COMPLIANCE IN MANAGED CARE-HCCA MANAGED CARE COMPLIANCE PROGRAM-2009

JIM SHEEHAN
Medicaid Inspector General
New York State
JGS05@OMIG.State.Ny.us

TODAY'S GOALS

- CHALLENGES FOR MANAGED CARE COMPLIANCE IN GOVERNMENT PROGRAMS
- IDENTIFIED COMPLIANCE ISSUES FROM CASES AND REGULATORY ACTIONS
- REVIEW OF EXISTING COMPLIANCE REQUIREMENTS
- PREDICTION OF MANAGED CARE COMPLIANCE FUTURE

THANK YOU TO HCCA-WE REALLY NEEDED THIS PROGRAM

- NO FEDERAL OIG GUIDANCE SINCE 1999
- FEW CORPORATE INTEGRITY AGREEMENTS W/MANAGED CARE
- NO TRADE/INDUSTRY GROUP WITH GUIDELINES ON MANAGED CARE COMPLIANCE
- LIMITED EXTERNAL SUPPORT/TRAINING FOR MCO COMPLIANCE OFFICERS

SPECIAL ISSUES FOR MCO COMPLIANCE

- CONTRACTORS AND EMPLOYEES
- PAYOR AND PROVIDER
- FEDERAL AND STATE REGULATION
- PROCUREMENT AND INSURANCE RULES
- NCQA AND STATE QUALITY REQUIREMENTS
- COMPLEX AND DETAILED GOVERNING CONTRACTS

HEADLINE NEWS-MANAGED CARE COMPLIANCE FAILURES

- Cal7/08-deals with **Anthem Blue Cross** and with **Blue Shield of California** to restore coverage to 2,220 individual customers whose policies been canceled unfairly. The health plans will pay fines to the state totaling at least $13 million. State Insurance settlement
- In Re Managed Care-2003-2007—settlement with mcos about use of claims edit systems for hundreds of millions;private class action
- Ill. 2007-Amerigroup $225 million settlement after loss at trial-refusal to enroll pregnant women-whistleblower, state AG, US DOJ
- Ga., Tx, NY-Prompt payment penalties for failure to claims on time. State Insurance settlement

HEADLINE NEWS-MANAGED CARE COMPLIANCE FAILURES

- Mn 12/07-Dr. McGuire of United Health pays back $600 million for backdated stock options; current CEO and General Counsel pay back over $270 million; head of board compensation committee agrees to arbitration; SEC settlement
- NY 9/08-Healthfirst CEO indicted for false statements; plan agrees to pay NY $35 million for bounty payments to sales reps; AG settlement NY
- NY 1/09 settlement for $50 million with United and Ingenix (United subsidiary) over database used to pay out-of-network physicians. Other major NY insurors enter similar agreements. State AG settlement, related class action settlements

HEADLINE NEWS ON COMPLIANCE PLANS FOR MANAGED CARE

- NEW YORK OFFICE OF MEDICAID INSPECTOR GENERAL MANDATES "EFFECTIVE" COMPLIANCE PROGRAMS FOR MANAGED CARE BEGINNING SPRING 2009
- OFFICE CIRCULATES DRAFT COMPLIANCE GUIDANCE FOR MANAGED CARE
- CMS (1/1/2009) says plans **should** have "*procedures to voluntarily self-report potential fraud or misconduct related to the MA program to CMS or its designee*."
- NEW YORK-Spring 2009-plans **must** have an "effective" plan, "including disclosure of overpayments"
- NEW YORK-Spring 2009 draft Managed Care Compliance Guidance available
- NEW YORK-2009-10 WORK PLAN-We will review plans for effective compliance programs

HEADLINES - SEE OUR NEW COMPLIANCE REGULATION AND OUR WORK PLANS, AND GET REGULAR UPDATES

- www.omig.state.ny.us
- Sign up for our listserve (many of our subscribers are outside New York)
- Learn the coming attractions in other states-we share ideas and audit/investigative techniques, as well as our annual work plan

PROGRAM INTEGRITY-A QUALITY AND DATA PROBLEM

- MEDICAID IMPROPER PAYMENT RATE-18% (PRELIMINARY PERM REPORT, 2007-17 state review) (NEW YORK WAS NOT REVIEWED)
- MEDICARE FFS-ABOUT 4%
- MEDICARE ADVANTAGE- ABOUT 10%
- MEDICAID RATE PROBABLY OVERSTATED, BUT. . .
- CREDIT CARD (THIRD PARTY PAYOR) LOSS RATE FROM IMPROPER PAYMENTS-.07%
- USING DATA TOOLS AND SYSTEMS TO REDUCE IMPROPER PAYMENTS AND UNNECESSARY OR HARMFUL SERVICES
- USING DATA TOOLS TO FOCUS ENFORCEMENT

New York State Medicaid Managed Care

- 2008 direct expenditures over $8.9 billion/year (14% increase over prior year)
- 65% of Medicaid beneficiaries (2.5 million people) now enrolled in managed care (75% in greater New York area) (more than doubled in five years)
- Significant supplemental payments to health providers serving managed care patients

WHEN IS IT FRAUD OR ABUSE?

- COMMON MISTAKE-Fee for service providers defraud plans-but we're not at risk, and why is it a fraud on the government?
  - Managed care plans fail to pay claims to providers - "it's a contract dispute"
  - capitated subcontractors take plan money but don't provide medically necessary service-"you can always appeal the denial"
  - Marketers slam beneficiaries into plans they never agreed to-"it's a market regulation issue"
  - Providers falsify credentials-"it's a credentialing dispute"
  - Sanctioned, excluded providers remain in network

WHEN IS IT FRAUD OR ABUSE?

- Scheme to avoid paying medically necessary claims is a mail fraud-In Re Managed Care
- Taking subcapitation money while avoiding provision of care is fraud on plan and on beneficiaries
- Slamming beneficiaries is a fraud on the beneficiary and the payor (and possibly the Plan)
- Falsifying credentials is a fraud (USA v. Tremoglie). Referring patients to an uncredentialed provider can be a false claim.

WHEN IS IT FRAUD OR ABUSE?

- USING EXCLUDED PROVIDERS IN MEDICAID MANAGED CARE NETWORK IS ILLEGAL, AND CAN SUBJECT PLAN TO CMPs AND RECOVERY
- PROVIDING SERVICES ORDERED BY EXCLUDED PROVIDER IS ILLEGAL AND NONREIMBURSABLE
- USING SUBCONTRACTORS TO ARRANGE FOR SERVICES OR PROVIDE THEM, WHERE THOSE SUBCONTRACTORS EMPLOY EXCLUDED PERSONS, CAN BE ILLEGAL AND NONREIMBURSABLE

Effect of Exclusion From Participation in Medicaid

- September 1999 OIG bulletin
- No excluded person can receive any compensation from federal health care programs
- In effect, this bars even janitors if their compensation is derived in any part from Medicaid
- http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/effected.htm

We are in this together

- THERE IS FRAUD IN MANAGED CARE, AND FRAUD DETECTION AND CONTROL NEED TO BE BUILT INTO BUSINESS PROCESSES FOR STATES, MCOS, AND SUBCONTRACTORS
- WE NEED TO ASSURE THAT MANAGED CARE ENROLLEES HAVE ACCESS TO NEEDED CARE
- WE NEED TO SUPPORT AND COLLABORATE WITH MANAGED CARE SIUs, AND ADDRESS PROVIDER FRAUD AGAINST MCOS
- MCOS NEED TO INVEST IN COMPLIANCE AND SIU PROGRAMS WHICH ADDRESS FRAUD, ABUSE, AND UNACCEPTABLE PRACTICES

WHY THIS TOPIC IS CRITICAL NOW

- LIMITED POLICY ON MANAGED CARE COMPLIANCE SYSTEMS BY FEDERAL GOVERNMENT IN SEVEN YEARS (OUTSIDE OF PART D)
- ONLY SIGNIFICANT MEMBERSHIP GROWTH AREA FOR MANAGED CARE-MEDICAID, SCHIP, FAMILY HEALTH PLUS PROGRAMS IN STATES
- SOME KIND OF HEALTH INSURANCE BASIC COVERAGE FOR ALL, BUILT ON A MANAGED CARE MODEL, IS LIKELY IN NEXT FIVE YEARS

EXISTING FEDERAL SOURCES OF INFORMATION ON MANAGED CARE FRAUD ISSUES

- "Guidelines for Addressing Fraud and Abuse in Managed Care" -HCFA 10/2000 from the National Medicaid Fraud and Abuse Initiative
- "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations" CMS Medicaid Alliance for Program Safeguards-May 2002

EXISTING FEDERAL COMPLIANCE REQUIREMENTS FOR MEDICAID HMOS

- Medicaid HMO must have administrative and management procedures, and a mandatory compliance plan to guard against fraud and abuse. 42 CFR 438.608
- Usual seven elements of compliance program
- Compliance officer and compliance committee accountable to senior management

EXISTING FEDERAL COMPLIANCE REQUIREMENTS FOR MEDICAID HMOS

- Cannot use services or accept orders from providers who have been excluded from Medicare, Medicaid, or SCHIP
- Plan must have system to verify that services are actually provided-42 CFR 455.1
- Plan must report suspected fraud and abuse to the state- 42 CFR 455.1
- Plan report to state must include:
  - Number of complaints made to state that warrant preliminary investigations
  - For each complaint that warrants investigation
    - Name/id number, source of complaint, type of provider,
    - Nature of complaint, dollars involved, disposition
-

MANDATORY COMPLIANCE PROGRAMS IN NEW YORK

- ON JANUARY 14, 2009,THE NEW YORK OMIG PUBLISHED PROPOSED REGULATIONS REQUIRING EVERY MEDICAID PROVIDER, INCLUDING MCOS, WHICH RECEIVES MORE THAN $500,000 IN MEDICAID PAYMENTS PER YEAR, TO HAVE AN "EFFECTIVE" COMPLIANCE PROGRAM
- CERTIFICATION ENROLLMENT-PROVIDER CERTIFIES THAT IT SATISFIES COMPLIANCE PROGRAM REQUIREMENTS. PENALTY FOR FAILURE TO HAVE "EFFECTIVE" COMPLIANCE PROGRAM-EXCLUSION
- Section 363-d of the Social Services Law
- www.omig.state.ny.us (comment period ends 2/28/09)

8 Elements: Mandatory Compliance Programs in NY

1. Written policies and procedures, including code of conduct, how to report
2. Employee designated as chief compliance officer-must report periodically "directly to governing body" on compliance activities
3. Training of everyone on compliance, including orientation for new executives and governing body members about compliance expectations

21

8 Elements: Mandatory Compliance Programs in NY

4. Communication lines from employees to chief compliance officer, including anonymous and confidential reporting
5. Discipline for failure to report suspected problems, permitting non-compliant behavior
6. Routine identification of compliance risk areas, including internal audit and appropriate external audit

22

8 Elements: Mandatory Compliance Programs in NY

7. System for responding to compliance issues as they are raised; correcting such problems promptly and thoroughly, and identifying and reporting compliance issues to DOH or the OMIG; refunding overpayments
8. Non-intimidation and Non-retaliation

23

NEW YORK MANAGED CARE COMPLIANCE GUIDANCE

- GOAL-USEFUL ADVICE FOR PLANS, BOARDS,SENIOR EXECUTIVES, COMPLIANCE OFFICERS AND CMTEES.
- PROCESS-ADVISORY COMMITTEE OF PLAN AND PROVIDER MANAGERS, COMPLIANCE OFFICERS, PATIENT AND PROFESSION ADVOCATES

NY MANAGED CARE COMPLIANCE GUIDANCE- 8 MANDATORY ELEMENTS, PLUS 7 GUIDANCE AREAS

- REPORTING
- CREDENTIALING
- MARKETING
- QUALITY
- GOVERNANCE
- DOCUMENTATION
- SIU

GOVERNANCE-COMPLIANCE INFORMATION PROVIDED TO BOARD MEMBERS

- reports from high-level management
- findings of claim reviews and resulting actions
- compliance officer's summary and description of non-compliance job responsibilities
- compliance officer's opinion as to whether adequate time and resources are provided to perform the required compliance duties
- compliance officer's identification of all areas in need of improvement or correction, impediments to compliance, and steps taken to effectuate change
- identification of and measures to address risk areas
- a summary of information maintained by the compliance officer
- frequency, effectiveness and type of information generated regarding hotline use
- the number and percentage of individuals associated with the managed care organization whohave completed all required training, identifying the topics covered

- actions taken to identify, quantify, and repay any overpayments to the medical assistance program relating to items or services furnished, ordered, or prescribed by excluded persons
- kk. summary of retaliation and intimidation allegations

GOVERNANCE-COMPLIANCE OBLIGATIONS

- 3. Governing authority's compliance obligations
  - acknowledge role in and support of compliance program
  - ensure all governing authority members receive training on compliance program duties on a regular basis
  - emphasize the importance of employee participation and training
  - receive sufficient information to evaluate compliance and effectiveness of compliance program[1]
  - ensure systems exist to implement policies and procedures regarding identifying compliance problems and reducing potential for recurrence
  - meet with compliance officer at least quarterly (may be accomplished through an appropriate subcommittee) and at least annually in a prescheduled executive session
  - ensure systems exist to implement policies and procedures regarding marketing requirements and plan enrollment
- [1] The Office of the Medicaid Inspector General highly recommends that governing authority members familiarize themselves with the Office of Inspector General's and the American Health Lawyers Association's publication "Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors" found at http://oig.hhs.gov/fraud/docs/complianceguidance/040203CorpRespRsceGuide.pdf.

GOVERNANCE-CONFLICTS OF INTEREST

- Governing authority conflicts of interest
- require all governing authority members to disclose actual and potential conflicts of interest through a written disclosure form upon joining, annually, and as conflicts arise; disclosure should be shared with governing authority and audit and compliance committee dependent on organizational structure
- maintain written requirements addressing actual and potential conflicts of interest relevant to each managed care organization committee and each governing authority member
- ensure that systems exist that minimize/manage conflicts of interest
  - a potentially conflicted governing authority member is prudently uninvolved in any vote and does not attempt to influence the outcome of the governing authority's consideration
- ii. governing authority should review and consider the managed care organization's filings with the IRS, including Form 990 non-profit return

GOVERNANCE-QUALITY, INTEGRITY

- Governing authority's oversight of quality
- a. take measures to ensure quality goals are appropriate
- b. maintain internal quality controls
- Governing authority's oversight of fiscal integrity
  - take appropriate measures to ensure sufficient capitalization
  - maintain internal controls
  - ensure managed care organization is able to and does promptly repay overpayments or penalties to the Medicaid program

DOCUMENTATION

- Medical records
  - managed care organizations shall require their subcontractors, including participating providers, to maintain appropriate records including records related to services provided to enrollees, as required by the Medicaid Managed Care and Family Health Plus Model Contract section 19.1. managed care organizations shall monitor participating providers to ensure that records, including electronic records, are timely, thorough, accurate, and with respect to written records, legible. managed care organizations shall use best efforts to ensure that records, including electronic records, maintained by non-participating providers are timely, thorough, and accurate, and, with respect to written records, legible.
- 2. Encounter data
- a. managed care organizations shall prepare and submit encounter data to NYS DOH as required by the Medicaid Managed Care and Family Health Plus Model Contract section 18.5
- 3. Record retention
  - managed care organizations ensure that policies and procedures address the preservation, accessibility, retention, storage, retrieval and destruction of documents and are consistent with the Medicaid Managed Care and Family Health Plus Model Contract section 19.1
  - all records necessary to protect the integrity of the managed care organization's compliance program are maintained
  - records demonstrate that compliance expectations are being met, e.g., documentation that employees were adequately trained

- 4. Confidentiality of information
  - 2
    - **Claims processing and payment**
- Claims
- a. guidelines used by managed care organizations to process provider claims must be in writing
- b. staff assigned to process provider claims must be knowledgeable about coding and receive recurring training in coding
- c. appropriate auditing and monitoring of coding exists
- d. managed care organizations shall comply with the requirements set forth in Insurance Law sections 3224-a and 3224-b when processing and paying provider claims
- e. managed care organizations ensure that recoupment and recapture projects are fairly administered, based upon information reasonably available to providers, independently verifiable and consistent with articulated claims rules and payment data
- Computer software for processing provider claims
  - managed care organizations ensure that
- software used for claims processing is current and includes all features necessary for accurate processing of claims
- Manufacturer updates that revise software programs are timely reprogrammed to include necessary values for accurate processing of claims
- 3. Bundled services
  - services are not unbundled
- Third party health insurance
    - managed care organizations ensure that all other insurers are billed before billing the Medicaid program
    - managed care organizations shall establish policies and procedures and have adequate staffing to address post-payment identification of other insurers by managed care organization or other sources
- Cost reports
  - managed care organizations ensure that cost reports are the result of proper calculations based on appropriate data including reasonable, allowable expenses accurately claimed during the appropriate time period. Policies and procedures should include:
  - creation and maintenance of supporting work papers
  - accumulation of non-financial information for cost report preparation
  - compliance expectations with respect to managed care organization's obligation to make diligent efforts to determine whether enrollees have third party health insurance, and to make good faith efforts to coordinate benefits with and collect third party health insurance and collect recoveries from other insurers
  - reporting of third party health insurance recoveries on cost reports and periodic review of cost reports by external sources
- b. managed care organizations ensure that administrative expenses are appropriately and consistently allocated
- c. managed care organizations must accurately report and allocate contract expenses across all lines of business
- 6. Billing/submission of claims to Medicaid program
- a. managed care organizations shall submit claims for monthly capitation payments consistent with the Medicaid Managed Care and Family Health Plus Model Contract and the Managed Care Billing Guidelines

DOCUMENTATION

- 4. Confidentiality of information
  - managed care organizations shall comply with the requirements set forth in the Federal Heath and Portability and Accountability Act, in the Medicaid Managed Care and Family Health Plus Model Contract in Public Health Law § 18 and in 10 NYCRR § 98-2.12
    - **Claims processing and payment**
- Claims
- a. guidelines used by managed care organizations to process provider claims must be in writing
- b. staff assigned to process provider claims must be knowledgeable about coding and receive recurring training in coding
- c. appropriate auditing and monitoring of coding exists
- d. managed care organizations shall comply with the requirements set forth in Insurance Law sections 3224-a and 3224-b when processing and paying provider claims
- e. managed care organizations ensure that recoupment and recapture projects are fairly administered, based upon information reasonably available to providers, independently verifiable and consistent with articulated claims rules and payment data
- Computer software for processing provider claims
  - managed care organizations ensure that
- software used for claims processing is current and includes all features necessary for accurate processing of claims
- Manufacturer updates that revise software programs are timely reprogrammed to include necessary values for accurate processing of claims
- 3. Bundled services
  - services are not unbundled
- Third party health insurance
    - managed care organizations ensure that all other insurers are billed before billing the Medicaid program
    - managed care organizations shall establish policies and procedures and have adequate staffing to address post-payment identification of other insurers by managed care organization or other sources
- Cost reports
  - managed care organizations ensure that cost reports are the result of proper calculations based on appropriate data including reasonable, allowable expenses accurately claimed during the appropriate time period. Policies and procedures should include:
  - creation and maintenance of supporting work papers
  - accumulation of non-financial information for cost report preparation
  - compliance expectations with respect to managed care organization's obligation to make diligent efforts to determine whether enrollees have third party health insurance, and to make good faith efforts to coordinate benefits with and collect third party health insurance and collect recoveries from other insurers
  - reporting of third party health insurance recoveries on cost reports and periodic review of cost reports by external sources
- b. managed care organizations ensure that administrative expenses are appropriately and consistently allocated
- c. managed care organizations must accurately report and allocate contract expenses across all lines of business
- 6. Billing/submission of claims to Medicaid program

Marketing

- 1. Marketing practices meet the requirements set forth in Social Services Law § 364-j and are consistent with Medicaid Managed Care and Family Health Plus Model Contract section 11 and Appendix D
- 2. Managed care organizations ensure
- a. completeness and accuracy of marketing material
- b. marketing materials correctly and completely describe plan information
-
- 3. Marketing activities
- a. Managed care organizations ensure that marketing materials are developed and that marketing activities are carried out in accordance with the Medicaid Managed Care and Family Health Plus Model Contract Appendix J
- b. Managed care organizations ensure that marketing materials are developed and that marketing activities are carried out consistent with Limited English Proficiency guidelines
- **B. Enrollment**
- 1. Enrollment practices are consistent with Medicaid Managed Care and Family Health Plus Model Contract section 6 and Appendix H
- 2. Facilitated enrollment terminations for cause should be reported

CREDENTIALING

- a. managed care organizations shall have in place a formal credentialing process as set forth in the Medicaid Managed Care and Family Health Plus Model Contract section 21.4.
- b. managed care organizations must retain oversight and control if delegating credentialing function
- c. managed care organizations shall ensure, in accordance with Article 44 of the Public Health Law, that persons and entities providing care and services for the organization in the capacity of physician, dentist, physician assistant, registered nurse, other medical professional or paraprofessional, or other such person or entity satisfy all applicable licensing, certification, or qualification requirements under New York law and that the functions and responsibilities of such persons and entities in providing Benefit Package services do not exceed those permissible under New York law.
- . A managed care organization's compliance program should ensure that any required credentialing processes are in place and functioning effectively.[1]

[1] *See* 10 NYCRR § 98-1.12(k) and (l)

REPORTING

- The compliance program should ensure that systems exist to facilitate effective reporting. Managed care organizations should exercise due diligence and good faith in meeting obligations to ensure accurate and complete reporting
- Detailed list of reporting requirements: contract, state law and regulation, federal law
- The compliance officer need not be substantively responsible for these complex reporting requirements, but should know how they are being met

NEW YORK STATE REQUIREMENTS SPECIFIC TO MEDICAID MCOS

- Plans are required to submit report of fraud and abuse prevention activities due each year

- 10 NYCRR Sub-Part 98

MORE NEW YORK STATE REQUIREMENTS SPECIFIC TO MCOS

- Fraud and Abuse Prevention Plan must be filed with the Commissioner of Health
- Special Investigation Unit for detection, investigation,and prevention of fraud
- (Medicaid managed care model contract, Section 23)

ISSUES OF INTEREST

- Credentialing
  - Who are these providers?
  - Excluded providers
  - Delegation to subcontractor providers
  - Delegation to specialized organizations
  - Data oversight and recredentialing

ISSUES OF INTEREST

- ACCESS TO PRIMARY CARE
- ACCESS TO SPECIALISTS AND IN-PATIENT SERVICES
- ACCESS FOR PATIENTS WITH SPECIAL NEEDS
- QUALITY PROVIDERS

ISSUES OF INTEREST

- Fraud against MCOs
  - Fee for service
  - Done?
  - Necessary?
  - Charges?
  - Coding?

FRAUD AGAINST HMOS

- No or limited access
- Failure to provide necessary services
- Mandated referrals to non-participating providers (anesthesiology, radiology)
- REMEMBER: Fraud against a Medicaid HMO is fraud against the State of New York

ISSUES FOR HMOs

- Credentialing
- Claims processing and payment
- Access
- Multiple beneficiary numbers-multiple payments
- Payment under fee for service for mco-contracted services

ISSUES FOR MCOS AND OMIG

- Billing/ payment for dead beneficiaries
- Multiple billing/payment for single beneficiary to single plan
- Multiple enrollments for single beneficiary in multiple plans
- Overlaps in eligibility and care with specialized plans (AIDS, long term care)

ISSUES FOR MCOS AND OMIG

- Pregnant males
- Pregnant females under 12
- Pregnant females over 50
- "born again" beneficiaries
- Data entry, accuracy by county offices
- Data entry, accuracy for encounter information
- Pharmacy services for MCO beneficiaries

Working Together

- Huge growth in Medicaid Managed Care over past five years
- Heavy big city concentration
- We need to focus on fraud against and fraud within MCOs
- Increased attention to MCO issues at state and federal level

IN YOUR SPARE TIME. . .

- Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care (October 2000)

http://www.cms.hhs.gov/FraudAbuseforProfs/02_MedicaidGuidance.asp#TopOfPage
Scroll to bottom of page and select Managed Care - click on fraudgd.pdf.

- Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans (May 2002)

http://www.cms.hhs.gov/FraudAbuseforProfs/02_MedicaidGuidance.asp#TopOfPage
Scroll to bottom of page and select Managed Care – click on mccomplan.pdf.

- The Florida Senate Interim Project Report 2006-133 (November 2005)

http://www.flsenate.gov/Publications/2006/Senate/reports/Workprogram/pdf/workprogram.pdf (Page 97)

- Ohio Performance Audit (December 2006)

http://www.auditor.state.oh.us/AuditSearch/Reports/2006Ohio_MedicaidProgram_12_19.pdf
This file will take approximately 11 minutes to download.