DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

August 9, 2024

TO: Daniel Tsai
Deputy Administrator and Director
Center for Medicaid and CHIP Services

FROM: Amy J. Frontz /s/
Deputy Inspector General for Audit Services

SUBJECT: Office of Inspector General's Partnership With the Ohio Auditor of State: Auditor of State's Report *Ohio Department of Medicaid: The Cost of Concurrent Enrollment* (A-09-23-02004)

This memo transmits the findings of the Ohio Auditor of State (AOS) audit report *Ohio Department of Medicaid: The Cost of Concurrent Enrollment*, issued March 26, 2024. AOS conducts examinations, analysis, inspections, and audits of all public offices to make Ohio Government more efficient, effective, and transparent by placing checks and balances on State and local governments for taxpayers. This audit was conducted as part of AOS's oversight of Ohio's Medicaid program.

The objective of AOS's audit was to determine the impact of concurrent Medicaid enrollment on Ohio's Medicaid program from January 1, 2019, through December 31, 2022.

As part of the Office of Inspector General's (OIG's) efforts to partner with State auditors and expand oversight coverage of the Medicaid program, OIG assisted AOS with its audit by:

- matching Medicaid claims from the Centers for Medicare & Medicaid Services' (CMS's) Transformed Medicaid Statistical Information System (T-MSIS) to identify capitated payments that Ohio made on behalf of enrollees for whom another State also made capitated payments for the same enrollees in the same months,
- performing data validation procedures of the matched Medicaid claims,
- providing the resulting Medicaid matches to AOS,
- meeting routinely with AOS auditors to discuss audit work, and
- monitoring the progress of AOS's audit.

To accomplish its audit objective, AOS analyzed the results of OIG's data match and reviewed a stratified random sample of 125 Medicaid enrollees for whom the Ohio Department of Medicaid (ODM) made 3,135 capitated payments totaling more than $3 million and for whom a concurrent capitated payment was made in another State or Territory.

AOS found that of the 3,135 capitation payments that ODM made on behalf of the sampled enrollees, 804 payments (26 percent) were for enrollees who resided outside of Ohio. Based on its analysis, AOS concluded that ODM made approximately $209 million in capitation payments from January 1, 2019, through December 31, 2022, to managed care organizations for those enrollees.

AOS identified the following factors that contributed to the improper capitated payments:

- Enrollees self-attest their residency, and the information is not confirmed unless ODM becomes aware of conflicting information.

- The eligibility actions (i.e., renewals and disenrollments) taken by staff who perform Medicaid eligibility work at county departments of job and family services (CDJFS) offices were impacted by the Federal Government's increased focus on ensuring that individuals maintain their Medicaid eligibility.

- ODM was not able to disenroll individuals who receive Supplemental Security Income (SSI) unless and until the Social Security Administration provided updated information to ODM regarding an enrollee's eligibility for SSI.

- The large number of alerts, including those from the Public Assistance Reporting Information System (PARIS), related to the public assistance programs that use Ohio's eligibility system, such as the Medicaid and CHIP programs, were overwhelming and were not being worked for various reasons, including staffing shortages. There were also issues related to communicating with other States and lack of enrollee response to notices.

AOS made five recommendations (with multiple subparts) to ODM related to: (1) increasing the use of technology in the Medicaid application process, (2) earlier identification of concurrent enrollment, (3) improvements in clearing of PARIS alerts, (4) reducing the financial impact of concurrent enrollment, and (5) reviewing subsequent concurrent enrollment. The specific text of AOS's recommendations can be found in the report.

In its comments on AOS's report, ODM provided responses to each of AOS's recommendations and the multiple subparts. The specific text of ODM's responses to each recommendation can be found in the report. ODM's responses are summarized below:

- For the first recommendation, ODM commented that it was uncertain how to respond to the recommendation because the PARIS system already exists and its purpose is to identify individuals enrolled in another State's Medicaid program. ODM stated that it agrees with leveraging technology, but there are limitations to Ohio's ability to make national changes;

disenrollment solely based on verification of residency from another State would require a change to Federal law.

- For the second recommendation, ODM commented that it currently asks in its online application whether an applicant is currently (or was previously) receiving benefits from another State and that it will explore the possibility of adding these questions to the paper application.

- For the third recommendation, ODM described actions it has taken and stated that it is committed to continue working with its State and county partners to improve the processing of PARIS alerts.

- For the fourth recommendation, ODM commented that Federal and State privacy laws prevent States' access to the type of T-MSIS datasets that were used in the audit and that the T-MSIS data, if accessible to ODM, may not provide a meaningful improvement to resolving concurrent enrollment. ODM also commented that moving enrollees from managed care to fee-for-service may significantly disrupt an individual's care and adversely impact capitation payment rates and overall State expenditures in the long term.

- For the fifth recommendation, ODM commented that it addressed this recommendation in its response to the fourth recommendation. ODM stated that the issue of concurrent enrollment that resulted from the requirement to maintain an enrollee's enrollment during the COVID-19 public health emergency has already been addressed through the redetermination of eligibility that took place over the past year.

AOS is responsible for the attached audit report and the conclusions expressed in it. We are not expressing an opinion on the report or its results; however, we encourage CMS to consider this report and its results, and to work with State Medicaid agencies to prevent payments resulting from concurrent enrollment from occurring in the future.

This memo and the AOS report, including ODM's written comments, will be posted on the OIG website.

If you have any questions or comments about this memo, please do not hesitate to contact John Hagg, Assistant Inspector General for Audit Services, at John.Hagg@oig.hhs.gov. Please refer to report number A-09-23-02004 in all correspondence.

Attachment

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OHIO AUDITOR OF STATE
KEITH FABER

Ohio Department of Medicaid

THE COST OF CONCURRENT ENROLLMENT

Auditor of State Report

MARCH 2024

Efficient • Effective • Transparent

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KEITH FABER

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Letter from the Auditor

To the Governor's Office, General Assembly, Director and Staff of the Ohio Department of Medicaid, Ohio Taxpayers and Interested Citizens:

Ohio's Medicaid program provides assistance to approximately three million individuals and had expenditures of $28.5 billion during state fiscal year 2022. Over 90 percent of Medicaid recipients receive their benefits through a managed care structure in which Ohio makes a monthly per member per month payment (capitation payment) to a managed care entity. Because of this structure, it is critically important that enrollment of recipients is both current and accurate.

For this audit, we collaborated with the Office of Audit Services in the U.S. Department of Health and Human Services, Office of Inspector General and found that for four years - 2019 through 2022 – there were over 124,000 recipients enrolled in Ohio's Medicaid program at the same time they were enrolled in another state's Medicaid program. Ohio spent over $1 billion in capitation payments for these concurrently enrolled individuals. The impact of concurrent enrollment extends beyond Medicaid as many of these individuals were receiving additional benefits such as the Supplemental Nutrition Assistance Program (SNAP).

This costly issue impacts state budgets across the country and action is needed to impact federal and state requirements that contribute to this issue, along with improvements to processes used within Ohio Medicaid to better detect and address changes in state residency. It is my hope that the results of this audit will be used by the Ohio Department of Medicaid and the State's policy leaders as a resource for strengthening this important program.

This audit report can be accessed by visiting the Auditor of State's website at OhioAuditor.gov and choosing the "Search" option.

Keith Faber
Auditor of State
Columbus, Ohio

March 13, 2024

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EXECUTIVE SUMMARY

We conducted this audit to determine the impact of concurrent Medicaid enrollment on Ohio's program during the period of January 1, 2019 through December 31, 2022. This audit was performed pursuant to the State Auditor's authority as set forth in Ohio Rev. Code § 117.11.

Over 124,000 individuals were concurrently enrolled in Ohio's Medicaid program and the Medicaid program of at least one other state during the audit period. Of these individuals, over 2,300 were concurrently enrolled for the entire four-year period.

For this audit, we collaborated with the Office of Audit Services in the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) to obtain capitation payment data (a fixed per-member per-month payment). We used this data 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.

The data contained over 124,000 individuals that were enrolled in Ohio's program and at least one other state's program at the same time. We selected a sample of 125 enrollees from the 11 states with the highest number of shared enrollees. For each capitation payment made on behalf of the selected 125 enrollees, we reviewed various information to confirm that the enrollee resided in Ohio during the period covered by the capitation payment.

We were unable to confirm Ohio residency for 40 percent of the tested capitation payments. The reviewed data indicated residency in another state for 26 percent of the payments and, for 14 percent of the payments, the documentation was inconclusive as to the residency of the individual. Using these results, we estimate that the potential impact for Ohio due to concurrent enrollment of individuals in these top 11 states to be $209 million. While this financial impact is based on Ohio's capitation payments, the waste of public funds is greater when considering the payments made by other states. For each concurrently enrolled individual, there is at least one state making an unnecessary payment.

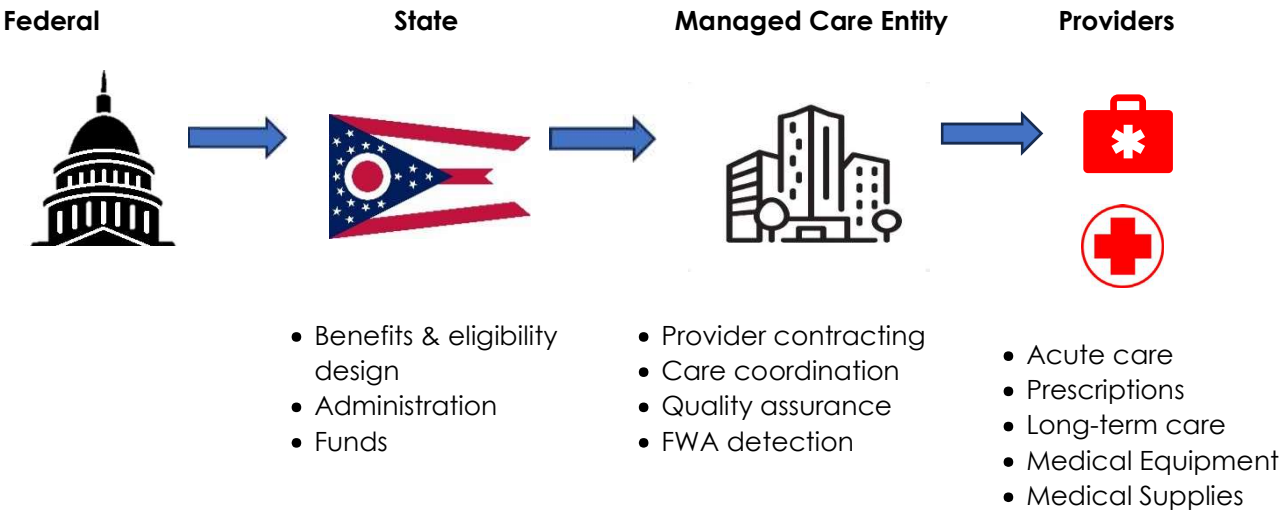
The results highlight that the Medicaid program lacks adequate procedures to prevent concurrent enrollment from occurring, to timely identify concurrent enrollment or to resolve concurrent enrollment between states in an efficient manner. This report includes recommendations for improvement in the Medicaid program's use of technology, streamlining the communication and coordination between state Medicaid programs, implementing changes for earlier identification of individuals with concurrent enrollment, continuing efforts to address residency related system alerts, evaluating changes to reduce the financial impact of concurrent enrollment and reviewing subsequent concurrent enrollment data. The Department disagreed with one recommendation and partially agreed with the remaining four recommendations.

OVERVIEW

While Medicaid is jointly financed by the federal and state governments, each state administers its own program which includes the eligibility determination process. One element of eligibility, which in Ohio is determined by county departments of job and family services (CDJFS offices), is that the applicant must be a resident of the state. Address/residency is a self-attested item which means that no confirmation of address is needed unless conflicting information comes to the attention of CDJFS staff.

Issues with Ohio's Medicaid eligibility system have been addressed in prior reports issued by the Auditor of State's office.[1] Ohio, along with the majority of other states, has contracts with Medicaid managed care entities[2] and, for individuals enrolled in managed care, the Department pays a fixed per-member per-month payment to the selected managed care entity which is referred to as a capitation payment. The Department makes the capitation payment to the managed care entity and then, when an enrollee receives a covered service, the provider of the service submits a claim to the managed care entity for payment. The following diagram depicts the structure of Medicaid managed care.

Managed Care Structure



A number of audits have addressed the issue of concurrent enrollment in which an individual is enrolled in Medicaid in two or more states at the same time. These audits have shown that Ohio along with other states[3,4] have made capitation payments for

[1] Ohio's Medicaid Eligibility Determination Process (November 2020) and the State of Ohio Single audits for year Ended June 30, 2021, Year Ended June 30, 2022 are available on the AOS website at Audit Search (ohioauditor.gov)

[2] Per the Kaiser Family Foundation (State Health Facts), Ohio along with 39 other states (including the District of Columbia) had contracts with Medicaid managed care entities (MCEs) as of July 1, 2020.

[3] Ohio Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries with Concurrent Eligibility in Another State (November 2020) is available at: HHS-OIG 2020 Ohio Concurrent Eligibility Report.

[4] Nearly All States Made Capitation Payments for Beneficiaries Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Two States (September 2022) is available at: HHS-OIG 2022 Report on Capitation Payments.

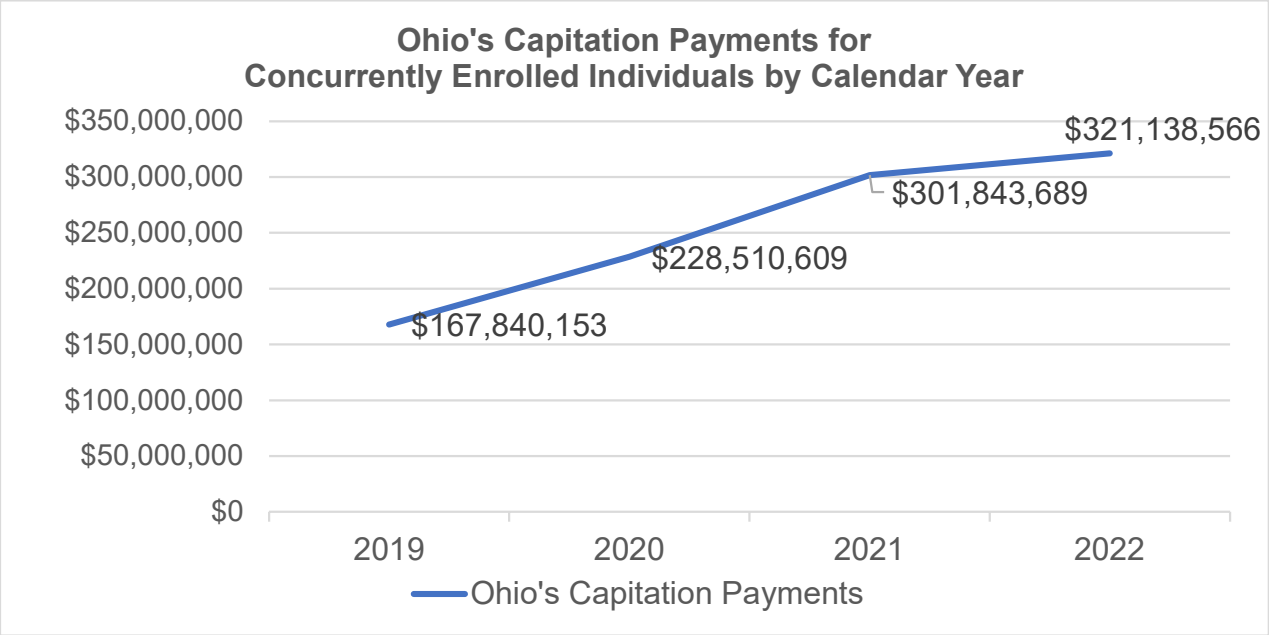
individuals concurrently enrolled in a Medicaid in at least two states. We conducted this audit to determine the impact of concurrent Medicaid enrollment on Ohio's Medicaid program during the period of January 1, 2019 through December 31, 2022.

BACKGROUND

Concurrent Enrollment in Ohio's Medicaid Program

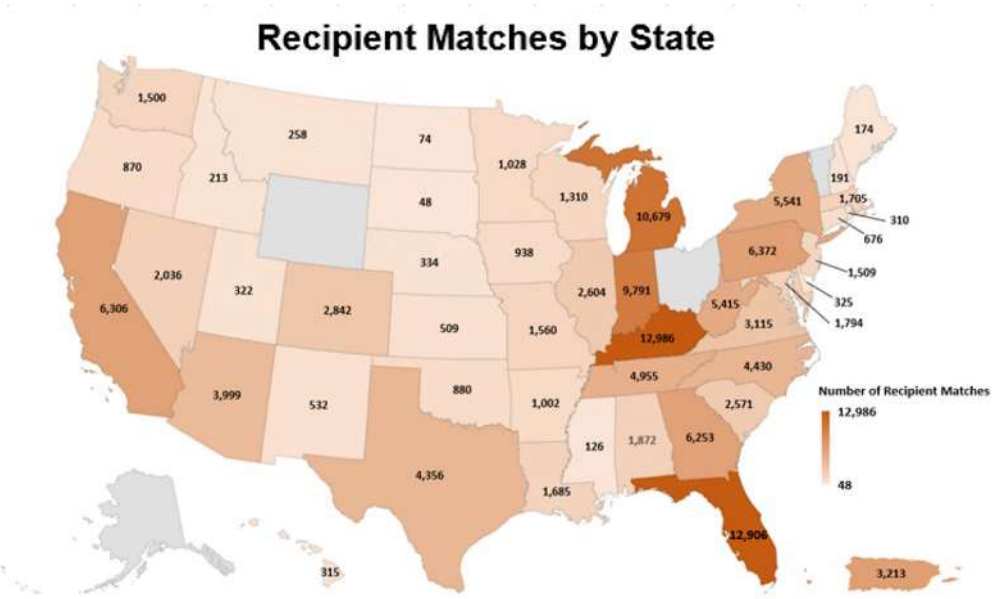
For this audit, the HHS-OIG provided data from the Transformed Medicaid Statistical Information System (T-MSIS) database which is maintained by the Centers for Medicare and Medicaid Services (CMS) and contains data from all 50 states, the District of Columbia, and the United States territories. The database includes information on eligibility, enrollment and claims data for Medicaid enrollees.

The 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. The Department made capitation payments totaling more than $1 billion for these enrollees during the audit period. The table below shows Ohio's capitation payments by calendar year. The increase in payments during this period reflects an increase in enrollment during the public health emergency (PHE) which started in 2020 and expired after the audit period.



Source: T-MSIS data
Note: The total of Ohio's capitation payment for the four-year period for concurrently enrolled individuals is $1,019,333,017.

Ohio's concurrent enrollment matches included 46 other states, the District of Columbia and Puerto Rico. The following map provides a breakdown of the enrollee matches by state. A breakdown of enrollees matches by state can also be found in **Appendix A**.



Source: T-MSIS data. Note: the number of enrollees by state does not represent unique individuals as some individuals were enrolled in more than two states at the same time.

For 2,372 enrollees, both Ohio and at least 1 other state made a capitation payment for each month during the four-year audit period.

In addition, there were individuals that were concurrently enrolled in Ohio and two or more other states during the same month. The table below provides a breakdown for these individuals.

Individuals Currently Enrolled in Ohio and Two or More Other States			
Number of Other States	**Concurrently Enrolled Individuals**	**Number of Ohio Capitation Payments**	**Amount of Ohio Capitation Payments**
2	6,603	51,947	$31,942,531
3	479	2,811	$1,895,003
4	54	329	$280,318
5	20	94	$75,837
6	3	16	$16,429
7	1	3	$3,299
8	1	1	$767
	Total	**55,201**	**$34,214,184**

Source: T-MSIS data. Note: The numbers do not represent unique enrollees as some individuals were enrolled in different states at different periods of time.

The following table provides three examples of enrollees with concurrent enrollment in Ohio and two or more other states.

Examples of Enrollees with Concurrent Enrollment	
Enrollee "A"	
Enrollment Date Span	*Enrolled States*
1/2022 through 12/2022	Ohio, Alabama, Florida and Tennessee
Enrollee "B"	
Enrollment Date Span	*Enrolled States*
1/2020 through 4/2020	Ohio and New York
5/2020 through 8/2020	Ohio, New York and California
8/2020 through 12/2020	Ohio, New York, California and Washington
Enrollee "C"	
Enrollment Date Span	*Enrolled States*
1/2021 through 2/2021	Ohio, Virginia, Kentucky, Massachusetts, Montana, Indiana and New Jersey
3/2021	Ohio, Virginia, Kentucky, Massachusetts, Montana, Indiana and Wisconsin
4/2021	Ohio, Virginia, Kentucky, Massachusetts, Montana, Indiana, Wisconsin and Connecticut
5/2021	Ohio, Virginia, Kentucky, Massachusetts, Indiana, Wisconsin and Connecticut
6/2021 through 7/2021	Ohio, Virginia, Kentucky, Massachusetts, Montana, Indiana, Wisconsin and Connecticut
8/2021 through 10/2021	Ohio, Virginia, Kentucky, Massachusetts, Montana, Wisconsin and Connecticut
11/2021 through 12/2021	Ohio, Virginia, Kentucky, Massachusetts, Montana and Connecticut

Source: T-MSIS data. Note: The months with concurrent enrollment are based on months in which the state made a capitation payment on behalf of the enrollee.

Key Residency Requirements

The Code of Federal Regulations (CFR) Title 42 § 435.403(a) and (j)(3)) require that States provide Medicaid services to residents and excludes residents who have established residency in more than one state for Medicaid. The Medicaid agency may not deny or terminate a resident's Medicaid eligibility because of that person's temporary absence from the state if the person intends to return, unless another state has determined that the person is a resident there for purposes of Medicaid. CFR Title 45, Part 155.335 contains the federal requirements for Medicaid eligibility re-determinations and requires that states redetermine a members' eligibility annually.

Ohio Admin. Code § 5160:1-2-10(B)(2) states that to be determined eligible for medical assistance, an individual shall be a resident of the state of Ohio on the date of application or requested coverage begin date. In addition, the rule specifies that the individual shall not be eligible for and receiving medical assistance in another state or U.S. territory. In accordance with Ohio Admin. Code § 5160:1-2-01(I), the Department uses its electronic eligibility system[5] to determine eligibility or renewal of an individual's eligibility for Medicaid.

State residency is a requirement for Medicaid enrollment and this requirement continued throughout the public health emergency.

Public Assistance Reporting Information System (PARIS)

PARIS is a federal-state partnership that produces a quarterly interstate data match of enrollees for states to use to determine if the enrollees are receiving benefits in two or more states.[6] Following receipt of the PARIS matches, efforts to contact an enrollee should be initiated. If the enrollee verifies Ohio residency, benefits are continued. If the response indicates an out of state residency, benefits are discontinued. A state can also verify an enrollee's residency by contacting the other state in which the enrollee is receiving benefits.

Impact of the Public Health Emergency

In March 2020, the Families First Coronavirus Response Act (FFCRA) was signed into law, allowing states to receive a temporary Federal Medical Assistance Percentage (FMAP) increase if they met certain conditions. One of the conditions was to maintain continued enrollment for any enrollee deemed eligible for Medicaid on or after March 18, 2020 until the end of the PHE. The FFCRA allowed exceptions to continued enrollment for individuals who requested voluntary termination or ceased to be residents of the state.

Following the enactment of the FFCRA, CMS issued additional policy and regulation which clarified the process by which states could terminate coverage for enrollees. In October 2020, CMS provided clarification on how states could use a PARIS match to disenroll an enrollee. In calls with state officials, CMS representatives explained 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, unlike prior to the PHE when a PARIS match and no response from an enrollee was sufficient to terminate enrollment.

[5] The Ohio Benefits system is a centralized web-based database used to determine Medicaid eligibility. See Ohio's Medicaid Eligibility Determination Process (November, 2020) available on the Auditor of State (AOS) website at Ohio's Medicaid Eligibility Determination Process.
[6] For additional information, see audit report on PARIS Alerts issued by Auditor of State, Keith Faber, on December 15, 2022 which is available on the AOS website: Public Assistance Reporting Information System Alerts

SCOPE AND METHODOLOGY

The scope of this audit was limited to the $676.2 million in Medicaid managed care capitation payments made by the Department on behalf of 81,976 Ohio enrollees who were concurrently enrolled in one of the following 11 other states during the period of January 1, 2019 through December 31, 2022: California, Florida, Georgia, Illinois, Indiana, Kentucky, Michigan, New York, Pennsylvania, Tennessee and West Virginia. We selected and reviewed a stratified random sample of 125 enrollees with capitation payments totaling over $3 million, to determine whether the enrollees were residing in Ohio during the period covered by the capitation payment.

To identify concurrently enrolled individuals, we used the T-MSIS data file provided by the HHS-OIG. The data identified those instances in which the Department made at least three consecutive monthly capitation payments for enrollees who concurrently had capitation payments made on their behalf by another state or territory. The data matches included enrollees in the Ohio Healthy Start program (federally known as Children's Health Insurance Program (CHIP)).[7]

Data Reliability

For the T-MSIS data file, we performed validity and integrity tests on the data, including (1) testing for blank fields, (2) testing for duplicates, (3) looking for dates outside the audit period and (4) checking data fields for validity errors. We selected a random sample of 60 capitation payments and agreed the T-MSIS data with information in Ohio's Medicaid Information Technology System (MITS)[8]. Based on these procedures, we determined that the T-MSIS data obtained was sufficiently reliable for the purpose of this audit.

Sampling Approach

From the T-MSIS data file, we removed capitation payments associated with enrollees that had been determined to reside outside of Ohio as part of a previous audit conducted by the Ohio Auditor of State's Office[9]. We then ranked each state and territory based on the total dollar value of the concurrent payments and selected 11 states that had the highest dollar value of concurrent capitation payments and enrollee matches during the audit period. We used a stratified sampling methodology as follows:

1) Stratum one includes enrollees who had concurrent enrollment with a least one other state for all of the 48 months of the audit period;
2) Strata two, three and four include enrollees who had concurrent enrollment with at least one other state (excluding Kentucky) and are further grouped by the dollar range of Ohio's capitation payments for the enrollees; and
3) Stratum five includes enrollees who had concurrent enrollment with Kentucky.

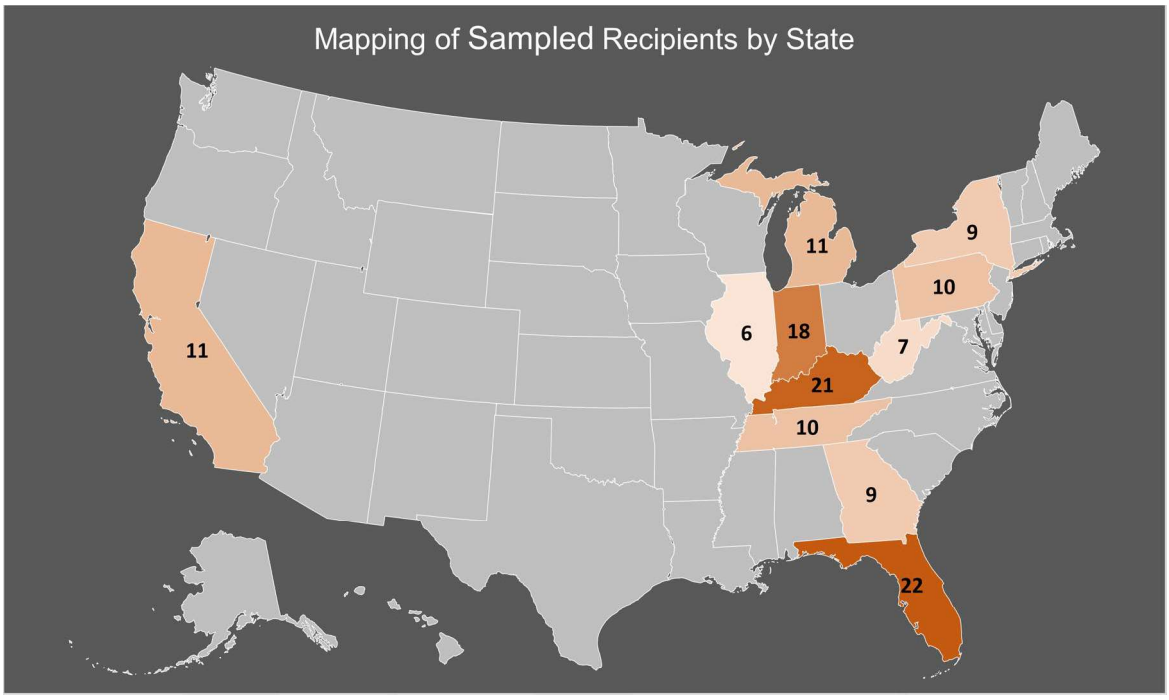
[7] One of the items required for eligibility for Healthy Start is Ohio residency.
[8] MITS contains information on enrollees and Medicaid payments.
[9] Public Assistance Reporting Information System Alerts (December 2022) is available at: Auditor of State 2022 PARIS Alerts Report

We then selected a random sample of 125 enrollees. The table below details each of the five strata.

Sample Summary			
Stratum	**Number of Enrollees Sampled**	**Number of Sampled Capitation Payments**	**Dollar Value of Sampled Capitation Payments**
1	15	720	$541,706
2	20	199	$71,275
3	55	1,390	$1,146,611
4	15	595	$1,094,157
5	20	231	$157,570
Total	**125**	**3,135**	**$3,011,319**

Source: Ohio Auditor of State (AOS)

A detailed sampling methodology can be found in **Appendix B**.



Source: AOS. Note: The total number of enrollees shown on the map (134) exceeds the number of enrollees sampled (125) as some enrollees matched in multiple states.

Work Performed

We reviewed the results of the prior audit conducted by HHS-OIG which identified that Ohio made an estimated $5.9 million in capitation payments for August 2018 on behalf of individuals who were concurrently enrolled and residing in another State. We also reviewed the residency requirements for the Medicaid program and a summary of the transcripts of weekly CMS All State calls from March 17, 2020 to December 17, 2020. In addition, we interviewed three CDJFS offices (Clermont, Lawrence and Lucas counties) to gain an understanding of the residency determination process and to identify areas for improvement in reducing concurrent enrollment. Further, we obtained input and clarification from the Department on enrollment requirements and processes along with the number of pending PARIS alerts as of January 5, 2023.

For the 125 sampled enrollees, we reviewed the following information to help determine if the individual was a resident of Ohio during time covered by the payment:

- We contacted Medicaid officials in each of the 11 states and sent a questionnaire designed to validate the T-MSIS information and to determine the enrollee's residency during the month covered by the capitation payment. The questionnaire included the following: the date on which the individual enrolled in the other state's Medicaid program, the period of enrollment and whether the enrollee received any covered services during the period in which the individual was enrolled in Ohio.

- We reviewed Ohio's claims data to determine whether the sampled enrollees received services during the concurrent enrollment period.

- We accessed Ohio's eligibility system which contains the eligibility case file information to help determine if the enrollee resided in Ohio. Specifically, we looked for the following attributes:

  - Whether each enrollee was present in the system and currently enrolled;

  - Whether a PARIS data match or other residency related alert was triggered;

  - Whether residency in Ohio was verified or if a change of address to another state was reported; and

  - Whether the enrollee received other benefits such as the SNAP and Temporary Assistance to Needy Families (TANF).

- We also obtained access to Ohio's electronic document management system to determine if there was documentation to support Ohio residency. The system contains residency information, such as utility bills, lease agreements, correspondence and returned mail.

- We used Accurint, which is a LexisNexis national investigative data depository that is used by more than 3,000 agencies across the country to helps enforce laws and regulations. Accurint contains address data, driver's license information, vehicle registration, property records, criminal records and voter registration.

RESULTS

We determined if the information reviewed supported Ohio residency during the month covered by the capitation payment. The following table breaks out Ohio's 3,135 capitation payments made for the sampled 125 enrollees by the residency status based on the information reviewed. We identified one individual whose date of death was prior to one capitation payment.

Capitation Payments by Determination Status				
Unable to Verify Residency	**Out of State Resident**	**Ohio Resident**	**Deceased**	**Total**
433 (14%)	804 (26%)	1,897 (60%)	1 (0%)	3,135

Source: AOS

Examples of cases that were determined in each of the categories:

1) *Unable to verify residency*: For one individual, we found no documentation to support residency for the selected months; however, the Ohio Benefits system contained a journal entry indicating mail was returned with a Pennsylvania address. Per Accurint, this enrollee had a Pennsylvania address, but also had an Ohio driver's license.

2) *Out of State Resident*: One individual applied in Florida in 2020 and received services in that state following the application. In addition, a Florida driver's license was issued in the summer of 2019.

3) *Ohio Resident*: One individual was enrolled in Illinois but had no Medicaid services in that state. Documentation indicated there was earned income associated with an Ohio address and the enrollee had a car registered in Ohio.

We estimated the impact, based on the sample results, of any capitation payments made by the Department on concurrently enrolled individuals in one of the 11 selected states where the information reviewed indicated residency in another state. We used the Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software to calculate this estimate. This estimate does not include the 14 percent of payments where we were unable to verify residency. The financial impact identified includes both state and federal funds.

The information reviewed for the 125 concurrently enrolled individuals indicated that, for 26 percent of the capitation payments for these enrollees, the individual was residing outside of Ohio.

The estimated impact on Ohio's capitation payments for individuals residing in one of these 11 other states is over $209 million. See Appendix C for a detailed breakdown of the sampled results and estimation.

While this financial impact is based on Ohio's capitation payments, the waste of public funds is greater when considering the payments made by other states. For each of the 124,448 individuals, there is at least one state making an unnecessary payment. Combined, concurrent enrollment represents a waste of state and federal public funds that could be used for other purposes.

Factors Contributing to Concurrent Medicaid Eligibility

Address is Self-Attested Information

During interviews with CDJFS staff, it was confirmed that address/residency is a self-attested item and, as such, no confirmation is needed unless conflicting information comes to the CDJFS's attention. It was also noted that Medicaid enrollees include transient populations and enrollees may report a change of address to the post office but often do not inform the CDJFS. In addition, if an individual reports leaving the state for a temporary period with the intent to return, the individual remains enrolled and these individuals may then need medication or services during these temporary absences which could lead to filing an application in the other state.

Enrollees are likely unaware of the costs that continue when they move out of the state and do not report the address change. Also, enrollees may be hesitant to report that an individual is no longer in the home for fear of the impact on their own benefits. Our review of Ohio's eligibility system found that approximately 62 percent of the sampled enrollees received another benefit such as the SNAP or TANF.

Emphasis on Continued Enrollment

The focus from the federal government has centered on ensuring that individuals maintain Medicaid eligibility and CMS has developed several flexibilities to assist states in completing application renewals. In responses to audit recommendations from HHS-OIG regarding concurrent eligibility, CMS has indicated that the PARIS system is sufficient and that no additional benefit would come from sharing matches based on T-MSIS data. In addition, a scan of information contained on CMS's website finds no topic or resources for reducing the problem of concurrent eligibility.

On December 18, 2023, the Secretary of Health and Human Services wrote a letter to Ohio's Governor as Ohio was among the nine states with the largest number or highest percentage of children who have lost Medicaid or Children's Health Insurance Program (CHIP) coverage. This letter outlined the ways in which CMS put forth strategies to make renewals easier. In the letter, Ohio was encouraged to adopt additional flexibilities to improve its auto renewal rates.

This emphasis from the federal government impacts states' actions which are then transmitted to staff that perform the eligibility work. This emphasis is evident in that the Department sends out a daily email[10] to each CDJFS with their disenrollments to check that the disenrollments were completed correctly. CDJFS staff interviewed reported that, as a result of these daily emails, some staff are hesitant to take any action to disenroll an individual.

One additional issue stems from the inability of states to disenroll enrollees receiving Supplemental Security Income (SSI) unless and until the Social Security Administration (SSA) provides an update through a file from the SSA. For SSI enrollees who report a move to another state, Ohio has been instructed to inform the enrollee to report the new address to the SSA and wait for the updated information. While it was outside of the scope of this audit to determine the length of time it takes for the updated SSA files to be received by the states, this was a factor in the some of the individuals identified with concurrent enrollment.

Alerts in Ohio's Eligibility System

The state fiscal year 2022 financial audit of the state of Ohio identified more than 15.5 million alerts that were issued related to all public assistance programs that utilize Ohio's eligibility system, including the CHIP and Medicaid programs. One type of alert included in these numbers is the PARIS alert. For those sampled enrollees that were determined to be an out of state resident, 73 percent had a PARIS alert connected to the case.

During the PHE, there was guidance from CMS of conditions that had to be met with a PARIS match to disenroll. These included verifying that the individual was enrolled in another state (i.e., document attempt to obtain this verification from the other state) or reach the enrollee to verify enrollment in another state's program and desire to be dis-enrolled in Ohio. In cases with no PARIS alert, if mail was returned with no forwarding address, the case had to be left open. If an out-of-state forwarding address was obtained, CDJFS staff would then need to make contact to confirm with the enrollee prior to removing from the Medicaid program.

According to CDJFS staff, the eligibility system does not force a worker to acknowledge or clear an alert to process the case. PARIS alerts are a tool; however, the number of alerts is overwhelming. Due to the backlog in work, alerts are not worked timely and some

[10] This list did not include deceased enrollees or enrollees that have moved out of state.

concurrent enrollment may be a result of this. There are reported staff shortages in some CDJFS offices which contributes to the backlog.

One way for CDJFS staff to resolve an alert is through communicating with other states; however, CDJFS staff noted that state systems do not communicate with each other which can be an issue in resolving residency issues. Additional comments from CDJFS staff highlighted that notices sent to enrollees are difficult to read/understand and that there is no consequence to enrollees for having concurrent enrollment (not informing CDJFS offices of change of address). In addition, CDJFS staff noted that individuals experiencing difficulties and living on limited income are often in survival mode and do not follow through with required notices.

RECOMMENDATIONS

RECOMMENDATION 1: Increase the Use of Technology in Application Process

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 at the time of the initial application. 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 initiate the disenrollment process of 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.

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.

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[11]. 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.

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.[12] Because of this significant use of managed care, the Department should request that CMS provide matches based on T-MSIS data, similar to the data used for this audit, that show concurrent enrollment. This data combined with the PARIS alerts can be used to identify concurrent enrollment that has not yet been resolved, and enrollees that frequently move between states or that spend a regular portion of the year in another state and enroll in that state's Medicaid program during that time.

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

[11] See audit report on PARIS Alerts issued by Auditor of State, Keith Faber, on December 15, 2022 which is available on the AOS website: Public Assistance Reporting Information System Alerts.
[12] Statistic reported on Ohio Department of Medicaid's website as of January, 5, 2024.

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 benefits, then Ohio will not incur any costs for this individual as opposed to continuing to make unnecessary capitation payments.

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 CMS provide the data matches using the T-MSIS data for 2023, similar to what was used for this audit, to identify 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.

MATTER FOR FURTHER STUDY

The Interstate Driver License Compact provides for the exchange of driver's information between states. The compact formally includes 46 states; however, the other four states[13] also comply with the compact. Name, date of birth, license number and the last five digits of the social security number are shared among states. Ohio is a "one ID" state meaning you can have a license in Ohio or another state, but never both. Some other states may allow an individual to have an identification card in their state and driver's license in another state.

[13] Georgia, Massachusetts, Tennessee, and Wisconsin are not a part of the compact.

The Ohio Bureau of Motor Vehicles (BMV) maintains the date of issuance of the other license and what state issued it in the Driver's License System. Currently, data is shared with the Secretary of State for voting purposes. A representative from the Ohio BMV indicated data that the Driver's License System could be shared with the Department through a memorandum of understanding and the data could assist the Department in determining if an individual is still a resident of the state.

CONCLUSION

Whether or not the enrollees tested in this audit were found to be in Ohio or not, the data shows that public dollars were misspent due to concurrent enrollment. All taxpayers are impacted when each State is not making every effort to guard against misspent public dollars. The importance of having a sound process to verify Medicaid eligibility is magnified by the use of managed care as the state is making a monthly payment to the managed care entity regardless of if the enrollee ever uses any services. While the recent focus on the return to "normal" operations has been on ensuring that the unwinding process is done correctly, there is also a need to focus on the issue of concurrent enrollment.

The results of this audit demonstrate that while efforts to better address PARIS matches are warranted, this process is not sufficient to address the scope of the concurrent enrollment issue. Improved use of technology and enhanced communication between states, changes in federal requirements, earlier identification of concurrent enrollment, along with the improved clearance of alerts, could be beneficial in reducing the number of individuals with concurrent enrollment thereby saving public dollars.

In its response to the audit, the Department stated that it was unable to validate the audit report's conclusions and has questions about the audit's methodology. The Department also provided a response[14] to the recommendations which can be found in **Appendix D**.

We reviewed the Department's response and added additional information to Appendix C regarding the methodology used to identify the impact on Ohio's capitation payments. We also clarified language in the first recommendation to reflect that it pertains to the application process and that information would be used to initiate the disenrollment process. Nothing in our recommendation indicated that recipients would not be afforded their notice and hearing rights. In addition, we clarified language in recommendations four and five to reflect that the Department should request that CMS provide similar data from the T-MSIS system as used in this audit to identify concurrent enrollment. One additional clarification was made to recommendation four to highlight that those individuals spending a period of time in another state and applying for Medicaid in the other state is the issue and not an individual maintaining Ohio residency during a temporary absence from the state. Except as noted above, we made no additional changes to the report, and maintain that our results and recommendations are valid.

[14] In its response, the Department used both "the Department" and "ODM" to reference the Ohio Department of Medicaid. A copy of the complete response can be obtained from the Department located at 50 W. Town Street, Suite 400, Columbus, Ohio 43215.

APPENDIX A
Enrollee Matches by State

State	Number of Enrollees
Alabama	1,872
Arizona	3,999
Arkansas	1,002
California	6,306
Colorado	2,842
Connecticut	676
District of Columbia	338
Delaware	325
Florida	12,906
Georgia	6,253
Hawaii	315
Idaho	213
Illinois	2,604
Indiana	9,791
Iowa	938
Kansas	509
Kentucky	12,986
Louisiana	1,685
Maine	174
Maryland	1,794
Massachusetts	1,705
Michigan	10,679
Minnesota	1,028
Mississippi	126
Nebraska	334

State	Number of Enrollees
Missouri	1,560
Montana	258
Nevada	2,036
New Hampshire	191
New Jersey	1,509
New Mexico	532
New York	5,541
North Carolina	4,430
North Dakota	74
Oklahoma	880
Oregon	870
Pennsylvania	6,372
Puerto Rico	3,213
Rhode Island	310
South Carolina	2,571
South Dakota	48
Tennessee	4,955
Texas	4,356
Utah	322
Virginia	3,115
Washington	1,500
West Virginia	5,415
Wisconsin	1,310
Total	**132,768**

Note: The total number of enrollees (132,768) does not match the number of unique enrollees (124,448) as some enrollees matched in multiple states.

APPENDIX B
Sampling Methodology

POPULATION

The population consisted of Ohio Medicaid enrollees who were concurrently enrolled in at least one of the following 11 states during the audit period: California, Florida, Georgia, Illinois, Indiana, Kentucky, Michigan, New York, Pennsylvania, Tennessee and West Virginia.

SAMPLING FRAME

The sampling frame was paid capitation payments from the T-MSIS database of individuals concurrently enrolled in Ohio and at least one other state or territory for at least three consecutive months.

SAMPLE UNIT

The primary sampling unit was an enrollee.

SAMPLE DESIGN

We used a stratified random sample.

Stratified Population Summary				
Stratum	**Dollar Range of Stratum**	**Number of Enrollees**	**Population Dollar Value**	**Sample Size**
1	$7,017 – $138,767[1]	1,321	$51,193,380	15
2	$368 – $9,999	52,507	$188,504,729	20
3	$10,001 - $59,992	14,873	$300,327,631	55
4	$60,003 – $159,423	437	$30,865,227	15
5	$398 – $118,707	12,838	$105,322,773	20
Total		**81,976**	**$676,213,740**	**125**

[1] Stratum 1 consists of enrollees that were concurrently enrolled all 48 months of the audit period.

APPENDIX C
Sample Results and Estimate

Table 1: Sample Results

Stratum	Capitation Payments in Sample	Total Value of Sample	No. of Improper Capitation Payments	Total Value of Improper Capitation Payments
1	720	$541,706	61	$42,705
2	199	$71,275	56[1]	$21,398
3	1,390	$1,146,611	400	$396,304
4	595	$1,094,157	210	$354,608
5	231	$157,570	78	$49,193
Total	**3,135**	**$3,011,319**	**805**	**$864,208**

[1] This includes one capitation payment made after the individual's date of death.

To estimate the impact of the sample results, the results of each stratum were projected to the population from which the stratum was pulled. An estimated impact was then calculated for each stratum. Table 2 shows the sum of the five strata estimates.

Table 2: Estimated Impact on Ohio's Capitation Payments

Number of Enrollees in Population[1]	81,976
Number of Enrollees Sampled	125
Number of Capitation Payments in Error	805
Total Amount Ohio Medicaid Paid for Population	$676,213,740
Amount Paid for Enrollees Sampled	$3,011,319
Estimated Impact on Ohio's Capitation Payments (Point Estimate)	$209,012,714

Note: We used the OIG/OAS statistical software RAT-STATS to estimate the impact of capitation payments made by the Department on behalf of individuals enrolled in Ohio and residing in another state during our audit period. Estimations were calculated for each of the strata and totaled.
[1] The population is comprised of the total matches from the 11 selected states.

APPENDIX D
The Department's Response to the Audit Report's Recommendations

Recommendation 1: Increase the Use of Technology

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.

Recommendation 2: Earlier Identification of Concurrent Enrollment

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).

Recommendation 3: Improvements in Clearing of PARIS Alerts

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.

Recommendation 4: Reducing Financial Impact of Concurrent Enrollment

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.

Recommendation 5: Review Subsequent Concurrent Enrollment Data

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.

OHIO AUDITOR OF STATE
KEITH FABER

OHIO DEPARTMENT OF MEDICAID - THE COST OF CONCURRENT ENROLLMENT

FRANKLIN COUNTY

AUDITOR OF STATE OF OHIO CERTIFICATION

This is a true and correct copy of the report, which is required to be filed pursuant to Section 117.26, Revised Code, and which is filed in the Office of the Ohio Auditor of State in Columbus, Ohio.

Certified for Release 3/26/2024

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