancing efforts: The State Medicaid Agency should consider more proactive strategies toward expanding community-based services.	ODJFS has implemented the Money Follows the Person (MFP) Program; however, ODJFS is still developing a State Profile Tool that will be used to measure the success of the MFP program. In addition, Ohio expanded its assisted living Medicaid waiver program.	P
R4.8 Eliminate certificate of need and lift the moratorium on beds in Ohio: Ohio should eliminate certificate of need and lift the moratorium of beds in Ohio.	ODH has not developed a new bed-need formula. In addition, ODH indicated that the Administration is not pursuing the elimination of the CON.	N
R4.9 Take steps to ensure quality standards are met and readily available for comparison by consumers: With the removal of certificate of need, Ohio should ensure quality standards are met and readily available for comparison. Ohio may also consider quality of care fines.	The CON process remains in place and Ohio has not implemented the other components of this recommendation. ODH continues its surveys of nursing facilities to ensure quality standards are being met. ODA maintains a Long-Term Care Consumer Guide (www.ltcohio.org) that includes information about quality standards.	N
R4.10 In the event Ohio continues to use certificate of need to control construction and remodeling of nursing homes, it should update its certificate of need process.	There has been no changes to the CON process. Additionally, bed shifting among counties has not been authorized. The ULTCB workgroup analyzed the CON and alternatives for long-term care. As recommended, ODH convened a stakeholder group that met for two months and developed draft recommendations for revisions to CON criteria.	P
R4.11 Work with the long-term care industry to implement policies that reduce the number of beds in the system and redistribute them in a manner that provides access to Medicaid.	ODJFS has not implemented policies that reduce the number of nursing facility beds and redistribute them in a manner that meets the needs of the State. ODJFS believes that its rebalancing efforts will, over time, reduce excess capacity; however, this has not been completed.	N

2006 Recommendation	Actions Taken	Status
R4.12 Publish quarterly occupancy levels by county: The State should collect and publish quarterly occupancy by levels by county.	ODJFS continues to publish annual occupancy data, but has not identified a methodology to collect the data on a monthly or quarterly basis.	N
R4.13 Monitor nursing home facility quality and condition: The single State Medicaid Agency should monitor the nursing home industry for quality and the condition of its facilities.	Quality indicators are included in the rate-setting methodology under the new pricing system for nursing facilities. However, ODJFS has not monitored quality standards to determine any impact on these standards as a result of the new pricing system.	N
R4.14 Place nursing home reimbursement formula in OAC: The nursing home reimbursement formula should be removed from ORC.	The nursing home reimbursement formula has not been removed from the ORC. However, the statute no longer guarantees rate increases for providers.	N
R4.15 Require notice to the State upon death of a recipient: Ohio should add require that beneficiaries of assets must give notice upon death of the recipient.	The ORC has been amended to require the person responsible for the estate of a Medicaid recipient to notify the State upon death of the recipient. Additionally, the ORC requires that a properly completed Medicaid estate recovery reporting form be submitted to the section administrator of the Medicaid Estate Recovery Program.	I
R4.16 Implement a medication therapy management program for fee-for service recipients: The State Medicaid Agency should develop a medication therapy management pilot program for aged, blind and disabled Medicaid recipients that will not be enrolled into a managed care plan.	The State Medicaid Agency has not piloted a Medicaid Therapy Management (MTM) program. The State Medicaid Agency believes the development of this program would duplicate existing efforts due to some Medicaid claimants already receiving MTM as part of the Voluntary Medicare Prescription Drug Benefit Program.	N
R4.17 Contract out the retrospective drug utilization review program: The State Medicaid Agency should contract for its retrospective drug utilization review program.	In March 2008, ODJFS selected the University of Cincinnati's College of Pharmacy to conduct research on the evaluation of prescription drug use and will start sharing data with the University beginning in SFY 2009. In addition, the Agency contracted with a pharmacist to serve as its DUR Program Coordinator. However, ODJFS did not complete its DUR project related to behavioral health medications. The Agency indicated it will be able to complete the same work in-house in the future.	P

2006 Recommendation	Actions Taken	Status
R4.18 Monitor the effect of Medicare Part D on supplemental prescription rebates and increase generic substitution: The State Medicaid Agency should monitor the impact of Medicare Part D and managed care on the prescription drug program, specifically its supplemental rebates from manufacturers.	ODJFS monitored the impact of Medicare Part D and statewide managed care on the Medicaid prescription drug program by conducting analysis of pharmaceuticals as required under Am. Sub. HB 119. In SFY 2006, the State Medicaid Agency achieved a generic dispensing rate of 60.25 percent of all claims. However, the implementation of Medicare Part D increased generic dispensing rates in most states by about 3 percent. As of 2006, generic dispensing rates had reached over 69 percent in Massachusetts, Hawaii, and New Mexico and were above 67 percent in Illinois, Kentucky, Alabama, and Utah.	P
R4.19 Use waiver programs to implement pioneering approaches to services and coverage: The State Medicaid Agency should pursue pioneering approaches to services and coverage, through federal waivers.	The State Medicaid Agency was exploring a possible 1115 waiver as well as other waiver options for long-term services and supports delivery system within the ULTCB; however, it has not yet identified potential programs, services, or populations that would benefit from a 1115 or 1915(b) waiver. ODMRDD is working with ODJFS to develop an additional waiver for community-based services for children with intensive behavioral needs.	N
R4.20 Implement a Cash and Counseling or Independence Plus program: The State Medicaid Agency should develop and implement a Cash and Counseling or Independence Plus program in Ohio.	ODJFS indicated it had modified current waiver programs, Ohio Home Care and Transitions Carve-Out, to incorporate greater independence, such as in the area of self-administration of medications. However, both Cash and Counseling and Independence Plus models suggest more than the steps taken by ODJFS. Cash and Counseling provides recipients a flexible monthly allowance and Independence Plus gives beneficiaries individual budgets to manage services. The Choices waiver, which is administered by ODA and is a consumer-directed program, is scheduled to be expanded into northwest Ohio (currently available in central and southern Ohio).	P
R4.21 Implement a regular process to evaluate rates and rate setting methodologies, and set rates to achieve program purposes: The State Medicaid Agency should implement a regular process for the periodic evaluation of all Medicaid service rates and should examine each of its rate setting methodologies separately as it undertakes rate adjustment strategies.	In Spring, 2008, the State Medicaid Agency modified the reimbursement methodology to ensure the rates were commensurate with those paid by Medicare. However, ODJFS was unable to provide documentation of a regular process to evaluate all Medicaid service rates.	P

2006 Recommendation	Actions Taken	Status
R4.22 Improve the transparency of the rate-setting process: The State Medicaid Agency should consistently keep stakeholders and providers informed of pending rate changes and seek their input.	ODJFS recently shared information with providers explaining the State Medicaid Agency's methodology used to set rates. However, this communication was sent out after the rate setting process occurred. While ODJFS met with some stakeholders and providers, the State Medicaid Agency could make rate setting more transparent by consistently keeping stakeholders and providers informed of pending changes and seeking their input. Furthermore, OHP should formally document its rate setting prioritization and goals. ODJFS is pursuing a State plan amendment to move alcohol, drug addiction, and mental health services from a cost-based to a fee schedule payment system.	P
R4.23 Document the rate setting process and prioritization goals: The State Medicaid Agency should develop a policy containing goals for setting reimbursement strategies and rate reductions.	The State Medicaid Agency was unable to provide a documented policy containing detailed goals for rate setting reimbursement strategies. ODJFS targeted most frequently used services and modified rates to ensure that Medicaid rates were commensurate with Medicare rates. ODJFS communicated this process and the underlying rational in its provider newsletter.	P

Source: AOS 2006 Medicaid Performance Audit, ODJFS, ODMRDD, ODA, ODMH, ODADAS, ODH

Managed Care/Care Management

The expansion of managed care for Covered Families and Children (CFC) and select Aged, Blind, and Disabled (ABD) populations, which enrolled 1.3 million Medicaid consumers into managed care plans, was completed in June 2007. The State was divided into eight regions and each region is required to have a minimum of two and a maximum of three plans. After a scored application process, ODJFS selected managed care plans to serve each region. As of June 2008, Anthem and Wellcare stopped serving ABD recipients and, as there is no longer the minimum of two plans in the affected Northeast and Northwest regions, those consumers will either join a different managed care provider (MCP) or return to fee-for-service (FFS) arrangements. Additionally, Anthem no longer serves the CFC population as of April 2008 and those consumers could choose between the two remaining plans in the central and northeast regions.

State and federal regulation changes have been a key factor for the Ohio Medicaid Program. State regulation changes include a requirement that data be shared with the MCPs for better care coordination. As a result, ODJFS began sharing re-determination dates for consumers with the MCPs. Federal changes include the following:

- The Centers for Medicare and Medicaid Services (CMS) has tightened the cost reporting requirements for Medicaid, which have been added to all of the interagency agreements between ODJFS and the sub-recipient agencies.

- CMS also developed new rules regarding targeted case management services, which could affect consumers who receive services through multiple agencies. The new rules prohibit the use of multiple care managers and care teams. The new rule was scheduled to become effective on April 1, 2009; however, there is a moratorium[5] on the implementation of some of the rule changes. ODJFS has begun developing its State plan amendments in response to the rule changes.

There have been several changes to ABD and CFC contracts that impact managed care and/or care management. These changes include:

- OAC §5101:3-26, and ORC Chapter 4723 updated the definition of primary care providers to include advanced nurses and this change was reflected in the ABD and CFC contracts;
- Within the ABD and CFC contracts, pay for performance has been encouraged;

[5] The Supplemental Appropriations Act, 2008 (Public Law 110-252) was signed into law on June 30, 2008 and precludes CMS from taking any action prior to April 1, 2009 that would be more restrictive than applied on December 3, 2007 with respect to the provisions of CMS's interim final rule implementing section 6052 of the Deficit Reduction Act of 2005.

- ABD and CFC contracts include Health Plan and Employer Data Information Set (HEDIS) performance measures;
- Within the managed care contract, performance measures and provider panel standards are described; and
- ABD and CFC contract managed care plans have been updated to include more disease management and case management programs for various diseases.

Since the 2006 Ohio Medicaid performance audit was conducted, several states have implemented managed care and care management practices similar to those recommended by the audit. The following practices have been incorporated into other state Medicaid programs:

- Colorado and New York are piloting programs that target the ABD population by improving the delivery systems for the highest cost beneficiaries, thereby decreasing costs. New York is using a predictive algorithm to target high-cost beneficiaries for the next 12 months. Colorado is focusing on a care management continuum model to target high-cost consumers through plan, site and facility based care management programs.

- Arizona and Rhode Island are piloting new pay-for-performance programs at the provider level which will set common goals across plans. Arizona has proposed a program that does not directly pay providers but goes through the managed care plans' brokers. The broker gathers the state and plan payments for each provider and distributes a "global payment" to the providers. Rhode Island's program relies on the managed care plans to develop their own provider level incentives. The state then gives each plan the bonus payments to distribute to its providers.

- Idaho focused its performance program on diabetes disease management. The program started with six indicators that paid a certain amount to the provider for each diabetic patient. After the first year of the program, the state added six more indicators for incentives. As of July 2008, Idaho had delayed adding any other diseases to its disease management program.

- Indiana implemented the Select Care Program that targets its ABD, waiver, Adoption Assistance and Medicaid buy-in recipients. This program more effectively tailors the benefits to the members' needs while improving outcomes and controlling costs. The program focuses on assessing needs, designing a care management plan for those needs, coordinating care for the member, and finally, measuring outcomes for the members.

- Washington has implemented a Patient Activation Measurement (PAM) tool. PAM focuses on 13 questions to measure client confidence in self-management and understanding of health conditions. Chronically ill patients play a larger role in their disease management and care plans are tailored to the patients' ability and willingness to self-manage their care. Oregon also uses a PAM tool called CareSupport for its ABD

population. Oregon has determined that over 75 percent of these members are not optimally managing their diseases. The program trains case managers to help members manage their diseases through motivational interviewing. The goals of the program are to increase the managers' ability to help members self manage, improve member engagement, improve clinical outcomes, and reduce hospitalizations and emergency room visits.

Table 1-4 illustrates the 2006 performance audit recommendations from the **managed care/ care management** (MC/CM) section as well as the actions taken in response to the recommendations and the implementation status. The status of the recommendations is indicated by: I (fully implemented), P (partially implemented), or N (not implemented).

Table 1-4: Implementation Status of MC/CM Recommendations

2006 Recommendation	Actions Taken	Status
R5.1 Develop and use a meaningful system to monitor managed care and fee-for service delivery systems: The State Medicaid Agency should develop and use a meaningful evaluation system to monitor managed care and fee-for service delivery systems.	ODJFS completed the mandatory managed care process for CFC and ABD populations. There has not been adequate time to evaluate the implementation and operation of mandatory managed care. There is no change in the process used to evaluate the FFS delivery system.	N
R5.2 Pilot alternative care models and implement effective models in Ohio: The State Medicaid Agency should pilot and evaluate alternative care models to determine which programs would be most effective in Ohio.	ODJFS has not piloted any alternative care programs.	N
R5.3 Implement pay-for-performance: The State Medicaid Agency should implement pay-for-performance programs within the Ohio Medicaid Program and encourage the adoption of pay-for-performance within the sub-recipient agency programs.	ODJFS has not implemented any type of provider level pay for performance programs, although the Medicaid Care Management Working Group recommended developing an incentive program targeted at providers.	N
R5.4 Develop performance standards for the Aged, Blind, and Disabled managed care plans: The State Medicaid Agency should strengthen oversight of the Aged, Blind and Disabled (ABD) managed care program.	ODJFS has required MCPs to report clinical performance measures that are specific for the ABD population. ODJFS has begun collecting the data for these measures; however, due to newness of program there has not been sufficient time to analyze and report on the outcomes. Also, with MCPs pulling out of the ABD market, ODJFS will need to continue working with stakeholders to ensure access to care.	P
R5.5 Incorporate greater case management components for ABD managed care plans and implement non-medical case management: The State Medicaid Agency should incorporate greater case management components as a condition of service for managed care plans.	ODJFS has expanded the requirements for care management in the ABD contract, but has not piloted any new projects.	P

2006 Recommendation	Actions Taken	Status
R5.6 Pilot forms of behavioral health "carve in" managed care programs: The State Medicaid Agency should closely examine other states' practices of managing behavioral health and pilot different types of "carve in" and behavioral health managed care programs.	ODJFS has not piloted forms of behavioral health "carve in" managed care programs.	N
R5.7 Collect data for all HEDIS indicators of managed care clinical performance and collect fee-for-service performance measures: The State Medicaid Agency should immediately begin collecting data for all HEDIS indicators to monitor managed care plan clinical performance.	ODJFS continues to use some "home grown" performance measurements that differ from HEDIS. ODJFS has recently contracted with a private company to study how to move to full HEDIS. The Agency is also considering "deeming", under which it would recognize accreditations from other entities, such as the National Committee for Quality Assurance (NCQA). The NCQA requires MCPs to gather all HEDIS measures.	P
R5.8 Improve the use of consumer surveys: The State Medicaid Agency should improve the use of the consumer survey (CHAPS) to monitor recipients' access to care, customer service concerns, and perceptions of unmet medical needs.	There have been no changes to improve the use of CAHPS consumer survey. While there are no changes to the CAHPS survey, ODJFS indicated it has contracted with the Ohio State University to conduct the 2008 Ohio Family Health Survey. This survey was previously conducted in 2004 to investigate health care status and health insurance coverage among the entire Ohio population.	N
R5.9 Enforce prompt payment of provider claims by managed care plans and review pending and denied claims: The State Medicaid Agency should enforce the requirements surrounding the prompt payment of individual claims by each managed care plan.	Both the CFC and ABD contracts have provisions detailing prompt payment. There are also prompt payment audit reports which explain how each of the reviewed MCPs performed in compliance with ODJFS rules. ODJFS has not required monthly aging reports.	P
R5.10 Include services provided by additional specialty types under Medicaid: The State Medicaid Agency should seek approval from the General Assembly to include services provided by additional specialty types.	OAC, ORC, and CFC and ABD contract sections have been updated to include advanced practice nurses in the definition of primary care providers.	I
R5.11 Ensure physician access standards are appropriate for Ohio Medicaid managed care plans: The State Medicaid Agency should examine the time and distance standards, as well as the usefulness of its ratios, in determining appropriate numbers of physicians and dentists required under contract with its managed care plans.	There have been no new methods of evaluating providers' proximity to the recipients.	N

2006 Recommendation	Actions Taken	Status
R5.12 Improve access to providers through diversifying delivery system partners, using risk-sharing models, and improving administrative processes: The State Medicaid Agency should take steps to improve access to providers.	ODJFS and sub-recipient agency staff reported that communication with MCPs has improved. Churning issues have been improved through ODJFS sharing re-determination dates with MCPs, as was statutorily mandated.	P
R5.13 Offer alternatives, incentives, or increased rates to ensure access to hard to find specialists: The State Medicaid Agency should consider offering alternatives to joining a managed care plan to hard-to-find specialists and dentists.	MCPs must assure access to all medically necessary services for their recipients. If an MCP does not have a particular provider in its network and a member requires care from this provider, then the services must be approved.	P
R5.14 Implement community-based low birth weight programs and seeks to expand community-based programs into other areas: The State Medicaid Agency should seek to implement low birth weight programs throughout the State.	Although ODJFS has not implemented CHAPS, Ohio received a Medicaid Transformation Grant, for a Neonatal Project to improve neonatal outcomes.	P
R5.15 Lengthen re-determination periods to reduce churning: The State Medicaid Agency should examine the re-determination schedule and strongly consider lengthening the time between re-determination periods, particularly for the ABD population.	During the 2006 audit, the re-determination schedule was every six months. As of September 2007, recipient re-determination dates are shared with the MCPs and most recipients are on a 12-month cycle.	P
R5.16 Implement case management for fee-for-service programs: The State Medicaid Agency should implement a case management program for all Medicaid recipients remaining in fee-for-service and not enrolled in a waiver program in which case management is already a component.	ODJFS has a prescription drug management program for fee-for-service recipients but does not have any other programs at this time. There have been changes at the federal level regarding Targeted Case Management and ODJFS is in the process of filing State plan amendments to address the changes. ODJFS is researching possible federal-approved programs that can be used to enhance care management to the ABD population. The federal rule changes greatly affect consumers who receive services through multiple agencies, such as someone receiving their medical services through a home care waiver but also receiving mental health therapies from a local Alcohol, Drug Abuse, and Mental Health Board.	N
R5.17 Ensure consistent case management services between managed care and fee-for-service: The State Medicaid Agency should mandate the managed care plans to expand their case management programs to include the same diseases as the fee-for-service case management model.	ODJFS has not implemented comprehensive case management for FFS and therefore has not expanded its requirements for MCPs.	N

2006 Recommendation	Actions Taken	Status
R5.18 Develop program-wide case management: The State Medicaid Agency should work with sub-recipient agencies to develop a program-wide case management system.	Although a Program-wide case management system has not been developed, the ATLANTES System is being configured to collect patient assessment and care plan data for ODJFS-administered Ohio Home Care, Transitions MR/DD, and Transitions Carve-Out waivers.	N
R5.19 Implement disease management for fee-for service recipients: The State Medicaid Agency should implement a disease management program for Medicaid fee-for-service recipients.	ODJFS has not implemented any type of disease management program for FFS recipients.	N
R5.20 Require managed care plans to expand the focus of disease management programs: The State Medicaid Agency should encourage the managed care plans to expand their focus of disease management and case management.	The ABD and CFC contracts stipulate the member medical conditions that must be managed. Although some of the diseases recommended in the performance audit are not included, the plans have been expanded.	I
R5.21 Develop and use benchmarks to measure improvements in health outcomes due to disease management programs: The State Medicaid Agency should develop benchmarks that would measure each disease and the improvements in health outcomes due to the expanded disease management program.	ODJFS is in the process of using CY 2007 as a benchmark to measure improvements in health outcomes achieved by disease management programs; however, it has not had enough time to measure the effectiveness of disease management programs.	P
R5.22 Develop means to provide disease management continuity as Medicaid recipients transition off Medicaid: The State Medicaid Agency should investigate means to assist its transitioning recipients in continuing their disease management program.	No means to provide disease management continuity as Medicaid recipients transition off Medicaid have been developed. ODJFS's application for the transformation grant was denied by CMS.	N
R5.23 Enhance utilization review and utilization management: The State Medicaid Agency should begin evaluating Medicaid health care expenditures through enhanced utilization review and/or utilization management.	ODJFS has made progress toward coordination with the sub-recipient agencies through interagency agreement changes as well as continuing to use SURS reviews.	P
R5.24 Track and report participation in the Primary Alternative Care and Treatment (PACT) program: The State Medicaid Agency should track and report participation in PACT, the program used to manage recipients with a history of over-utilization of services, and the potential cost avoidance generated by member participation in the program.	ODJFS indicated it was tracking PACT enrollment and had initiated a study to assess impact PACT had on cost containment and consumer utilization. As managed care is expanded, the PACT enrollment has decreased significantly and the MITS implementation is expected to help ODJFS assess the cost avoidance and consumer utilization of the program.	P
R5.25 Expand the use of State universities to research and administer related programs: The State Medicaid Agency should expand its use of State universities to research and administer Medicaid-related projects.	ODJFS has begun four new MEDTAPP projects with State colleges and university through the Ohio Board of Regents.	P

2006 Recommendation	Actions Taken	Status
R5.26 Implement a High Risk Pool program for uninsured Ohioans: The General Assembly and the Governor, should implement a High Risk Pool program for uninsured Ohioans and access funding available under U.S. Senate Bill 288.	The Governor's Turn Around Ohio initiative proposed, and the General Assembly enacted, a Children's Buy-In program (CBI) for children who could not otherwise be covered by health insurance due to catastrophic circumstances. The CBI program was implemented April 1, 2008; however, no one had been enrolled at the time of this analysis.	P
R5.27 Implement a Premium Assistance/Covered at Work program for uninsured Ohioans: The State Medicaid Agency should apply for a federal demonstration waiver to implement a Premium Assistance/Covered at Work program for uninsured Ohioans.	There has not been a Premium Assistance/ Covered at Work program implemented for uninsured Ohioans. The Governor's Initiative on Health Care Reform is researching the possibility of a premium assistance program for the working population that are self-insured or whose employers do not offer health coverage.	N
R5.28 Pilot and test programs for the uninsured in Ohio: The State Medicaid Agency should use Ohio State-funded universities to examine programs for the uninsured in Ohio, their financial impact, and the impact of the uninsured on Medicaid.	There have been no pilot or test programs for the uninsured in Ohio.	N

Source: AOS 2006 Medicaid Performance Audit, ODJFS, ODMRDD, ODA, ODMH, and ODADAS

Technology

The Medicaid Information Technology System (MITS) is expected to be functional in October 2009, replacing the Medicaid Management Information System (MMIS). The MITS system is expected to have a major impact on Ohio Medicaid technology and should allow for increased flexibility to adapt to evolving technology needs within the Medicaid Program. MITS is expected to:

- Further the use of technology during the eligibility determination process;[6]
- Provide a platform for automating work processes;
- Accept information submitted from external systems, regardless of format;
- Provide a web portal for eligibility and claims submission;
- Potentially assist in the consolidation of data warehousing functions, including the potential for storage of non-Medicaid information; and
- Allow real-time access to information instead of the current point-in-time access.

The EMMA Consolidation Exploration Team subcommittee has reportedly increased communication among all Medicaid agencies. The subcommittee's challenge is to identify opportunities to consolidate business processes across Medicaid agencies with a particular focus on the Medicaid Information Technology Architecture (MITA) and MITS. According to ODJFS, EMMA is discussing various technology issues such as centralized claims processing, electronic health records, and data warehousing. The subcommittee's charter and membership were recently established. The subcommittee has only begun its work and has not completed any work products.

In addition to the implementation of MITS, ODJFS has created a pre-emptive third-party liability system which identifies and bills applicable third-party insurers instead of the Medicaid Program. ODJFS has set up a system to check eligibility with major insurance carriers within the State to determine whether patients are insured. When a private insurer is identified, medical claims are billed to the insurer rather than Medicaid, the payer of last resort.

Since the 2006 Ohio Medicaid performance audit was conducted, several states have implemented technology initiatives similar to those recommended within the audit. The following technology initiatives have been incorporated into other state Medicaid programs:

- Texas has implemented the Texas Integrated Eligibility Redesign System (TIERS), which is an integral part of the Texas Health and Human Services Commission's efforts to modernize its eligibility system. The TIERS online query system connects with the Social Security Administration using a secure Internet line for instant verification of eligibility

[6] MITS will not replace the eligibility system (Client Registry Information System –Enhanced (CRIS-E)) that is used for Medicaid determination. Rather, MITS will enhance determinations of eligibility for waiver programs.

information. TIERS also links to two dozen government agencies to enhance data collection and save time. These interfaces allow TIERS to retrieve extensive data, including birth certificates, credit information, and number of school-age children in the household, as well as welfare fraud sanctions and data on unpaid child support obligations. The system will help the state better match consumer needs with state programs, while reducing fraud and repetitious work for employees.

- The Mississippi Medicaid Program is saving approximately $1.2 million per month in prescription costs as a result of equipping 225 doctors with handheld e-prescribing devices. Prescribers who use the handheld devices write fewer prescriptions on average, which reduces costs to the state. After 18 months of steady savings, the Mississippi Division of Medicaid is negotiating with its contractor to expand the e-prescribing program. The state is also saving nearly $27,000 per month ($324,000 per year) on hospitalizations avoided because the prescribers receive real-time alerts about drug interactions. The program costs the state approximately $35,000 per month ($420,000 per year).

- New York City has equipped doctors with computer software that tracks patients' medical records. The program is intended to help doctors provide better preventive care. The new system provides doctors with up-to-date information through a series of alerts and shares data with other doctors. The program also provides information about the current best practices for treating illnesses. Two hundred doctors with 200,000 patients have committed to using the system, and the City hopes to have 1,000 doctors with one million patients using it by the end of the 2008. The system also provides the health department with general data from health care providers, although individual patient information is restricted to doctors and the patients. The cost of the system was approximately $60 million, with approximately $30 million paid by the City and $30 million by the State and Federal Governments.

- Medicaid recipients in Leon County, Florida, which includes the City of Tallahassee, are piloting an electronic health records (EHR) program. The program creates EHRs for the 25,000 Medicaid recipients in the county by collecting medical information from the diagnostic and procedural codes entered for a patient's Medicaid claim and assembling the data into a single coherent file. The information is sent electronically to the state's existing Medicaid Management Information System. The resulting file then becomes a foundation for an individual health record, consolidating key information such as current health records, lab results, and X-rays.

Table 1-5 illustrates the 2006 performance audit recommendations from the **technology** section as well as the actions taken in response to the recommendations and the implementation status. The status of the recommendations is indicated by: I (fully implemented), P (partially implemented), or N (not implemented).

Table 1-5: Implementation Status of Technology Recommendations

2006 Recommendation	Actions Taken	Status
R6.1 Create a State Coordinator for Health Information Technology position to improve health information leadership: Ohio should create the position of State Coordinator for Health Information Technology to provide leadership in creating a single statewide consumer-centric health information technology infrastructure.	Although the position of State Coordinator for Health Information Technology was not created, OHP and many stakeholders from around the State participate in a Health Information Partnership Advisory Board (HIPAB) which researches and shares best practices in health information technology.	P
R6.2 Develop a long-term health information technology plan: The State Coordinator for Health Information Technology should facilitate a long-term strategic plan which identifies the State's technology needs for the next five years.	ODJFS has not developed a long-term strategic plan which identifies the State's technology needs beyond the two-year plan required by the Office of Information Technology.	N
R6.3 Solicit feedback from stakeholders when implementing Medicaid technology changes: The State Medicaid Agency should solicit input when implementing changes to Medicaid technology and should facilitate an on-going workgroup which includes all provider groups and agencies that have a role in the claims process.	The Governor created EMMA which discusses Medicaid technology issues between agencies.	I
R6.4 Require electronic storage of recipient eligibility information at county offices: The State Medicaid Agency should adopt a policy requiring the electronic storage of recipient eligibility verification information in county-level offices.	This recommendation was included in Am. Sub. HB 119, but was vetoed by the Governor.	N
R6.5 Allow Medicaid applicants to complete eligibility determination forms on-line.	Some specific potential recipients are able to pull and fill out various Medicaid eligibility forms online prior to submitting them, but recipients must still go to County offices to apply.	P
R6.6 Install kiosks at high volume county offices to allow applicants to apply for services without meeting with a caseworker: The State Medicaid Agency should pilot an initiative to streamline the eligibility process by installing kiosks at county offices with high caseloads.	This recommendation was not implemented and ODJFS has not had discussions regarding kiosks at county offices. Ohio has implemented the Ohio Benefit Bank, which is a web-based computer program to connect low and moderate-income Ohioans with access to work supports such as tax credits and public benefits. However, the Benefit Bank does not have an on-line application system for public benefits.	N

2006 Recommendation	Actions Taken	Status
R6.7 Implement e-prescribing for the Medicaid Program in Ohio: The State Medicaid Agency should pilot an e-prescribing program and develop a plan to implement e-prescribing statewide.	E-prescribing has not been fully implemented. ODJFS is entering into a contract with a vendor to provide pharmacy history online for providers to access. This will allow providers to access patient specific information/data and enable providers to access Preferred Drug List. The target go-live date is August 25, 2008	P
R6.8 Pilot pre-emptive benefits coordination: The State Medicaid Agency should pilot an automated pre-emptive coordination of benefits process.	ODJFS has created an in-house preemptive coordination of benefits system which allows it to check recipient third party eligibility information.	I
R6.9 Centralize claims acceptance within the State Medicaid Agency: As part of the implementation of the new Medicaid Information Technology System, the State Medicaid Agency should design a workflow model which centralizes claims acceptance with the State Medicaid Agency but pulls information from systems used by ODA and ODMRDD.	Claims acceptance has not been centralized.	N
R6.10 Use electronic file transfer to reduce manual entry of eligibility data by ODA: ODA and the State Medicaid Agency should review the processes which results in the manual entry of Medicaid eligibility data and should transfer this information through electronic file transfer.	Both agencies have acknowledged the need to share information; however, it has not been a priority, mainly due to the MITS implementation.	N
R6.11 Consolidate and centralize data warehousing activities: The State Medicaid Agency should consolidate the data warehousing activities of various State agencies and centralize the data warehouse environment.	Data warehousing activities have not been consolidated, but ODJFS is looking into the functionality of the MITS system and its reporting capabilities.	N
R6.12 Develop regional health information organizations (RHIO) to collect clinical outcome data and create a statewide health information network: The State Medicaid Agency should develop RHIOs which will collect clinical outcome data as it becomes available and then link RHIOs thereby creating a statewide health information network. **R6.13 Encourage the adoption of electronic health records**	Although these recommendations have not been fully implemented, the Governor's Executive Order 2007-30S states that the Health Information Advisory Board will develop an operational plan which will include a business proposal for creating a state-level, public/private organization to coordinate ongoing efforts to implement a strategy for the adoption and use of electronic health records and exchange of health information.	P

2006 Recommendation	Actions Taken	Status
R6.14 Reduce paper claims submissions: The State Medicaid Agency should identify the reduction of paper claims submissions as a formal strategic objective.	ODJFS developed a web-portal for claims submission which went into full production on July 1, 2008. Use of the web portal is not mandated. ODJFS publicizes electronic submission on its website by listing the trading partners to promote them and their use. It also offers free training and reconciliation of claims and upfront editing to find errors prior to submitting for payment. The number of claims submitted in paper format has decreased from 7.7 million in 2004 to 4.3 million in 2007. Based on the first 6 months, paper claims will be reduced to approximately 3.2 million in 2008. If ODJFS continues at this pace and the cost avoidance per paper claim reduced is consistent with the estimates in the 2006 performance audit, the State will avoid about $700,000 in claim processing costs.	I
R6.15 Require electronic claims submission: The State Medicaid Agency should adopt a formal policy requiring all providers to submit claims electronically unless explicitly permitted to submit paper claims by the State Medicaid Agency.	ODJFS has not mandated electronic claims submission for all providers. ODJFS reported that it has mandated electronic claims submissions for nursing facilities and will review this for other providers after MITS is implemented .	P
R6.16 Change State statute to allow the State Medicaid Agency to regulate claims submission processes: The State Medicaid Agency should pursue changes to the OAC to emphasize the change to electronic processes and allow the State Medicaid Agency to regulate claims submissions.	There have been no administrative rule changes regarding claims submission.	N
R6.17 Create an Office of Information Security to centralize participating agencies response to information security: The State Medicaid Agency should include an Office of Information Security, which is charged with developing a centralized response to information security and privacy needs. **R6.18 Organize a privacy review committee:** The Office of Information Security should also be charged with organizing and chairing a privacy review committee.	Although the Office of Information Security and privacy review committee have not been created, ODJFS has a security policy in place as well as a Chief Security Officer and Security Committee process for review of external requests for access to ODJFS data.	P

2006 Recommendation	Actions Taken	Status
R6.19 Develop a coordinated strategy for communicating with providers: The State Medicaid Agency should develop a coordinated strategy for communicating with providers.	ODJFS has decreased the number of provider customer service numbers listed on the website. It has also opened various lines of communication to providers, although the Medicaid agencies are still in the process of consolidating help desk functions. Once the transition is complete, the consolidation is intended to give providers a single point of contact for all claims processing needs.	P

Source: AOS 2006 Medicaid Performance Audit, ODJFS, ODMRDD, ODA

Program Integrity

Program integrity at the federal level has been impacted by the creation of the Medicaid Integrity Program, a comprehensive federal strategy to prevent and reduce fraud, waste, and abuse in the Medicaid Program. The Medicaid Integrity Program consists of two groups—the Medicaid Integrity Group (MIG) and the Medicaid Integrity Institute (MII). The MIG was created in 2006 and its responsibilities include overseeing contractors who review and audit Medicaid provider claims. It also conducts provider education, and data mining and analysis to identify emerging trends in Medicaid fraud and abuse. It also provides support and assistance to states regarding fraud, waste, and abuse by developing initiatives, identifying best practices, and providing technical assistance.

MII began in federal fiscal year 2008 and is part of an interagency agreement between the Centers for Medicare and Medicaid Services (CMS) and the Department of Justice. CMS provides funding to develop training for the state Medicaid staff on program integrity issues, such as interacting with the media, managing staff, data analysis techniques, working with vendors, and other essentials of program integrity. MII's goal is to focus on courses taught by experts in the area of program integrity.

Within the Ohio Medicaid Program, program integrity operations were impacted by the creation of the EMMA Legal and Program Integrity Subcommittee. This subcommittee plans to coordinate system-wide program integrity goals and objectives within all Medicaid agencies, and centralize program integrity-related communication, education, monitoring, and training.

Several State law changes have impacted program integrity. These changes include:

- Am. Sub. HB 119 required ODJFS to phase in the use of time-limited Medicaid provider agreements during a period beginning no later than January 1, 2008 and ending January 1, 2011. OAC §5101:3-1-17.4 specifies the length and type of provider agreements. Time-limited provider agreements are for a specific period of time and expire on a designated date unless renewed in accordance with the ODJFS re-enrollment process. The time-limited agreements are for a period no longer than three years from the effective date. OAC gives ODJFS the authority to determine the length of time-limited agreements, depending on provider type, but requires the length of the agreement to be consistent for all like provider types.

- Am. Sub. HB 119 required ODJFS to conduct a cost-benefit analysis associated with participating in the Public Assistance Reporting Information System (PARIS). The report found participation to be cost effective and ODJFS became the 44th jurisdiction to join PARIS.

- OAC 5101:3-26-06 (B) authorizes ODJFS or its designee, as well as the Auditor of State, Attorney General's Medicaid Fraud Control Unit (MFCU), and U.S. Department of Health and Human Services to evaluate or audit a managed care plan's performance. Provider compliance with the OAC rule is referenced in the Ohio Medicaid Assistance Provider Agreements for Managed Care Plans.

Table 1-6 illustrates the 2006 performance audit recommendations from the **program integrity** section, as well as the actions taken in response to the recommendations and the implementation status. The State Medicaid Agency has not implemented many of the program integrity-related recommendations because it asserts these issues will be resolved with the implementation of MITS. The status of the recommendations is indicated by: I (fully implemented), P (partially implemented), or N (not implemented).

Table 1-6: Implementation Status of Program Integrity Recommendations

2006 Recommendation	Actions Taken	Status
R7.1 Develop and implement a comprehensive risk assessment planning process: The State Medicaid Agency should develop a comprehensive, risk assessment planning process to identify and measure risks and establish goals and objectives and performance measures.	The Medicaid Program Integrity Group is in the final stages of completing a statewide risk assessment of the Ohio Medicaid Program by the major category of service groupings in the program.	P
R7.2 Track and monitor the results of provider background and fingerprint checks: The State Medicaid Agency should track and monitor the results of provider background and fingerprint checks and require State sub-recipients agencies to ensure that all Medicaid providers obtain State and federal-level checks.	ODJFS does not track and monitor the results of background and fingerprint checks for providers who apply for Medicaid certification. Also, the interagency agreements with Medicaid agencies do not require that all providers submit to State and federal-level checks.	N
R7.3 Link surety bonds to provider risk levels: The State Medicaid Agency should link surety bond-related requirements to a formal risk assessment plan and accompanying risk measures and should require that any provider who has ever been investigated for fraud obtain a surety bond.	This recommendation was not enacted under Am. Sub. HB 119 and ODJFS is no longer pursuing this recommendation.	N
R7.4 Require providers to reenroll in Medicaid at least once every three years: The State Medicaid Agency should require that all providers, regardless of the State sub-recipient agency to which they report, periodically re-enroll in Medicaid at least once every three years.	Am. Sub. HB 119 requires ODJFS to phase in the use of time-limited Medicaid provider agreements between January 2008 and January 2011.	I

2006 Recommendation	Actions Taken	Status
R7.5 Purge inactive providers from the Medicaid information system: As Ohio moves to implement national provider identifiers, the State Medicaid Agency should purge all inactive provider numbers, as recommended by the Commission and Government Accountability Office.	ODJFS purged all inactive provider numbers in September 2005 and April 2008. With the implementation of time-limited provider agreements (see **R7.4**), the Medicaid information system will reflect active providers.	I
R7.6 Become an active participant in the Public Assistance Reporting Information System (PARIS): The State Medicaid Agency should join and participate as an active member of the PARIS program.	Am. Sub. HB 119 required ODJFS to perform a cost/benefit analysis regarding participating in PARIS and, if it was cost beneficial, to join the program. ODJFS became the 44th jurisdiction to join PARIS; the first data match was conducted in August 2008.	I
R7.7 Centralize Medicaid program integrity related training, education and monitoring activities: The State Medicaid Agency should centralize program integrity-related training, education and monitoring activities with a program integrity manager or Medicaid Chief Inspector who is independent of OHP.	Program integrity-related training, education, and monitoring activities have not been centralized.	N
R7.8 Provide explanation of benefit statements to all Medicaid recipients. Although ODJFS's EOB survey process has been recognized as a best practice, the State Medicaid Agency may wish to consider providing explanation of benefits to all Medicaid recipients when it issues monthly Medicaid cards.	Limitations on MMIS resources prevent ODJFS from providing an explanation of benefits to all providers. The State Medicaid Agency believes that the implementation of MITS will enable it to implement this recommendation.	N
R7.9 Publish State-disciplined and federally-excluded providers on a central, public web site: The State Medicaid Agency should publish State-disciplined and federally-excluded providers on a centralized, public website.	ODJFS has information regarding sanctioned or terminated providers on its web site; information regarding federally-excluded providers is available on the U.S. Health and Human Services Office of Inspector General web site.	I
R7.10 Centralize coordination and monitoring of the recovery audit/review process: The State Medicaid Agency should centralize coordination and monitoring of the recovery audit/review process with a program integrity manager or Medicaid Chief Inspector who is independent of OHP.	ODJFS has not created a program integrity manager independent of OHP. The State Medicaid Agency is in the process of assessing the coordination and monitoring of the recovery audit review process through the development of an internal workgroup.	P

2006 Recommendation	Actions Taken	Status
R7.11 Ensure that provider recovery audits/reviews are conducted under consistent procedures, in accordance with standard auditing practices. The program integrity manager or Medicaid Chief Inspector should work to ensure that provider recovery audits/reviews are conducted consistently, in accordance with standard auditing procedures.	Limited or desk reviews are not conducted under consistent procedures and in accordance with standard auditing practices. Furthermore, ODJFS has not consolidated the recovery audit/review procedure development process, instead delegating and fragmenting these responsibilities among sub-recipient and other State agencies. ODJFS, ODMH, and ODADAS recently established a Behavioral Health System Audit Team to review all auditing functions within the systems and identify ways to streamline processes and eliminate redundancies.[1]	N
R7.12 Centralize post-payment and cost reconciliation auditing: If centralization and improved oversight are ineffective, the State Medicaid Agency should consider encompassing all post-payment and cost report reconciliation auditing under its auspices.	ODJFS indicated it supports the centralization of post-payment and cost reconciliation auditing for sub-recipient agencies; however, implementation would require rule changes.	N
R7.13 Consider using neural networking to identify fraudulent providers: The State Medicaid Agency should examine the use of neural networking as a means of identifying fraudulent patterns.	ODJFS is supportive of neural networking, subject to the availability of resources to plan, develop, and implement such a program.	N
R7.14 Update managed care contracts to allow the Surveillance and Utilization Review Section (SURS) and Auditor of State (AOS) to audit/review all data related to a claim: The State Medicaid Agency should update its contracts with managed care plans to formally stipulate that SURS and AOS personnel may periodically audit/review all data related to a claim.	Per revised OAC, ODJFS or its designee can evaluate or audit a managed care plan's performance.	I
R7.15 Establish a Medicaid Chief Inspector position wholly responsible for Medicaid program integrity functions: The State Medicaid Agency should consider establishing a Medicaid Chief Inspector position that is wholly responsible and accountable for all program integrity functions.	The establishment of the position of a Medicaid Chief Inspector position was not implemented.	N
R7.16 Develop and publish a comprehensive program integrity annual report: The State Medicaid Agency should develop and publish one annual report that provides operational and financial statistics on efforts to minimize fraud, waste, and abuse.	ODJFS has not taken steps toward publishing a comprehensive annual program integrity report.	N

2006 Recommendation	Actions Taken	Status
R7.17 Establish and monitor program integrity related goals and measures, and adjust program integrity efforts based on outcomes; The State Medicaid Agency should establish specific goals and measures for reducing improper payments and periodically monitor the progress in achieving the established performance measures.	ODJFS has not developed goals related to program integrity.	N
R7.18 Develop universal and comprehensive performance measures for Medicaid program integrity: The State Medicaid Agency should develop universal and comprehensive performance measures.	ODJFS has not developed universal and comprehensive performance measures related to program integrity.	N

Source: AOS 2006 Medicaid Performance Audit, ODJFS, ODMRDD, ODA, ODMH, ODADAS

[1] The review of auditing functions was initiated as part of a Memorandum of Understanding (MOU) reached in response to a lawsuit filed by a behavioral health care provider. The MOU calls for ODJFS, ODMH, and ODADAS to reduce inconsistencies and duplicative or conflicting auditing requirements for behavioral health care providers.

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