

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**OHIO DID NOT ALWAYS
PROPERLY CLAIM MEDICAID
REIMBURSEMENT FOR
HOSPICE CLAIMS**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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Sheri L. Fulcher
Regional Inspector General

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Office of Inspector General

<https://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

Ohio did not always properly claim Federal Medicaid reimbursement for hospice claims.

WHY WE DID THIS REVIEW

Hospice care is a program of palliative care that provides for the physical, emotional, and spiritual care needs of a terminally ill patient and his or her family. The goal of such care is to achieve the highest quality of life as defined by the patient and his or her family through the relief of suffering and control of symptoms. Previous Office of Inspector General reviews found that States did not always comply with Federal and State requirements for hospice claims.

The objective of this review was to determine whether Ohio properly claimed Federal Medicaid reimbursement for hospice claims submitted by hospices in Ohio.

BACKGROUND

A hospice is a public agency, private organization, or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. Hospice care can be provided to individuals in a home, hospital, nursing home, or hospice facility.

In Ohio, the Department of Job and Family Services (the State agency) administers its Medicaid program in accordance with the Centers for Medicare & Medicaid Services (CMS) approved State plan. The State plan establishes what services the Medicaid program will cover including hospice care. To be eligible to elect hospice care under the Medicaid program, an individual must be certified by a physician as terminally ill. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is six months or less. If an individual elects to receive hospice care, he or she must file an election statement with a particular hospice.

For hospice services to be covered under Medicaid, services must be provided in accordance with the *State Medicaid Manual* (the Manual) issued by CMS. The Manual specifies the requirements for: proper pricing procedures, physician certification, the use of licensed workers, provider reimbursement at the proper amount and level of care, and election statement content.

HOW WE CONDUCTED THIS REVIEW

We limited our review to Medicaid hospice claims of \$100 or more paid to Ohio hospices during the 2-year period July 1, 2009, through June 30, 2011. For the purpose of this report, we will refer to Medicaid costs for room and board or hospice care services, or both, paid for one beneficiary during a month as a claim. From a total of 103,668 hospice claims totaling approximately \$388 million (\$282 million Federal share), we reviewed a random sample of 100 hospice claims totaling \$382,408 (\$278,616 Federal share) from 48 Ohio hospices.

WHAT WE FOUND

The State agency did not always properly claim Federal Medicaid reimbursement for hospice claims. Of the 100 sampled claims, the State agency properly claimed Federal Medicaid reimbursement for 84 claims. The State agency did not properly claim Federal Medicaid reimbursement for the 16 remaining claims. However, the unallowable dollar amounts related to these 16 claims are immaterial.

For the 16 improper claims, the hospices:

- did not claim the correct room and board rate (9 claims),
- did not properly apply the patient liability portion to the claimed room and board amount (7 claims), and

In addition, hospices did not always meet election statement requirements. Of the 100 claims reviewed, hospices met the election statement requirements for 40 claims. Hospices did not meet the election statement requirements for the remaining 60 claims. For these claims, the hospices:

- did not maintain a Medicaid election form on file (46 claims), and
- did not ensure election statements contained required language (14 claims).

A dually eligible beneficiary must elect both Medicare and Medicaid hospice benefits. However, for Medicaid payment, claims for room and board are not considered hospice benefits. Therefore, we did not take exception to the 60 claims or estimate an error rate or improper payment amount. The election statement deficiencies occurred because the State agency did not have a uniform election statement for use state-wide by all hospices.

WHAT WE RECOMMEND

We recommend that the State agency:

- ensure that hospice claims are processed correctly, and adjusted when necessary, to meet Medicaid reimbursement requirements;
- monitor hospices to ensure that Federal and State requirements are met with regard to election statement content; and
- establish a uniform election statement to be used state-wide by all hospices and ensure that all required language is included in the statement.

STATE AGENCY COMMENTS

In written comments to our draft report, the State agency concurred with our recommendations and provided information on actions that it plans to take to address our recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

Hospice care is a program of palliative care that provides for the physical, emotional, and spiritual care needs of a terminally ill patient and his or her family. The goal of such care is to achieve the highest quality of life as defined by the patient and his or her family through the relief of suffering and control of symptoms. Previous Office of Inspector General reviews found that States did not always comply with Federal and State requirements for hospice claims.¹

OBJECTIVE

Our objective was to determine whether Ohio properly claimed Federal Medicaid reimbursement for hospice claims submitted by hospices in Ohio.

BACKGROUND

The Medicaid Program: How It Is Administered and What Hospice Services It Covers

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 Medicaid program. In Ohio, the Department of Job and Family Services (the State agency) administers its Medicaid program in accordance with the CMS-approved State plan. The State plan establishes what services the Medicaid program will cover including hospice care when it is provided by a licensed hospice.

Hospices Provide Care to Terminally Ill Patients and Patient Eligibility

A hospice is a public agency, private organization, or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. Hospice care can be provided to individuals in a home, hospital, nursing home, or hospice facility.

A Medicaid participating hospice meets the Medicare conditions of participation for hospices and has a valid provider agreement. To be eligible to elect hospice care under the Medicaid program, an individual must be certified by a physician as terminally ill. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course. If an individual elects to receive hospice care, he or she must file an election statement with a particular hospice.

¹ U.S. Department of Health and Human Services, Office of Inspector General, report number A-01-10-00004 entitled *Review of Medicaid Hospice Payments Made by Massachusetts for State Fiscal Years 2007 and 2008*, issued February 18, 2011; A-01-10-00012 entitled *Review of Medicaid Hospice Payments to Evercare Hospice & Palliative Care for State Fiscal Years 2007 Through 2009*, issued September 23, 2011; A-01-11-00005 entitled *Rhode Island Did Not Always Comply With State Requirements on Medicaid Payments for Hospice Services*, issued March 26, 2012; and A-01-12-00002 entitled *Rhode Island Hospice General Inpatient Claims and Payments Did Not Always Meet Federal and State Requirements*, issued August 13, 2012.

How Hospice Care Services Are Reimbursed Under the Medicaid Program

A hospice is reimbursed for each day that an individual is under its care based on the type and intensity of the services, or level of care furnished to the individual for that day. The different levels of care include, but are not limited to, continuous home care and routine home care.

For continuous home care, the amount of payment is determined based on the number of hours of continuous care furnished to the individual for that day. A minimum of 8 hours per day must be provided. Routine home care is paid without regard to the volume and intensity of services provided on any given day. A hospice is paid at the routine home care rate for each day that an individual is under its care and does not qualify at another rate.

When hospice care is furnished to an individual residing in a nursing facility, the hospice is paid an additional amount to take into account the expense of the room and board furnished by the facility. The amount that the hospice is paid is equal to ninety-five percent (95%) of the State agency's calculated per diem rate for basic care at that nursing facility, minus any applicable patient contribution. States are required to reduce payments to a hospice for services provided to certain Medicaid-eligible individuals by amounts deducted from an individual's income to pay for medical expenses.² In Ohio, this amount is referred to as the patient liability.

For hospice services to be covered under Medicaid, services must be provided in accordance with the *State Medicaid Manual* (the Manual) issued by CMS. The Manual specifies the requirements for: proper pricing procedures, physician certification, the use of licensed and qualified workers, provider reimbursement at the proper amount and level of care, and election statement content.

HOW WE CONDUCTED THIS REVIEW

We limited our review to Medicaid hospice claims³ of \$100 or more paid to Ohio hospices during the 2-year period July 1, 2009, through June 30, 2011 (audit period). From a total of 103,668 hospice claims totaling approximately \$388 million (\$282 million Federal share), we reviewed a simple random sample of 100 hospice claims totaling \$382,408 (\$278,616 Federal share) from 48 Ohio hospices. A claim represented the Medicaid costs for room and board (94 claims) or hospice services (3 claims), or both (3 claims), paid for one beneficiary during the month.⁴

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

² The amount deducted from each individual's income is based on the individual's total income, a personal needs allowance, and other considerations specified in regulation 42 CFR § 435.832.

³ For the purpose of this report, we will refer to Medicaid costs for room and board or hospice care services, or both, paid for one beneficiary during a month as a claim.

⁴ Of the 100 sampled claims, 94 room and board claims were for dually eligible beneficiaries. The remaining 6 hospice service claims relate to Medicaid only beneficiaries.

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 A contains the details of our audit scope and methodology. Appendix B contains excerpts from the Manual detailing, among other things, the content requirements for the election statement and from the Ohio Administrative code regarding Ohio hospice reimbursement and election form requirements.

FINDINGS

The State agency did not always properly claim Federal Medicaid reimbursement for hospice claims. Of the 100 sampled claims, the State agency properly claimed Federal Medicaid reimbursement for 84 claims. The State agency did not properly claim Federal Medicaid reimbursement for the 16 remaining claims. However, the unallowable dollar amounts related to these 16 claims were immaterial.

For the 16 improper claims, the hospices:

- did not claim the correct room and board rate (9 claims),

did not properly apply the patient liability portion to the claimed room and board amount (7 claims), and

The improper claims occurred because the State agency did not adequately monitor hospices for compliance with State requirements related to the processing of the claims and having proper election forms.

Additionally, hospices did not meet election statement requirements related to 60 claims sampled. Specifically, hospices:

- did not maintain a Medicaid election form on file (46 claims), and
- did not maintain a Medicaid election form containing the required election statement language (14 claims).

Pursuant to the CMS *Medicare Benefit Policy Manual*, Chapter 9, § 20.3, a beneficiary who is dually eligible must elect both Medicare and Medicaid hospice benefits if the State offers hospice benefit under its Medicaid program. This section sets requirements for Medicare payments of hospice services and does not affect Medicaid payments for room and board claims. Therefore, we did not take exception to the 60 claims or estimate an error rate or improper payment amount. The election statement deficiencies occurred because the State agency did not have a uniform election statement for use state-wide by all hospices.

HOSPICES DID NOT CLAIM THE CORRECT ROOM AND BOARD RATE

For 9 hospice room and board claims, hospices billed and the State agency processed an incorrect rate when pricing and paying hospice claims as required.⁵

For 5 of the room and board claims, hospices used a previous period's nursing facility room and board per diem rate instead of the applicable rate for the time period.

- For example, one provider used the previous fiscal year's rate of \$188.16 instead of the nursing facility per diem rate of \$186.44 applicable to that particular fiscal year to calculate the monthly room and board reimbursement. The provider should have billed 95 percent of \$186.44 for each day of the 31-day patient stay. As a result, the State agency paid the provider \$5,542 when it should have paid \$5,491, an overpayment of \$51.

For the remaining 4 room and board claims, the hospices billed the room and board per diem rate at 100 percent of the nursing facility's per diem rate instead of the required 95 percent.

- For example, one provider billed the full 100 percent of the nursing facility rate of \$169.87 per day for the patient's 31-day stay, instead of 95 percent of the rate, or \$161.38, less the patient liability portion of \$698. As a result, the State agency paid the provider \$4,568 when it should have paid \$4,305, an overpayment of \$263.

HOSPICES DID NOT PROPERLY APPLY THE PATIENT LIABILITY PORTION TO THE CLAIMED ROOM AND BOARD AMOUNT

For 7 hospice room and board claims, hospices billed and the State agency processed hospice claims that contained improperly applied patient liability amounts.

- For 4 of the room and board claims, hospices did not subtract the patient liability amount from the room and board claim. For example, one provider billed 95 percent of the nursing facility per diem rate of \$220.73 for the patient's 13-day stay. However, the provider did not subtract the patient's liability of \$557 from the bill. As a result, the State agency paid the provider \$2,726 when it should have paid \$2,169, an overpayment of \$557.
- For 2 of the room and board claims, hospices billed an incorrect patient liability amount. For example, another provider's billing software was not able to calculate and appropriately subtract the entire patient's liability amount. The provider subtracted a patient liability amount of \$2,213 from the total room and board claim, instead of the appropriate \$2,354. As a result, the State agency paid the provider \$3,318 for room and board, when it should have paid \$3,177, an overpayment of \$141.

⁵ Ohio Administrative Code (chapter 5101:3-56-06 (C)(1)).

- For the remaining 1 claim, the hospice incorrectly applied the patient liability portion of \$957 to 100 percent of the rate of \$199.84 before multiplying by the 95 percent of the rate (\$189.85) for the patient's 31 day stay. As a result, the State agency paid the provider \$4,976 when it should have paid \$4,928, an overpayment of \$48. .

Hospices attributed the incorrect room and board payments and the patient liability errors to clerical errors and to computer software that could not calculate partial day billings for patient liability.

HOSPICES DID NOT MEET ELECTION STATEMENT REQUIREMENTS

For 60 room and board claims, hospices did not meet the election statement requirements of the Manual, as follows:

- For 46 claims, the hospice election statement did not state that the beneficiary was electing the Medicaid hospice benefit
- For 14 room and board claims, the Medicaid hospice election statement did not include a waiver of all rights to Medicaid payments for services.⁶

Pursuant to the CMS *Medicare Benefit Policy Manual*, Chapter 9, § 20.3, a beneficiary who is dually eligible must elect both Medicare and Medicaid hospice benefits if the State offers hospice benefit under its Medicaid program. This section sets requirements for Medicare payments of hospice services and does not affect Medicaid payments for room and board claims. Therefore, we did not take exception to the 60 claims or estimate an error rate or improper payment amount. The election statement deficiencies occurred because the State agency does not have a uniform election statement used state-wide, which, if adopted, would ensure the required language is included in the election statements.⁷

RECOMMENDATIONS

We recommend that the State agency:

- ensure that hospice claims are processed correctly, and adjusted when necessary, to meet Medicaid reimbursement requirements;
- monitor hospices to ensure that Federal and State requirements are met with regard to election statement content; and

⁶ CMS State Medicaid Manual § 4305.2, see Appendix D.

⁷ States with uniform election statements include, but are not limited to, Connecticut, Florida, Mississippi, Missouri, and New Jersey.

- establish a uniform election statement to be used state-wide by all hospices and ensure that all required language is included in the statement.

STATE AGENCY COMMENTS

In written comments to our draft report, the State agency concurred with our recommendations and provided information on actions that it plans to take to address our recommendations. The State agency's comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

For the audit period, we limited our review to Medicaid payments made by the State agency to hospices for hospice care provided to Medicaid beneficiaries as authorized under the State plan. We excluded claims in which the paid amount was less than \$100.⁸

After taking into account the exclusions above, we determined that the State processed and paid 103,668 Medicaid hospice claims totaling \$388 million (\$282 million Federal share) for hospice care provided during the audit period. We reviewed a random sample of 100 claims. A claim represented the Medicaid costs for room and board (94 claims) and hospice services (3 claims), or both (3 claims), paid for one beneficiary during the month.⁹

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we limited our internal control review to the objective of our audit.

We conducted fieldwork at 48 individual hospices around the State of Ohio.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- held discussions with State agency officials to gain an understanding of the State agency's hospice care program;
- obtained Medicaid paid claims for service dates during the audit period, from the State agency;
- identified a sampling frame of 103,668 hospice claims, totaling \$387,987,282 (\$281,895,275 Federal share); and
- selected a simple random sample of 100 hospice claims from our sampling frame, and for each claim, obtained and reviewed the related hospice documentation to determine whether hospice care was provided in accordance with Federal and State requirements.

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

⁸ For the purpose of this report, we will refer to Medicaid costs for room and board or hospice care services, or both, paid for one beneficiary during a month as a claim.

⁹ Of the 100 sampled claims, 94 room and board claims were for dually eligible beneficiaries. The remaining 6 hospice service claims relate to Medicaid only beneficiaries. .

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: FEDERAL AND STATE REQUIREMENTS FOR HOSPICE CARE

FEDERAL ELECTION STATEMENT CONTENT REQUIREMENTS

Pursuant to section 4305.4 of the Manual, to be covered, a certification that the individual is terminally ill must have been completed as set forth in § 4305.1 and hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care in accordance with § 4305.2....

Pursuant to section 4305.2 of the Manual, if an individual elects to receive hospice care, he or she must file an election statement with a particular hospice. An election may also be filed by a representative acting pursuant to State law. With respect to an individual granted the power of attorney for the patient, State law determines the extent to which the individual may act on the patient's behalf.

Pursuant to section 4305.3 of the Manual, the election statement must include the following items of information: identification of the particular hospice that will provide care to the individual; the individual's or representative's acknowledgement that he or she has been given a full understanding of hospice care; the individual's or representative's acknowledgement that he or she understands that the Medicaid services listed in § 4305.2 are waived by the election; the effective date of the election; and, the signature of the individual or representative.

The services that must be waived pursuant to section 4305.2 are:

- Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice); and
- Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except for services—
 - Provided (either directly or under arrangement) by the designated hospice;
 - Provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services; or
 - Provided as room and board by a nursing facility if the individual is a resident.

Pursuant to the CMS *Medicare Benefit Policy Manual*, Chapter 9, § 20.3, a beneficiary who is dually eligible must elect both Medicare and Medicaid hospice benefits if the State offers hospice benefit under its Medicaid program.

OHIO HOSPICE REIMBURSEMENT AND ELECTION FORM REQUIRMENTS

Ohio regulations state that when the consumer is a resident of a nursing facility, the hospice shall be reimbursed for room and board....To receive reimbursement, the hospice must bill the State agency the amount equal to ninety-five per cent of the Medicaid nursing facility per diem rate as obtained from the nursing facility (chapter 5101:3-56-06 (C)(1) of the Ohio Administrative Code).

Ohio regulations state that if the consumer is enrolled or becomes enrolled in Medicare, the consumer must elect the Medicare hospice benefit at the same time that the Medicaid hospice benefit is elected in order to assure that Medicaid is the secondary payor (chapter 5101:3-56-02 (A)(3) of the Ohio Administrative Code).

APPENDIX C: STATE AGENCY COMMENTS



John R. Kasich, Governor
John B. McCarthy, Director

April 28, 2014

Ms. Sheri L. Fulcher
Office of Audit Services, Region VI
233 North Michigan, Suite 1360
Chicago, IL 60601

Re: Report Number A-05-12-00087

Dear Ms. Fulcher,

Please accept this letter as Ohio's response to the draft OIG Audit report listed above. Ohio concurs with the recommendations identified in the report. Ohio's response is included below.

Recommendation: Ensure that hospice claims are processed correctly and adjusted when necessary, to meet Medicaid reimbursement requirements.

Nature of corrective action: Ohio will implement system edits by December 31, 2014 to ensure hospice claims are processed correctly and meet Medicaid reimbursement requirements. By the end of 2014, Ohio will also reduce incorrect hospice claims by implementing semi-annual reviews of hospice payments. These reviews will check to ensure the following:

- use of the correct nursing facility rate;
- use of the correct patient liability amount; and
- compliance with hospice payment methodology.

Recommendation: Monitor hospice to ensure that Federal and State requirements are met with regard to election statement content

Nature of corrective action: By the end of calendar year 2014, Ohio will conduct semi-annual reviews of election statements to ensure compliance with Federal and State requirements.

Recommendation: Establish a uniform election statement to be used state-wide by all hospices and ensure that all required language is included in the statement

Nature of corrective action: Ohio will implement a standardized federally compliant election statement and will require use by all Hospice providers by the end of calendar year 2014.

Thank you for your report. We look forward to collaborating with you on future endeavors.

Sincerely,

A handwritten signature in black ink that reads "John B. McCarthy". The signature is written in a cursive style and includes a small flourish at the end.

John B. McCarthy
State Medicaid Director

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Columbus, Ohio 43215

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