OHIO AUDITOR OF STATE
KEITH FABER

Ohio Department of Medicaid

IMPROPER CAPITATION PAYMENTS

Auditor of State Report

December 28, 2021

OHIO AUDITOR OF STATE
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Letter from the Auditor

To the Governor's Office, General Assembly, Director and Staff of the Ohio Department of Medicaid, Ohio Taxpayers, and Interested Citizens:

The Auditor of State's Office recently completed an audit regarding monthly per member per month capitation payments made by the Ohio Department of Medicaid (the Department) to its contracted managed care organizations. This audit focused on duplicate payments due to a recipient having multiple identification numbers; payments for individuals not eligible for managed care due to their incarceration in a state facility; and payments for recipients in the month following their death. This audit was initiated in response to findings identified by a federal agency on Ohio's program and audits of Medicaid programs in other states.

The audit found that, while the Department has processes in place to identify and recoup erroneous payments, a significant number of these payments went unidentified and were not recouped. Medicaid is Ohio's largest program, with annual spending of approximately $28.2 billion in state fiscal year 2020 and 64 percent of the dollars expended in the program go to the managed care organizations. To ensure that the significant financial resources dedicated to this important program are managed efficiently, it is imperative that the capitation payments be accurate.

This audit report contains recommendations, supported by detailed analysis, to enhance the Medicaid program. The report has been provided to the Department and its contents have been discussed with the appropriate staff and leadership within the Department. It is the Auditor's hope that the Department will use the results of the audit as a resource for improving operational efficiency.

This audit report can be accessed by visiting the Auditor of State's website at ohioauditor.gov and choosing the "Search" option.

Sincerely,

Keith Faber
Auditor of State
Columbus, Ohio

December 28, 2021

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Executive Summary

The majority of individuals covered by Ohio's Medicaid program are enrolled with a managed care organization (MCO). The Department of Medicaid (Department) sends a monthly payment to the selected MCO for each enrolled individual and this monthly payment is referred to as a capitation payment. The Department makes the capitation payment regardless of whether the Medicaid recipient receives any medical care. In return, if the recipient does receive medical care, the MCO is responsible for the payment. Used effectively, managed care can help states reduce Medicaid costs; however, the risk of making incorrect payments, such as duplicate payments or payments for ineligible recipients, still exists in managed care. We conducted this audit to determine if the Department made improper Medicaid managed care capitation payments during state fiscal years (SFY) 2018 through 2020 (July 1, 2017 through June 30, 2020).

The audit objectives were to identify any duplicate capitation payments, capitation payments for incarcerated adults and capitation payments for deceased individuals that the Department did not subsequently take back (recoup). We analyzed data from the Department and from the Quality Decision Support System (Medicaid database) and matched this information to data from the Ohio Department of Rehabilitation and Corrections (ODRC) and the Ohio Department of Health (ODH) to meet the audit objectives.

We identified over $118.5 million in improper capitation payments that had not been recouped by the Department in these three fiscal years. Additionally, we found recipients in each SFY that were missing a first and last name or did not have an accurate name. For example, instead of a name, the system showed a number. There were also recipients with inaccurate dates of birth (DOBs) in each SFY. For example, the year of birth was 1899. Finally, there were over 80,000 recipients with an invalid social security number (SSN) such as 000-00-0000 or 999-99-9999.

Duplicate Capitation Payments

We found 11,089 SSNs in which each SSN linked to two Medicaid recipient identification numbers (IDs), 91 SSNs in which each SSN linked to three recipient IDs and four SSNs in which each was linked to four recipient IDs. The Department made 61,852 capitation payments totaling $29,175,678 on behalf of recipients with the same SSN. This amount reflects the total payment - both the original and the duplicate payments. As a result, approximately $14.5 million were for duplicate capitation payments that were not recouped by the Department.

We also performed a data match using the last name, first four letters of the first name and DOB to identify any additional duplicate recipients. This resulted in 15,597 potential additional matches and capitation payments of approximately $135 million. We did not remove any associated recoupments for these payments. We provided the Department with these matches to further determine whether these were confirmed matches and if duplicate capitation payments were made and not recouped. If these are confirmed as duplicates, the savings to the program could be as much as $67.5 million.

Capitation Payments for Incarcerated Individuals

We obtained a data file from the ODRC for all adults incarcerated at a state institution during the audit period. We matched Medicaid recipients against the ODRC data file using the last name, first four letters of the first name, SSN, and DOB. We found 29,412 recipients and 160,850 capitation payments totaling over $100 million during a period of incarceration that were not recouped.

We also identified capitation payments made for individuals that matched the ODRC data file using the same name and DOB, but the SSN did not match or with the same name and SSN, but the DOB did not

match. This resulted in 1,281 potential matches with over $4 million in additional payments. This amount does not reflect any recoupments that may have already been made by the Department. We provided the Department with these matches to further determine whether these were confirmed matches and if improper capitation payments were made and not recouped.

Capitation Payments for Deceased Individuals

We obtained access to the ODH's Ohio Public Health Data Warehouse Death Data system. We queried the data for all individuals that died in Ohio during calendar years 2017 through 2020 and matched this data to Medicaid recipients using the last name, first four letters of first name, last four digits of SSN, and the DOB. We found 3,560 capitation payments totaling over $3 million on behalf of deceased individuals which were not recouped.

We also identified capitation payments made for individuals that matched with the ODH death data file using the same name and DOB, but the last four digits of the SSN did not match or with the same name and last four digits of the SSN, but the DOB did not match. These included 904 potential matches with approximately $12.6 million in additional improper payments on behalf of deceased individuals. We did not remove any associated recoupments for these payments. We provided the Department with these matches to further determine whether these were confirmed matches and if improper capitation payments were made and not recouped.

Recommendations

We recommend that the Department:

- Recover the approximately $14.5 million in duplicate capitation payments, $100,663,282 in capitation payments for incarcerated individuals and $3,383,680 in capitation payments for deceased individuals from the managed care organizations (MCOs) and refund the federal share;
- Review the potential improper capitation payments for each objective and identify and recoup all improper capitation payments;
- Evaluate current processes for identifying duplicate recipient IDs, incarcerated individuals and deceased individuals and updating recipient data files in a timely manner;
- Assess the steps taken to recoup all appropriate capitation payments when a change is recorded that impacts recipient's eligibility, such as incarceration or when a duplicate payment is identified; and
- Correct or enhance system controls to prevent erroneous capitation payments in the future and to improve accuracy of the data on participation in the Medicaid program.

Matter for Further Study

The costs of the services delivered to managed care recipients are covered by the MCO; however, certain services are excluded from managed care coverage and the Department reimburses these services on a fee-for-service basis. One risk to the efficient use of resources is the Department paying directly for services that are the responsibility of the MCO[1]. We performed an initial match of fee-for service payments for recipients enrolled in managed care and identified over $8 million in fee-for service payments during a period of managed care enrollment. However, based on the exceptions to services covered by managed care along with the complexity of eligibility determinations, this issue requires further analysis. We recommend that the Department perform a more detailed review of the fee-for-service payments identified in the preliminary match to determine if any were improper payments.

[1] See "Medicaid Claims Processing Activity October 1, 2015 Through March 31, 2016 (November 2016)" released by the New York Office of the State Comptroller.

Overview

We conducted this audit to determine if the Department made improper Medicaid payments on behalf of recipients with multiple Medicaid recipient IDs, during a period of incarceration or after a date of death. This audit was performed pursuant to the State Auditor's authority as set forth in Ohio Rev. Code § 117.11 and covered SFYs 2018 through 2020 (July 1, 2017 through June 30, 2020).

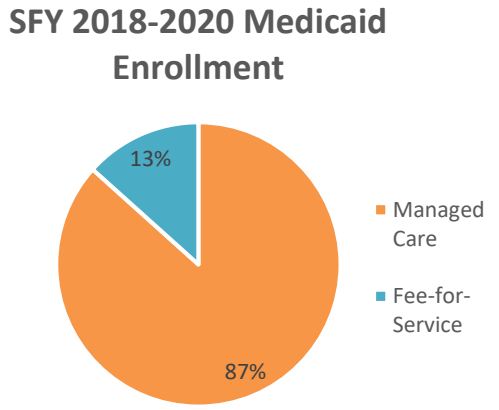
Recent reports from the Department of Health and Human Services – Office of the Inspector General (HHS-OIG)[2] found instances in which Ohio made duplicate capitation payments and capitation payments on behalf of deceased beneficiaries. The purpose and scope of this audit follows up on the HHS-OIG reports to determine if the prior issues found in Ohio have improved and includes payments for incarcerated individuals as an area of risk based on reports of other states[3] and a recent HHS-OIG work plan[4].

Background

The Social Security Amendments of 1965 created Medicaid by adding Title XIX to the Social Security Act. The program provides medical assistance to individuals who lack resources and the income to maintain costs of necessary medical services. Ohio's Medicaid program covers low-income individuals, adults over 65, blind and disabled individuals, pregnant women, infants, children, and other groups. Medicaid is a jointly funded program in which the federal government matches state funding to enable the states to provide health care coverage to residents meeting certain eligibility requirements. *See* Ohio Rev. Code Title 51 and Ohio Admin. Code Chapter 5160. The criteria for each group was summarized in a recent report released by the Auditor of State (AOS)[5]. Eligibility for the Medicaid program is based on various factors such as income, household size, citizenship, resources, and health status.

The Department is the single state agency responsible for the administration of Ohio's Medicaid program. Ohio Rev. Code § 5160.30(B) allows the Department to enter into an agreement with one or more agencies to accept applications, determine and re-determine eligibility and perform related administrative activities. The Department utilizes the Ohio county departments of job and family services (CDJFS) to perform eligibility determinations and re-determinations, as well as, enroll individuals in Medicaid.

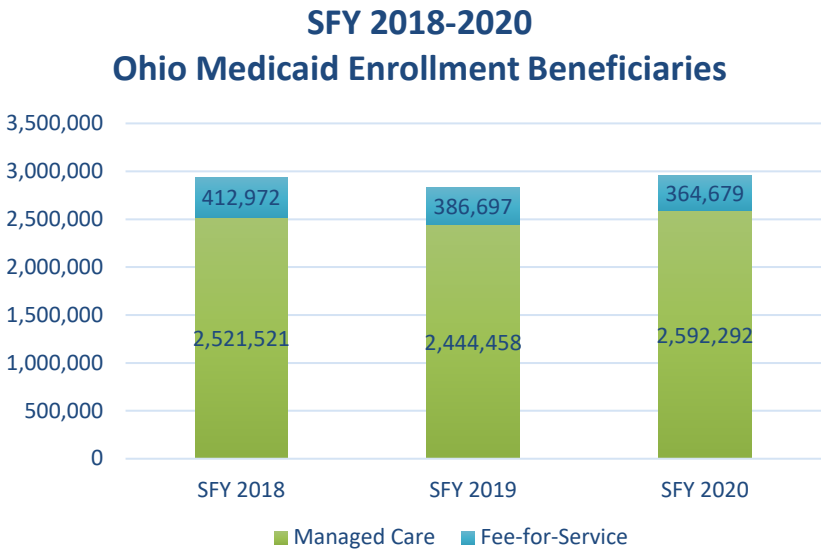
Most eligible beneficiaries in Ohio's Medicaid program are enrolled in managed care. Beneficiaries not enrolled in managed care receive Ohio Medicaid under a fee-for-service model.



Source: The Department - Budget Variance Caseload Reports

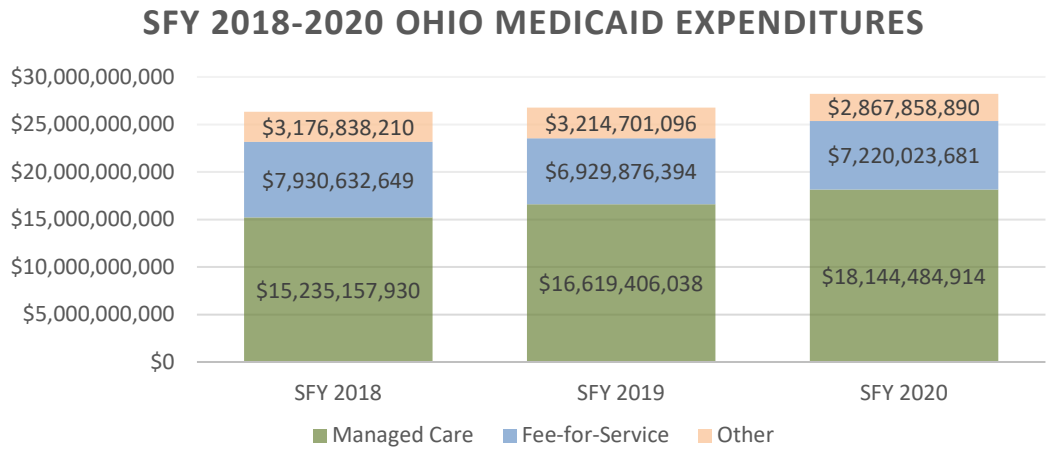
[2] Ohio Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries Death (October 2018) and Ohio Made Capitation Payments that Were Duplicative or Were Improper Based on Eligibility Status of Demographics (September 2019)
[3] Identification of Incarcerated Medicaid Recipients (October 2018) released by the Louisiana Legislative Auditor
[4] https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000325.asp
[5] Ohio's Medicaid Eligibility Determination Process (November 2020)

Ohio's Medicaid program is responsible for providing health care coverage to approximately 2.9 million beneficiaries through a network of more than 165,000 services providers. The chart below shows the breakdown of Medicaid beneficiaries enrolled in Ohio's Medicaid Program during the audit period by fee-for service and managed care.



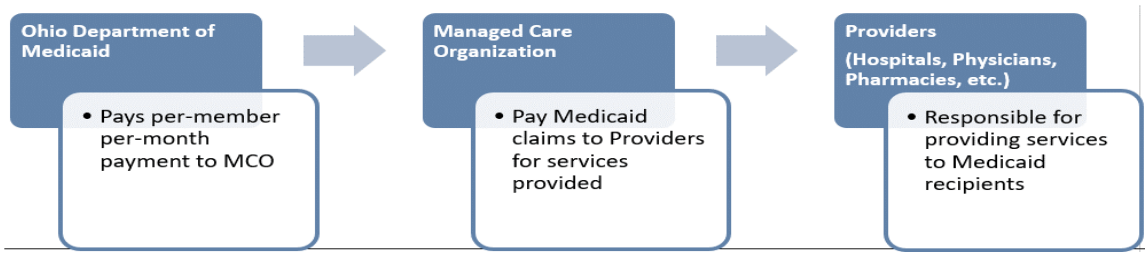
Source: The Department - Budget Variance Caseload Reports

Ohio's Medicaid program also accounts for a significant portion of the State's annual budget, representing 38 percent of the State's SFY 2020 budget. The chart below details the total Ohio Medicaid expenditures and breaks down the expenditures by fee for service, managed care and other. Other expenses include, but are not limited to, Medicare premium assistance and the Hospital Care Assurance Program.



Source: The Department – Budget Variance Expenditure Reports

For recipients enrolled in managed care, the Department sends a monthly fixed per-member per-month payment to the selected MCO which is referred to as a capitation payment. The Department makes the capitation payment regardless of whether the recipient receives services during the period covered by the payment. In return, the MCO is responsible for paying providers for services to Medicaid recipients. This payment process is shown below.



Source: The Department

The Department contracts with a firm to provide actuarial and consulting services related to the development of capitation rates for its managed care program. Historical data, which includes historical enrollment and eligibility files provided by the Department, trends and utilization levels, regions within the State, and aid category are among the resources used to develop capitation rates. The *Calendar Year 2021 Medicaid Managed Care Provider Agreement Rate Amendment Summary* notes the presence of incarcerated members in the data used to develop the CY 2019 base data. The 2021 report indicates that the firm used data regarding incarcerated individuals identified by the Department to estimate the impact to the projected benefit expense of removing these members.

Methodology

To identify the population of recipients with capitation payments during the audit period, we used the Department's Medicaid database to obtain the following recipient information: recipient ID, full name, DOB, SSN, gender and address. We reviewed the recipient data file for each SFY to ensure validity and reliability.

There were over 140 recipient IDs in SFY 2018 which were missing a name and had an invalid DOB and SSN. We obtained the missing information from the Medicaid Information Technology System[1] (MITS). Additionally, there were also recipients in each SFY that did not have an accurate name, for example, the name field contained a "1", "A" or "Blank". There were also recipients with inaccurate DOBs in each SFY such as 12/31/1899 or 1/1/1900. Finally, there were over 80,000 recipients with an invalid SSN such as 000-00-0000 or 999-99-9999.[6] These data validity issues were considered for each objective and we performed multiple matches with different criteria.

To ensure the payment data was valid and complete, we sampled the capitation payments from the Medicaid database for recipients identified in the primary matches (identified in each section below) and compared the data to payment information in MITS. We determined that the Medicaid database accurately reflected the capitation payment amount when MITS reflected no associated recoupment; however, the Medicaid database did not accurately report the capitation payment when MITS showed that a recoupment was subsequently made. As a result, we obtained recoupment data from the Department for all recipient matches and the capitation payment data associated with the recoupments. We used the data from both the Medicaid database and the Department's data files to identify improper capitation amounts for each objective.

We obtained description of the Department's processes to identify duplicate payments and payments for incarcerated or deceased individuals. This audit did not include a test of the controls described by the Department and we cannot provide any assurance as to whether these controls are operating as designed.

[6] In some instances, these SSNs are used for newborn children or non-citizen residents.

Results and Recommendations

We identified over $118.5 million in improper capitation payments that had not been recouped by the Department in the three fiscal years tested. While the Department outlined its processes to identify these payment errors and is recouping some payments, these controls are not sufficiently robust to ensure that all improper payments are identified. In addition, when the Department did identify a duplicate payment or a payment made for an incarcerated or deceased individual and updated its systems to stop future improper payments, it did not fully recoup the improper payments previously issued.

For each objective, we performed a primary (first level) data match which has the highest confidence of identifying an improper payment. The primary matches were performed as follows:

- For duplicate payments, we matched recipient ID numbers to all nine digits of a valid SSN;
- For capitation payments on behalf of incarcerated adults, we matched to recipients using the last name, first four letters of first name, SSN, and DOB; and
- For deceased individuals, we matched to recipients using the last name, first four letters of first name, last four digits of SSN, and DOB.

The following table reflects the results of the primary matches - the duplicate capitation payments, payments made for incarcerated individuals and payments after the month of the recipient's death that have not been recouped by the Department in each of the SFYs tested.

RESULTS OF PRIMARY (LEVEL ONE) MATCHES

	SFY 2018	SFY 2019	SFY 2020
Duplicate Capitation Payments	$6,800,000	$4,000,000	$3,700,000
Capitation Payments While Incarcerated	$32,907,609	$34,833,048	$32,922,625
Capitation Payments After Date of Death	$1,043,394	$1,057,906	$1,282,380
Total All Objectives	**$40,751,003**	**$39,890,954**	**$37,905,005**

In addition to the amounts reflected above, we performed a second level match for duplicate payment and second and third level matches for incarcerated and deceased recipients. We performed these additional matches using three criteria – last name, first four letters of the first name and DOB – to identify any additional duplicate recipients. For incarcerated and deceased individuals, we matched combinations of last name, first four letters of the first name and DOB or SSN.

These additional matches identified $84 million in potential capitation payments that should be fully recouped but would require additional steps to confirm the match. We provided the results of these additional matches to the Department and recommend it take steps to further analyze the data and to recoup any additional capitation payments paid in error.

The Department noted that the Ohio Benefits system, which is the statewide eligibility system, generates several alerts to notify a CDJFS caseworker of a Medicaid recipient's death or to report a change in incarceration status as reported by the ODRC. Prior reports issued by AOS have identified weaknesses with alerts, highlighting the burdensome volume of alerts, multiple and repetitive alerts, irrelevant alerts, and difficulties in the steps required to complete alerts.

In addition, interviews with CDJFS staff in 2020 identified concerns with duplicates in the system (same customer on multiple cases and multiple person identifiers for the same customer) and stated that caseworkers cannot delete customers added in error or on duplicate applications.[7] The results of this audit reflect the impact of these systemic issues.

Objective 1: To identify duplicate capitation payments that have not been recouped by the Department.

The Department assigns each beneficiary enrolled in Ohio Medicaid a unique ID that is used as the recipient identifier when the Department generates the monthly capitation payment to the MCO. The objective for this audit was to determine if a recipient was issued multiple IDs and, as a result, multiple monthly capitation payments were made to the MCO on behalf of the same recipient.

The Department stated that its staff review monthly reports to identify potential recipients with multiple IDs based on matching name and SSN and that the MCOs also notify the Department when there is an indication that a member may have multiple IDs. When a duplicate ID is identified, the Department reported that it makes the necessary changes to the recipient's eligibility and reconciles and recoups the monthly capitation payments from the MCO.

This audit did not include a test of the controls described by the Department to identify duplicate recipients and we cannot provide any assurance as to whether these controls are operating as designed.

Analysis

In order to determine if any duplicate capitation payments for recipients with multiple IDs were made and not recouped by the Department, we summarized the recipient data file obtained from the Medicaid database by recipient ID, last name, first name, SSN and DOB.

For the primary (first level) match, we removed the records with an invalid SSN and performed a data match using only the SSN to identify recipients in which one SSN was associated with multiple recipient IDs.

Duplicate Matching Criteria	
Primary(First Level) Match	All Nine Digits of Valid SSN
Second Level Match	Last Name, First Four Letters of First Name, and DOB

We then obtained the monthly capitation payments for each of the recipient matches identified in the primary match from the Medicaid database and determined if a capitation payment was made in the same month to a duplicate recipient ID. From this data, we removed any capitation payments associated with the primary match which the Department had fully recouped. We also removed duplicates related to children in foster care and during an out-of-home transition along with duplicates related to retroactive payments for recipients subsequently determined to be disabled.

The primary match results below also do not include duplicates that were connected to the public health emergency (PHE) during the last quarter of the audit period (April to June 2020); however, while the Families First and Coronavirus Response Act required continuous coverage through the end of the PHE, we confirmed with the Centers for Medicare and Medicaid Services (CMS) that states should ensure that duplicate payments are not being made for the same beneficiary.

[7] Ohio's Medicaid Eligibility Determination Process

Results

Primary Match Results

The Department made 61,852 capitation payments totaling $29,175,678 on behalf of recipients with the same SSN in the primary match. This amount includes both the appropriate payments and the inappropriate duplicate payments. As a result, approximately $14.5 million for the three SFYs in inappropriate duplicate payments were not recouped.

Included in the duplicate payments identified above are 9,007 payments in which the Department stated the duplicates were accounted for in the rate setting process. The Department explained that lower rates are paid to the MCOs because of the additional member months being included in the calculation. They also explained that the consulting actuary began recognizing duplicate IDs in the capitation rate setting process for calendar year 2019. We did not remove these duplicates payments in this report as we were unable to verify the impact on the capitation rate.

We identified 11,184 unique SSNs that were associated with 22,467 Medicaid recipient IDs. Additionally, nine SSNs (35 capitation payments) were also identified as being incarcerated during the month in which the duplicate payments were made.

Results on Primary Match:

- **11,089 SSNs – each SSN linked to 2 recipient IDs**
- **91 SSNs – each SSN linked to 3 recipient IDs**
- **4 SSNs - each SSN linked to 4 recipient IDs**

Our analysis found that for 75 percent of the 11,184 unique SSNs associated with multiple recipient IDs, there were less than three months in which a duplicate payment was made indicating that the managed care benefit span on the duplicate recipient ID was terminated and stopped any additional duplicate capitation payments from being made to the MCO. However, the duplicate capitation payments already made were not retroactively recouped. Additionally, we noted 284 unique SSNs in which more than 12 months of capitation payments were made under duplicate recipient IDs which were not recouped.

Length of Time to Terminate Duplicate ID	*Number of Unique SSNs*	*Percentage of Total*
Less than 3 months	8,338	75%
3 to 6 Months	1,628	15%
7 to 9 Months	509	4%
10 to 12 Months	425	4%
More than 12 Months	284	2%

Second Level Match Results

For a second level match, we removed the SSN only matches and included records with the invalid SSNs into the population. We performed a match using three criteria – last name, first four letters of the first name and DOB – to identify any additional duplicate recipients. This resulted in 15,597 potential additional matches. We obtained the capitation payments for these additional matches which totaled $134,906,167. We did not remove any associated recoupments for these payments. We provided the Department with these matches to further determine whether these were confirmed matches and if duplicate capitation payments were made and not recouped. The potential loss to the Medicaid program for these matches is approximately $67.5 million.

Recommendations

We recommend that the Department:

- Recover the approximately $14.5 million in duplicate capitation payments from the MCOs and refund the federal share;
- Identify and recover additional duplicate capitation payments that occurred during the PHE and refund the federal share;
- Implement a process to accurately identify the correct recipient ID and merge claims records from the duplicate IDs to the correct recipient to allow for a complete history of services provided to the recipient;
- Evaluate its current process for identifying duplicate recipient IDs and determine why duplicates are not being identified timely and payments are not being recouped;
- Review the capitation payment matches identified in the second level match to determine if additional duplicate capitation payments were made and recoup all improper payments; and
- Improve system controls to prevent further erroneous capitation payments and to ensure that accurate data is provided to the firm engaged to develop future managed care capitation rates.

Objective 2: To identify capitation payments for incarcerated individuals that have not been recouped by the Department.

According to Ohio Admin. Code § 5160:1-1-03, Medicaid will not pay for services provided to an individual who is an inmate of a public institution[8]. Additionally, inmates of a public institution are excluded from managed care enrollment unless otherwise specified by the Department per Ohio Admin. Code § 5160-26-02.

The Department becomes aware of a recipient's incarceration status through alerts designed in the Ohio Benefits system. In August 2016, new incarcerated codes were implemented in the Ohio Benefits system, as well as functionality to import a daily file from the ODRC with its incarcerated population. A change in a recipient's incarceration status may also be reported to the CDJFS caseworker by family members, other adults on the same case, caregivers and facilities.

When a change has been reported that could affect a recipient's ongoing eligibility, the Department must make a re-determination within 10 calendar days per Ohio Admin. Code § 5160:1-2-01. Positive incarceration matches trigger an alert in the Ohio Benefits system to the CDJFS caseworker to reclassify benefits from full Medicaid to the limited benefits for the span of the recipient's incarceration. Recipient's with the limited benefit plan are enrolled in fee-for-service and dis-enrolled from managed care, stopping capitation payments to the MCO.

At the time we initiated this audit in March 2021, the Department began a process to identify incarcerated individuals and reassign to the appropriate limited benefit span. They reported reassigning 3,555 incarcerated individuals, dis-enrolling these individuals from managed care. The Department also implemented a robotic process automation in June 2021 which uses the incarceration data from ODRC to identify the incarcerated recipient and automatically move the recipient to the limited benefit plan and dis-enroll from managed care. The termination of the enrollment triggers the MITS to evaluate the capitation of each month covered or previously covered by the enrollment.

[8] Inmate of a public institution is defined as a person who is living in a public institution per Ohio Admin. Code § 5160:1-1-03. Exceptions are permitted for an inpatient or outpatient stay in a hospital, nursing facility, juvenile psychiatric facility, intermediate care facility for individuals with intellectual disabilities, clinic or physician office.

If there is a capitation payment for a month that does not fall within an active enrollment span, the Department indicated that MITS will automatically recover the capitation payment from the MCO. This audit did not include a test of the new controls described by the Department and we cannot provide any assurance as to whether these controls are operating as designed.

Analysis

To determine if any capitation payments were made on behalf of an individual during a period of incarceration that were not recouped by the Department, we requested and obtained a data file from the ODRC for all adult individuals incarcerated in Ohio at a state institution from July 1, 2017 through June 30, 2020. The data contained the date in which the individual was admitted into a state institution and the date in which the individual was released, if applicable.

From the unique recipient data file obtained from the Medicaid database, we performed a primary match against the ODRC data file to identify any recipient matches on four criteria – last name, first four letters of the first name, SSN and DOB.

Incarcerated Matching Criteria	
Primary (First Level) Match	Last Name, First Four Letters of First Name, SSN, and DOB
Second Level Match	Last Name, First Four Letters of First Name, and DOB
Third Level Match	Last Name, First Four Letters of First Name, and SSN

We then obtained the monthly capitation payment data for each of the recipient matches identified in the primary match from the Medicaid database and determined if a capitation payment was made during a period of incarceration[9]. From this data, we removed any capitation payments associated with the primary match which the Department had fully recouped. We further removed any capitation payments that were made during a period in which the recipient had an inpatient hospital stay. We sampled 15 of these capitation payments identified by the Department and confirmed using MITS data that 13 of the 15 had inpatient hospital stays covered by an MCO.

The primary match results below to do not include capitation payments identified by the Department as related to the PHE; however, we confirmed with CMS that its guidance did not prohibit the state from changing the Medicaid status of individuals that become incarcerated or require the payment of capitation for these individuals. Incarceration limits the availability of Federal Financial Participation (FFP) to inpatient services.

Results

Primary Match Results

We found 29,412 recipients in which capitation payments were made on their behalf during a period of incarceration and were not recouped. The Department made 160,850 capitation payments totaling $100,663,282 on behalf of these 29,412 incarcerated recipients. We further assessed the number of months where a payment was made for the incarcerated recipient.

Length of Time to Terminate Managed Care Benefits	*Number of Incarcerated Recipients*	*Percentage of Total*
Less than 3 months	9,019	31%
3 to 6 Months	12,063	41%
7 to 9 Months	3,783	13%
10 to 12 Months	1,902	6%
More than 12 Months	2,645	9%

[9] We did not include capitation payments for the first month of incarceration and the month of release.

Our analysis found that for 31 percent of the 29,412 incarcerated recipients with capitation payments, there were less than three months in which an improper payment was made prior to the Department terminating the managed care benefit span; however, the improper capitation payments were not retroactively recouped. Additionally, we noted 2,645 incarcerated individuals in which more than 12 months of improper capitation payments were made which were not recouped.

Second and Third Level Match Results

We also identified capitation payments made to individuals that matched with the ODRC incarcerated data file in the second and third level matches. These recipient IDs had the same last name, first four letters of the first name and DOB, but the SSN did not match or they had the same last name, first four letters of the first name and SSN, but the DOB did not match. For example, in these matches, we identified recipients in which the SSN was the same except for one digit or the DOB was off by one day or year (i.e. 2/15/1973 instead of 2/15/1975) indicating that these have strong possibility of being additional matches. These included 1,281 potential matches with over $4 million in additional payments on behalf of incarcerated individuals. This amount does not reflect any recoupments that may have already been made by the Department. We provided the Department with these matches to further determine whether these were confirmed matches and if improper capitation payments were made and not recouped.

Recommendations

We recommend that the Department:

- Recoup $100,663,282 in improper capitation payments from the MCOs and refund the federal share;
- Identify and recoup any additional improper capitation payments for incarcerated individuals during the PHE to ensure that claims for FFP are limited for inmates of a public institution to covered inpatient services;
- Expand efforts to identify and recoup improper capitation payments to ensure that claims for FFP are also limited for incarcerated juveniles to covered inpatient services;
- Evaluate current process for identifying incarcerated individuals and determine how incarcerated individuals are not being identified and/or status updated in eligibility system;
- Review process to identify and recoup all improper capitation payments for incarcerated individuals;
- Review the capitation payments from the second and third matches to determine if additional improper capitation payments were made and recoup all improper payments; and
- Improve system controls to prevent further erroneous capitation payments and to ensure that accurate data is provided to the firm engaged to develop future managed care capitation rates.

Objective 3: To identify capitation payments for deceased individuals that have not been recouped by the Department.

According to Ohio Admin. Code § 5160-26-02.1, the Department will terminate a member's enrollment in a managed care upon the date of death. The Department shall recover from the MCO any capitation payments paid for retroactive enrollment termination. The managed care provider agreement also requires that the MCO notify the Department when it becomes aware of the death of a member.

The Department can become aware of a recipient's death through various means. The Ohio Benefits system is designed to generate alerts to notify CDJFS caseworkers of a deceased match as received from the National Technical Information Services or the Social Security Administration. Additionally, the death of a recipient may be reported to the CDJFS caseworker by family members, other adults on the same case, caregivers or facilities.

As stated above, the Department has 10 calendar days to process a re-determination when a change has been reported that could affect a recipient's ongoing eligibility. When the Department has been notified of a potential death of a recipient, the recipient is removed from managed care and placed in fee-for-service until confirmation of the death is received.

Information reported through an alert or a friend/neighbor is considered a lead and independent verification must be obtained. Changes reported by family members, caregivers, medical or nursing facilities are accepted without additional verification.

Once a death is confirmed, the CDJFS caseworker enters the information into the Ohio Benefits system. This triggers the date of death to be sent to MITS and the MCO is informed via an enrollment file. The process for terminating enrollment upon death and recouping capitation payments from the MCO is the same as when an individual is incarcerated.

The Department also receives a monthly data file from the ODH of deaths reported in Ohio. This data is used to produce a list of Medicaid recipients with a reported date of death. The Department uses this to end enrollment in MITS and reconcile enrollment spans that overlap with a recipient's date of death, as well as, prevent future enrollment from occurring. In 2021, the Department obtained access to the Ohio Public Health Data Warehouse Death Data system maintained by ODH.

This audit did not include a test of the controls described by the Department to identify deceased recipients and we cannot provide any assurance as to whether these controls are operating as designed.

Analysis

To determine if any capitation payments were made on behalf of a deceased individual that was not recouped by the Department, we obtained access to the ODH's Ohio Public Health Data Warehouse Death Data system. We queried data for all individuals that died in Ohio during calendar years 2017 through 2020.[10]

From the unique recipient data file that we obtained from the Medicaid database, we performed a primary match against the ODH data file to identify any recipient matches on four criteria – last name, first four letters of the first name, SSN and DOB.

Deceased Matching Criteria	
Primary (First Level) Match	Last Name, First Four Letters of First Name, Last Four Digits of SSN, and DOB
Second Level Match	Last Name, First Four Letters of First Name, and DOB
Third Level Match	Last Name, First Four Letters of First Name, and Last Four Digits of SSN

We obtained the monthly capitation payment data for each of the recipient matches identified in the primary match from the Medicaid database. We then performed additional analysis to determine whether a capitation payment had been made after the recipient was deceased.

Similar to the process used for the other two objectives, we obtained recoupment payment and associated capitation payment data from the Department. From this data, we removed any capitation payments associated with the primary match which had been fully recouped.

[10] These data were provided by the ODH. The ODH specifically disclaims responsibility for any analyses, interpretation or conclusions.

Results

Primary Match Results

We identified 647 recipients in which 3,560 capitation payments totaling $3,383,680 were made on behalf of deceased individuals and were not recouped. Our analysis found that for 46 percent of the 647 deceased individuals with capitation payments, there were less than three months in which an improper payment was made indicating that the managed care benefit span was terminated which stopped further capitation payments to the MCO; however, the improper capitation payments already made were not retroactively recouped. Additionally, we noted 54 deceased individuals in which more than 12 months of improper capitation payments were made which were not recouped. Further, we noted 96 deceased individuals with dates of death between March 2017 and May 2020 in which capitation payments were still being made on their behalf as of the end of our audit period, June 2020.

Length of Time to Terminate Deceased Individual Benefits	*Number of Deceased Individuals*	*Percentage of Total*
Less than 3 months	298	46%
3 to 6 Months	131	20%
7 to 9 Months	90	14%
10 to 12 Months	74	12%
More than 12 Months	54	8%

Second and Third Level Match Results

We also identified capitation payments made to individuals that matched with the ODH death data file in the second and third level matches. These recipient IDs had the same last name, first four letters of the first name and DOB, but the last four digits of the SSN did not match or they had the same last name, first four letters of the first name and last four digits of the SSN, but the DOB did not match. These included 904 potential matches with almost $12.6 million in additional payments on behalf of deceased individuals. We did not remove any associated recoupments for these payments. We provided the Department with these matches to further determine whether these were confirmed matches and if improper capitation payments were made and not recouped.

Recommendations

We recommend that the Department:

- Recoup $3,383,680 in improper capitation payments from the MCOs and refund the federal share;
- Identify the 96 deceased individuals with capitation payments on their behalf as of June 2020 and ensure their benefit span has been terminated and capitation payments recouped;
- Evaluate current process for identifying deceased individuals to ensure all deceased Medicaid recipients are identified and payments are recouped;
- Review the capitation payment matches from the second and third level matches to determine if improper capitation payments were made and take steps to recoupment all improper payments; and
- Improve system controls to prevent further erroneous capitation payments and to ensure that accurate data is provided to the firm engaged to develop future managed care capitation rates.

Matter for Further Study

Fee-for-Service Payments for Managed Care Services

In general, the Department pays health care providers directly for Medicaid-eligible services rendered to Medicaid recipients or it pays each MCO a monthly payment and the MCO arranges for the provision of services. The costs of the services delivered to managed care recipients are covered by the MCO; however, certain services are excluded from managed care coverage and the Department reimburses these services on a fee-for-service basis. One risk to the efficient use of resources is the Department paying directly for services that are the responsibility of the MCO[11].

Ohio Admin. Code § 5160-26-03 and the managed care provider agreements identify services that are covered by managed care. There are services outside of managed care, such as home and community-based services (HCBS) provided to a member who is enrolled on an HCBS waiver or services provided through the Medicaid school program. There are exceptions to these limitations, for example, in the MyCare Ohio program, the MCOs are responsible for HCBS services in select urban counties and, although Federally Qualified Health Centers (FQHCs) are covered under managed care, when the total MCO payment to an FQHC is less than what the FQHC would have been paid under a different system[12], the Department pays the difference. In addition, behavioral health services provided by the community mental health system were paid as fee-for-service prior to SFY 2019.

The Department's claim processing system, MITS, includes edits to prevent payment for certain services when an individual is enrolled in managed care. If a provider were to bill fee-for-service Medicaid for a managed care enrollee, MITS will post an edit to notify the provider of the managed care enrollment. However, in the past there were delays between the establishment of Medicaid eligibility and enrollment in a managed care plan. Due to this delay, individuals were covered by fee-for-service Medicaid until enrollment occurred which caused confusion as to the responsible payer.

ODM reported that it implemented several managed care enrollment changes to prevent this scenario from occurring. Beginning January 1, 2018, newly eligible individuals are assigned to an MCO effective on the first day of the month in which their eligibility is determined. However, when an individual is determined Medicaid eligible prior to the current calendar month (retroactive eligibility), managed care is effective the first day of the month the determination is made. In this situation, prior months of eligibility are covered by fee-for-service.

We performed an initial match of fee-for service payments for recipients enrolled in managed care. We removed services rendered by FQHCs and rural health clinics, HCBS services, services provided through the Medicaid school program and by mental health and addiction treatment service providers (prior to SFY 2019). From this match, we identified over $8 million in fee-for service payments during a period of managed care enrollment. However, based on the exceptions to services covered by managed care along with the complexity of eligibility determinations, this issue requires a more detailed analysis than was within the scope of this audit.

We recommend that the Department perform a more detailed review of the fee-for-service payments identified in the preliminary match to identify improper payments. In addition, the Department should review its controls to ensure that no payments are made for a service that should have been covered by the MCO.

[11] See "Medicaid Claims Processing Activity October 1, 2015 Through March 31, 2016 (November 2016)" released by the New York Office of the State Comptroller.
[12] FQHCs are paid through a prospective payment system or an alternative payment method. The difference in payments is called a supplemental, or wraparound payment.

Conclusion

The Department provided a response to the results of this audit which can be found in the Appendix. In the response, the Department indicated that we included payments made for recipients identified as pre-release in the improper capitation payments; however, our methodology did exclude both the first month of incarceration and the month of release so we made no change to our results.

The Department indicated that 193 payments totaling $225,000 for deceased individuals were incorrect due to errors in the reported dates of death. We requested the specifics for these 193 payments and the Department provided the 92 unique recipient IDs associated with these payments. We searched for obituaries or notices of death for these individuals and, for those individuals where we did not find any obituary or notice, we reviewed information in Ohio Benefits. We identified nine recipients where the obituary or notice matched the date of death in MITS as reported by the Department and subsequently removed $9,687 from our results. For the remaining individuals, the documentation found did not support the date of death in MITS. It appeared that the date in MITS often reflected the date the CDJFS office was notified of the death and not the actual date of death.

In its response, the Department indicated that the PHE limited its ability to make changes to Medicaid benefits. During the audit, we clarified with CMS regarding the requirements related to the PHE and incorporated this clarification in our methodology.

The Department indicated it must perform additional analysis to determine the impact on the capitation rates of recouping payments from the MCOs. We have requested that the Department provide AOS a copy of that additional analysis when it is completed.

We reviewed the Department's response and updated our results to remove nine capitation payments totaling $9,687 for deceased individuals. We made no further changes to our results or recommendations.

Ohio | Department of Medicaid

Mike DeWine, Governor
Jon Husted, Lt. Governor

Maureen M. Corcoran, Director

December 17, 2021

Keith Faber, Auditor of State of Ohio
Attn: Kristi Erlewine, Chief Auditor
Medicaid/Contract Audit Section
88 East Broad Street, 4th Floor
Columbus, Ohio 43215

Dear Auditor Faber:

Thank you for the opportunity to respond to the draft report issued by the Auditor of State (AOS) regarding the review of Improper Capitation Payments. The Ohio Department of Medicaid (ODM) offers the following response.

Introduction

The Auditor of State audited Ohio Medicaid eligibility and payment data to determine compliance with Medicaid requirements regarding all capitation payments made:

- For the same recipient resulting in duplicate payments.
- On behalf of beneficiaries after their date of death.
- During a period of incarceration in a state correctional facility.

The AOS reviewed data from state fiscal years (SFYs) 2018, 2019 and 2020 and identified $118.6 million in potentially improper capitation payments. During these three fiscal years ODM paid more than $56 billion in capitation payments to the managed care organizations (MCOs) to provide necessary healthcare to Medicaid recipients. The AOS also provided documentation, referred to as the "second level match," for further analysis by ODM.

ODM takes seriously its responsibility to make capitation payments based on the most accurate data available and has implemented the processes described in this response to improve and monitor managed care enrollment and capitation payments to MCOs. The AOS report highlights areas where ODM has worked to address issues it identified and other audits have raised. ODM agrees with many of the AOS's recommendation and has been working to improve many of the processes discussed in the report. To understand the ODM work that has gone into ensuring we are making actuarily sound capitation payments for the proper individuals, it is also important to understand three key factors:

Since 2019, ODM and our partners have strengthened Ohio Benefits system capabilities and standardized eligibility processes including:

- Deployed nine system releases and reduced the number of defects from 1,500 to approximately 360.
- Invested thousands of hours in county caseworker training and field support to standardize and streamline eligibility processes.
- Introduced more than 100 system enhancements control mechanisms to prevent data entry errors or overrides.
- Leveraged dashboards, artificial intelligence, and robotic process automation to gain efficiencies in identifying and correcting improper capitation payments.

- Many of the improper payments identified by the AOS were driven by defects and design issues in ODM's eligibility system, Ohio Benefits. ODM has undertaken extraordinary efforts to improve Ohio Benefits since January 2019, the midpoint of this audit period.
- ODM's actuary sets the capitation rates that it pays MCOs in a complex, actuarily sound process. When recouping capitation payments from an MCO, ODM must consider the cause of the overpayment, how the payment was made to the MCO, how the underlying data used to develop the capitation rates was impacted by the overpayment, and any other prior overpayments.
- The review includes the first three months of the Public Health Emergency, when CMS guidance on what actions ODM could take to terminate an individual's Medicaid eligibility delayed ODM's work reconciling capitation payments.

Ohio Benefits Issues and Improvement: As the AOS is aware, this ODM administration inherited an eligibility system, Ohio Benefits, with serious defects. ODM has undertaken extraordinary efforts to improve Ohio Benefits since January 2019, the midpoint of this audit period. Among other issues, the system allowed for overwriting of eligibility data and documentation, eliminating necessary historical documentation, and diminishing the reliability of the data in Ohio Benefits. It created alerts to notify county caseworkers of potential changes

in an individual's circumstances that may affect Medicaid eligibility, such as a potential death, but it created these alerts at such volume that caseworkers could not come close to addressing them all. Ohio Benefits also created incorrect dates to start an individual's federally required renewal process, or sometimes it did not start the renewal process at all. The list goes on and each of these defects affected the eligibility data on which ODM relies to help create its capitation rates, enroll individuals into MCOs, and make capitation payments to those MCOs.

Many of the improper payments identified by the AOS were first and foremost driven by defects or design issues in ODM's eligibility system, Ohio Benefits. ODM has undertaken extraordinary efforts to improve Ohio Benefits since January 2019, the midpoint of this audit period. These efforts include:

- In late 2018, ODM began reviewing all outstanding Ohio Benefits defects and enhancement requests to identify and prioritize specific functional areas for fixes and enhancements. ODM changed its approach for how it prioritized correcting defects and implementing enhancements in the system. In the new approach, it classified all necessary changes into functional areas, including Income Overwrites, Change Reporting, Alerts, and Rules, and grouped these improvements together for targeted releases. ODM, ODJFS, DAS, and Accenture staff categorized 1,500 defects and 500 enhancements into 13 priority areas. Between August 2019 and December 2020, nine releases fixed nearly 1,000 of these defects and deployed many related enhancements. Multiple releases in 2021 continued to address issues in these functional areas.
- ODM fixed defects and implemented enhancements in April 2019 to prevent caseworkers from updating more than one demographic detail (first name, last name, date of birth, etc.) at the same time. In addition, new functionality creates warnings specific to each demographic detail when a worker attempts to change a demographic detail, and automatically creates journal entries to record the change.
- In April 2020, ODM made significant changes to reduce the number of duplicates created by the Presumptive Eligibility Portal by creating temporary billing numbers until a county worker can determine if the individual is known to the system.
- Starting in 2020, ODM worked with the Ohio Department of Job and Family Services (ODJFS) to review every alert generated in Ohio Benefits, seeking to reduce unnecessary, duplicative, or unhelpful alerts sent to caseworkers, making it easier for caseworkers to address notifications of potential deaths or incarceration.
- Once ODM and ODJFS completed the review described above, project staff began engaging in "sprints", a project management approach to identify, design, and deploy changes to functionality that can be made quickly but with a significant impact. ODM completed four sprints from March to July of 2021, addressing alerts received from

multiple sources. The sprints significantly decreased the number of alerts sent to caseworkers, cutting them nearly in half, and reduced duplicate alerts.

- In June of 2021, ODM implemented robotic process automation, or the DRC BOT, into Ohio Benefits to identify individuals incarcerated by the Ohio Department of Rehabilitation and Correction (ODRC) and move the individuals to incarcerated aid codes and disenroll them from managed care. The DRC BOT is working as expected.

In addition to these system fixes and improvements, ODM contracted with an end-to-end vendor for a review of Ohio Benefits infrastructure, application, and management of the system. The vendor specifically addressed findings from CMS's Payment Error Rate Measurement (PERM) review, which identified significant eligibility determination errors. The vendor has completed this portion of the assessment and ODM is currently reviewing its findings, along with short-term and long-term recommendations for Ohio Benefits improvements.

ODM completed this work in Ohio Benefits while simultaneously reducing the number of pending Medicaid applications. In January 2019, there were almost 100,000 Medicaid program blocks with an application pending a determination in Ohio Benefits. Of those, more than 53,000 had been pending for more than 45 days. CMS requested, and ODM submitted, a formal corrective action plan to address this backlog of applications. By November 2021, the total number of pending applications decreased to approximately 46,000 and only 10,217 were pending for more than 45 days.

> ODM's progress reducing application backlogs is notable.
>
> In January 2019, nearly 100,000 applications were pending determination, and more than half were 45 days or older.
>
> By November 2021, as applications continued to grow during the pandemic, pending applications were 46,000, and 10,217 aged 45 days or more.

After three years of work, ODM can better rely on the data in Ohio Benefits when enrolling individuals into MCOs and making capitation payments.

Capitation Rates: ODM bases its capitation payments on the best data available related to, among other factors, service utilization, data trends, and policy changes, to identify reasonable and appropriate costs for an MCO under the terms of its provider agreement with ODM. Changes in these inputs may affect the amount ODM should pay an MCO. For example, the AOS calculated that the duplicate payments identified could be divided in half to identify an

improper payment or that one duplicate capitation payment to an MCO creates an improper payment of the same amount. However, given the process used to set capitation rates for MCOs, that calculation may not be correct.

Capitation rate setting is very detailed, applying trend factors addressing cost and utilization developed from actual experience of the Medicaid population and considering prospective policy changes. ODM must pay rates that are actuarially sound, as determined by an outside actuary in accordance with 42 CFR 438.4(b) and CMS's "Managed Care Rate Setting Consultation Guide." Ohio Medicaid capitation rates are "actuarially sound" for the period covered by the certification; the projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. ODM pays MCOs per member per month. Costs considered in the capitation rate payment include, but are not limited to, expected health benefits, administrative expenses, the cost of capital, and government mandated assessments, fees, and taxes. All rates and actuarial methods can be found on the ODM website in Appendix E of both the Medicaid Managed Care and MyCare Ohio provider agreements. When data underlying the assumptions in capitation rate development is incomplete, ODM considers how that data affects the rates MCOs were paid before recouping all potentially incorrect payments.

The Public Health Emergency: The AOS's review includes the first three months of the Public Health Emergency (PHE), when CMS guidance on what actions ODM could take to terminate an individual's Medicaid eligibility, or change his/her eligibility category, delayed ODM's work reconciling capitation payments. Under section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA), states claiming the 6.2 percentage point Federal Medical Assistance Percentage (FMAP) increase (including Ohio) are not permitted to discontinue Medicaid coverage for individuals who were enrolled in the program on March 18, 2020, or who become enrolled during the emergency period, unless the individual voluntarily requests a discontinuance of eligibility, is no longer a resident of the state, or is deceased. Per CMS's original guidance regarding this provision, states were also not permitted to reduce benefits for any individual enrolled in Medicaid on or after March 18, 2020, through the end of the month in which the PHE ends. The prohibition against reducing benefits also precluded transitioning individuals between Medicaid categories.

On November 2, 2020, a provision implementing section 6008(b)(3) of the FFCRA in CMS-9912 Interim Final Rule with Comment (CMS-9912 IFC) became effective. The interim final rule with comment (IFC) established a new section 433.400 in Part 433 of Title 42 of the Code of Federal Regulations (CFR) and contains CMS's reinterpretation of the continuous enrollment condition in section 6008(b)(3) of the FFCRA. This reinterpretation allowed states to begin transitioning individuals from their existing eligibility categories to other categories for which they are eligible, provided both categories offer minimum essential coverage as defined in section

5000A(f) of the Internal Revenue Code of 1986 and implementing regulations at 26 CFR §1.5000A-s.

Improvements identified in this response include systems changes to lessen the burden on counties, prioritizing and addressing system defects, changes to internal processes, implementation of automation, and changes to capitation rate setting. It may take time to fully realize the impact of these improvements, but ODM is confident, and its data shows, that its work is improving the accuracy of its data and payments.

Improvements include systems changes to lessen the burden on counties, changes to internal processes, implementation of automation, and changes to capitation rate setting. ODM is confident, and its data shows, that its work is improving the accuracy of its payments.

Duplicate Capitation Payments

Finding

The Auditor of State found duplicate capitation payments in the amount of approximately $14.5 million.

Current State

Every state managed care program includes de minimis numbers of duplicate payments and some incomplete data. States often address duplicate payments through rate adjustments in addition to retroactive recoupment. As an example of the incomplete data described by the AOS in its description of the methodology used, the AOS noted the number of incorrect social security numbers (SSNs) found in the Medicaid Information Technology System (MITS). Upon ODM review, of the 80,000 individuals entered with an SSN of 999-99-9999 or 000-00-0000, roughly 60% of these are children under the age of two. Generally, this is a result of a newborn being added to the case before there is an SSN to enter. These newborns are entered into the system intentionally with a 999-99-9999 SSN.

In Ohio's managed care program, duplicate capitation payments occur when a Medicaid recipient has more than one Medicaid ID. ODM works to prevent these scenarios; however, they are not fully preventable. A County Department of Job and Family Services (CDJFS) caseworker or ODM system may create a duplicate ID for an individual for many reasons including timing of Social Security disability determinations, children entering the foster care system, and federal requirements related to the use of SSNs (such as 42 CFR §435.1102(d) and 42 CFR §435.910).

ODM previously identified two primary scenarios resulting in duplicate IDs: individual demographics updates and Presumptive Eligibility Portal entries. ODM implemented the

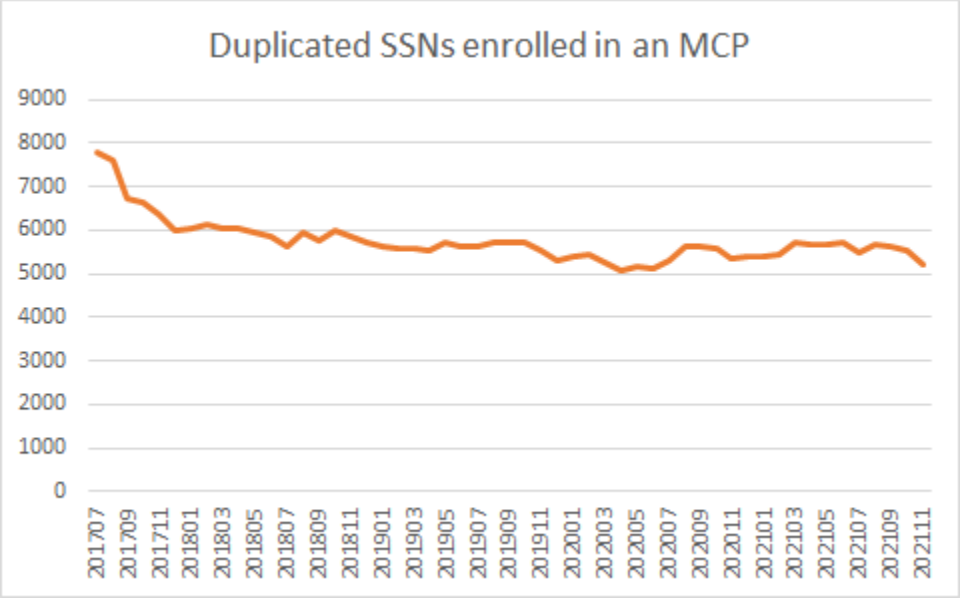
following system changes to combat these issues. In April 2019, ODM implemented several system improvements in Ohio Benefits to encourage CDJFS caseworkers to verify the beneficiary's date of birth or gender before making changes to those fields. Functionality added to prevent a worker from changing more than one demographic detail per transaction resulted in a decrease in duplicate IDs. In March 2020, ODM made changes to the Presumptive Eligibility Portal to assist qualified entities with presumptive eligibility decisions, which also resulted in fewer duplicate IDs. While individuals enrolled in presumptive eligibility Medicaid are not enrolled in an MCO, this process and limitations related to use of an SSN for presumptive eligibility contribute to duplicate IDs in the system and over time may result in duplicate capitation payments.

MITS automatically takes back the capitation payment from the impacted MCO during the monthly capitation cycle. In instances where duplicate IDs are with the same MCO, the secondary ID is historied and capitation payment recouped. If the overlapping spans are with different MCOs with claims paid for both IDs, the previous enrollment remains, and capitation is not recouped to avoid undue hardship for the service provider. ODM notifies MCOs of recoupments monthly. Until recently, ODM did this work by manually combining reports from a variety of sources to identify duplicate IDs. Effective December 2021, ODM created a monthly dashboard that collects information from these various sources and simplifies the process. When ODM identifies a duplicate ID, a primary ID is chosen using a complex method considering eligibility and MCO enrollment and the two IDs are linked. As appropriate, overlapping managed care spans on secondary IDs are ended in MITS.

> In April 2021, ODM mobilized additional internal resources to assist with linking multiple IDs in MITS after reconciliation occurs in Ohio Benefits.

The AOS made findings related to duplicate payments for Medicaid members. Specifically, the AOS identified duplicates (9,007 totaling $4,754,611) where the same capitation payment for one individual was made twice in one month. In this finding it is 9,007 out of approximately 2.9 million enrollees, or 0.3% of the total Medicaid population. The AOS report also identified another 11,184 individuals (unique SSNs) who were associated with a duplicate ID. This is approximately a 0.38% error rate. Of these 11,184 individuals, ODM corrected 75% of the duplicate IDs within three months.

There has been a gradual downward trend in the number of duplicate IDs from SFY 2018 to today as shown in the table on the following page.



Response to Auditor of State Recommendations

1. Recover the approximately $14.5 million in duplicate capitation payments from the MCOs and refund the federal share.

   ODM Response: ODM will need to conduct additional analysis to determine the ultimate overpayment amount for the duplicate payments. The AOS primary match results identified 61,852 payments totaling approximately $29 million including both IDs. The AOS divided that number in half to come up with the $14.5 million amount of this finding. In many instances the two capitation payments are for different amounts. ODM will need to conduct further analysis to determine which capitation payment is the correct payment based on the individual's Medicaid aid category. ODM suspects the actual amount will be less than $14.5 million because generally the higher capitation payment is correct.

   ODM will review the impact of recoupment from the MCOs on both ODM and the MCOs. ODM will consider how these duplicate IDs may have affected capitation payment rates, any rate recertification costs for the periods affected, the administrative burden on both the MCOs and ODM, whether any amounts were previously recouped outside of MITS, and will determine whether to recover the identified payments. In the meantime, for those capitation payments where it has not already returned the federal share, ODM will repay the federal share of the identified capitation payments to the federal government.

2. Identify and recover additional duplicate capitation payments that occurred during the PHE and refund the federal share.

   ODM Response: ODM will work to identify duplicate capitation payments that occurred during the PHE and as discussed above, will consider the implications of recovery from the MCOs, and refund the unreturned federal share.

3. Implement a process to accurately identify the correct recipient ID and merge claims records from the duplicate IDs to the correct recipient to allow for a complete history of services provided to the recipient.

   ODM Response: ODM agrees with this recommendation and believes its recently implemented changes will improve this process. In this updated process, when ODM dashboards identify a Medicaid recipient who may potentially have multiple Medicaid IDs, ODM staff will correct the recipient's eligibility, reconcile MCO enrollment, and generally payments are recouped from an MCO. The multiple IDs are linked together in both Ohio Benefits and MITS to prevent future duplicate payments. This linkage already creates a comprehensive claims history, which essentially merges the claims records. ODM will monitor the success of the newly implemented dashboard and adjust the process as needed.

4. Evaluate its current process for identifying duplicate recipient IDs and determine why duplicates are not being identified timely and payments are not being recouped.

   ODM Response: ODM staff historically worked monthly reports produced using data from MITS and Ohio Benefits that identify duplicate IDs based on matching name and SSN. As noted above, staff now use a monthly dashboard to proactively identify duplicate IDs. The dashboard includes reporting tools including a map level view allowing ODM staff to monitor for trends that might indicate areas for improvement.

   Regarding recoupment, when a Medicaid recipient is identified with multiple IDs and is enrolled in different MCOs, there are situations when the enrollment is only reconciled prospectively, and capitation is not recouped. This may occur when both MCOs have paid provider claims and recouping an MCO capitation payment may result in provider hardship when obtaining payment for services rendered appropriately and in good faith.

ODM will evaluate these processes for identifying duplicate recipient IDs to identify opportunities for improvement and will incorporate changes specifically related to timeliness of identification.

5. Review the capitation payment matches identified in the second level match to determine if additional duplicate capitation payments were made and recoup all improper payments.

   ODM Response: ODM staff are in the process of reviewing the capitation payment matches identified in the second level match. When the analysis is complete, as discussed above, ODM will consider the implications of recovery from the MCOs and refund the unreturned federal share.

6. Improve system controls to prevent further erroneous capitation payments and to ensure that accurate data is provided to the firm engaged to develop future managed care capitation rates.

   ODM Response: As noted above, ODM implemented changes in 2019, 2020, and 2021 to redress deficiencies related to duplicate IDs. ODM continues to implement processes to prevent and identify duplicate member IDs. ODM will continue to provide information to the actuary in its efforts to mitigate the impact of de minimis duplicate IDs within the systems.

Capitation Payments After Date of Death

Finding

The Auditor of State found capitation payments for individuals after their date of death (DOD) totaling approximately $3.4 million.

Current State

The process and regulatory requirements related to validating a date of death result in a de minimis number of capitation payments after the date of death. ODM receives information regarding a Medicaid recipient's date of death in several ways. Ohio Benefits generates alerts to notify a CDJFS caseworker of a Medicaid recipient's death as received from the National Technical Information Service (NTIS) or Social Security Administration (SSA). MCOs are required to notify ODM of any deceased member within 30 days of becoming aware of the death of the member and ODM receives a monthly file from the Ohio Department of Health (ODH). In

addition, family members, other adults on the same case, caregivers, and facilities may report a Medicaid recipient's death, or the CDJFS caseworker may become aware through other means such as a news article or obituary.

The SSA receives reports of death from several sources in the daily operation of its various programs, including from family members, friends, neighbors, funeral homes, financial institutions, postal authorities, and other federal agencies. The SSA compiles this death information, known as the Death Master File (DMF). The DMF is an extract of death information on the NUMIDENT, which is the electronic database that contains the SSA's records of Social Security Numbers (SSNs) assigned to individuals since 1936. A public file of the SSA's death information is provided to the Department of Commerce's National Technical Information Service (NTIS), which in turn sells the public DMF (also known as the Limited Access DMF) to other agencies and private organizations such as banks and credit companies in accordance with the requirements of section 203 of the Bipartisan Budget Act of 2013.

The federal statute at 5 USC §552a limits the use of electronic data sources to the extent that no recipient agency may suspend, terminate, reduce, or make a final denial of any financial assistance or payment under a federal benefit program regarding an individual, or take other adverse action against an individual, as a result of information received via electronic data sources until –

A. (i) the agency has independently verified the information; or
   (ii) the Data Integrity Board of the agency, or in the case of a non-Federal agency the Data Integrity Board of the source agency, determines in accordance with guidance issued by the Director of the Office of Management and Budget that –
   (I) the information is limited to identification and amount of benefits paid by the source agency under a Federal benefit program; and
   (II) there is a high degree of confidence that the information provided to the recipient agency is accurate;
B. the individual receives a notice from the agency containing a statement of its findings and informing the individual of the opportunity to contest such findings; and
C. (i) the expiration of any time period established for the program by statute or regulation for the individual to respond to that notice; or
   (ii) in the case of a program for which no such period is established, the end of the 30-day period beginning on the date on which notice under subparagraph (B) is mailed or otherwise provided to the individual.

Independent verification referred to in the paragraph above requires investigation and confirmation of specific information relating to an individual that is used as a basis for an adverse action against the individual.

The Computer Matching and Privacy Protection Act (CMPPA) Agreement between the Social Security Administration (SSA) and each state sets forth the terms and conditions governing disclosures of records, information, or data made by the SSA to various State agencies and departments that administer federally funded benefit programs. State Agencies that use SSA data to administer federally funded benefit programs are required to comply with the terms and conditions of the CMPPA Agreement. The Agreement also reiterates statutory language by including a clause which requires that "State Agencies will not terminate, suspend, reduce, deny, or take other adverse action against an applicant for, or recipient of federally funded, state-administered benefits based on data disclosed by SSA from its SORs [systems of records] until the individual is notified in writing of the potential adverse action and provided an opportunity to contest the planned action. 'Adverse action' means any action that results in a termination, suspension, reduction, or final denial of eligibility, payment, or benefit."

The CMPPA Agreement further indicates that SSA's Data Integrity Board "has determined that State Agencies may use SSA's benefit data without independent verification. SSA has independently assessed the accuracy of its benefits data to be more than 99 percent accurate when the benefit record is created. Prisoner and death data, some of which is not independently verified by SSA, does not have the same degree of accuracy as SSA's benefit data. Therefore, State Agencies must independently verify these data through applicable State verification procedures and the notice and opportunity to contest procedures specified in Section V of this Agreement before taking any adverse action against any individual."

> Federal statute and existing Ohio Administrative Code require ODM to obtain independent verification of death before taking any action to terminate, suspend, reduce, or deny eligibility and benefit payments. See OAC 5160:1-2-01(H).

Based on federal statute and the terms of ODM's agreement with the SSA, the agency is not permitted to use date of death information provided via an electronic data source (SSA sources such as BENDEX, SDX, SVES, and SOLQ, as well as the NTIS source because it uses SSA Death Master File data) to update case information. The information provided in the interface is a lead and workers are required to follow up with the individual to request independent verification of the information prior to taking any action that results in a termination, suspension, reduction, or final denial of eligibility, payment, or benefit.

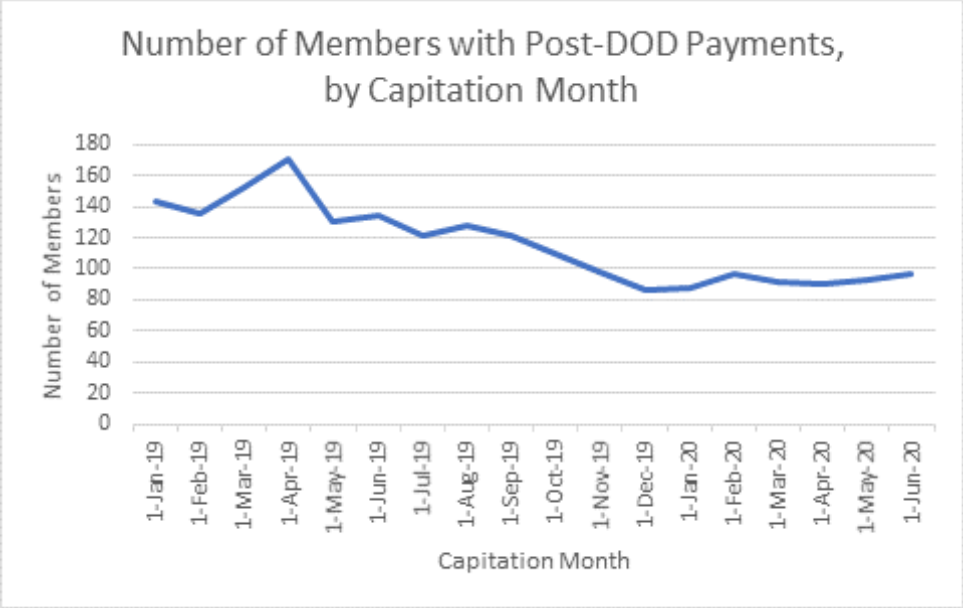
When ODM receives a lead indicating an individual is deceased, it removes the individual from managed care and assigns him/her to fee-for-service Medicaid until confirmation is received. Prior to 2018 this process was only used when the MCO provided date of death notification. ODM updated this process in 2018 to include the information received on the ODH monthly file. Only information reported by family members, caregivers, and facilities is acceptable to act upon without additional documentation.

The public health emergency impacted the process of following up on leads and terminating Medicaid enrollment. To follow up on a lead, CDJFS agencies send requests for verification to the individual if the worker cannot immediately verify the date of death. However, during the PHE, the CDJFS agencies have been instructed that they cannot discontinue Medicaid during the PHE if there is no response to the verification request. The date of death must be verified to discontinue Medicaid eligibility. Outside of the PHE, a non-response would result in termination of eligibility for the individual.

> During the PHE, when the CDJFS does not receive a response, it must leave the case open.

When changing from CRIS-E to using Ohio Benefits for eligibility and enrollment, ODM was granted approval from CMS to postpone eligibility renewals, which contributed significantly to the 2018 HHS/OIG capitation payment for deceased individuals finding. Since that time, the processes described above have been put into place to identify and disenroll members from managed care appropriately.

The chart below shows fewer capitation payments for members after date of death over time.



Response to Auditor of State Recommendations

1. Recoup $3,393,367 in improper capitation payments from the MCOs and refund the federal share.

   ODM Response: Upon further review of the data provided by AOS, ODM found 193 capitation months identified in the report, in the amount of $225,000, where ODM made the capitation payments identified *before* the individual's date of death listed in MITS. . The MITS death date field is validated and submitted by the county and ODM believes these 193 capitation payments are valid.

   For the remaining payments, ODM will review the impact of recoupment from the MCOs on both ODM and the MCOs. ODM will consider how these payments after an individual's date of death may have affected capitation payment rates, any rate recertification costs for the periods affected, the administrative burden on both the MCOs and ODM, whether any amounts were previously recouped outside of MITS, and will determine whether to recover the identified payments. In the meantime, for those capitation payments where it has not already returned the federal share, ODM will repay the federal share of the identified capitation payments to the federal government.

2. Identify the 96 deceased individuals with capitation payments on their behalf as of June 2020 and ensure their benefit span has been terminated and capitation payments recouped.

   ODM Response: ODM has initiated this process by reviewing the list of 96 individuals, identifying the individuals enrolled in Medicaid then sending those Medicaid IDs to the CDJFS agencies responsible for verifying the date of death and subsequently terminating Medicaid enrollment. Upon disenrollment, ODM will review any potentially inappropriate capitation payments as discussed above.

3. Evaluate current process for identifying deceased individuals to ensure all deceased Medicaid recipients are identified and payments are recouped.

   ODM Response: In response to this audit, in December 2021, ODM staff made changes to the ODH report process. ODM expects using a name and date of birth match in addition to the existing SSN match will capture additional recipients who may have been missed in the prior process. ODM staff will continue to use this new report to add

special conditions in MITS to prevent future managed care enrollment from occurring, as well as to end date and reconcile enrollment spans that overlap the date of death. ODM will monitor the success of these changes and will make necessary adjustments.

As noted in the AOS report, prior reports issued by AOS identified weaknesses with alerts and highlighted the burdensome volume. Because Ohio Benefits sends CDJFS caseworkers date of death alerts to verify, ODM has worked to reduce the number of alerts county caseworkers receive, and to improve the quality of these alerts, so that caseworkers can more easily prioritize the most important and time sensitive alerts. ODM and ODJFS met bi-weekly from April 2020 to March 2021 to review every alert currently being generated in Ohio Benefits to determine what information is being communicated, how often the alert is being generated, whether the alert is something Ohio customized, and whether there are any state and/or federal mandates requiring the alert. Analysis began with the alerts that represented the highest volume and the most error prone with any defects or enhancements that were identified being prioritized for upcoming releases as capacity is available.

To bring faster improvements to the usefulness of alerts in Ohio Benefits, project staff began engaging in "sprints", a project management approach to identify, design, and deploy changes to functionality that can be made quickly but with a significant impact. The first sprint, deployed in early March 2021, reduced the number of IRS Unearned Income alerts by more than 60% per month by implementing smarter alert logic, such as not creating a second alert if a prior alert has not yet been cleared. The number of IRS Unearned Income alerts generated per month varies significantly, but only 33,017 were generated in March 2021, compared to the lowest number in the prior year, which was 72,118.

In early April 2021, a second sprint focused on State Wage Information Collection Agency (SWICA) alerts was completed. It is expected to reduce the number of newly created alerts from about 280,000 to 140,000 each month. In July 2021, sprints three and four targeted alerts being generated from UCB, SDX, and SSI. Ohio Benefits release 3.8 implemented a Medicaid-only enhancement to reduce duplicative alerts being received for Healthchek, pending verification, long-term care (LTC), the Ohio Department of Developmental Disabilities (DODD), the Ohio Department of Rehabilitation and Correction (DRC), State Verification Exchange System (SVES) Prisoner, the Asset Verification System (AVS), and Medicare Buy-In.

In August 2020, ODM implemented functionality in Ohio Benefits which modified the Case Summary page (which is typically the first screen accessed by caseworkers) to include a new Alert and Task Dashboard; previously alerts were only viewable from an alert widget. This dashboard displays the number of pending and overdue alerts as well as hyperlinks for easier access. Changes were also implemented to reduce the number of duplicate alerts by providing only one alert per worker (per case). In addition, a batch process was added to clear alerts associated to Medicaid program blocks that have been closed longer than the 90-day appeal period.

A total of 36 defect corrections and 24 enhancements associated with alerts have been implemented from April 2020 to present. New reports for outstanding alerts have been developed and piloted with several counties and are now available to all 88 counties

> ODM implemented 24 system enhancements and 36 defect corrections associated with alerts from April 2020 to the present. Due to this work ODM cleared nearly 3.5 million pending alerts for the CDJFS caseworkers.

4. Review the capitation payment matches from the second and third level matches to determine if improper capitation payments were made and take steps to recoup all improper payments.

   ODM Response: ODM staff are in the process of reviewing the capitation payment matches identified in the second level match. When the analysis is complete, as discussed above, ODM will consider the implications of recovery from the MCOs and refund the unreturned federal share.

5. Improve system controls to prevent further erroneous capitation payments and to ensure that accurate data is provided to the firm engaged to develop future managed care capitation rates.

   ODM Response: As noted above, ODM implemented changes in 2018 and 2021 to redress deficiencies related to identification of deceased Medicaid recipients. ODM continues to implement processes to identify deceased recipients. ODM will continue to provide information to the actuary in its efforts to mitigate the impact of de minimis Medicaid eligibility spans for deceased members within the systems.

Capitation Payments During Incarceration

Finding
The Auditor of State found capitation payments for incarcerated individuals totaling approximately $100 million.

Current State
Ohio Benefits generates alerts to report a change in incarceration status as reported by the Ohio Department of Rehabilitation and Correction (ODRC). In addition, family members and other adults on the same case may report a Medicaid recipient's incarceration, or the worker may become aware of an individual's incarceration through other means like a news article.

ODM must also follow the requirements in OAC 5160:1-2-01, noted above, when utilizing information reported related to incarceration status to change an individual's Medicaid eligibility.

ODM makes capitation payments during the first month an individual is incarcerated or for the month of an individual's release, due to pre-release program eligibility requirements. ODM noted 550 capitation months included in the AOS findings as appropriate pre-release payments; however, the AOS did not remove these payments from the final report. This accounts for approximately $318,007 or about 0.3% of the $100 million.

As noted in the audit summary, in August 2016, ODM implemented a new incarcerated living arrangement code and new incarcerated aid category codes in Ohio Benefits, as well as functionality to import a daily file from ODRC of its incarcerated population. Ohio Benefits first matches the ODRC daily incarceration file with member information in Ohio Benefits using SSN. If there are no matches on SSN, then matching occurs on first name, last name, and date of birth. Positive hits trigger an alert to the CDJFS caseworker to perform a benefit reclassification from full Medicaid to the appropriate incarcerated aid category for the span of the individual's incarceration. Individuals with eligibility in an incarcerated aid code are assigned the limited inpatient hospital services benefit plan (IHSP) in MITS, enrolled in Medicaid fee-for-service (FFS) and disenrolled from managed care, effectively stopping capitation payments to the MCOs. This change is characterized as a reduction in benefits and as such, notice of adverse action requirements apply. Therefore, the IHSP effective date is prospective instead of retrospective.

The IHSP benefit plan prevents future enrollment in managed care. Capitation payments are aligned with MCO enrollment and are not adjusted to align with dates of admission to ODRC facilities. ODM enrolls individuals in managed care prior to their release from incarceration, as

part of the Medicaid Pre-Release Enrollment program, on the first calendar day of the month of release, regardless of release date; and pays the MCOs a full month's capitation payment for these individuals.

> Between March and June, ODM focused resources to reclassify benefits for incarcerated individuals, reassigning 64% of cases to the correct aid code and reducing the possibility of erroneous capitation payments during incarceration.

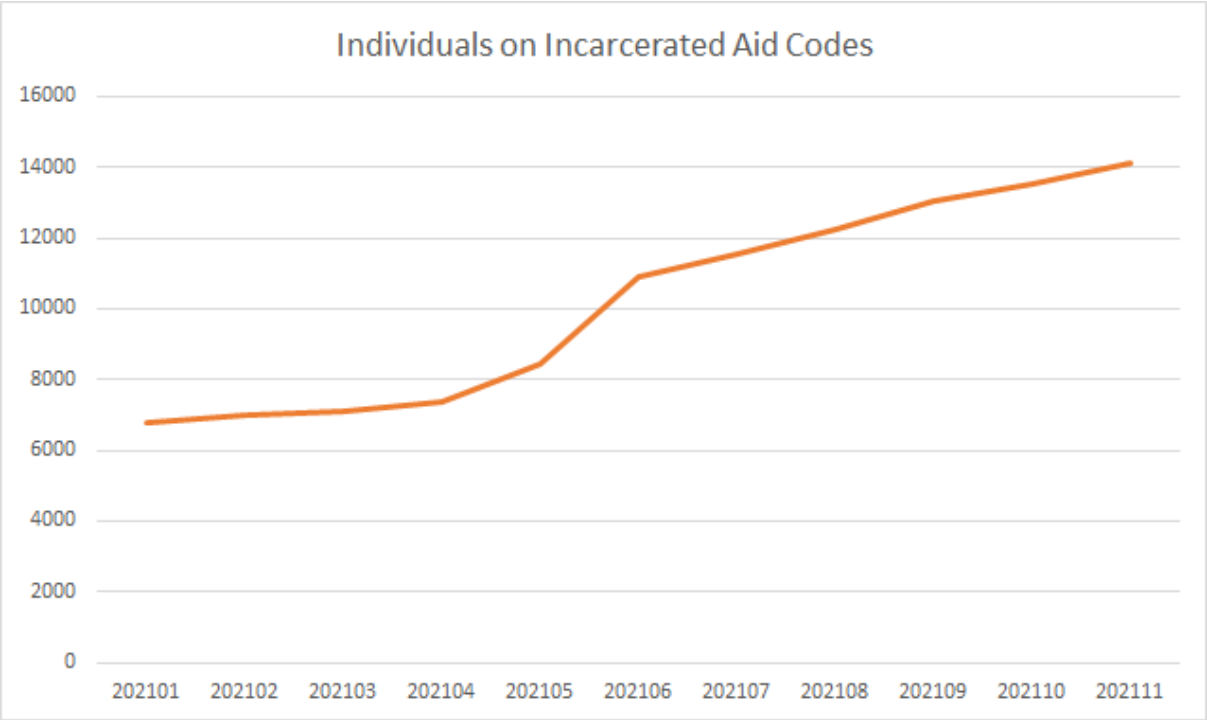
As described in the audit summary, from March through June of 2021 (dates after the audit period), ODM performed an analysis using an ODRC daily file to identify the extent to which incarcerated individuals were not reclassified to the appropriate living arrangement, aid category code, and benefit plan. ODM mobilized internal resources to reclassify benefits for identified individuals. As a result of the manual clean-up, ODM assigned 3,555 individuals (or about 64% of the individuals identified in the analysis) to an incarcerated aid code. ODM could not change the remainder of cases because the individuals had been released, were in the Pre-Release Enrollment program, or had no matches in Ohio Benefits, to name a few reasons.

In June 2021, ODM implemented robotic process automation (DRC BOT). This automation leverages incarceration data from the daily interface to update the living arrangement code; processes single household cases with active Medicaid; and, after all case details are updated, runs the eligibility determination and benefit calculation (EDBC) for the next month to move the individual to the incarcerated aid code and disenroll him/her from managed care. The DRC BOT processes alerts from ODRC for new incarcerations daily. Cases that the DRC BOT cannot process fall out to the CDJFSs for processing.

Individuals on Incarcerated Aid Codes, below, shows the steady increase in individuals who have an incarcerated aid code in MITS. ODM also completed a comparative analysis of matches between Ohio Benefits and the ODRC daily file using data from 2/28/2021, or three months before implementation of the DRC BOT, to a file from 9/30/2021, or about three months after implementation.

> ODM's comparative analysis of matches between Ohio Benefits and daily ODRC files revealed a reversal in the number of incarcerated aid codes within matched records. In February, 37% of records matched as compared to 65% matching by September.

This chart reflects the March through June 2021 clean-up efforts and implementation of the DRC BOT. The BOT is working as expected.



Response to Auditor of State Recommendations

1. Recoup $100,663,282 in improper capitation payments from the MCOs and refund the federal share.

   ODM Response: ODM will review the impact of recoupment from the MCOs on both ODM and the MCOs. ODM will consider how these identified payments may have affected capitation payment rates, any rate recertification costs for the periods affected, the administrative burden on both the MCOs and ODM, whether any amounts were previously recouped outside of MITS, and will determine whether to recover the identified payments. In the meantime, for those capitation payments where it has not already returned the federal share, ODM will repay the federal share of the identified capitation payments to the federal government.

2. Identify and recoup any additional improper capitation payments for incarcerated individuals during the PHE to ensure that claims for FFP are limited for inmates of a public institution to covered inpatient services.

   ODM Response: ODM will work to identify capitation payments for incarcerated individuals that occurred during the PHE, and as previously discussed, will consider the implications of recovery from the MCOs and refund the unreturned federal share.

3. Expand efforts to identify and recoup improper capitation payments to ensure that claims for FFP are also limited for incarcerated juveniles to covered inpatient services.

   ODM Response: In August 2018, the Ohio Department of Youth Services (DYS) began providing data in a monthly batch file of all individuals who were newly admitted or recently released from a state facility. Upon receipt of this file, the Ohio Benefits Worker Portal creates an interface record for every matching individual reported on the file linked to a case in Ohio Benefits. For matched individuals, an alert 'DYS Individual Match – New Admission' is generated for the CDJFS caseworker to take appropriate action. The CDJFS caseworker contacts ODM's Direct Enrollment Unit to confirm the youth's status, i.e., incarcerated or residing in an alternative placement facility. The youth's status will determine eligibility. Incarcerated youth are only eligible for the limited IHSP benefit plan; however, youth in DYS custody residing in alternative placement facilities could be eligible for full Medicaid. In the case where a youth is incarcerated, the CDJFS caseworker updates the address, updates the living arrangement to incarcerated, and runs EDBC to approve the appropriate incarcerated aid category code. This process was formally memorialized in a CDJFS caseworker job aid in May 2020.

   Reporting capabilities exist to support counties in managing Ohio Benefits system alerts/ exceptions; however, the sheer number of alerts generated monthly combined with staffing and resource constraints experienced by counties and ODM impedes an ability to comprehensively manage and monitor alerts. Details of system updates to relieve county caseworkers of many alerts are included above. Developing and implementing a more robust oversight strategy is an opportunity for improvement for the Department.

4. Evaluate current process for identifying incarcerated individuals and determine how incarcerated individuals are not being identified and/or status updated in eligibility system.

ODM Response: ODM implemented the DRC BOT as described above in June 2021, after this audit period. Weekly statistics on the performance of the DRC BOT are produced and reviewed by ODM Leadership. To date, the DRC BOT has reviewed 19,970 alerts: it processed 10,633 (or 53%) end-to-end; it communicated 6,492 cases (or 33%) to counties as exceptions; and it identified 2,845 cases (or 14%) as pre-release individuals with proper MCO enrollment. These performance statistics as well as the analysis results depicted in above figure 'Individuals on Incarcerated Aid Codes' demonstrate the new process is effective at identifying and updating incarceration status in the Ohio Benefits system.

Reporting capabilities also exist to support counties in managing OB system alerts/exceptions. As ODM's improvements to the alerts process described above alleviate county caseworker burden, caseworkers should be able to work the incarceration alerts more quickly and efficiently. Developing and implementing a more robust oversight strategy is an opportunity for improvement for the Department.

5. Review process to identify and recoup all improper capitation payments for incarcerated individuals.

   ODM Response: Where the DRC BOT is working to reduce managed care enrollment for incarcerated individuals, ODM will work to develop and improve the process to identify individuals not captured by the DRC BOT and a process to recoup or adjust capitation payments going forward.

6. Review the capitation payments from the second and third matches to determine if additional improper capitation payments were made and recoup all improper payments.

   ODM Response: ODM staff are in the process of reviewing the capitation payment matches identified in the second level match. When the analysis is complete, as discussed above, ODM will consider the implications of recovery from the MCOs and refund the unreturned federal share.

7. Improve system controls to prevent further erroneous capitation payments and to ensure that accurate data is provided to the firm engaged to develop future managed care capitation rates.

   ODM Response: As noted above, ODM implemented changes in 2021 to redress deficiencies related to identification of incarcerated Medicaid recipients. ODM continues to implement processes to identify incarcerated recipients and disenroll them

from managed care. ODM will continue to provide information to the actuary in its efforts to mitigate the impact of Medicaid eligibility spans for incarcerated members within the systems.

Fee-for-service (FFS) and Managed Care Enrollment

Medicaid providers may bill an incorrect payer due to eligibility and enrollment factors or confusion. MITS billing edits are in place to prevent payment for services when an individual is enrolled in an MCO. If a provider were to bill FFS Medicaid for a person enrolled in managed care, MITS notifies the provider of managed care enrollment. MCOs have similar edits in their billing systems to prevent improper claims payment.

ODM has implemented several managed care enrollment changes, including "managed care day one" enrollment and changes to presumptive eligibility to prevent FFS payments during managed care enrollment from occurring.

Effective January 1, 2018, newly eligible individuals are assigned to an MCO effective on the first day of the month in which their Medicaid is approved, known as "managed care day one." Prior to "managed care day one," it took an average of 45 days for a Medicaid eligible individual to be enrolled in an MCO. Due to this delay, ODM covered individuals under FFS Medicaid until MCO enrollment, which often caused provider confusion related to Medicaid payer. There is no longer a FFS time period for most services. There is an exception for prescription drug payments made within the first seven days of managed care enrollment due to the nature of pharmacy claims being point of sale. This is to ensure Medicaid recipients receive lifesaving medications timely. In 2019 ODM reviewed this process and made additional updates to shorten the time frames in which a member is assigned to an MCO.

A presumptively eligible Medicaid recipient is enrolled in FFS until a permanent Medicaid determination is made. During the ODM review in 2019, MITS configuration related to presumptive eligibility was the most frequent scenario where managed care retroactively enrolled an individual after FFS claims were paid for that month. To correct this issue, in October 2020, ODM made MITS changes and worked with our enrollment broker to identify recipients who transition from presumptive to full Medicaid and to assign those members to an MCO with a future effective date to eliminate the overlap in managed care and FFS periods.

Response to Auditor of State Recommendations

1. We recommend that the Department perform a more detailed review of the fee-for-service payments identified in the preliminary match to identify improper payments.

   ODM Response: ODM staff are in the process of reviewing the fee-for-service payments identified in the preliminary match to identify potential improper payments.

2. In addition, the Department should review its controls to ensure that no payments are made for a service that should have been covered by the MCO.

   ODM Response: ODM will continue to assess whether payments made under fee-for-service should be covered by the MCO. Implementation of the single pharmacy benefit manager (SPBM) will mitigate instances where fee-for-service pays point of sale pharmacy claims to ensure access to care. These amounts paid by fee-for-service are considered in development of the capitation rates. Implementation of the Fiscal Intermediary in July 2022 may offer some opportunities to implement additional controls in the future.

Conclusion

ODM appreciates the opportunity to work with the AOS through this audit and explain the progress it has made in improving the quality of its data, enhancing its processes, and reducing improper payments. Our response describes a variety of activities taken over the audit period, and after it, that have resulted in marked improvement to preventing, identifying, and correcting incorrect capitation payments made to MCOs for duplicate IDs, deceased beneficiaries, and incarcerated individuals. As ODM prepares to launch its Next Generation of Managed Care and implement a new Fiscal Intermediary to make capitation payments and pay claims, it will retain this focus on increased transparency and accountability.

ODM appreciates the Auditor of State's review and recommendations. Thank you for the opportunity to provide comments on the draft report. Please let me know if you have questions or need additional information.

Sincerely,

Maureen M. Corcoran, Director

OHIO AUDITOR OF STATE
KEITH FABER

OHIO DEPARTMENT OF MEDICAID - IMPROPER CAPITATION PAYMENTS

FRANKLIN COUNTY

AUDITOR OF STATE OF OHIO CERTIFICATION

This is a true and correct copy of the report, which is required to be filed pursuant to Section 117.26, Revised Code, and which is filed in the Office of the Ohio Auditor of State in Columbus, Ohio.

Certified for Release 1/13/2022

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