Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OHIO MADE MEDICAID CAPITATION PAYMENTS THAT WERE DUPLICATIVE OR WERE IMPROPER BASED ON BENEFICIARY ELIGIBILITY STATUS OR DEMOGRAPHICS

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A-05-16-00061

Office of Inspector General

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Report in Brief
Date: September 2019
Report No. A-05-16-00061

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Ohio Made Medicaid Capitation Payments That Were Duplicative or Were Improper Based on Beneficiary Eligibility Status or Demographics

Why OIG Did This Review

Ohio makes capitation payments to five managed care organizations (MCOs) for beneficiaries in the Medicaid Managed Care (MMC) program. Previous OIG reviews in other States identified Medicaid payments made on behalf of ineligible beneficiaries and duplicative monthly capitation payments.

Our objective was to determine whether Ohio made capitation payments for its MMC program in accordance with certain Federal and State requirements.

How OIG Did This Review

Our review covered $7.7 billion in MMC program capitation payments for July 1, 2014, through June 30, 2015 (audit period). We summed capitation payments by beneficiary and month. This resulted in 21.6 million beneficiary-months. We performed a risk assessment of those beneficiary-months to focus our sampling on moderate- to high-risk beneficiary-months. We determined 651,374 beneficiary-months ($326.8 million) to be moderate- to high-risk and included those in the sampling frame. Finally, we selected a stratified random sample of 200 beneficiary-months from the sampling frame and reviewed related documentation.

What OIG Found

Ohio did not always make capitation payments for its MMC program in accordance with Federal and State requirements. For 135 of 200 sampled beneficiary-months, Ohio either made proper capitation payments or cancelled the capitation payments before we selected the sample. Capitation payments for the remaining 65 beneficiary-months were improper. Specifically, Ohio made duplicative monthly capitation payments (50 beneficiary-months), made capitation payments that did not correspond with the beneficiary's eligibility status or category (11 beneficiary-months), and made capitation payments that did not correspond with the beneficiary's age or gender (4 beneficiary-months). On the basis of our sample results, we estimated that Ohio claimed net overpayments totaling at least $10.6 million ($6.7 million Federal share) for beneficiary-months in the sampling frame. Generally, Ohio made these improper payments because eligibility system controls did not prevent them, payment system controls did not adjust them, or users entered incorrect data in the eligibility systems.

What OIG Recommends and Ohio Comments

We recommend that Ohio refund $6.7 million to the Federal Government. We also make three procedural recommendations about controls to prevent improper capitation payments in the future.

In written comments on our draft report, Ohio agreed to refund $6.7 million to the Federal Government. Ohio concurred with one of our procedural recommendations but did not concur with the other two. However, Ohio described actions it has taken or planned to take in response to all three procedural recommendations. After reviewing Ohio's comments, we maintain that our findings and recommendations are valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

The Ohio Department of Medicaid (State agency) contracts with managed care organizations (MCOs)[1] to provide comprehensive health care services in return for a monthly fixed payment for each enrolled beneficiary and, in some cases, an additional fixed payment when an enrolled beneficiary has a live birth (capitation payments). The State agency makes capitation payments to the five MCOs that participate in the largest of its three Medicaid managed care programs, the Medicaid Managed Care (MMC) program.[2] Previous Office of Inspector General (OIG) reviews in other States identified Medicaid payments made on behalf of ineligible beneficiaries[3] and duplicative monthly capitation payments.[4]

OBJECTIVE

Our objective was to determine whether the State agency made capitation payments for its MMC program in accordance with certain Federal and State requirements.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. In Ohio, the State agency administers its Medicaid program in accordance with a CMS-approved State plan. Although the State agency has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements. The State agency reports capitation payments on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64) and is reimbursed by CMS for the Federal Government's share of those expenditures (Federal share).

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[1] The State agency refers to these as managed care plans. However, for purposes of this report, we will refer to them as MCOs.

[2] The other two Medicaid managed care programs are MyCare Ohio and Program of All-Inclusive Care for the Elderly.

[3] One of the most recently issued OIG reports on this topic is *California Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements* (A-09-17-02002). In that review, we determined whether certain California eligibility determinations were proper. In this review, we accepted State agency officials' statements about their eligibility determinations as long as such statements were not contradicted by our assessment of applicable documentation.

[4] The most recently issued OIG report on this topic is *Georgia Made Unallowable Capitation Payments for Beneficiaries Assigned Multiple Medicaid Identification Numbers* (A-04-16-07061).

Eligibility Determinations

The State agency may make MMC program capitation payments only on behalf of individuals it determines to be Medicaid-eligible.[5] In addition, the State agency must maintain records that include facts essential to determining initial and continuing Medicaid eligibility (42 CFR § 431.17). From July 1, 2014, through June 30, 2015 (audit period), Ohio was in the process of converting its primary eligibility system from the Client Registry Information System–Enhanced (CRIS-E) to the Ohio Benefits system, but it was still using both systems. County caseworkers used these systems to determine and document eligibility for Medicaid as well as other programs managed by other State agencies (e.g., the Supplemental Nutrition Assistance Program and Temporary Assistance to Needy Families). The State agency provided oversight of county caseworkers' Medicaid eligibility determinations and documentation (e.g., providing training and monitoring compliance).

Capitation Payments

The State agency uses the Medicaid Information Technology System (MITS) to enroll beneficiaries with a contracted MCO in the MMC program and to process capitation payments to the MCO on the beneficiaries' behalf. During the audit period, MITS received beneficiary eligibility information from both CRIS-E and Ohio Benefits and used it to determine the appropriate capitation payment based on a variety of demographic factors. Those factors included the beneficiary's age, gender, geographic region, and eligibility category.[6, 7, 8]

Federal Requirements

If the State agency claims amounts in excess of allowable amounts (overpayments) on the Form CMS-64, it generally must refund the Federal share.[9] Overpayments include duplicative monthly capitation payments[10] and payments that result from data processing errors, such as

[5] The Social Security Act (the Act) § 1903(m)(2)(A)(iii).

[6] These factors were consistent with those in 42 CFR § 438.6(c)(3)(iii) in effect during the audit period.

[7] For this report, we limit our use of the term "eligibility category" to those categories that affect capitation payments (e.g., when a beneficiary's eligibility category changes from one based on modified adjusted gross income to one based on being aged, blind, or disabled).

[8] Capitation payment amounts also varied by MCO to adjust for each MCO's risk associated with beneficiaries whose eligibility category was aged, blind, or disabled.

[9] The Act § 1903(d)(2) and 42 CFR § 433.312.

[10] In the MMC program, multiple monthly capitation payments for the same individual and calendar month are duplicate payments for coverage of the same services and are improper.

capitation payments for individuals not determined to be eligible and capitation payments that do not correspond with beneficiary demographic factors.[11]

HOW WE CONDUCTED THIS REVIEW

Our review covered $7.7 billion in MMC program capitation payments for 21.6 million beneficiary-months[12] in the audit period. We performed a risk assessment of those beneficiary-months to focus our sampling on moderate- to high-risk beneficiary-months.[13] The sampling frame contained 651,374 beneficiary-months ($326.8 million).[14] We determined the remaining beneficiary-months to be low-risk and did not include them in the sampling frame.

In the sampling frame, we determined 29,104 beneficiary-months ($20.2 million)[15] to be high-risk because they contained multiple monthly capitation payments for the same valid Social Security number (SSN) and month. We determined 585,933 beneficiary-months ($281.8 million)[16] to be moderately high-risk because they were either missing eligibility data or had invalid SSNs, increasing the risk that the beneficiaries had not been determined to be eligible. We determined the remaining 36,337 beneficiary-months ($24.9 million)[17] to be moderate-risk. Most of them included capitation payments that did not correspond with beneficiary demographic factors.

We selected a stratified random sample of 200 beneficiary-months from the sampling frame. When reviewing each beneficiary-month, we accepted State agency officials' statements about their eligibility determinations and beneficiary demographic factors as long as such statements were not contradicted by our assessment of applicable documentation in CRIS-E, Ohio Benefits, and MITS. Beyond that, we limited our review of internal controls to those applicable to our objective.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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[11] 42 CFR § 431.960(b).

[12] A beneficiary-month includes all capitation payments associated with a particular individual and calendar month.

[13] We assessed the risk or likelihood that improper capitation payments had been made.

[14] The actual dollar amount is $326,831,688.

[15] The actual dollar amount is $20,203,955.

[16] The actual dollar amount is $281,753,564.

[17] The actual dollar amount is $24,874,169.

Appendix A contains our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

The State agency did not always make capitation payments for its MMC program in accordance with Federal and State requirements. For 135 of 200 sampled beneficiary-months, the State agency either made proper capitation payments or cancelled the capitation payments before we selected the sample. Capitation payments for the remaining 65 beneficiary-months were improper.[18] Specifically, the State agency made duplicative monthly capitation payments (50 beneficiary-months), made capitation payments that did not correspond with the beneficiary's eligibility status or category (11 beneficiary-months), and made capitation payments that did not correspond with the beneficiary's age or gender (4 beneficiary-months). On the basis of our sample results, we estimated that the State agency claimed net overpayments totaling at least $10.6 million ($6.7 million Federal share)[19] for beneficiary-months in the sampling frame. Generally, the State agency made these improper payments because Ohio Benefits controls did not prevent them, MITS controls did not adjust them, or county caseworkers entered incorrect data in the eligibility systems.

FEDERAL AND STATE REQUIREMENTS

If the State agency claims amounts in excess of allowable amounts (overpayments) on the Form CMS-64, it generally must refund the Federal share.[20] Overpayments include duplicative monthly capitation payments. The MCO contract also supports recovery of duplicative monthly capitation payments that were made to the same MCO.[21] Overpayments also include payments that result from data processing errors, such as capitation payments for individuals not determined to be eligible and capitation payments that do not correspond with beneficiary demographic factors.[22]

THE STATE AGENCY MADE DUPLICATIVE MONTHLY CAPITATION PAYMENTS

For 50 of 200 sampled beneficiary-months, the State agency made duplicative monthly capitation payments, resulting in overpayments totaling $17,580 ($11,079 Federal share).[23]

[18] The State agency claimed all improper capitation payments on the Form CMS-64.

[19] The actual dollar amounts are $10,630,695 and $6,729,855, respectively.

[20] The Act § 1903(d)(2) and 42 CFR § 433.312.

[21] MCO contract, appendix C, paragraph 31.b.iii.

[22] 42 CFR § 431.960(b).

[23] For 25 of those beneficiary-months, the State agency made duplicative monthly capitation payments to the same MCO.

MITS made a monthly capitation payment for each active Medicaid identification number, and Ohio Benefits controls did not prevent a beneficiary from having multiple active Medicaid identification numbers at the same time.

State agency officials told us that after our audit started, they added controls to Ohio Benefits. Those controls were designed to prevent multiple active Medicaid identification numbers for the same beneficiary and duplicative monthly capitation payments. For example, in October 2017, the State agency implemented an Ohio Benefits control prohibiting county caseworkers from entering an SSN already in use. However, State agency officials also told us that while they have done some controls testing, they have not yet tested monthly capitation payment data to determine whether the Ohio Benefits controls added after our audit period are effectively preventing duplicative monthly capitation payments.

THE STATE AGENCY MADE IMPROPER CAPITATION PAYMENTS BASED ON ELIGIBILITY STATUS OR CATEGORY

For 11 of 200 sampled beneficiary-months, the State agency made improper capitation payments that did not correspond with the beneficiary's eligibility status or category, resulting in a net overpayment totaling $690 ($470 Federal share).

For 10 of the 11 sampled beneficiary-months, the State agency made improper capitation payments that did not correspond with the beneficiary's eligibility status, resulting in overpayments totaling $1,892 ($1,228 Federal share). State agency officials stated that the individuals were not determined to be eligible for the sampled months, and documentation in the CRIS-E, Ohio Benefits, and MITS systems supported the State agency officials' statements. Therefore, the State agency should not have made capitation payments for these beneficiary-months.[24]

For 1 of the 11 sampled beneficiary-months, the State agency made an improper capitation payment that did not correspond with the beneficiary's eligibility category, resulting in an underpayment totaling $1,202 ($758 Federal share). State agency officials stated that the capitation payment did not correspond with the beneficiary's aged, blind, or disabled eligibility category. Documentation in the CRIS-E, Ohio Benefits, and MITS systems supported the State agency officials' statements. The capitation payment for the sampled beneficiary-month was $244 ($154 Federal share) when it should have been $1,446 ($912 Federal share).

For these 11 sampled beneficiary-months, improper capitation payments remained at the time of our review because MITS controls did not adjust them. When MITS receives an eligibility system update with a retroactive eligibility status or category change,[25] it does not adjust

[24] The Act § 1903(m)(2)(A)(iii).

[25] The 11 sampled beneficiary-months did not involve initial eligibility determinations. We limit our use of the term "retroactive eligibility" to circumstances associated with those sampled beneficiary-months.

capitation payments previously made. MITS cannot determine whether such updates are generated by proper eligibility system changes. Therefore, MITS cannot automatically and accurately address such retroactive changes.

THE STATE AGENCY MADE IMPROPER CAPITATION PAYMENTS BASED ON AGE OR GENDER

For 4 of 200 sampled beneficiary-months, the State agency made improper capitation payments that did not correspond with the beneficiary's age or gender, resulting in a net overpayment totaling $586 ($367 Federal share). State agency officials stated that the capitation payments did not correspond with the beneficiary's age or gender. Documentation in the CRIS-E, Ohio Benefits, and MITS systems supported the State agency officials' statements. The capitation payments for the 4 sampled beneficiary-months totaled $2,151 ($1,350 Federal share) when they should have totaled $1,565 ($983 Federal share).[26]

For these 4 sampled beneficiary-months, the State agency made improper capitation payments because county caseworkers entered incorrect data in the eligibility systems. The county caseworkers inappropriately changed the beneficiary's date of birth or gender in the eligibility systems, and MITS made improper payments consistent with eligibility system updates including those changes. State agency officials told us that they have not yet implemented system prompts in Ohio Benefits to encourage users to verify the beneficiary's date of birth or gender before making changes.

RECOMMENDATIONS

We recommend that the Ohio Department of Medicaid:

- refund $6,729,855 (Federal share) in overpayments to the Federal Government,
- test monthly capitation payment data to determine whether Ohio Benefits controls added after our audit period are effectively preventing duplicative monthly capitation payments,
- implement a process that addresses beneficiary system updates to MITS with retroactive eligibility status and category changes on a case-by-case basis, and
- implement system prompts in Ohio Benefits that encourage users to verify the beneficiary's date of birth or gender before making changes in the system.

[26] For 3 of the sampled beneficiary-months, the State agency made overpayments. For 1 of the sampled beneficiary-months, the State agency made an underpayment.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency agreed to refund to the Federal Government the $6.7 million in our first recommendation. The State agency also concurred with our second recommendation and stated that it had tested for duplicative monthly capitation payments and would continue to do so through its next quarter.

The State agency did not concur with our third recommendation. It stated that it "conducts a monthly review and analysis of certain eligibility types for the month prior" and refunds any identified overpayments. However, the State agency added that it would review its procedures to determine how it could make modifications to address retroactive eligibility status and category changes on a case-by-case basis. The State agency also did not concur with our fourth recommendation. Although it did not concur, the State agency stated that it had recently acted to encourage users to verify the beneficiary's date of birth or gender before making changes in the system and that this action addressed our recommendation. The State agency's comments are included in their entirety as Appendix D.

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. The State agency described corrective actions it has taken or planned to take, but it is beyond the scope of our review to verify those statements. CMS will decide whether the State agency's actions adequately address our findings and recommendations.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered $7,700,596,731 in MMC program capitation payments for 21,631,618 beneficiary-months[27] in the audit period.[28] We performed a risk assessment of those beneficiary-months to focus our sampling on moderate- to high-risk beneficiary-months. The sampling frame contained 651,374 beneficiary-months ($326,831,688).[29] We determined the remaining beneficiary-months to be low-risk and did not include them in the sampling frame.

We limited our review of internal controls to those applicable to our objective, which included CRIS-E, Ohio Benefits, and MITS system controls and related personnel activities necessary to understand the causes for our findings.

We conducted our fieldwork from May 2017 through November 2018.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- reviewed State agency contracts with the MCOs for the audit period;
- met with State agency officials to gain an understanding of applicable systems and procedures;
- obtained capitation payment and eligibility data from State agency officials and discussed those data with them;

[27] Initially, we defined beneficiary-month to include all capitation payments associated with a particular Medicaid identification number and calendar month.

[28] We excluded from our review beneficiary-months (1) related to two other OIG audits or (2) that did not have net-positive capitation payment amounts.

[29] Initially, we determined 680,590 beneficiary-months ($326,831,688) to be moderate- to high-risk. In that group, we determined 58,320 beneficiary-months ($20,203,955) to be high-risk because they contained multiple monthly capitation payments for the same valid SSN and month. (Valid SSNs were those that were not known to be invalid. For example, an invalid SSN is 999-99-9999.) For the 58,320 beneficiary-months, we redefined beneficiary-month to include all capitation payments associated with a particular SSN and calendar month. Each SSN had multiple Medicaid identification numbers and monthly capitation payments associated with it, and we wanted to review the items together as a sample unit. Redefining beneficiary-month resulted in 29,104 beneficiary-months ($20,203,955).

- removed capitation payments that were not for our audit period or were not for the MMC program;

- summed capitation payments by beneficiary-month and removed those related to other OIG audits and those having net-zero or -negative payment amounts;

- performed a risk assessment of the remaining beneficiary-months;

- developed our sampling methodology based on that risk assessment;

- selected a stratified random sample of 200 beneficiary-months;

- obtained access to CRIS-E, Ohio Benefits, and MITS to review documentation for sampled beneficiary-months;

- identified improper capitation payments and determined the Federal share claimed;

- estimated overpayments for beneficiary-months in the sampling frame; and

- met with State agency officials to discuss our findings and recommendations.

Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of all beneficiary-months (1) with net-positive capitation payments that the State agency made for the MMC program for the audit period, (2) that were not related to other OIG audits, and (3) that we determined to be moderate- to high-risk.

SAMPLING FRAME

The State agency provided a data set of managed care transactions, totaling $35,669,065,686, applicable to multiple OIG audits.[30] Starting with that data set, we removed transactions that were not for our audit period or were not for the MMC program. All of the remaining transactions were capitation payments. Next, we summed capitation payments by beneficiary-month and removed beneficiary-months related to two other OIG audits and those with net-zero or -negative capitation payment amounts. The remaining data set contained net capitation payments of $7,700,596,731 for 21,631,618 beneficiary-months. Finally, we removed beneficiary-months that we determined to be low-risk. The resulting sampling frame contained net capitation payments of $326,831,688 for 651,374 beneficiary-months.

SAMPLE UNIT

The sample unit was a beneficiary-month.

SAMPLE DESIGN AND SIZE

We used a stratified random sample and divided the sampling frame into three strata based on our assessed risk for each beneficiary-month.[31]

[30] State agency officials told us that the data set they provided was missing transactions that were part of the target population because certain transactions were difficult to extract on a large-scale basis. Summary information for the missing transactions indicates that the impact of the missing transactions was insignificant.

[31] We separated capitation payments into strata based on the Medicaid identification number of the individual for whom payment was made and the calendar month for which payments were made.

Table 1: Strata Information

Stratum	Assessed Risk	Beneficiary-Months[32]	Net Payment Amount	Sample Size
1	High	29,104	$20,203,955	55
2	Moderately high	585,933	281,753,564	124
3	Moderate	36,337	24,874,169	21
Total		**651,374**	**$326,831,688**	**200**

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in each stratum, and after generating the random numbers for each stratum, we selected the corresponding sample units for review.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the amount of overpayments claimed by the State agency for beneficiary-months in the sampling frame. To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total in the sampling frame 95 percent of the time.

[32] A beneficiary-month is defined differently for stratum 1 than for strata 2 and 3. Stratum 1 contains beneficiary-months with multiple monthly capitation payment records associated with the same SSN but different Medicaid identification numbers. To review these payments as a unit, we defined beneficiary-month based on a particular SSN and calendar month for this stratum. Strata 2 and 3 contain beneficiary-months with capitation payment records associated with missing or invalid SSNs. Therefore, for these two strata, we defined beneficiary-month based on a particular Medicaid identification number and calendar month.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Table 2: Sample Results by Stratum[33]

Stratum	Frame Size	Total Value of Frame	Sample Size	Total Value of Sample	Sample Items With Improper Payments	Value of Overpayments in Sample
1	29,104	$20,203,955	55	$38,081	50	$17,580
2	585,933	281,753,564	124	57,678	10	1,892
3	36,337	24,874,169	21	14,862	5	(616)
Total	**651,374**	**$326,831,688**	**200**	**$110,621**	**65**	**$18,856**

ESTIMATES

Table 3: Estimates of Overpayments in the Sampling Frame
(Limits Calculated for a 90-Percent Confidence Interval)

Estimates	Total Amount	Federal Share
Point estimate	$17,178,268	$10,991,915
Lower limit	10,630,695	6,729,855
Upper limit	23,725,841	15,253,975

[33] The values in Table 2 include both the State and Federal share.

Ohio | Department of Medicaid

Mike DeWine, Governor
Jon Husted, Lt. Governor

Maureen M. Corcoran, Director

August 2, 2019

Ms. Sheri L. Fulcher
Regional Inspector General for Audit Services
Office of the Inspector General
Office of Audit Services, Region V
233 North Michigan, Suite 1360
Chicago, Illinois 60601

Dear Ms. Fulcher:

Thank you for the opportunity to respond to the draft report issued by the Office of the Inspector General (OIG) report entitled "Ohio Made Medicaid Capitation Payments That Were Duplicative or Were Improper Based on Beneficiary Eligibility Status or Demographics (A-05-16-00061)".

After review of the draft and the recommendations provided in the audit conducted for the period July 1, 2014 through June 30, 2015, the Department of Medicaid ("Department") offers the following comments for consideration:

First, based on the recommendation to refund the overpayments to the Federal Government, the Department will make an adjustment to the CMS-64 in the amount of $6,729,855 (Federal share) to address the overpayment.

Second, the Department concurs with the recommendation to actively test the capitation payment data to determine whether the Ohio Benefits controls implemented are effectively preventing duplicative monthly capitation payments and it is actively doing this testing. There are no longer duplicate payments being made for any of the beneficiary-months identified by the OIG's review. Additionally, a review was conducted of over 1,000 recipient Social Security Numbers that were enrolled in managed care in May 2019 and July 2019. This review found only five duplicate payments that had not already been recouped before the review. Three additional duplicate payments had been issued but had already been recouped. This testing will continue throughout the next quarter.

In response to the third recommendation, the Department does not concur. Currently the Department conducts a monthly review and analysis of certain eligibility types for the month prior. Where errors resulting in a positive adjustment to federal funds are detected, the CMS-64 is adjusted and a recipient specific spreadsheet is provided to the federal auditor who conducts the quarterly review of the CMS 64. The Department will review its existing process and determine how it may be modified to reflect the addition of FMAP changes due to reported and determined retroactive eligibility status and category changes on a case by case basis.

The Department also does not concur with the fourth recommendation. In April of this year, working with the Ohio Benefits vendor, the Department implemented several system improvements in Ohio Benefits that encourage users to

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verify the beneficiary's date of birth or gender before making changes to those fields in the system. These changes have already addressed the recommendations that OIG makes here.

Specifically, functionality was put into place to only allow a worker in Ohio Benefits to only change one demographic detail per transaction. If a worker attempts to change more than one of the fields on the Individual Demographics page and clicks 'Save and Return' or if they are updating a 'New' indicator record and click 'Check All', a hard stop will be triggered. The message, "Error! You can only change one of the following data elements for a person at a time: First Name, Last Name, Date of Birth, Gender, Social Security Number, or Alien Number" will be displayed.

Also at this time, functionality was put into place to incorporate soft warnings specifically tailored to each demographic detail collected in Ohio Benefits when changing or updating the Individual Demographic page. These warnings will appear in a lightbox when 'Save and Return' is clicked. In addition, an automatic Journal entry is created whenever a demographic change is made and workers are still required to document in the Journal the reason for the change. The soft warnings are now in place for changes to first name, last name, date of birth, gender, social security number, and alien number.

The Department appreciates the OIG's review and recommendations. Thank you for the opportunity to examine and provide comments on the draft report. Please let me know if you have questions or need additional information.

Sincerely,

/Maureen M. Corcoran/

Medicaid Director