

Office of Health Transformation **Fight Medicaid Fraud and Abuse**

Background:

Ohio Medicaid is committed to combating Medicaid provider fraud and abuse that take money from needy children, the elderly, and people with disabilities. The majority of providers and their billings are honest and accurate. However, one dishonest provider can take thousands of dollars over time by billing for services not rendered or medically necessary, or through organized crime take hundreds of thousands of dollars illegally in a few weeks or months.

Ohio Medicaid will spend \$19.6 billion in FY 2013 to provide health care to more than 2.3 million Ohioans. The size and scope of the program demand strong financial stewardship. Ohio Medicaid employs auditors, analysts, and fraud examiners, as well as private-sector experts and other professionals to identify, recover, and prevent overpayments. Through the collective and ongoing efforts of the Program Integrity Group, Ohio's Office of the Attorney General has become a national leader in convicting and indicting Medicaid fraud and abuse.

In addition to prosecuting fraud cases and chasing down overpayments, Medicaid program integrity also is about promoting a policy environment in which expectations and incentives are aligned to promote efficiency and quality, and prevent misuse of services. It also includes effective program management and ongoing monitoring. These efforts create a culture that drives better health outcomes and common-sense ways to eliminate fraud and abuse.

Executive Budget Proposal and Impact:

The Executive Budget includes numerous provisions to combat Medicaid fraud and abuse, and it reflects savings for some new initiatives that have been launched recently. The purpose is to promote economy, efficiency, accountability, and integrity in the management and delivery of Medicaid services. In combination, these provisions are projected to save \$74.3 million (\$27.4 million state share) over the biennium.

- ***Increase Medicaid audit capabilities.*** The Executive Budget adds five full-time positions to the Medicaid audit team to perform additional on-site monitoring reviews and to ensure the state's new recovery audit contract (RAC) is properly monitored and provider appeals are completed in a timely manner. Additional on-site monitoring of Medicaid providers will increase the amount of overpayments that Ohio Medicaid can recover, and is projected to save \$1.5 million (\$554,000 state share) over the biennium.
- ***Increase audit recoveries.*** The federal government requires states to contract with a recovery audit contractor in order to identify overpayments and underpayments by the state Medicaid program, and recoup overpayments. Ohio selected CGI in May 2011 to

serve as Ohio's recovery audit contractor. Based on projections provided by CGI, Medicaid expects to save \$48 million (\$18 million state share) over the biennium.

- **Manage hospital utilization.** Ohio Medicaid recently contracted with Permedion to perform both pre- and post-payment review of hospital services, and provide technical advice to the Ohio Medicaid program regarding coverage and utilization management policies. This provision is projected to save \$19 million (\$7 million state share) over the biennium. In addition to the hospital project, Permedion has identified other program integrity and cost avoidance activities that are estimated to save an additional \$6 million (\$2.2 million state share) over the biennium.

In addition to the initiatives described above, the Executive Budget makes other changes that are expected to improve program integrity and save taxpayer dollars, but actual savings are difficult to estimate and not included in budget estimates.

- **Involve providers in third-party recoveries.** Ohio Medicaid is the payer of last resort and contracts with a vendor to recover Medicaid payments when the beneficiary has other insurance coverage that should cover all or part of the medical expenses. In some cases, the other insurance pays better than Medicaid, so the provider has an incentive to seek payment from the other insurance, not Medicaid. The Executive Budget clarifies that Medicaid may involve the provider to identify and recover overpayments, and that the provider can bill the third party insurance versus Medicaid billing the third party directly. Also, the Budget requires legal representatives to cooperate with medical providers to reveal a client's third party insurance when that client has Medicaid.
- **Revalidate providers every five years.** The Executive Budget authorizes Ohio Medicaid to revalidate providers every five years instead of the current seven years, and includes incentives for providers to submit a complete application during the revalidation process. The five-year revalidation is a new federal requirement that is intended to identify and eliminate fraudulent providers.
- **Track trusts as part of recovery.** The Executive Budget requires Medicaid applicants to provide Ohio Medicaid with a copy of any trust of which they are a beneficiary. Currently, Medicaid does not have any mechanism for tracking trusts, and recoveries from trusts are missed. This provision will enable Medicaid to identify when a trust is involved and improve collection of payments when a Medicaid beneficiary dies.
- **Streamline the nursing facility claims review process.** Program integrity activities related to nursing facilities focus on accurate billings and payment, and the quality of the services purchased. The Executive Budget aligns the Medicaid claims review process for nursing facilities with that applied to other provider types, streamlining the process, and allowing nursing homes and Ohio Medicaid to resolve payment issues more quickly.

- **Terminate special focus nursing facilities.** The Executive Budget authorizes Ohio Medicaid to terminate the Medicaid provider agreement of nursing facilities with a history of providing poor quality care without improvement. The federal government operates a Special Focus Facility Program that identifies facilities with more deficiencies than most facilities, more serious deficiencies, and a pattern of serious deficiencies. They publish a list monthly identifying those facilities newly added to the list, those that remain on the list without improving, those that remain on the list but are improving, and those that recently graduated from the list. The budget gives Ohio Medicaid another tool to ensure the quality of long-term services and supports in Ohio by terminating the provider agreement of a facility that either fails to improve within 12 months of being placed on the list or fails to graduate from the list within 24 months of being placed on the list.
- **Medicaid access to Ohio's prescription monitoring program.** The Executive Budget clarifies that Ohio Medicaid "shall" (not "may") have access to the Ohio Automated Rx Reporting System (OARRS) and specifies that Medicaid is able to see information about prescriptions that were not paid for through Medicaid. This access will allow Medicaid to confirm that, if a consumer is assigned to a specific provider through the coordinated services program to curtail prescription drug abuse, the provider is not allowing the recipient to receive controlled substances outside the Medicaid program.
- **Expect personal responsibility from Ohioans who benefit from Medicaid.** In order to ensure individuals in the Medicaid program take personal responsibility for their health care services and also become ready to move off of Medicaid and into private insurance, Medicaid is proposing new cost sharing requirements for every adult above 100 percent of poverty. This proposal is in line with proposed federal regulations on cost sharing. Ohio will require an \$8 co-payment for use of an emergency room for non-emergency conditions, \$8 co-pays for non-preferred drugs, and \$3 co-pays for preferred drugs. Certain long-term maintenance drugs (such as insulin) will have no co-pay. Also, under new federal rule changes, a provider can deny a service if the person does not pay the co-pay. For example, a pharmacist could deny the person the non-preferred drug for not paying the \$8 co-pay but instead offer the preferred drug at the \$3 co-pay.

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