Via Electronic Mail

March 6, 2024

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

Dear Auditor Faber:

Thank you for the opportunity to respond to the draft report issued by the Auditor of State (AOS or Auditor) regarding potential concurrent enrollment during the public health emergency (PHE).

At the outset of this response, The Ohio Department of Medicaid (ODM, the Department, or Medicaid) does want to acknowledge that more work needs to be done to continue to improve Medicaid eligibility processes. That said, ODM has worked incredibly hard—especially over the past several years—to reduce burdens on county caseworkers, dramatically decrease the number of alerts that county eligibility caseworkers receive, and improve the accuracy of Medicaid eligibility rolls.

While ODM appreciates the continued work of AOS and the work associated with this audit, ODM was unable to validate the draft audit report's conclusions and has questions about the audit's methodology. In addition, despite much of the audit period falling within the COVID-19 public health emergency, the report did not account for the heightened federal requirements in place at that time. These requirements significantly affected the ability of States to remove individuals from Medicaid rolls.

Before addressing these concerns, however, ODM believes a brief background of the Medicaid work in the eligibility space would be helpful.

1. **Beginning in 2019, Medicaid Adopted Multiple Enhancements that have Improved the Eligibility System, Reduced Alerts, and Increased Efficiency.**

In 2019, at the start of this administration, ODM began meeting with county caseworkers to better understand issues with eligibility system alerts and to identify areas for system improvement. Among other work, ODM invited eligibility specialists from several counties to visit ODM and discuss ways to improve the eligibility process. Discussion with these specialists highlighted that caseworkers encountered difficulty when attempting to identify more meaningful alerts related to eligibility given the overabundance of Ohio Benefits (OB) alerts generally. The excessive number of alerts also created issues for caseworkers when trying to prioritize their work.

In 2020, ODM, the Ohio Department of Job and Family Services (ODJFS), and the Ohio Department of Administrative Services (DAS) formed the OB Program team, which was tasked with reducing the volume

of alerts generated in the system. The team started analysis in 2020, reviewing the alerts that represented the highest volume and the highest error rates and prioritizing any defects or enhancements identified for upcoming releases. Since that time, the OB Program team has completed significant work to reduce the number of alerts generated by OB.

Part of the work of this team consisted of "sprints," a project management approach to identify, design, and deploy changes to functionality that can be made quickly but without significant operational disruption. This work removed redundant alerts, corrected system defects, cleared outdated alerts, and improved income comparison logic and automation. Since 2020, the OB Program team's work has reduced the volume of alerts between 8.5 and 12 million per year.

ODM undertook extraordinary efforts to reduce eligibility system alert volume by between 8.5 and 12 million per year since 2020.

In addition, ODM has developed Bots and program enhancements that have successfully auto processed numerous alerts and given county caseworkers more time to process applications and redeterminations and address system alerts that require manual resolution. As a few examples of the Bots and program enhancements:

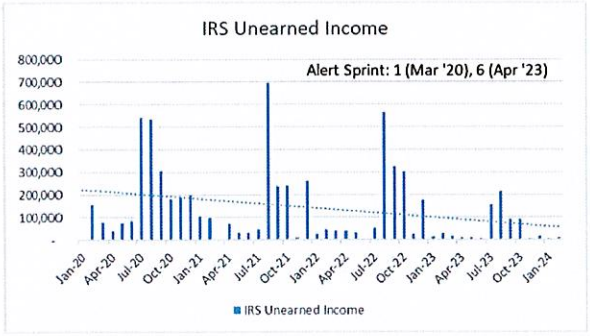
- **DRC Bot** – This program has processed over 200,000 alerts related to incarcerations.
- **Baby Bot** – This Bot adds a newborn's information to their mother's Medicaid case for all counties and has generated Medicaid IDs for over 51,000 newborns.
- **Pregnancy Bot** – This program ensures that pregnant individuals are assigned to the correct aid code and considered for postpartum coverage. It has cleared thousands of alerts.
- **SSP Case Linking Request Bot** – This Bot reviews case-linking requests submitted by individuals. It has processed nearly 500,000 of these requests.
- **Alert Sprint Six** – Implemented in April 2023, this focused on IRS IEVS alerts and IEVS e-Verify alerts. This work reduced the volume of incoming IRS alerts by approximately 70% and e-Verify alerts by approximately 90% compared to 2022.
- **Automated Notices** – In June 2023, in response to feedback from county caseworkers, ODM programmed improvements related to Public Assistance Reporting Information System (PARIS)[1] notices, including a system update that automatically generated address verification second notices, eliminating the need for caseworkers to manually generate the notices.
- **Correction of Defects** – The OB Program team identified two defects related to PARIS alerts. The team slotted one defect fix related to system-generated PARIS contact notices for release on

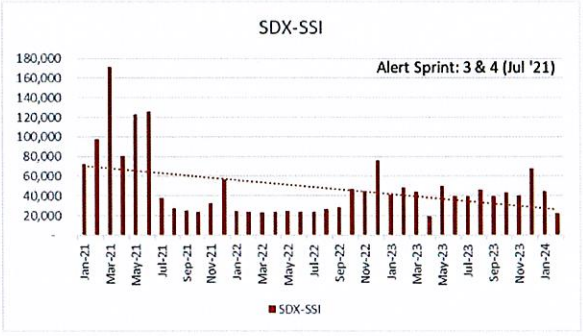
[1] PARIS is a data matching service matching recipients of public assistance in multiple States. *See* https://www.acf.hhs.gov/paris.

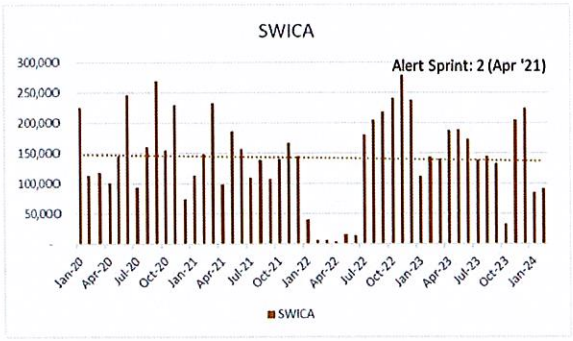
December 10, 2022. The second defect fix related to performance of the interstate matches coming into OB and was completed on January 23, 2023.

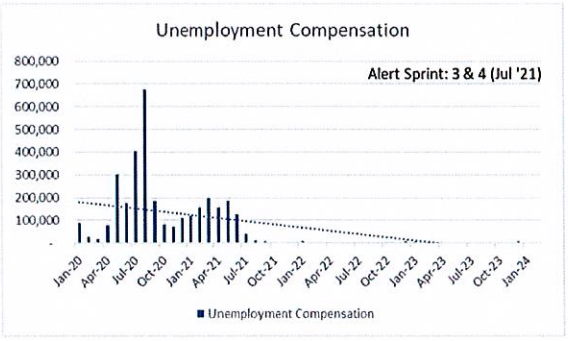
The charts below help illustrate how these and other Bots and process improvements have reduced alerts over the past several years:

Number of Alerts









Similarly, the chart below illustrates the dramatic reduction of alerts based on the work of the OB Program team:

Year	Total estimated alerts without Bots and other system improvements	Total actual alerts after the work of the OB Program Team	Reduction of Alerts based on the work of the OB Program Team
2020	24,000,000	23,330,786	669,214
2021	27,500,000	18,949,621	8,550,379
2022	27,000,000	15,078,176	11,921,824
2023	29,000,000	17,919,084	11,080,916

Ohio has significantly improved its eligibility accuracy for the Medicaid program resulting from these initiatives and other hard work. And this is reflected in federal audits.

Every three years, the Centers for Medicare & Medicaid Services (CMS) completes a Payment Error Rate Measurement (PERM) audit. In PERM audits, CMS samples Medicaid fee-for-service (FFS) claims, managed care capitation payments, and the payments resulting from eligibility determinations to estimate overall Medicaid and CHIP program error rates. The results demonstrated that the accuracy of Ohio's payment and eligibility determinations has dramatically improved over the past several years, with Ohio's estimated Medicaid payment error rate based on eligibility determinations dropping from 43.49% in Reporting Year (RY) 2019 to 8.23% in the RY 2022 report.[2]

Ohio's payment error rate based on eligibility determinations has substantially improved from Reporting Year 2019 to Reporting Year 2022.

While much work remains to be done, ODM has worked exceptionally hard to reform Medicaid eligibility processes, and audits such as the RY 2022 PERM reflect significant improvements.

2. Questions Exist Concerning the Methodology and Conclusions of the Audit Report.

AOS "conducted [its] audit to determine the impact of concurrent Medicaid enrollment on Ohio's program during the period of January 1, 2019 through December 31, 2022." Auditor of State, *Ohio Department of Medicaid: The Cost of Concurrent Enrollment* (January 31, 2024) at p. 1. For calendar years 2019 through 2022, AOS "obtain[ed] capitation payment data (a fixed per-member per-month payment) . . . to identify instances in which the Ohio Department of Medicaid (the Department) made capitation payments for enrollees who concurrently had capitation payments made on their behalf by another state or territory." *Id.* at p. 1. AOS stated that "data obtained for this audit identified 124,448 individuals concurrently enrolled in Ohio and at least one other state for at least three consecutive months" over the four-year period. *Id.* at p. 3.

Out of the 124,448 individuals concurrently enrolled in Ohio Medicaid and another state Medicaid program over the four-year span of 2019 to 2022, AOS "selected a sample of 125 enrollees from the 11 states with the highest number of shared enrollees" with Ohio. *Id.* at p. 1; *see* section 2(c), *infra*, for a discussion about the sample and questions about this statement in the report. AOS concluded that 26% of the capitation payments for the 125 enrollees were made when the individual was residing outside of Ohio at the time and extrapolated from the sample of 125 individuals that "[t]he estimated impact on Ohio's capitation payments for individuals residing in one of these 11 other states is over $209 million" over the four-year period. Auditor's Report at 10-11.

The following sections address some of the Department's concerns with the audit's structure, methodology, findings, and conclusions.

---

[2] *2019 Medicaid & CHIP Supplemental Improper Payment Data*, page 45, https://www.cms.gov/files/document/2019-medicaid-chip-supplemental-improper-payment-data.pdf-1 (last accessed 2/26/24); *2022 Medicaid & CHIP Supplemental Improper Payment Data*, page 53, https://www.cms.gov/files/document/2022-medicaid-chip-supplemental-improper-payment-data.pdf-0 (last accessed 2/26/24).

a. The Audit Sample Occurred Largely During the Public Health Emergency During Which CMS Required "Affirmative Confirmation" that an Individual was no Longer a Resident of the State.

From January 2020 through May 11, 2023, the Health and Human Services Secretary issued a Public Health Emergency (PHE) based on the COVID-19 pandemic.[3]

The auditor's report covered 48 months—**34 of which overlapped with federal PHE requirements that made it much harder for States to disenroll enrollees based on individuals potentially relocating to a different State.**

71% of the audit time period occurred during the Public Health Emergency when federal requirements made disenrolling enrollees much more difficult.

During the PHE, beginning on March 18, 2020, to help offset additional costs associated with the COVID-19 pandemic, States could opt for enhanced federal funding, known as the State's federal medical assistance percentage (FMAP), for their Medicaid programs. *See* The Family First Coronavirus Response Act, Pub. Law 116-127, § 6008; 42 CFR 433.400. To remain eligible for this additional federal assistance, States were required to maintain the eligibility of all Medicaid enrollees except in one of only three circumstances:

> (i) The beneficiary or the beneficiary's representative requests a voluntary termination of eligibility;
>
> (ii) The beneficiary ceases to be a resident of the state; or
>
> (iii) The beneficiary dies.

Id. at (d)(1). These requirements (and others) were known as the federal "maintenance of operations" requirements (MOE). The purpose of these requirements was simple—to ensure that much needed health benefits remained available to as many individuals as possible during the COVID-19 pandemic.

CMS elaborated on the residency exception (the second circumstance above) and made clear that during the MOE, to disenroll an individual from Medicaid, States needed to "**affirmatively confirm**" that an enrollee had relocated to a different State with the intent to remain there. Prior to the MOE, a PARIS match followed by an individual not responding to notices was sufficient to remove the individual from the Medicaid program of the State. During the MOE, however, non-responses were no longer sufficient. A State needed to take additional steps, including "affirmative confirmation."

CMS later added that States could not remove enrollees if any information indicated that the enrollee may still be a state resident.

More specifically, during an all-state call on November 5, 2020, in response to a question about the treatment of PARIS matches, a CMS representative confirmed:

---

[3] On January 31, 2020, the Health and Human Services Secretary issued a Public Health Emergency declaration with an effective date of January 27, 2020 (https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx). On May 11, 2023, the Secretary declared the end of the Public Health Emergency (https://www.hhs.gov/about/news/2023/05/11/hhs-secretary-xavier-becerra-statement-on-end-of-the-covid-19-public-health-emergency.html).

> "There is an exception in the FFCRA and the IFC for individuals who are no longer residents of the state. If the state can **affirmatively confirm** that a beneficiary is no longer a resident of that state and is in fact a resident of another state, that individual's eligibility would be terminated under this exemption. But it's important to keep in mind that especially during the pandemic, many Americans are temporarily moving around, and may be located in a different state but have no intention of staying in that state, and in effect would be considered temporarily absent under the state's policy."[4]

The following month, in December 2020, CMS provided additional instructions:

> "That the - it's not quite the same process as prior to COVID because the - what we're looking at here is whether the - through a PARIS match you identify that an individual is no longer a state resident. So as you indicated, the expectation would be that if you identify an individual on a PARIS match you would first, you know, reach out to the individual to have them confirm district residency. **If the individual does not respond, that is not sufficient information at this point, to determine that they are no longer a resident and terminate their eligibility.** We don't describe explicitly which data sources a state would need to check but yes, DMV, checking other information in your state case records to identify **whether you have information that would indicate that they may** in fact be a state resident. If you have any information that does, you would not be able to terminate eligibility. **In the IFC we also clarify that there'll be an expectation too, to communicate with the other states in which it appears the individual may be enrolled, prior to terminating eligibility**."[5]

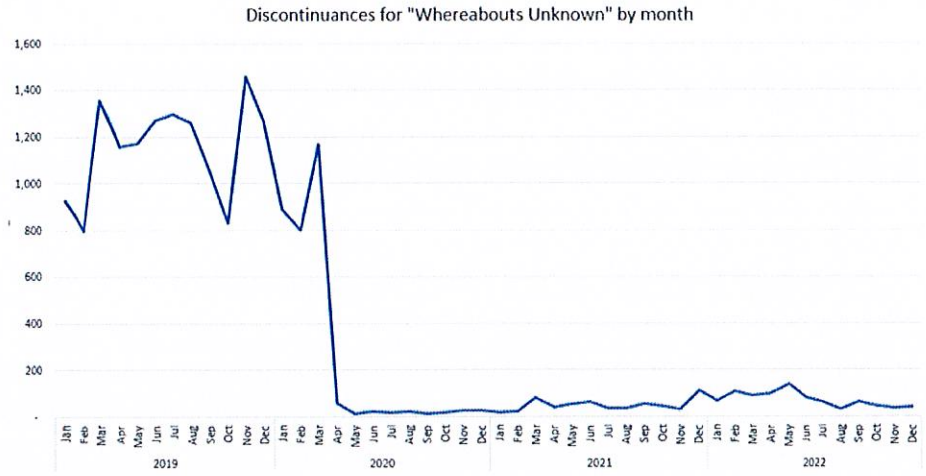
During the PHE and the MOE, States had to affirmatively confirm relocation to a different State and could no longer rely on unreturned notices.

These additional restrictions significantly affected the removal of enrollees during the MOE based on a change in residency. The chart below helps illustrate the dramatic drop in the removal of enrollees based on returned mail or failure to respond to notices following PARIS matches. The counties typically record returned mail and non-responses as "Whereabouts Unknown/Loss of Contact."

---

[4] *Centers for Medicare & Medicaid Services COVID-19 Medicaid & CHIP All State Call 11-5-2020/3:00 pm ET* Transcript, page 12, https://www.medicaid.gov/sites/default/files/2023-04/TranscriptCOVID19AllStateCall11052020.pdf (last accessed 2/13/24) (emphasis added).

[5] *Centers for Medicare and Medicaid Services COVID-19 All State Call 12-15-20/4:15 ET Transcript*, page 26, https://www.medicaid.gov/sites/default/files/2023-04/TranscriptCOVID19AllStateCall12152020.pdf (last accessed 2/16/24) (emphasis added).



This chart further illustrates that the PHE and MOE was an abnormal time with different rules and regulations. **Caution should be used in attempting to extrapolate any findings from this period into "regular" periods of operation, outside of declared health emergencies.**

AOS's report dedicated two paragraphs to the MOE requirements and significantly downplayed the impact of the strict requirements. Indeed, the consequences of noncompliance were significant—a State's failure to comply with the heightened requirements created a risk of the State losing the enhanced federal match, which for Ohio was approximately $4.34 billion. The report does not discuss the possibility of the MOE causing (or even contributing to) the bleak picture portrayed in the report about concurrent eligibility and state spending.

Moreover, AOS's statement that "a PARIS match could be used to terminate enrollment if an enrollee was notified and did not respond and the state was unable to verify residency through other reasonable means" is not an accurate description of the MOE requirement and downplays the enhanced requirement. As stated above, any "indication" that a person "may" still be a resident of the State required that the State maintain Medicaid benefits. And "affirmative confirmation" was required.

The audit report should have examined and assessed the impact of the strict MOE requirements. It did not. While AOS **may** have been able to confirm residency in hindsight using data and data sources not available to county caseworkers at the time (or now), this does not necessarily mean that the county action on the PARIS alerts with the information available at the time of the alert was incorrect.

b. AOS did not Provide Sufficient Information and Data about the Sample and ODM was Unable to Test, Confirm, or Replicate the Audit.

Despite ODM's request for this data, AOS did not identify the 125 enrollees in its sample. AOS also did not identify the residence of each sampled individual for each month, the State or States where each individual was enrolled each month, or the dates of any services and claims.

Without this basic information, ODM was unable to verify or replicate the audit methodology or validate any of the findings.

ODM was unable to replicate or validate the report's findings because the sample data was not provided.

The audit report also does not detail the methodology that the auditors used to assume the residency of each individual in the sample for each month during the audit period. While pages 9 and 10 of the report list several bullets with information that the auditors used to "help determine" residency, it remains unclear which of this information the auditors used for each individual in the sample. It is also unclear whether the auditors accessed all of this information for each specific month or whether the auditors made assumptions about residency for longer periods of time.

The assumed residency of the individuals in the sample for each month of the audited time period is not documented, and the report also does not indicate whether individuals relocated back to Ohio during the sample period. Relocations to and from Ohio are relevant to the assessment based on the quarterly PARIS interface matches.

Based on the information available in the draft report, actual residency may not have been established but merely approximated based on the bulleted list of information. Ohio Administrative Code 5160:1-1-01(B)(80) defines "residence" as the place the individual considers his or her established or principal home and to which, if absent, he or she intends to return." AOS staff acknowledged that they did not communicate with any of the 125 individuals in the sample to confirm whether the assumptions about residency were correct.

Also, while the report helps highlight potential hurdles that States encountered during the MOE, as drafted, the report could lead a reader to conclude the findings are attributable to Ohio alone, rather than all States collectively. The relevance of the report's findings to time periods outside of the MOE are also questionable given the MOE requirements ended in April 2023 and States were then required to redetermine eligibility for all enrollees and return to routine eligibility operations.

c. The Report Does Not Adequately Describe the Methodology Used in Selecting the Sample.

The report does not include sufficient detail for ODM and readers to understand and assess AOS's sampling methodology, which consisted of a stratified sample. Stratified sampling is typically a preferred methodology when there is concern that certain subsets are significantly different from the full population such that simple random sampling risks under inclusion or limited ability to examine. In cases where the likelihood of inclusion is not at risk, the use of simple random sampling is often preferred to ensure the results are as representative of the overall population as possible. AOS provided little discussion of the subpopulations in the strata and why there would be any concern that simple random sampling would result in under representation. With the limited information provided, it is quite difficult to assess the appropriateness of the stratification decisions made and of the resulting extrapolation from the sampled population up to the general population.

In particular, the Appendix identifies the number of individuals concurrently enrolled by the State. However, the sample was selected from the highest cost rather than the highest count of concurrent enrollments. Thus, several States with higher numbers of individuals concurrently enrolled were not included while Illinois—with a comparatively lower number of individuals—was included. The decision to include a State with a lower population should be connected to a methodologic justification related to sampling ability or validity, but no such logic is provided.

Similarly, basic descriptive statistics are a standard element of sampling methodology that are currently absent in the report. The number or percentage of the total concurrent population and of the sampled population that fall into meaningful groupings is important to establishing the validity of the sampled population. Some descriptive statistics that ODM would recommend to provide clarity within this report include frequency by major caseload grouping (*e.g.*, ABD, CFC, Expansion, etc.), the number or percent of individuals with only the minimum number of concurrent enrollments to qualify for inclusion (*i.e.*, only 3 months), the average number of months of concurrent enrollment, and the standard deviation of that average, the average cost per person, and the standard deviation on that average.

AOS does report that of the 124,448 individuals in the total population 2,372 were concurrently enrolled for 48 months. Although this means that such individuals comprise approximately 2% of the total concurrently enrolled population, the stratified sample of 125 that the AOS selected over represents these individuals. 12% of the individuals included in the sample were concurrently enrolled for the entire 48-month period. Given the intentional oversampling of this population, it then becomes imperative that the report include appropriate weights in any resulting extrapolation. Thus, ODM would also encourage the inclusion of the formulas utilized to move from the sampled population to the estimated $209 million impact for the 11 States from which samples were selected.

Finally, ODM appreciates that the quantitative elements of this report are enhanced with some qualitative work to gain additional insight into potential recommendations. Like the quantitative methodology, however, there is relatively little background provided about the method employed. As qualitative work involving interviews is especially susceptible to various forms of bias, it would have been a best practice for AOS to indicate the methodological precautions taken to ensure that the comments cited are representative of the overall caseworker/county experience. At first glance, a sample size of three (from the 86 CDJFSs) casts some doubt on the ability of this qualitative work to elucidate general experiences. Similarly, AOS did not provide ODM with the notes from county interviews, despite ODM's request for this information. Demonstration of methodologic rigor, including appropriately validated questions and interrater reliability measures, is a standard requirement of sound qualitative research.

d. The Report does not Include any Methodology for T-MSIS Matches.

The Transformed Medicaid Statistical Information System (T-MSIS) is a federal database that collects Medicaid and Children's Health Insurance Program (CHIP) data from U.S. states, territories, and the District of Columbia. The findings and conclusions of the audit report rely in part on data from T-MSIS. For example, the report concludes that "T-MSIS data obtained for this audit identified 124,448 individuals concurrently enrolled in Ohio and at least one other state for at least three consecutive months." Auditor's Report at p. 3. The report did not set forth the methodology, parameters, or controls that AOS used to make findings and conclusions based on T-MSIS. Consequently, ODM is unable to validate or replicate any of the audit findings and conclusions that used this database.

e. States Receive PARIS Data Only Quarterly and this Affects Concurrent Enrollment.

Section 1903(r)(3) of the Social Security Act requires States to have an eligibility determination system which provides for data matching through PARIS. *See* 42 U.S.C. §1396b(r)(3). Once a State receives a PARIS match, the State cannot deny or terminate eligibility or reduce benefits for any individual based

on information received through PARIS unless the State has sought additional information from the individual. *See* 42 CFR §435.952(d).

ODM receives PARIS interface matches on a quarterly basis in March, June, September, and December. Thereafter, county caseworkers send two subsequent notices to an enrollee's potential addresses to attempt to ascertain whether the enrollee has moved. Each notice requires a response within 10 days. ODM has recently (after the time period of the audit) automated the process of sending these notices. This automation is one of the improvements intended to help reduce the workload and burdens on county caseworkers.

As stated above, during the MOE, non-responses to these notices were insufficient justification for a State to remove an individual from the Medicaid roll. But even in normal times outside of the PHE, the quarterly distribution of data from PARIS means that there will likely be a coverage overlap for many enrollees who relocate out-of-state.

As an illustration, assume that ODM enrollee A moved from Ohio to Kentucky on January 1, 2021, and enrolled in Kentucky medicaid, but did not inform ODM. PARIS would not have sent an interface match to ODM until March. Thereafter, during normal circumstances outside of the PHE, ODM would mail enrollee A two subsequent notices in addition to a discontinuance Notice of Action prior to termination of benefits. During the PHE, however, the MOE required Ohio to do even more.

The PARIS database (used to identify potential concurrent eligibility) generates interface matches only quarterly.

Nonetheless, even outside of the PHE and the MOE, a person may be enrolled in Ohio and another State for several months before Ohio is even aware and able to take action to confirm residency. Notably, federal law requires a State to provide prior written notice of proposed disenrollment that includes hearing rights. *See* 42 CFR 435.917. In some circumstances, an individual is also entitled to continue receiving benefits until a hearing decision is issued. *See* 42 CFR 431.230. These federal due process requirements must also be considered when assessing a potential period of concurrent enrollment.

The timing of receiving PARIS data is a national topic. It is not Ohio-specific. It is unclear why the audit report did not address the timing of receiving PARIS data. Moreover, when AOS extrapolated "the impact on Ohio's capitation payments," it is unclear whether AOS accounted for the timing of receiving PARIS data. Given that the report did not discuss the timing of receiving PARIS data, it is unlikely that the timing of receiving PARIS data was considered or excluded from the chart on page 10 of the report.

Finally, out of the 125 individuals in the audit sample, AOS included 67 enrollees in States neighboring Ohio. Another 25 were in States immediately adjacent to one of the adjacent States. AOS focused on these neighboring States because they "had the highest dollar value of concurrent capitation payments and enrollee matches during the audit period." Audit's Report at p. 7. CMS, however, cautioned that during the PHE, "many Americans are temporarily moving around, and may be located in a different

state but have no intention of staying in that state, and in effect would be considered temporarily absent under the state's policy."[6]

Especially in urban areas close to neighboring States, such as Cincinnati, Toledo, and Youngstown, it would be unsurprising to see individuals relocate to the adjacent State only to return to Ohio several months later. The difficulties associated with receiving PARIS data only quarterly coupled with the federal MOE requirement to affirmatively identify when an individual relocated during the PHE would be compounded by such frequent moves.

f. The Estimated Impact on Capitation Payments did not Consider Actuarial Analysis

AOS extrapolated from the sample of 125 individuals that "The estimated impact on Ohio's capitation payments for individuals residing in one of these 11 other state is over $209 million." Auditor's Report at p. 11. Based on ODM's review of Appendix C, it appears that AOS may have simply used multiplication for this extrapolation. If this is the case, the figure of $209 million is unreliable because it does not take into consideration the complicated process of setting actuarially sound capitation rates.

AOS's extrapolation of a $209 million impact did not involve actuarial analysis and cannot be considered accurate or reliable.

ODM is required to conduct a sophisticated assessment of the Medicaid population to determine actuarial sound capitation rates for each member in the managed care population. Non-utilization of services by a member is one of many factors that tend to reduce rates overall. If there were concurrently eligible individuals for whom other state Medicaid programs paid claims, the low or non-utilization in Ohio for these individuals would decrease rates overall across all members. Absent an actuarial analysis, which ODM does not see in the report, AOS's extrapolation of a $209 million impact cannot be considered accurate or reliable.

As a final matter, AOS suggested that either Ohio or other States improperly made capitation payments for 124,448 individuals over the four-year span from 1999 to 2022 and the sum of these payments equaled $1 billion. The report does not break down the purported erroneous spending among States. Regardless, the observations in Sections 2(a) through 2(f) of this response would apply to this figure and whatever sub-part of the $1 billion that AOS would potentially attribute to Ohio. The concerns expressed throughout this response call into question the usefulness of this number, and the figure could lead to confusion or cause readers to draw incorrect conclusions.

---

[6] *Centers for Medicare & Medicaid Services COVID-19 Medicaid & CHIP All State Call 11-5-2020/3:00 pm ET* Transcript, page 12, https://www.medicaid.gov/sites/default/files/2023-04/TranscriptCOVID19AllStateCall11052020.pdf (last accessed 2/13/24) (emphasis added).

3. ODM's Responses to the Audit Report's Recommendations

a. Recommendation 1: Increase the Use of Technology

The Department should work with other state Medicaid agencies and CMS to maximize the use of information technology for identifying individuals already enrolled in the Medicaid program. Currently, the enrollment process includes the electronic verification of eligibility factors using various sources. Examples of eligibility factors include the verification of income and of non-financial factors such as citizenship and social security numbers. With state residency being a key requirement, the Department should advocate for a system that also returns information regarding an individual's enrollment in another state's Medicaid program.

Along with this added functionality, the Department should work with other Medicaid state agencies and CMS to develop a consistent and streamlined approach for communication between states, such as each state implementing a single email address that can be used to identify and address concurrent enrollment issues. Feedback from the CDJFS staff interviewed highlighted the difficulties in communicating with other states to resolve residency issues and the Department's staff echoed this concern.

The Department indicated that currently verification from another state would not be sufficient in verifying residency; therefore, the Department should advocate with CMS to change the requirements to allow for that type of verification to be sufficient. Sharing that an applicant has attested to residency in a different state should be sufficient for the prior state to disenroll the enrollee.

With an additional interface that allows states to identify an applicant who is already enrolled in another state's Medicaid program during the application process and an improved communication and coordination system between Medicaid state agencies, the Department would be able to identify and resolve potential concurrent enrollment in a proactive manner and save public dollars from being misspent.

ODM Response

There are multiple sub-parts within AOS Recommendation 1:

(1) *"With state residency being a key requirement, the Department should advocate for a system that also returns information regarding an individual's enrollment in another state's Medicaid program."*

ODM is uncertain how to respond to this recommendation because this system (PARIS) already exists and was a primary focus of this audit.

(2) *"Sharing that an applicant has attested to residency in a different state should be sufficient for the prior state to disenroll the enrollee."*

This recommendation would require a change to federal law. Under 42 CFR §435.952(d), a State agency "may not deny or terminate eligibility or reduce benefits for any individual" without "provid[ing] proper notice and hearing rights."

(3) *"With an additional interface that allows states to identify an applicant who is already enrolled in another state's Medicaid program during the application process and an improved communication and coordination system between Medicaid state agencies, the Department would be able to identify and resolve potential concurrent enrollment . . . ."*

This recommendation is unclear. The PARIS matching system already exists, and its purpose is to identify individuals "enrolled in another state's Medicaid program." If AOS is recommending a different process or electronic data source or system, which is unclear, the State would need to exercise caution. As described in 42 CFR 435.952(c)(2), the state may not rely on an electronic data source alone to disenroll an individual if the information received from that source is not "reasonably compatible" with information provided by the individual directly. Thus, if an individual indicates Ohio residency on the Ohio Medicaid application but an electronic data source indicates Kentucky residency, ODM is required by federal law to seek additional information or documentation from the individual to confirm residency. The state may not deny or terminate eligibility or reduce benefits for any individual on the basis of information received from electronic sources unless the agency has sought this additional information from the individual and provided proper notice and hearing rights. 42 CFR 435.952(d). Thus, the use of another process or system would likely not enable ODM to "resolve" potential current enrollment questions any quicker than it already does by using PARIS matches.

(4) *The department should advocate to CMS for changes.*

ODM agrees with leveraging technology to assist with proactively identifying concurrent enrollment; however, the draft audit report's recommendation seems to place the responsibility for overhauling the federal/state data exchange process on the shoulders of Ohio alone. While Ohio can advocate for creative advancements, there are limitations to Ohio's ability to make national changes. ODM does not have a complete or even partial picture of all available state and federal data sources, the integrity of those sources, or the complexities or time involved in building connections to access those sources. Moreover, ODM is required to follow federal law related to notices and hearings.

(5) *The department should "develop a consistent and streamlined approach for communication between states, such as each state implementing a single email address that can be used to identify and address concurrent enrollment issues."*

This process already exists. Instructions for States to provide "match contact information" can be found on the PARIS web site. *See* "State Administrative Representatives" on State Interstate Match Contact | The Administration for Children and Families (hhs.gov) (www.acf.hhs.gov/paris/map/state-interstate-match-contact#OH_5234) (last accessed 2/23/24). The web site lists the specific contact information for each State for enrollment issues.

b. Recommendation 2: Earlier Identification of Concurrent Enrollment

Ohio's current Medicaid application only includes prompts for the applicant to provide a home and a mailing address. The Department should expand the application to include questions to ascertain if the individual recently moved to Ohio and if the individual was enrolled in the Medicaid program in the prior state. This information would provide an additional avenue to proactively identify concurrent enrollment and avoid the overpayments currently being made.

The Department should advocate with other state Medicaid agencies and CMS to have a requirement that each state implement a similar process of inquiry to identify potential concurrent enrollment. This addition to the application process along with the consistent and streamlined communication between states (noted in recommendation 1) would allow states to reduce the incidence of concurrent enrollment. While Ohio Admin. Code § 5160:1-2-10(B)(2) indicates that processing delays in terminating medical assistance in the prior state of residence is not grounds for denying Medicaid benefits in Ohio, improvements in proactively identifying concurrent enrollment so that the prior state of residence can end its enrollment would be beneficial and reduce public funds being misspent.

In reviewing the information for the sampled enrollees, we noted that a significant number of individuals were enrolled in states for multiple years but never received any services through that state's Medicaid program. After the current unwinding process is complete, the Department should perform an administrative review of enrollees that have not received any services through the program in a set period, such as two years. The set period may be different for different age groups. In these instances, the Department should review the cases of these enrollees for issues such as outstanding PARIS alerts, returned mail with no forwarding address and/or returned mail with an out of state forwarding address, journal entries regarding address/residency and changes in other benefit programs.

Implementing these proactive steps to identify individuals that may no longer be residents of Ohio, along with the other recommendations included in this report will ensure Ohio has a robust system to reduce unnecessary capitation payments. Proactive identification of individuals that no longer reside in Ohio would also aid other benefit programs such as SNAP.

ODM Response

There are multiple sub-parts within AOS Recommendation 2:

(1) *"The Department should expand the application to include questions to ascertain if the individual recently moved to Ohio and if the individual was enrolled in the Medicaid program in the prior state."*

For online applications, ODM currently does ask whether an applicant is currently (or was previously) receiving benefits from another State. ODM will explore the possibility of adding these questions to the

paper application. Application modifications must be reviewed and approved by CMS prior to implementation.

(2) *"The Department should advocate with other state Medicaid agencies and CMS to have a requirement that each state implement a similar process of inquiry to identify potential concurrent enrollment."*

The CFR requires all States to use PARIS. *See* 42 CFR 435.945(d). Indeed, under federal law, "All State eligibility determination systems must conduct data matching through the Public Assistance Reporting Information System (PARIS)." *Id*.

(3) *"[T]he Department should perform an administrative review of enrollees that have not received any services through the program in a set period, such as two years."*

While claims data, or lack thereof, can be used as a lead to initiate contact with enrollees, this information cannot be used alone to discontinue coverage. *See* 42 CFR 435.916.

ODM would also caution the use of this report to make inferences about the typical state of concurrent eligibility and the disenrollment process. As discussed throughout this response, the PHE was a unique time with more individuals remaining continuously enrolled for longer lengths of time than is typical. As the unwinding takes place, many individuals will naturally be disenrolled due to failure to renew.

Notwithstanding the foregoing, ODM will consider whether the absence of claims followed by inquiry and processes to corroborate is a potential strategy that could be used to identify enrollees whose Medicaid eligibility should be discontinued. As stated above in the response to the third sub-part of the first recommendation, ODM would need to exercise caution because federal law places guardrails around disenrollments based on electronic data sources, without additional confirmation. *See* 42 CFR 435.952(c)(2), (d).

c. Recommendation 3: Improvements in Clearing of PARIS Alerts

The Department's data shows that there were over 64,000 pending PARIS alerts at the end of December 2022. The number of pending alerts ranged from three in one small county to over 15,000 in one of the larger metro counties. With the end of the PHE and completion of the unwinding process, there have been many changes that impacted CDJFS staff.

In previous audits, the Department has outlined efforts to improve its processing of PARIS alerts. These efforts included analyzing and improving the functionality of the eligibility system, deploying County Engagement managers to work closely with the CDJFS offices, and reducing the alerts generated by the eligibility system. The Department should continue in its efforts to work with CDJFS offices to address PARIS alerts.

In addition, the Department should work with other states and CMS to develop a simplified method to communicate issues involving an enrollee's residency status to assist all states in reducing the costs of concurrent enrollment. The Department should advocate for an enhancement to the PARIS alert data, specifically to have contact information for each state incorporated with the alerts. Currently the contact varies by state, with some states

using a single email address and others with relying on individual contact information. Including contact information in the alert would help ensure that there is a clear communication pathway which would benefit the entire program.

The Department should also evaluate benefits from increased collaboration between CDJFS offices. In 2014, Ohio launched County Shared Services, an initiative to expedite and standardize eligibility and enrollment processes across county lines for Medicaid and other programs. CDJFS staff suggested there may be a benefit in increased collaboration between CDJFS offices, building on the benefits currently gained in the shared services groups. For instance, CDJFS offices that do not have backlogs of uncleared alerts could assist CDJFS offices that have backlogs. The Department should continue to engage in dialogue with the CDJFS offices to explore this option and others that maybe identified to assist CDJFS offices in clearing backlogs with PARIS alerts along with other casework activities.

ODM Response

There are multiple sub-parts within AOS Recommendation 3:

(1) *"The Department should continue in its efforts to work with CDJFS offices to address PARIS alerts."*

ODM is committed to working with our state and county partners to improve the PARIS alerts process at both the State and county levels. ODM heard from counties that the volume of alerts generated in OB hindered the caseworkers' ability to complete daily tasks. The OB Program team worked collaboratively to reduce the volume of alerts generated in the system. The team started analysis in 2020, reviewing the alerts that represented the highest volume and the highest error rates and prioritizing any defects or enhancements identified for upcoming releases. Since that time, the OB Program team has completed significant work to reduce the number of all alerts generated by OB.

As discussed earlier in this response, to continue the effort of alert improvements in OB, staff continued engaging in "Sprints." Since the onset of alert sprint efforts, the project team has completed six alert sprints and a release focused on implementing smarter alert logic that includes removal of redundant alerts, clearing outdated alerts, re-evaluation of income comparison logic and automation of alert actions on behalf of the worker.

Also discussed earlier in this response, ODM has identified defects related to PARIS alerts. The OB Program team slotted one defect fix related to system-generated PARIS contact notices for release 4.4.1 on December 10, 2022, and the second defect fix related to performance of the interstate matches coming into OB was completed in release 4.5 on January 23, 2023. In April 2023, the OB Program team implemented Alert Sprint Six which targeted IRS IEVS alerts and IEVS e-Verify alerts. This reduced the volume of incoming IRS alerts by approximately 70% and e-Verify alerts by approximately 90% compared to 2022.

In June 2023, the OB Program team implemented an enhancement in OB in response to feedback from county caseworkers to add an actual due date on the PARIS notice that is generated by the system. In addition, the team updated the system to automatically generate the PARIS 7220 (second request) 10 days after the PARIS Contact Notice for all matches that have not yet been addressed in E-Verify on the 10th day, eliminating the need for the county caseworker to manually generate the request. The OB Program team continues to engage the counties and in January 2024, identified SWICA and UCB alerts as the next target for potential alert reduction efforts.

In addition to the OB systems work to reduce the volume of the alerts being generated, ODM has also implemented Bots to assist counties with working alerts that require manual intervention. These Bots are discussed earlier in this report.

The Department will continue to utilize county engagement managers to work closely with the counties to review the importance of PARIS alert processing, receive county feedback on the PARIS alert system, and discuss process improvements. The County Engagement managers will continue to review and provide feedback on county procedures for processing PARIS alerts.

(2) *The Department should advocate for contact information to be included with PARIS alerts.*

While ODM will consider this, any programming change to the generated PARIS interface match reports would need to incorporate the most up to date contact information for each State. If not, when a county caseworker processes an alert, such contact information may be obsolete. The preferable option may involve county caseworkers simply referring to the existing state contact information publicly available on the PARIS web site. ODM will remind counties about the availability of this contact information in future training sessions.

Importantly, when ODM identifies an issue from another State, ODM proactively attempts to correct it. For example, ODM recently learned of a neighboring State that is continuously sending erroneous matches due to an issue in the client record in that State's eligibility system. ODM, DAS, and ODJFS discussed the issue and ODJFS contacted that state to resolve the issue.

(3) *The department should continue to encourage collaboration among county offices.*

The Department will continue to promote the benefit of increased collaboration between CDJFS offices. During the PHE unwinding, county engagement staff coordinated partnerships between some CDJFS offices to assist one another with renewal processing. The Department will continue to explore different ways counties can assist one another, including working the backlog of PARIS Interstate alerts.

d. Recommendation 4: Reducing Financial Impact of Concurrent Enrollment

Today more than 90 percent of Ohioans enrolled in Medicaid are assigned to a managed care entity to receive their services. Because of this significant use of managed care, the Department should request from CMS the matches based on T-MSIS data and use that data along with the PARIS alerts to identify enrollees that are high risk for having concurrent enrollment. This combined data can be used to identify enrollees for whom

concurrent enrollment has been identified but not yet resolved, and enrollees that frequently move between states or that spend a regular portion of the year in another state.

The Department should evaluate the cost and benefit of moving select enrollees that have been identified as a risk for concurrent enrollment from managed care to the fee-for-service model. This may include, but is not limited to, enrollees that receive SSI and are identified in the data as being enrolled in another state. As noted above, the Department is not able to terminate the benefits for an enrollee receiving SSI that has moved out of Ohio and instead continues to make capitation payments for this individual until the Social Security Administration updates its file.

The Department indicated it does not currently have a process to move an enrollee from managed care to fee-for-service and that it would involve a manual process to suppress auto-enrollment which would be difficult and time consuming. And, if it was then determined that the enrollee was an Ohio resident, the Department would have to manually update information to re-enroll the enrollee in a managed care plan.

Despite the reported difficulties, changing the status to fee-for-service allows for the enrollee to access Medicaid services while efforts are made to verify residency. If the enrollee has moved out of state and is not using Ohio' Medicaid benefit, then Ohio will not incur any costs for this individual as opposed to continuing to make unnecessary capitation payments.

ODM Response

There are multiple sub-parts within AOS Recommendation 4:

(1) *ODM should request T-MSIS data from CMS.*

T-MSIS generates and provides aggregated and deidentified datasets about all States, but because of federal and state privacy laws, there is no permissible access available to States for identifiable individual level information. Even for the purposes of this audit, ODM understands that the AOS was given suspected Ohio matches, rather than being provided access to all state T-MSIS data to identify matches itself. Indeed, under federal and state privacy laws, ODM is not entitled or permitted access to identifiable data about individuals not enrolled in Ohio. *See* R.C. 5160.45; 42 CFR 431 Subpart F; and 45 CFR Subpart E. For access to the T-MSIS databases to be an effective tool, Ohio would need access to all States' information, and this is clearly impermissible under federal and state privacy laws.

Moreover, T-MSIS data, even if accessible to ODM, may not provide a meaningful improvement to resolving concurrent enrollment given most potential enrollment matches are identified via the PARIS file. In AOS's own estimation, less than 0.04% of the total T-MSIS population is suspected of being concurrent matches not already identified via the PARIS file (roughly 32k of the roughly 90 million recipients nationwide). And finally, the AOS draft report does not specify the criteria by which it determined a "match" utilizing T-MSIS data. For example, match logic relying only upon SSN may not be reliable, especially for children.

(2) *"The Department should evaluate the cost and benefit of moving select enrollees that have been identified as a risk for concurrent enrollment from managed care to the fee-for-service model."*

It is unclear from the draft report whether AOS considered the impact of this recommendation on the continuity of care of Medicaid members. Many managed care plans provide ancillary benefits like care coordination services to members and help connect members to medically necessary services and supports. Moving members from managed care to FFS (and back to managed care) may cause a significant disruption to an individual's care, create an obstacle to access, and would be very confusing for individuals.

Moving enrollees from managed care to FFS may have a significant and adverse impact to capitation payment rates and overall State expenditures in the long term. Based on ODM's review of Appendix C, it appears that AOS may have simply used multiplication for its extrapolation.

One of the benefits of utilizing a managed care service delivery model is to control costs to the State and shift risk from the State to the managed care plan. To appropriately compensate the managed care plans for this risk, ODM is required to conduct a sophisticated assessment of its population to determine actuarial sound capitation rates. *See* 42 CFR 438.4. Non-utilization of services by a member is one of many factors that tend to reduce rates overall. If there were concurrently eligible individuals in the audit's population for whom other state Medicaid programs paid claims, the low or non-utilization in Ohio for these individuals would decrease rates overall across all members. Removing individuals from managed care in large numbers would require a review of the underlying assumptions used to set rates, which may actually increase rates paid for all members, potentially resulting in higher costs to the State in the long term.

Moreover, if enrollees that are later confirmed to be Ohio residents are moved into FFS, the State faces an increased risk of higher expenditures for that individual. For example, the FFS reimbursement rate for an emergency room visit is far greater than a capitation payment. Shifting the risk of high-cost claims back to the State may actually result in increased costs, especially for members that historically have higher acuity and cost profiles like individuals in receipt of SSI.

e. Recommendation 5: Review Subsequent Concurrent Enrollment Data

While PARIS alerts are an important tool in identifying concurrent enrollment, these alerts are insufficient to identify all instances of concurrent eligibility. In our review of Ohio's eligibility system, we did not identify PARIS alerts for 27 percent of the individuals that were enrolled in another state. The Department should request the T-MSIS data for 2023 from CMS that identifies concurrent enrollment in another state.

The Department should determine if the concurrently enrolled individuals identified in the T-MSIS data are currently enrolled in Ohio's Medicaid program. For those currently enrolled individuals, Ohio should conduct a case review and contact the other state's Medicaid program to resolve the concurrent enrollment. In its review, the Department should prioritize those individuals that are concurrently enrolled in more than two states.

For any indication of fraudulent enrollment, the Department should contact the appropriate law enforcement agency. For those individuals that are found to have established residency in another state, the Department should ensure that enrollment in Ohio's program is terminated in a timely manner.

ODM Response

There are multiple sub-parts within AOS Recommendation 5:

(1) *The Department should request the T-MSIS data from CMS.*

ODM addressed this recommendation in its response to Recommendation 4. In addition, given that ODM has nearly completed unwinding activities and has returned to routine operations, the issue of concurrent enrollment that resulted due to the MOE requirements described above has already been addressed through the redetermination of eligibility that took place over the past year.

(2) *"For any indication of fraudulent enrollment, the Department should contact the appropriate law enforcement agency."*

ODM appreciates AOS's recommendation regarding treatment of potential Medicaid recipient fraud. In fact, when ODM is aware of evidence suggesting Medicaid recipient fraud, ODM already submits referrals to local county fraud units to review.

Conclusion

ODM takes seriously its responsibility to make capitation payments based on the most accurate data available and has processes in place to identify individuals who are enrolled in Ohio and another State or territory. The additional MOE requirements related to identifying individuals make the AOS report's data set unusual and not predictive of normal operational conditions.

The recommendations that involve changes to national systems, other States, and the federal government would need to be agreed upon by external parties. Ohio is committed to continuing the hard work of the past several years to reduce the volume of alerts and continue to improve the accuracy of eligibility determinations.

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

Sincerely,

Steven T. Voigt

Deputy Director
Office of Legal Counsel and the Bureau of Program Integrity
The Ohio Department of Medicaid