OHIO AUDITOR OF STATE
KEITH FABER

OHIO'S MEDICAID ELIGIBILITY DETERMINATION PROCESS

NOVEMBER 9, 2020

OHIO AUDITOR OF STATE
KEITH FABER

88 East Broad Street
Columbus, Ohio 43215
ContactUs@ohioauditor.gov
(800) 282-0370

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:

The Auditor of State's Office recently completed an audit of Ohio's Medicaid eligibility determination process. This audit was initiated in response to findings in prior State of Ohio Single Audits, audits conducted by federal agencies on this matter, and concerns with the backlog in Ohio's Medicaid determinations.

Despite efforts by the Ohio Department of Medicaid (ODM) and other state agencies, significant issues continue to impact the State's Medicaid eligibility determination process. These issues, compounded with the complexity of the program, the use of a county administered system, and the multiple avenues for information to be submitted, have resulted in confusing rules, system errors, human errors, and communication difficulties. The consequence is that it is difficult to see how Medicaid eligibility is being determined and to verify the accuracy of that determination.

Medicaid is Ohio's largest program, with annual spending of approximately $27 billion in state fiscal year 2019, and the financial resources used by the Program must be aggressively managed. At the same time, the number of people covered by Medicaid is growing, increasing the demands on the program and the necessary financial commitment. Our auditors tested the eligibility determination of 324 recipients from 27 different counties and found that 4.9 percent of those that received benefits were in fact ineligible for the program. Based on the error rate occurring in this sample, the potential loss to the program for that year is over $455 million.

This audit report contains recommendations, supported by detailed analysis, to enhance the Medicaid eligibility determination process. The report has been provided to ODM and its contents have been discussed with the appropriate staff and leadership within the Department. It is the Auditor's hope that ODM will use the results of the audit as a resource for improving operational efficiency as well as effectiveness. The analysis contained within are intended to provide management with information and recommendations to consider while making decisions about their operations.

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

Sincerely,

Keith Faber
Auditor of State
Columbus, Ohio

November 9, 2020

This page intentionally left blank.

OHIO'S MEDICAID ELIGIBILITY DETERMINATION PROCESS

TABLE OF CONTENTS

THIS PAGE INTENTIONALLY LEFT BLANK

REPORT SUMMARY

The Medicaid program is jointly financed by the federal and state governments and administered by the states under a Centers for Medicare and Medicaid Services (CMS) approved plan. The Ohio Department of Medicaid (ODM) is responsible for overall compliance and administration of Ohio's Medicaid program. ODM, through a Memorandum of Understanding with the Ohio Department of Job & Family Services (ODJFS), utilizes the 88 county departments of job and family services (CDJFS or counties) in the eligibility determination process to work with applicants, receive/enter eligibility documentation into the eligibility system, and follow up on system alerts.

According to ODM, Ohio has invested over $1.2 billion dollars in a new statewide eligibility system, known as Ohio Benefits (OB), that includes worker portals, electronic beneficiary accounts, interfaces to verification data sources, and automated rules' engines. Ohio began enrolling individuals in the OB system in 2014. However, after years of development and inclusion of other benefit programs, the system does not work properly—with inaccurate or missing data sometimes leading to incorrect determinations, overpayments and payments out of the wrong aid category. The State relied on the OB system to disburse approximately $22.3 billion and $19.3 billion in Medicaid funds in state fiscal year (SFY) 2018 and 2019, respectively.

The OB system allows Ohio residents to apply for Medicaid benefits online, by phone, or by contact with their local CDJFS. Counties accept applications, enter eligibility supporting documentation, verify or renew eligibility, and issue medical cards to customers determined eligible. Claims for individuals receiving medical services from eligible providers are then processed and paid by ODM or one of the state's Medicaid managed care organizations (MCOs).

We undertook an audit of Ohio's Medicaid eligibility determination process in response, in part, to findings in prior State of Ohio Single Audits[1] and audits performed by the U.S. Government Accountability Office (GAO), the U.S. Department of Health and Human Services – Office of Inspector General (HHS-OIG), and other state auditors' offices. In addition, Ohio's system came under scrutiny due to a significant increase in the number of applications not processed in a timely manner.

In a speech to the National Association of Medicaid Directors on November 12, 2019, the CMS Administrator highlighted that recent state audits and federal reviews identified deficiencies and lax eligibility practices that jeopardize the sustainability of the Medicaid program. Specifically she noted that states maintained insufficient documentation to substantiate eligibility determination, failed to conduct timely and appropriate annual redeterminations, and claimed customers under incorrect eligibility categories that provide a higher federal matching rate than was appropriate.

Our initial focus was to test the controls over the eligibility determination process at the CDJFS offices; however, the focus was expanded to include select functionality and programming aspects of the OB System. In response to a CMS request, ODM submitted a Corrective Action Plan (CAP) in January 2020 to address significant backlog in processing applications and renewals. CMS also released results of the FY2019 Payment Error Rate Measurement (PERM) report for Ohio which identified that the State was above the national average error rate in the area of Medicaid eligibility determination. In response, the Director of ODM characterized the OB system as "laborious and ineffective."

---

[1] State of Ohio Single Audits for Year Ended June 30, 2018 and Year Ended June 30, 2019 are available on the AOS website at: http://www.ohioauditor.gov/auditsearch/Search.aspx.

This report draws on data collected during interviews with ODM and the Ohio Department of Administrative Services (ODAS) staff, on-site interviews with administrators and caseworkers from 27 CDJFS[2] offices, Medicaid eligibility documentation for a sample of customers in each of the selected 27 counties and secondary data sources.

Recommendations

Ohio Benefits System

Despite efforts by ODM and other state agencies, significant issues continue to impact the State's Medicaid eligibility determination process. These issues, compounded with the complexity of the program, the use of a county administered system, and the multiple avenues for information to be submitted, have resulted in a morass of rules, versions, system errors, human errors, communication difficulties, etc. The culmination of this is that it is difficult to see how eligibility is determined and to verify its accuracy.

Updates to improve the functionality of the OB system are routinely made. Many of these updates result in changes to how county caseworkers process cases. In SFY2019, there were 654 changes to the OB system and these involved 533 changes in how caseworkers perform their work. Despite the many updates, the counties report significant issues continue.

We recommend that ODM implement the corrective action steps identified in its response to the 2019 State of Ohio Single Audit and release progress reports on system and process improvements and issues impacting Medicaid eligibility. These mechanisms could be a combination of a committee comprised of stakeholders meeting on a regular basis (i.e. quarterly) and frequent communication to the public via web-site, newsletters, or other means. Regular reporting on the process and system issues improves accountability for how public funds are spent and transparency on how the Medicaid program determines and processes eligibility. Information reported could include, but is not limited to, timeliness of processing application and renewals, backlog status, OB system changes, application procedures, feedback from counties and customers (i.e. surveys), rule changes, and state and federal audit results.

In addition, ODM has indicated that it will be contracting for an external review of the system. We recommend ODM ensure that this review include an evaluation of the effectiveness of corrective action steps. Monitoring and evaluating the OB systems' effectiveness and other processes and structures for determining Medicaid eligibility are critical to reduce the backlog of renewals and applications, to accurately determine Medicaid eligibility and to ensure a vulnerable populations' interaction with the Medicaid system is positive and efficient. Implementing recommendations to improve how Medicaid eligibility is processed through the OB system is essential to increase the confidence of the public and to ensure eligibility is determined according to standards and best practices.

Medicaid Eligibility Determinations

We found 41 of the 324 (12.7 percent) of the Medicaid customers tested in this audit were non-compliant. Of these, 16 customers (4.9 percent) were determined to be ineligible to receive benefits during all or a portion of SFY2019. These errors resulted in improper payments of $39,135. Applying the ineligible error rates found, the overall potential loss to the program is over $455 million. For many of the sampled cases, the system lacked the necessary historical information to identify edited, overridden, or written over information. This contributed to difficulties in determining how the caseworker verified eligibility at the time of the determinations.

---

[2] AOS sampled 24 offices involving 27 counties. Ohio Rev. Code § 329.40-329.46 allows for the formation of joint county departments of job and family services. South Central Job and Family Services District is a combination of Ross, Vinton and Hocking counties and Defiance/Paulding Consolidated Department of Job and Family Services is a combination of Defiance and Paulding counties.

We recommend that ODM evaluate the results for the 41 non-compliant customers and reimburse federal Medicaid dollars for the 16 ineligible customers identified in the sample. We also recommend that ODM address the system issues that contribute to the identified eligibility errors, develop accurate and timely reports that provide necessary data to monitor the work performed by the counties, and improve training for counties. (See recommendations on Data Governance Structure, Alerts in the OB System and Training Resources below). In addition, we recommend that ODM regularly evaluate selected benefit payments to verify the customer's eligibility, that the customer information entered into the OB System is accurate, and that information is being maintained to support the eligibility decision.

Data Governance Structure

We experienced issues in obtaining reliable and consistent OB system data and reports. There were instances in which we had to request reports multiple times because the original report did not contain all the data requested. For some of our requests, we received a revised report we could use for analysis, but in other instances we were unable to use the reports provided, or the data was never provided. We did not receive reports in a timely fashion. For example, we requested several reports in November 2019, and although we received various reports in the interim months, we did not receive many of the reports until early March 2020.

In our use of the Electronic Document Management System (EDMS) to view documents used to support eligibility determinations, we found the system to be slow, documents were difficult to locate (multiple years of support in a single folder, inconsistency in what a single scan may include, applications and renewal forms in the same folder, etc.) and we found instances in which documents were scanned under the incorrect social security number and, therefore, were not in the correct folder.

To ensure consistency and reliability of data, we recommend that ODM work with ODAS to emphasize and evaluate a data governance structure. Data governance is the process of managing the usability, reliability, availability and security of an organization's data. Focusing on effective data governance improves data quality and reliability of data used for analytical decision making by identifying and fixing errors before sharing information with other agencies and using for auditing purposes.

Ohio Benefit System Alerts

The OB system includes alerts that notify the counties of a potential change in a customer's circumstance that may impact Medicaid eligibility. This important control is not effective due to the number and duplication of the alerts being generated – in SFY 2019 there were approximately 11.8 million alerts. Counties described alerts as time consuming, a low priority, out of control and a never-ending cycle.

We recommend ODM continue to design and implement appropriate control procedures for monitoring Income Eligibility Verification System (IVES) and non-IVES alerts generated and processed in the OB system to help ensure the counties are completing them properly and timely. These monitoring procedures should be performed frequently, include appropriate follow up with the county if alerts are not being completed properly and timely, and be documented. Management should periodically review this documentation to ensure the control procedures are being performed as intended.

Training Resources

Ohio is one of only 10 states that has a decentralized county or local administered program. County staff process Medicaid applications and renewals, conduct quality assurance activities, obtain documentation to support eligibility decisions, address complaints, provide information for appeals, and are the primary users of the state system used to determine eligibility for Medicaid and other public assistance programs. Ohio's use of a county administered system necessitates that a sound training program is available that meets the needs of all 85 county offices. In addition, the errors in eligibility determination identified in multiple audits and reviews and the increasing number of state hearings point to the need to further evaluate how training is being conducted and how ODM can better support the county staff in this important work.

We recommend that ODM enhance its methods to train county staff on the OB system by better organizing information on the Ohio Benefits project website. Methods that could enhance how information is presented on the site include organizing information using drop-down menus where the most recent information is easily identified and accessible and older information archived or deleted. In addition, the training should incorporate information for effective operations of a call center. We found that the county offices are adjusting from a service delivery model in which they met face to face with customers to operating a call center. The interaction now with customers is almost all via phone or through electronic forms of communication such as emails and faxes. Counties responded in interviews that OB training could be improved by ODM offering more hands-on training and additional training resources on how to process long-term care (LTC) applications.

County Models

While the eligibility rules are consistent across the state and the OB system provides a statewide platform, there are differences in how counties are organized and the processes used to complete the enrollment process. These differences are due to various factors such as county size, the county's participation in a CSS region, and variations in county administration and management. As a result, a customer's experience with this statewide program will vary based on county of residence. Due to issues with the OB system highlighted in this report, we were unable to draw any conclusions as to the efficiency or effectiveness of any particular model or practice at the county level.

We recommend that after addressing system issues, alerts, training and data governance, ODM should conduct a formal program evaluation to identify best practices regarding the models used by the counties to administer Medicaid eligibility. In Ohio's 2020 CAP, ODM stated it collected best practices through visits to seven counties; however, ODM staff indicated this was an "informal process".

From interviews with counties, we found examples of different methods counties use to administer Medicaid eligibility, including casebank model, CSS call center, quality assurance to review accuracy, and different OB system and/or internally developed reports to monitor alerts, backlog, and timeliness of application and renewals. So although one practice may not be implemented the same in every county, an evaluation could give strategies for measuring the effectiveness of models and what model works best under certain circumstances.

This evaluation should address questions including:

- What are the best practices a CSS call center should use to provide customer service, accurately process Medicaid eligibility, reduce wait times and measure performance?
- Are there QA practices counties should consider to effectively reduce error rates for eligibility determinations and avoid escalation to hearing?
- What types of reports are available or are needed to effectively monitor alerts, backlog, and timeliness of processing application and renewals?
- Is the casebank model used by counties effective for processing Medicaid eligibility?

Table 1: Terminology and Acronyms

Abbreviation	Terminology	Definition
ACA	Affordable Care Act	The comprehensive health reform law enacted in March 2010 that allowed states to expand the Medicaid program.
County	County Department of Job and Family Services	County agency that coordinates a variety of assistance programs. Also referred to as county in this report.
CMS	Centers for Medicare & and Medicaid Services	The federal agency that runs the Medicare, Medicaid and Children's Health Insurance Programs, and the federally facilitated Marketplace.
CSS	County Shared Services	Call center system that offers flexibility to counties to decide how, and with which other counties, they wish to align processes and staffing resources.
EDBC	Eligibility Determination Benefit Calculator	A series of rules that determine eligibility of a customer based on non-financial and financial factors and performs related calculations.
EDMS	Electronic Document Management System	Ohio's central document repository for provider and/or customer related documents.
FPL	Federal Poverty Level	A measure of income issued annually by the Department of Health and Human Services and is used to determine eligibility for certain programs and benefits.
IEVS	Income Eligibility Verification System	Contains income and benefit information from the ODJFS and the social security administration.
MBIWD	Medicaid Buy-In for Workers with Disabilities	Provides coverage to working customers with disabilities to allow them to work, and still keep their Medicaid coverage.
MCO	Managed Care Organization	Organizations authorized to provide, or arrange for the provision of, health care services to Medicaid customers who are required or permitted to participate in the care management system
MITS	Medicaid Information Technology System	Browser-based administration platform used to process Medicaid payments.
OB System	Ohio Benefits System	An information technology system implemented in 2013 in order to comply with the ACA and intended as a simplified, online application process for various benefits, including Medicaid.
ODAS	Ohio Department of Administrative Services	State agency responsible for procuring goods and services, deliver information technology and mail, recruit and train personnel, promote equal access to the state workforce, lease and manage office space, process payroll, print publications and perform a variety of other services.
ODJFS	Ohio Department of Job and Family Services	State agency responsible for supervising the state's public assistance, workforce development, unemployment compensation, child and adult protective services, adoption, child care, and child support programs.
ODM	Ohio Department of Medicaid	State agency responsible for administering the Medicaid program.
PE	Presumptive Eligibility	Conditions under which a customer may receive time-limited medical assistance as a result of an initial, simplified determination of eligibility based on self-declared statements.

Abbreviation	Terminology	Definition
QE	Qualified Entity	A business or organization that is capable of conducting and authorizing PE determinations to identified groups.
SNAP	Supplemental Nutrition Assistance Program	Federal nutrition assistance program that provides benefits to eligible low-income customers and families to purchase eligible food in authorized retail food stores.
SSA	Social Security Administration	Federal agency responsible for administering SSI program, social security, social security disability insurance (SSDI) program, retirement and survivors' benefits.
SSI	Supplemental Security Income	A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind or age 65 or older. SSI benefits are not the same as Social Security retirement or disability benefits.
TANF	Temporary Assistance for Needy Families	A federal program that provides grant funds to states and territories to provide families with financial assistance and related support services which may include childcare assistance, job preparation and work assistance.

Purpose, Scope and Methodology

Purpose

The purpose of this audit included:

- To evaluate whether CDJFS are performing Medicaid eligibility administrative tasks in compliance with federal and state requirements;
- To determine whether ODM issued payments on behalf of ineligible customers;
- To identify barriers in the enrollment process; and
- To identify areas of risk for inaccurate eligibility determinations.

Medicaid is Ohio's largest program with annual spending of approximately $27 billion in SFY 2019, so processes and systems that are ineffective or inefficient have the potential to significantly impact the State. ODM is responsible for determining applicants' eligibility for Medicaid, including verifying eligibility at application and at the time of renewal (redetermination), and disenrolling individuals who are no longer eligible. Sound processes for determining eligibility are essential for this program.

In 2020, the GAO issued the "*Medicaid Eligibility Accuracy of Determination and Efforts to Recoup Federal Funds Due to Errors*" report in which it reviewed 47 state and federal audits across 21 states and identified multiple issues affecting the accuracy of states' Medicaid eligibility determinations as shown in **Table 2**.

Table 2: Summary of GAO Findings on Medicaid Eligibility Accuracy

Accuracy Issue Category	Number of Audits	Number of States
Incorrect or incomplete income or asset information	24	13
Eligibility redeterminations not made in a timely manner	20	10
Ineligible customer not dis-enrolled in a timely manner	14	9
Unresolved income discrepancies	10	7
Customers enrolled in incorrect basis of eligibility (enrolled in wrong aid category)	11	6
Unidentified or unaddressed changes in circumstances	11	5
Use of incomplete or incorrect information on household composition	5	4
Eligible customers who were not enrolled	4	3
Other	23	14

Source: GAO review of 47 states and federal audits conducted between 2014 and 2018, GAO-20-157
Note: Some states had multiple audits that found similar issues. As such, the number of audits that identified each type of accuracy issue may be greater than the number of states in which an issue was identified.

In addition, according to the 2019 GAO report "*Medicaid Eligibility Accurate Beneficiary Enrollment Requires Improvements in Oversight, Data, and Collaboration*", an accurate determination of eligibility is essential in ensuring only customers that meet requirements are enrolled and that they are enrolled in the correct eligibility group so that states' expenditures are properly matched with federal funds for Medicaid customers.

Reviews conducted by this office and HHS-OIG regarding Medicaid eligibility determinations in Ohio has identified errors. The previous five State of Ohio Single Audits (SFY2015 through SFY2019) and two recent reports released by the HHS-OIG[3] found instances in which Ohio's eligibility determinations were not

---

[3] *Ohio Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries Death* (October 2018) and *Ohio Made Capitation Payments that Were Duplicative or Were Improper Based on Eligibility Status of Demographics* (September 2019*)*

accurate, redeterminations were not completed timely, income or resources exceeded eligibility limits, information was entered into the OB system incorrectly, duplicative payments were made, eligibility status and demographics of age and gender were incorrect and payments were made on behalf of deceased beneficiaries.

In 2018, Ohio faced a significant increase in the backlog of applications not processed in a timely manner. This backlog has been the subject of news articles and acknowledged by ODM in its 2020 CAP.

Federal timeliness standards to determine eligibility are 90 days for customers with a disability and 45 days for all other customers. Ohio Admin. Code § 5160:1-2-01(K) states that timely determinations of eligibility must be made within:

- 10 days of receiving a report of a change that could affect a customer's on-going eligibility;
- 45 days from the date of application or scheduled renewal;
- 90 days for Aged, Blind or Disabled (ABD) applications; or
- 45 days of receipt of new or changed information from the income eligibility and verification system.

It should be noted that other states have experienced challenges with determining Medicaid eligibility. Findings in reports for other states included determining eligibility inaccurately based on standards, lack of documentation to support eligibility, not performing necessary verifications of eligibility, incorrect eligibility determinations for residents who did not meet the residency requirements, and timeliness of redeterminations.

Scope and Methodology

We selected 27 counties (see **Table 3**) for renewing eligibility in the OB system. We based the selection of counties on factors that included a low percentage of denials, a high percent of county population on Medicaid or weaknesses identified for the Medicaid program in the county's recent financial audit.

To select the sample for the redetermination, we obtained a unique list of Medicaid customers for each of the 27 counties. We identified customers in which there was a net payment or capitation amount greater than zero for SFY2019. As the scope of this audit was enrollment and included all applications regardless of outcome of the application, the term customer is used throughout this report to refer to anyone applying for or receiving Medicaid benefits.

We individually stratified each county using four strata based on these categories of Medicaid population: ABD, Group VIII Expansion, Covered Families and Children (CFC) and Other (i.e. pregnant mothers, deemed newborns). We then identified a stratified random sample from each county. Four customers were selected from the ABD and CFC strata; three customers from the Group VIII Expansion and one customer from the Other strata.

This resulted in a selection of 12 customers from each county and the final sample size was 324 customers. Because a customer could have changed aid categories during the period, customers were duplicated in the entire population but were not duplicated within a strata. We reviewed each customer's case in the OB system and the supporting documentation from EDMS.

We conducted on-site visits to all of the counties and spoke with administrators, supervisors and caseworkers to gain an understanding and demonstration of processes and to identify areas for improvement. We also met with ODM personnel to gain an understanding of processes and issues centered on Medicaid eligibility. In addition, we conducted telephone interviews with representatives from long-term care facilities and sent a questionnaire to the Ohio Medicaid MCOs[4] to gain stakeholder feedback on the

---

[4] Buckeye Community Health Plan, CareSource, Molina Healthcare, Paramount Advantage and United Healthcare Community Plan

eligibility determination process. We also obtained data on the Medicaid enrollment process from ODAS and ODM.

Table 3 shows the 27 counties selected and their Medicaid enrollment as a percentage of the county's population for SFY2019. See also **Appendix 6** for additional data on the 27 counties.

Table 3: Selected Counties

County	Medicaid Enrollment as Percent of County Population	County	Medicaid Enrollment as Percent of County Population
Butler	22.0%	Paulding	15.7%
Cuyahoga	29.9%	Pike	37.9%
Defiance	21.9%	Preble	21.1%
Franklin	25.1%	Ross	34.8%
Hamilton	24.6%	Sandusky	20.9%
Henry	15.1%	Seneca	20.6%
Highland	30.3%	Stark	23.3%
Hocking	23.3%	Summit	24.0%
Lorain	20.6%	Trumbull	27.8%
Lucas	30.4%	Tuscarawas	20.7%
Mahoning	31.9%	Vinton	25.3%
Monroe	24.7%	Williams	20.1%
Montgomery	26.9%	Wyandot	16.4%
Noble	18.9%		
Average Enrollment as Percent of Population for Selected Counties: 26.0%			

Source: ODM for enrollment data and Ohio Development Services Agency for population

Background

The Social Security Amendments of 1965 created the Medicaid program by adding Title XIX to the Social Security Act. Under the program, the federal government provides matching funds to states to enable them to provide medical assistance to residents whose incomes and resources are insufficient to meet the costs of necessary medical services. Eligibility for the Medicaid program is based on factors such as income, household size, citizenship, resources, and health status. Medicaid serves as the nation's primary source of health coverage for low-income populations.

Federal Rules Regarding Medicaid Eligibility

The Code of Federal Regulations (CFR) Title 42, Part 435 contains the federal requirements for Medicaid eligibility. Applicants to the program have to meet general eligibility requirements including state residency, U.S. citizenship and obtaining a valid social security number. Non-citizens may qualify for certain types of assistance. Certain groups of individuals are mandated to be covered including children, aged, blind, or disabled, and pregnant women, provided they meet general requirements and applicable financial requirements.

In 2014, the Affordable Care Act (ACA) expanded Medicaid coverage to give states the option to include more low income individuals, including non-disabled adults without dependent children. The ACA made changes to eligibility requirements, including calculating income based on modified adjusted gross income (MAGI). The ACA required states to develop a health insurance exchange (marketplace) to consolidate the interface for determining eligibility for Medicaid and other health insurance programs[5].

The ACA includes provisions requiring that multiple sources be made available to apply for coverage, and utilization of the Federal Data Services Hub (federal hub) and other electronic verification sources during the application and renewal processes. The federal hub is a CMS provided service to verify customer information used to determine eligibility for Medicaid as well as for enrollment in qualified health plans and insurance affordability programs. The federal hub pings the Internal Revenue Service (IRS), Department of Homeland Security (DHS), and Social Security Administration (SSA). The federal hub is used for verification for the following eligibility factors:

- Income (all MAGI countable income types) (IRS),
- Social Security Number (SSA);
- Citizenship (DHS, SSA);
- Immigration Status (DHS);
- Incarceration (SSA); and
- Birth Date (SSA).

Ohio's Medicaid Program

Under federal Medicaid laws, each participating state administers its own Medicaid program, establishes eligibility standards, determines the scope and types of services it will cover, and sets the rate of payment. Benefits and eligibility requirements vary from state to state. CMS monitors the state-run programs and establishes requirements for service delivery, quality, funding, and eligibility standards pursuant to each state's Medicaid plan.

ODM shares certain functions of the Medicaid program with the CDJFS. Counties accept applications, enter data into the OB system, and issue Medical cards to customers determined eligible. Individual Medicaid customers receive care from service providers (doctors, hospitals, pharmacies, nursing homes, etc.) who

---

[5] Examples of other health insurance programs include Children's Health Insurance Program or private medical insurance plans.

also must meet certain criteria to be eligible to participate in the Medicaid program. The Medicaid Information Technology System (MITS) is the State's automated claim processing system and it uses uploads of information from the OB system to verify Medicaid eligibility.

Ohio's Medicaid program covers low-income (defined as below federal poverty guidelines) customers, adults over 65, blind and disabled customers, pregnant women, infants, children, and other groups. The criteria for each group is found in Ohio Admin. Code § 5160:1 and is summarized in **Table 4**. Income and resource limits in effect on January 2019 are included in **Appendix 1**. ODM is the single state agency responsible for administration of the Medicaid program. The Medicaid program provided health care coverage to approximately 2.9 million Ohio residents in SFY2019 with over 130,000 active providers serving these citizens.

Table 4: Ohio's Medicaid Covered Groups

Group	Description
Aged, Blind & Disabled (ABD)	A customer who is age 65 or older or is blind or disabled as determined by either the Social Security Administration or ODM. Income and resource eligibility requirements apply. Category includes Medicare premium assistance programs.
Modified Adjusted Gross Income (MAGI)	Based on the modified adjusted gross income, household composition and family size. Categories children (includes 19 and 20), former foster care, adult expansion (group VIII), pregnant women, parent or caretaker relative, and deemed newborns.
Other Covered Groups	Categories include the residential state supplement program, breast and cervical cancer project, Medicaid buy-in for workers with disabilities, refugee medical assistance, alien emergency medical assistance, specialized recovery services and non-citizen victims of trafficking. Each category includes specific requirements.
Long-Term Care	A customer must be eligible for medical assistance in accordance with the ABD group, the MAGI group or another covered group, meet the non-financial eligibility requirements required for the type of long-term care services requested and not be subject to a restricted Medicaid coverage period. Income and resource eligibility requirements apply. Long-term care is care provided to customers residing in a nursing facility, intermediate care facility for individuals with intellectual disabilities or medical institution based on a determined level of care.

Source: ODM – Ohio Benefits Worker Portal and Ohio Medicaid Basics presentation

Expenditures

Table 5 shows Medicaid General Revenue Fund (GRF) and non-GRF expenditures by federal and State portion for SFY2015 through SFY2019. Medicaid's expenses represented 34 percent of the State's SFY2019 budget. Ohio paid over $19 billion ($19,310,986,073) in benefits in SFY2019 – 72 percent of the Medicaid budget.

Table 5: Ohio Medicaid Expenditures SFY2015 through SFY2019 (In Billions)

Funds	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
GRF State	$5,509.6	$5,328.4	$5,644.2	$5,003.4	$5,208.6
GRF - Federal	$9,353.6	$11,667.5	$11,793.2	$9,479.1	$9,844.3
GRF - Total	**$14,863.2**	**$16,995.9**	**$17,437.4**	**$14,482.5**	**$15,052.9**
Non-GRF -State	$1,873.8	$2,397.4	$2,284.1	$3,357.1	$3,284.3
Non-GRF Federal	$6,730.1	$5,900.6	$5,828.7	$8,503.0	$8,246.9
Grand Total	**$23,467.1**	**$25,293.9**	**$25,550.2**	**$26,342.6**	**$26,764.1**
Annual Percent Change	---	**7.8%**	**1.0%**	**3.1%**	**1.6%**

Source: Greenbook Legislative Budget Office Analysis of Enacted Budget Ohio Department of Medicaid
Note: The expenditures above show the Medicaid expenditures for ODM, Ohio Department of Developmental Disabilities (ODODD), ODJFS, Ohio Department of Health, Ohio Department of Mental Health and Addiction Services, Oho Department of Aging, Pharmacy Board, and Ohio Department of

Education. ODM and ODODD account for the majority of expenditures, with ODM representing 88.5 percent and ODODD 10.3 percent in SFY2019, for a total of 99 percent.

Role of State and County Agencies

ODM determines eligibility policy and criteria, service coverage and payment policy for Ohio's Medicaid program. State regulations for Medicaid eligibility can be found in Ohio Admin. Code Chapter 5160:1. ODM employs County Technical Assistance and Compliance staff responsible for determining eligibility for the Breast and Cervical Cancer Program, incarcerated individuals and those awaiting adjudication in the Ohio Department of Rehabilitation and Corrections or Ohio Department of Youth Services. ODM also has a central processing team responsible for various management and operational activities.

Ohio Rev. Code § 5160.30(B) allows the department to enter into an agreement with one or more agencies to accept applications, determine and renew eligibility and perform related administrative activities. ODM, through a Memorandum of Understanding with ODJFS, utilizes the 88 counties in the eligibility determination process to work with applicants, receive/enter eligibility documentation into the OB system, and follow up on alerts issued by the system.

County caseworkers process applications to determine initial eligibility and perform eligibility renewals for continuing Medicaid coverage. The counties also update cases when a customer reports a change in their circumstances and when prompted through a system alert. County offices also process enrollment for other public assistance programs including Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP). Customers can apply for one or multiple programs at the same time. The counties submit costs incurred to perform these functions and the State reimburses for the approved costs.

Table 6 shows the breakdown of the $161.6 million paid to county offices for activities related to administering Medicaid eligibility determination.

Table 6: Medicaid Administrative Expenses for Counties in SFY2019 (Actual)

Fund Description	Expenditure
Special Income Maintenance Project	$ 3,679,611
Medicaid	$ 14,927,594
Medicaid Healthchek Pass Thru	$ 296,277
Medicaid Incentives	$ 89,037
Medicaid Enhanced Federal	$103,633,298
Medicaid Enhanced Match	$ 7,421,861
Medicaid Income Maintenance	$ 28,593,611
Out Stationed Eligibility	$ 556,352
Medicaid Child Welfare Related	$ 2,393,765
Total	**$161,591,406**

Source: Ohio Administrative Knowledge System (OAKS) BI - VAP-0003 Report

Electronic Document Management System and County Shared Services

Ohio uses the Electronic Document Management System (EDMS) as a central repository for customer related documentation required to support Medicaid eligibility. EDMS allows county caseworkers and ODM to view customer eligibility supporting documentation online and contains a workflow component which allows caseworkers to track and manage their work. This system allows customer service across and between counties and ODM through a shared database. Each CDJFS office determines the components and functionality of the EDMS it uses. For example, one CDJFS office may use the workflow component while another CDJFS may use a separate system for that function.

Ohio's Medicaid Eligibility Determination Process

In 2014, Ohio launched County Shared Services (CSS), an initiative to expedite and standardize eligibility and enrollment processes across county lines for Medicaid and other programs. Participation in CSS is optional and counties have the flexibility of how and in what capacity to use the service. Customers call in to a single phone number, are prompted to enter their zip code and then are connected to a caseworker in the applicable group to apply for or renew Medicaid. The map in **Chart 1** shows the 77 counties using CSS: 67 counties operating in eight groups and the 10 stand-alone metro counties. As of April 2019, the remaining 11 counties were not a member of a CSS group.

Chart 1:
County Shared Services Groups

*Counties highlighted in gray are not a member of a county shared services group as of 04/2019.

Twenty-three of the 27 counties interviewed participate in CSS. Some counties use CSS for the Medicaid program only and others use CSS for Medicaid, SNAP and TANF. Each group determines its staffing levels and wait time goals so even with shared services in place, the application or renewal process could differ depending on the county of residence. One county interviewed responded that wait time for customers was approximately six minutes while another similarly-sized county indicated wait time could be hours during peak times. The State's implementation of CSS supports processing eligibility determinations over the phone, thereby limiting the necessity for face-to-face interaction with customers.

Most counties indicated that their shared services group functions effectively; however, there were county respondents who reported difficulties such as inconsistencies with journal entries, caseworkers not working alerts, and general staff morale issues related to inequity in staffing levels and pay differences.

Ohio's Medicaid Eligibility Determination Process

Qualified Entity

In addition to the county role in determining eligibility, Ohio allows a qualified entity (QE) to make eligibility determinations for the presumptive eligibility (PE) program which:

- reduces the time for emergency eligibility determinations;
- allows prospective Medicaid beneficiaries to receive immediate, time-limited access to medical services;
- provides a gateway into full Medicaid for Ohioans who may not have known they were eligible for full Medicaid benefits;
- gives pregnant, uninsured women access to prenatal care; and
- meets the needs of uninsured Ohioans at the point of care and assists them through the Medicaid application process.

Employees of QEs are able to run a simplified eligibility review for Ohioans which will grant immediate medical assistance to residents at the time that they require medical coverage. A customer may receive this time-limited assistance under PE as a result of a simplified determination based on self-declared statements. PE ends on the earlier of the date the customer is determined eligible or ineligible; or the last date of the month following the PE declaration if the customer does not file an application. PE determinations are limited to one coverage period in a 12 month time frame, except that pregnant women may have a coverage for each pregnancy.

According to Ohio Admin. Code § 5160:1-1-01, QEs include the following:

- a county;
- a hospital;
- the department of youth services;
- a federally qualified health center or a federally qualified health center look-alike;
- a local health department, a women, infants, and children clinic; and
- other designated entities.

As of December, 2019, there were 348 QEs in 72 counties approved by ODM. There were over 39,000 individuals at these 348 entities given responsibility to determine PE. The majority of approved entities are hospitals and community health centers.

QEs are responsible for meeting the following performance standards: at least 85 percent of all people enrolled presumptively by QEs must have applied for full Medicaid benefits within 90 days and at least 85 percent of all who applied for full benefits must be awarded Medicaid eligibility. Effective November 9, 2019 Ohio Admin. Code § 5160-1-17.12 provides for monitoring of QEs. Prior to this rule, there was no formal monitoring of these entities. Under the new rule, ODM may terminate a QEs authority for failure to meet the performance requirements. ODM stated that it has contracted with a vendor to report on the performance of Ohio QEs.

Ohio Medicaid Consumer Hotline

ODM contracts with a vendor to provide an Ohio Medicaid Consumer Hotline. The vendor's responsibilities include the following:

- providing managed care enrollment broker services and choice counseling to customers who need assistance with understanding Ohio's managed care programs and enrolling in a managed care plan;
- operating the managed care provider network system;
- operating a toll-free call center to provide customer service to Ohio residents and assisting with their questions about the Medicaid program;
- assisting with Medicaid applications and the annual renewal process;

- providing print services and mail fulfillment for all of ODM's managed care letters; and
- providing premium collection services for the Medicaid Buy-In for Worker's with Disabilities (MBIWD) program.

According to ODM, the vendor hotline contract was changed in SFY2019 to account for increased monthly call volume, increased service level agreement performance metrics, the addition of mailing managed care enrollment letters, and the addition of qualified income trust duties. ODM staff reported that they monitor the contract through monthly activity reports that detail its call center and enrollment activities as well as its performance on the service level agreements and weekly reports on the managed care provider network. ODM has standing biweekly meetings with vendor information technology staff in addition to biweekly meetings with the project director to review progress on work assignments, upcoming projects and any changes to the Medicaid program.

Counties indicated in interviews that, until recently, they did not receive notification when a customer called the hotline to initiate an application. As a result, the steps required by the applicable county to timely process the application were not performed. Yet, Ohioans using the hotline to initiate Medicaid applications were left with the impression their applications would be processed. After this audit was initiated and a number of the county interviews were conducted, county respondents reported that the vendor began sending them notices of customer contact and applications.

Ohio's Structure for Medicaid Enrollment

A. The Ohio Benefits System

> ### *Key Points*
>
> Ohio implemented the OB system to process enrollment in public assistance programs. Medicaid was the first program to use the OB system. The system provides flexibility in how customers can apply for benefits and facilitates the use of electronic data sources to verify information thereby reducing the burden on customers to provide documents. However, both ODM and the counties acknowledged that the OB system has significant shortcomings that create barriers to customer's obtaining benefits, to the county's ability to serve its customers and to the State's ability to have accurate and timely data to monitor this major program. While efforts have been made to address issues, a level of frustration and concern was expressed by many of the counties.

The OB system, initiated in 2013, is a centralized web-based database used to determine Medicaid eligibility. It was developed to meet requirements of the ACA, mandating states access and use electronic verification sources whenever available to determine eligibility before requiring paper documentation. The system replaced the Client Registry Information System Enhanced (CRIS-E). Starting in August 2016, all Medicaid and Children's Health Insurance eligibility determinations were made in the OB system and since July 2018, new applications for other assistance programs (SNAP and TANF) are also processed in the OB system.

ODAS is the administrator of the OB system and has a contract with a third party vendor to develop, test and implement the system. Primary users of the system for Medicaid are ODM and county caseworkers. Programmed edit routines help ensure the required application data is complete and accurate for manually-entered data as well as applications submitted electronically. The OB system performs an automated check of active and inactive customers to a master index to determine new or existing customers.

Currently, the counties process the bulk of the applications for Medicaid benefits. The caseworkers enter the customer's information into the OB system to determine initial eligibility and/or perform eligibility redeterminations on an annual basis or when prompted through an IEVS alert. The OB system is programmed with Ohio's eligibility requirements. Once the determination is made, the OB system uploads the eligibility information to MITS.

Chart 2 shows two of the screens in the OB system used to document income and resources which are the main components to eligibility determination (note: these screens were developed by ODM for training purposes and do not reflect any actual customer). Each of these areas have additional screens that provide more details (e.g. earned income and unearned income). The list on the left side of the screen shows the various financial categories including expenses, other health insurance, Medicare, etc. Numerous other screens include information such as citizenship, marital status, gender, household status, residency, medical condition and historical information on prior periods of eligibility.

The OB system supports case management activities. Emails can be sent to customers from the system; however it does not allow internal emails to supervisors or team members. It also has a journaling function so the caseworker can document work performed on a case which allows other users to see that information. In addition, certain automatic system processes produce a journal entry.

As seen in the screen shots, there is a "Reports" function in the OB system. Examples of the reports available in the system are in **Appendix 4**.

Ohio's Medicaid Eligibility Determination Process

Chart 2: Two Screens from the Ohio Benefits System

Source: OB System

B. Medicaid Application Process

> **Key Points**
>
> Ohio's system provides different avenues for customers to apply for Medicaid benefits and the State has seen a significant increase in the number of applications for this program. Some applications can be approved using electronic resources, referred to as no touch applications. These no touch applications shorten the process for the customer and lessen the workload for the counties. However, there are issues negatively impacting the no touch process and, in SFY 2019, only two percent of applications were processed as no touch. This leaves the majority of applications to be processed at the county level.
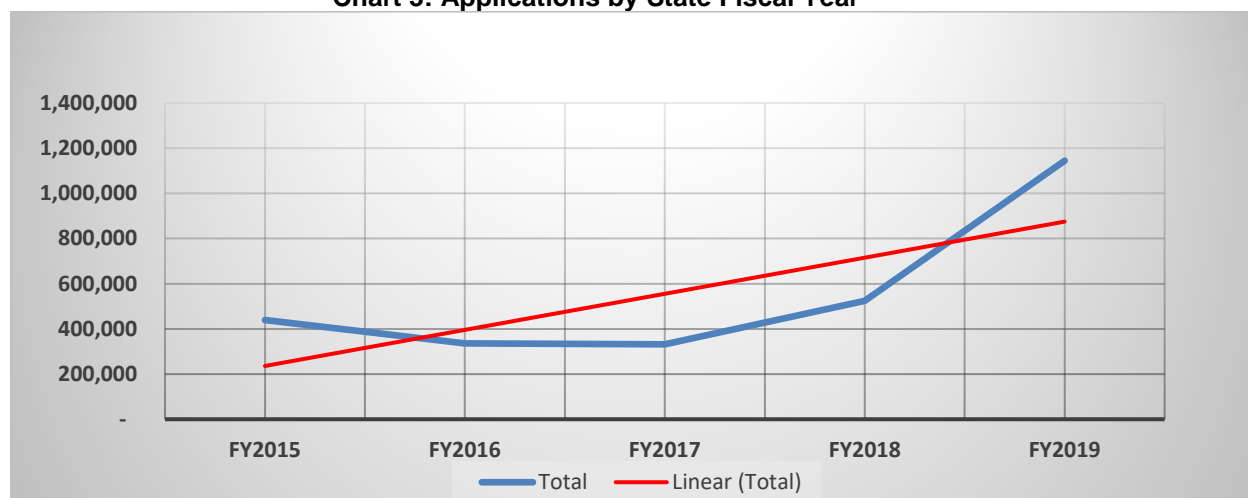
Federal regulations (42 CFR 435.940-435.965 and 457.380) require states to submit verification plans to CMS describing electronic sources and documentation requirements used for verification of eligibility factors, such as income and non-financial factors (i.e. citizenship). States list which factors are self-attested, and the reasonable compatibility standards applied when self-attested information is inconsistent with electronic data matches.

In Ohio, customers self-attest to residency, date of birth, household composition, pregnancy and caretaker relative status. These attestations are accepted unless conflicting information is received in which case paper documentation is then required. Elements that require verification include earned and unearned income, citizenship, immigration status, Medicare and former foster care status. In Ohio, self-attested income is first verified through pinging the federal hub and is deemed to be reasonably compatible if within five percent of the IRS value. If electronically verified then the customer does not need to submit any additional documentation.

Ohio offers various methods to apply for Medicaid including submission of a paper application (delivered via in person, mail or fax), an electronic application, a phone application and through a QE. In addition, when a customer applies for social security or health care coverage on the federal market place an application is created and "dropped" to the applicable county. The counties interviewed indicated applications from SSA and the federal market place tend to drop weeks, months or even years late. Other issues with these applications include incomplete information, existing information indicating the customer is over the income limit and customers being unaware that a Medicaid application was submitted on their behalf.

Chart 3 shows total applications for SFY2015 through SFY2019. Total applications increased 160 percent (from 439,976 to 1,144,742) during this period.

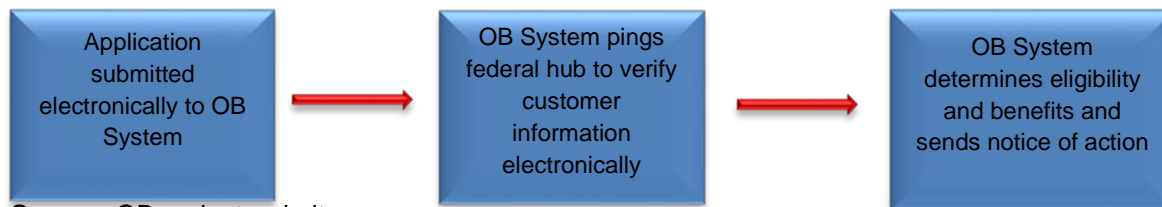**Chart 3: Applications by State Fiscal Year**

Source: ODAS

The OB system includes an automated no touch process for certain aid categories in which the system automatically attempts to electronically verify required elements. As part of this process the system performs verifications in two types of instances: when an application is submitted in the OB self-service portal or another interface, or when an application is created via the Ohio Benefits Worker Portal. The no touch process verifies information such as name, living arrangement, date of birth, income, social security number, citizenship and immigration status if applicable. As part of the no touch process, the system pings the federal hub. **Chart 4** shows the "no touch" process.

Chart 4: No Touch Process

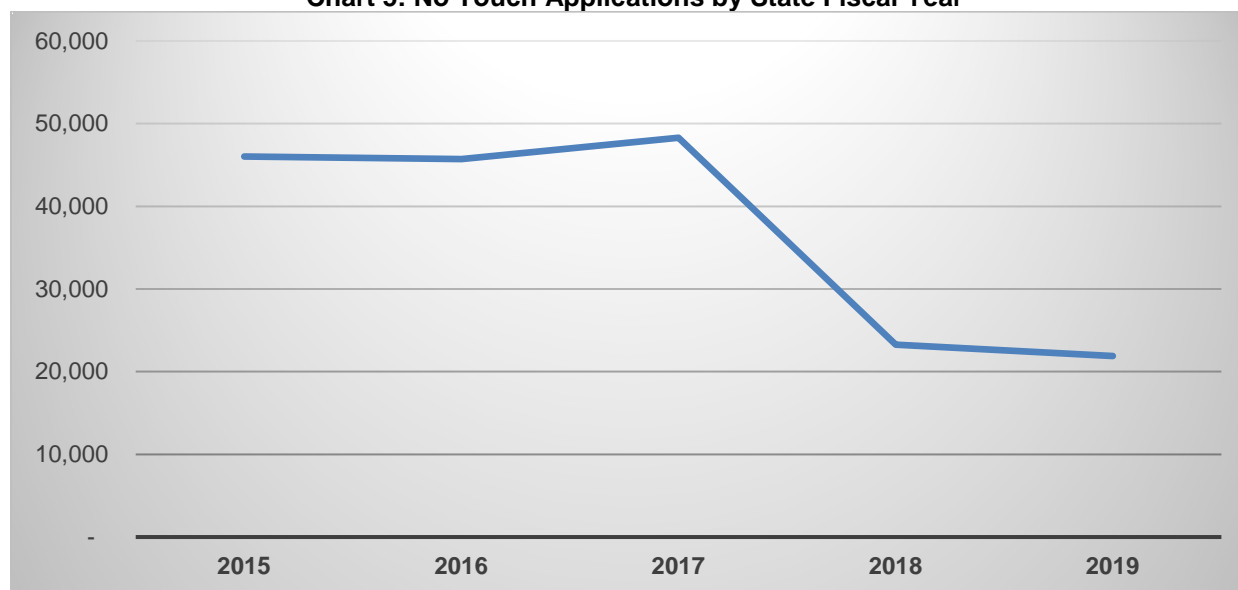| Application submitted electronically to OB System | → | OB System pings federal hub to verify customer information electronically | → | OB System determines eligibility and benefits and sends notice of action |

Source: OB project website

In SFY2019, 21,993 applications successfully passed through the no touch process, a decrease of 52 percent from the SFY2015 number of 46,032 (see **Chart 5**). Counties responded in interviews that the no touch process is not always effective in verifying information, for instance the tax data is from the prior year and may not accurately present current income.

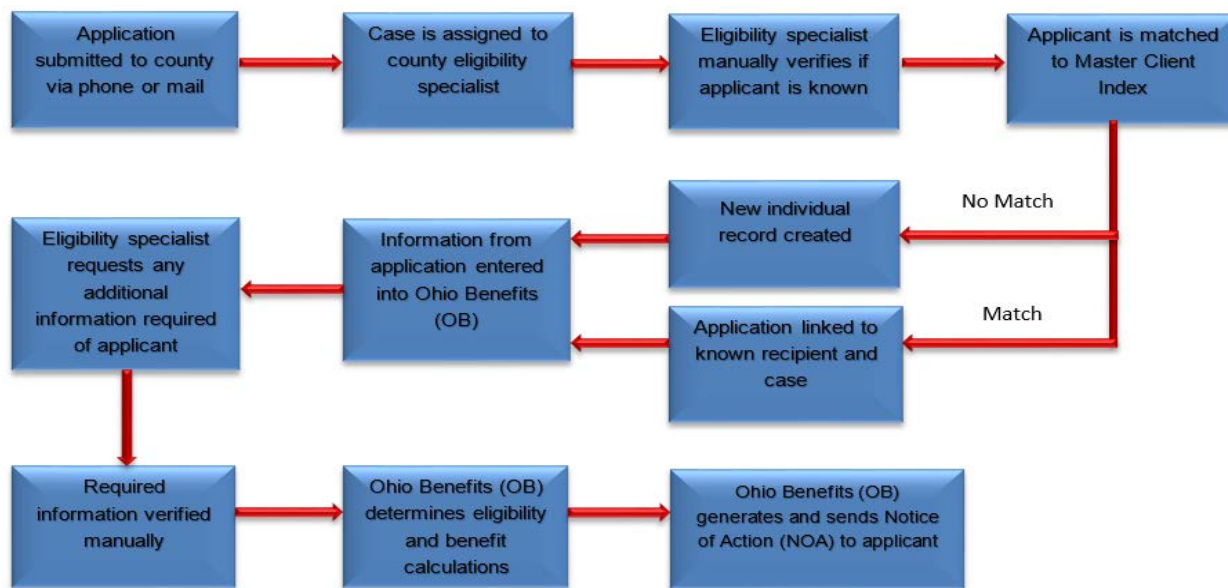**Chart 5: No Touch Applications by State Fiscal Year**

Source: ODAS

If the no touch process is unsuccessful, the application falls out and requires a caseworker to complete the process. Caseworkers can perform electronic verification of eligibility factors using the federal hub and additional electronic sources. Examples of other electronic data pinged to verify income include state wage data and unearned income. **Appendix 3** provides a list of electronic verification sources.

In county interviews, respondents indicated the federal hub is used for verification of non-financial factors such as citizenship and social security numbers and they generally use both electronic sources and obtain paper documentation for earned and unearned income. Counties indicated confusion on how to use electronic verification sources in that some stated they need customer permission to ping the federal hub and others did not. In addition, some indicated they lack confidence in the accuracy of the federal hub and other electronic sources in part because the eligibility determination is based on current income and the electronic verification provides older data. **Chart 6** describes the manual application process.

Chart 6: Manual Application Process

Source: OB project website

Once the required elements are verified, the caseworker runs the eligibility determination benefit calculator (EDBC) which determines eligibility (or ineligibility) and designates the group, category and eligibility period. The caseworker reviews and accepts the EDBC results and the system automatically creates a notice of action (NOA) informing the customer of the outcome. The notice is then mailed to the customer.

Many of the counties interviewed stated that EDBC results are not always correct and manual overrides must then be performed to show the correct eligibility status. Two counties indicated that caseworkers manually calculate the budget and determine eligibility prior to running the EDBC in order to evaluate the accuracy of the determination.

Other issues with the application process highlighted in the county interviews include the following:

- Long-term care applications are difficult to process in the OB system; at times it removes eligibility for the qualified Medicare beneficiary (QMB) and the specified low income Medicare beneficiary (SLIMB) so then premiums are deducted by social security and it can be cumbersome to re-instate a customer into the correct aid category.
- Duplicates in system (same customer on multiple cases and multiple person identifiers for the same customer) and caseworkers cannot delete customers added in error or on duplicate applications.
- The link between the OB system and MITS does not always work and there is a lag time between determination and MITS update during which customers cannot access services.
- Information on income does not always come over correctly from an electronic application.
- The pending citizenship screen requires a work around.
- Linked applications have incorrect and conflicting information.

C. Medicaid Renewals

> **Key Points**
>
> Once Medicaid eligibility is established, eligibility for most categories must be renewed every 12 months. The data shows that, over the past five state fiscal years, an average of 95 percent of renewals processed were approved. The OB system includes a passive renewal process that allows for eligibility to be verified using an electronic process which eases the burden on the customer and reduces workload of the county caseworkers. The rate of passive renewals decreased in SFY2019 from the prior year with approximately 21 percent being passively renewed. This leaves the majority of renewals to be processed at the county level.

Ohio Admin. Code § 5160:1-1-01(B)(68) states that a renewal is performed annually or when information about possible changes to a customer's eligibility is received. ODM indicated that approximately seven weeks prior to a customer's renewal month the system attempts to renew benefits based on electronic verifications via passive renewal (see *Passive Renewals* below). If the renewal passes, benefits extend 12 months from the renewal date and a notice is mailed to the customer. If the case information is not successfully verified, or the program is not approved for benefits, the program block[6] will fall out of the passive renewal process. The caseworker then follows a manual renewal process. Categories excluded from passive renewal are PE and Alien Emergency Medical Assistance.

Caseworkers process e-renewals and manual renewals. For these renewals, the system automatically generates a renewal packet which is mailed to the customer. The renewal packet lists various ways the customer can renew, including on-line, mail, and a centralized phone number. A manual renewal form is sent to the customer approximately four weeks prior to a customer's renewal month. The due date of the manual renewal form is 30 days from the mail date. If the customer does not return the renewal form within 10 days of the due date a reminder letter is sent. If the customer fails to respond to the renewal request, the case will be auto-discontinued by the OB system. If the customer responds to the renewal request prior to the auto-discontinuance date, the case will remain active and the county will process the renewal.

ODM's 2020 CAP noted issues with the OB system not identifying all cases that need renewed and making eligibility errors when the system performs an automated case closure. County respondents noted issues with redetermination packets, including that the packets are too long and difficult to understand, and do not request information on resources for those customers in an aid category in which resources are a determining factor.

Table 7 illustrates renewals by year for active, denied and discontinued cases[7]. Total renewals in SFY2019 was 671,539, which was a 434 percent increase from SFY2015. The data provided for this audit reflects significant variances, is unaudited and is of questionable reliability. The data shows a significant increase between SFY2017 and SFY2018 in which the renewals increased 265 percent and a minimal increase of approximately five percent from SFY2018 to SFY2019.

Table 7 also shows the percent of total renewals that are approved and demonstrates that the percent of approved renewals was consistent across the five years.

---

[6] Program blocks are the method in which the OB system organizes cases for budgetary purposes to determine eligibility. There are separate budgetary units within one program block for different household members. Budgeting units refer to all individuals who must be counted (either in household size or income).

[7] Discontinued is term used for denied renewal where the case had pending status prior to the denial.

Ohio's Medicaid Eligibility Determination Process

Table 7: Medicaid Renewals for State Fiscal Years 2015 – 2019

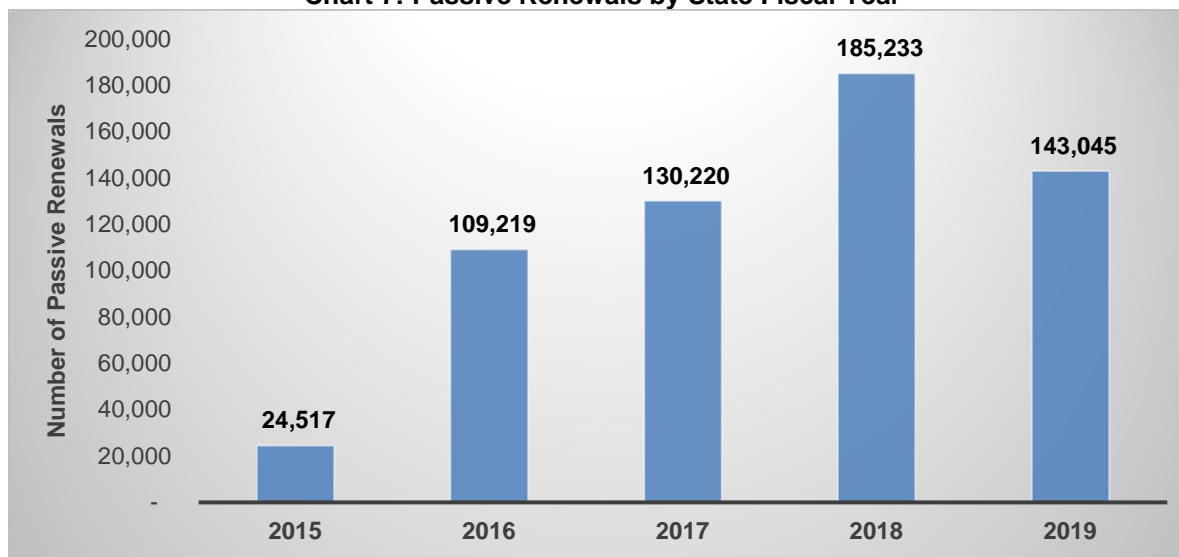| Status	SFY2015	SFY2016	SFY2017	SFY2018	SFY2019	Totals
Renewed (percent renewed)	119,064 (95%)	151,917 (94%)	163,607 (94%)	607,902 (95%)	643,109 (96%)	1,685,599 (95%)
Denied and Discontinued	6,599	10,556	10,907	29,639	28,430	86,131
Total	**125,663**	**162,473**	**174,514**	**637,541**	**671,539**	**1,771,730**

Source: ODAS

Passive Renewal

The OB system processes passive renewals monthly and can automatically renew customers based on the following criteria:

• Medicaid customers who are within 30 to 90 days of the current renewal due month;
• MAGI-based or non-MAGI based Medicaid;
• programs with the status of active;
• customer must have a social security number, last name and date of birth; and
• customers must not have an expense type of qualifying income trust[8] with a manual deposit.

ODM's 2020 CAP noted low passive renewal rates and county respondents stated that passive renewals do not always work properly. **Chart 7** illustrates passive renewals for SFY2015 through SFY2019 and shows that there was a 480 percent increase in this period; however, passive renewals decreased 23 percent from SFY2018 to SFY2019.

Chart 7: Passive Renewals by State Fiscal Year

Source: ODAS

---

[8] If customer requesting LTC services has income above special income level standard (see **Appendix 1**), they can deposit income in qualified income trust to become eligible for LTC services.

D. County Departments of Job & Family Services

Key Points

Ohio uses a county administered process to enroll most customers in the Medicaid program. While the eligibility rules are consistent across the State and the OB system provides a statewide platform, there are differences in how counties are organized and the processes used to complete the enrollment process. These differences are due to various factors such as county size, the county's participation in a CSS region, and variations in county administration and management. As a result, a customer's experience with this statewide program will vary based on county of residence. Due to issues with the OB system highlighted in this report, we were unable to draw any conclusions as to the efficiency or effectiveness of any particular model or practice at the county level.

There are common activities all counties perform to determine Medicaid eligibility including processing applications and renewals, training staff, conducting quality assurance and supervisory reviews, scanning records, addressing complaints, and providing information for hearings. Most of the counties interviewed indicated they had specialized staff that address long-term care cases due to the complexity of these eligibility rules.

The interviews with the counties also identified differences in business processes and workflow models (see **Appendices 6** and **7** for a comparison of sampled counties statistics and selected functions). For example, some counties use a casebank model where all cases are pulled from a central repository and multiple caseworkers perform tasks on a case as needed. Other counties assign each caseworker a case in a round-robin format and the caseworker performs all necessary functions to determine eligibility. Other differences in county processes include:

- not all counties use the work-flow functionality in EDMS;
- larger counties are more likely to have dedicated quality assurance staff while in smaller counties supervisors perform the QA function;
- some counties authorized caseworkers to perform overrides while others limit that function to supervisors;
- counties varied in the process for addressing complaints; for example, responsibility was with supervisors, special units or an ombudsman; and
- counties varied in deployment of staff resources for answering phones and manually processing cases.

E. Backlog of Medicaid Eligibility Determinations

Key Points

Backlog data refers to applications and renewals that are overdue – beyond the required timeframes for processing. There are many factors impacting Ohio's backlog which was identified as a concern both by the State and CMS and resulted in a corrective action plan (CAP) being developed by ODM. The counties interviewed indicated addressing the backlog has been a priority.

Federal timeliness standards to determine eligibility are 90 days for customers with a disability and 45 days for all other customers. There are also standards that require documentation to be maintained to support the eligibility decision.

States reported data to CMS on application processing time for MAGI and Children's Health Insurance Program applications in 2018 and 2019, covering the period of February to April in both years. **Table 8** shows a comparison of Ohio to the national average.
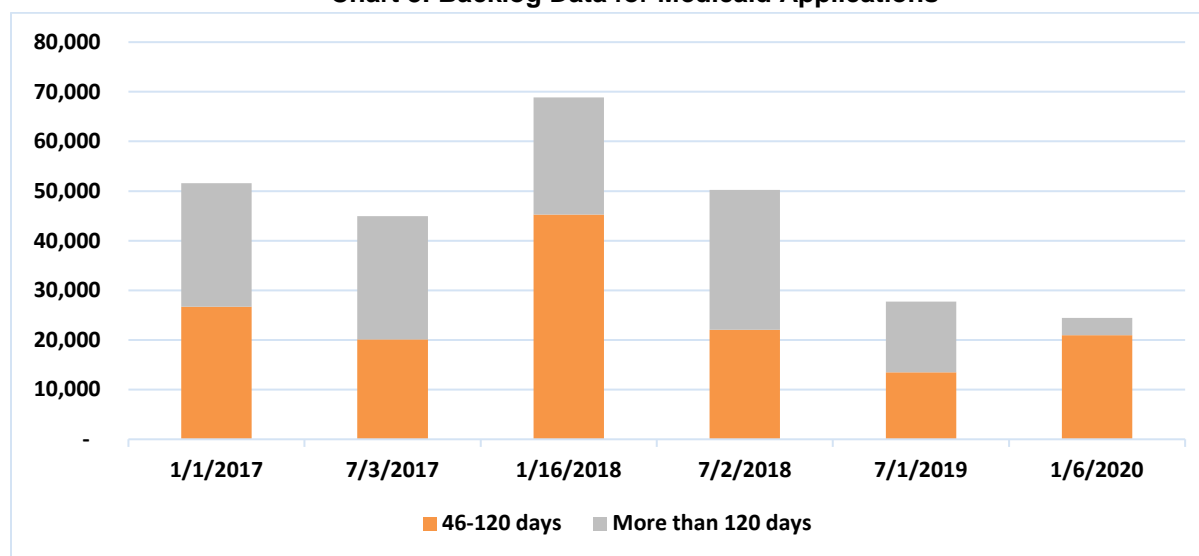
Table 8: Application Processing Time Comparison

2018	Percent of Determinations Under 24 Hours	Percent of Determinations Over 45 Days
Ohio	13.0% to 13.6%	25.5% to 28.6%
National Average	30.8% to 32%	17.9% to 18.2%
2019	Percent of Determinations Under 24 Hours	Percent of Determinations Over 45 Days
Ohio	17.9% to 18.6%	14.9% to 20.2%
National Average	31.8% to 47.1%	11.2% to 17.9%

Source: CMS

Ohio was below the national average in real-time application processing (less than 24 hours) in both years; however, Ohio did improve its real time application processing in 2019. Ohio is higher than the national average for percent of determinations greater than 45 days for 2018 and 2019, although Ohio also showed improvement in this category. Ohio's issues with backlog of application and renewals has been acknowledged by ODM. In a September, 2019 presentation to the Joint Medicaid Oversight Committee, the Director of ODM reported that the backlog issue was of such significance that CMS had required ODM to submit a CAP, which it did in January 2020.

ODM reported that it tracks backlog data and provided some of the reports it has developed for this purpose. **Chart 8** shows the trend for backlog data at various points from 2017 to 2020.

Chart 8: Backlog Data for Medicaid Applications

Source: ODM
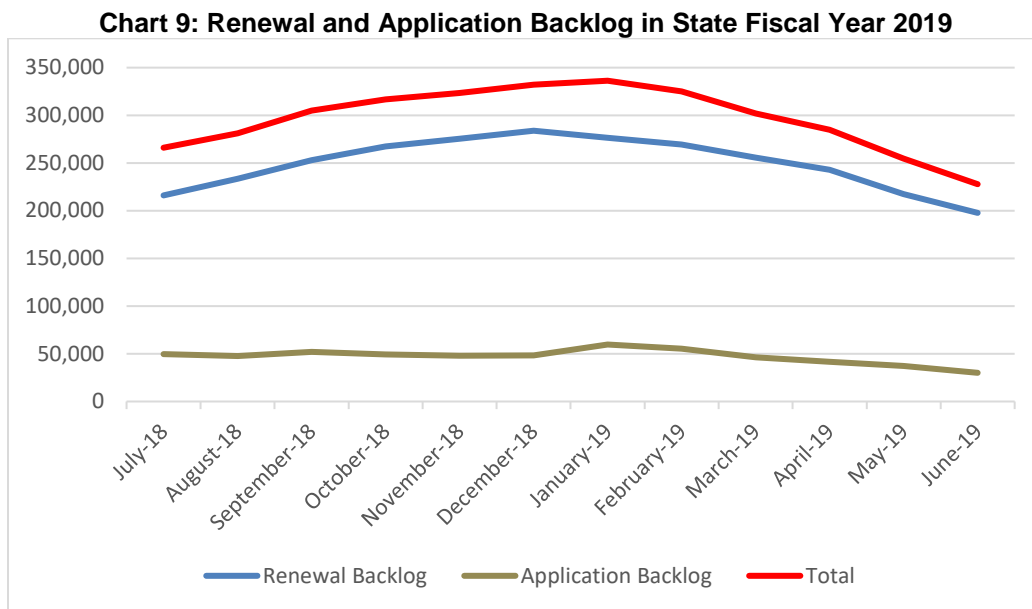
The data shows that applications processed over 45 days has declined since 2017. Since a peak in total backlog in January of 2018 of 68,894 cases, the backlog has decreased to 24,452. The largest source of applications processed over 45 days in 2018 and 2019 are by mail, followed by phone, in-person and fax. Electronic applications account for seven percent of applications over 45 days.

Ohio's Medicaid Eligibility Determination Process

Chart 9 shows renewals and application backlog separately and combined for SFY2019. The application backlog showed the most significant decrease of 40 percent while the renewal backlog decreased by approximately nine percent. Total backlog decreased in SFY19 by approximately 14 percent. Ohio's CAP indicated Technical and Assistance Compliance staff have been working with counties on the backlog of applications. In 2019, ODM also hired a subject matter expert to assist counties with improving work-flow for processing applications.

Chart 9: Renewal and Application Backlog in State Fiscal Year 2019

Source: ODM

F. Overrides in the Ohio Benefit System

> *Key Points*
>
> The OB system allows for data to be changed and results to be overridden. The override is required to "force" the correct result when the OB system does not function accurately. Most of the counties interviewed indicated that, due to the number of overrides needed to correctly determine eligibility, what was intended to be a supervisory function was changed to a caseworker function. There are a number of system generated updates to cases that occur; however, once an override is performed, these updates do not process correctly resulting in manual updates being performed at the county level.

An override is a type of workaround that caseworkers use to change EDBC results when the OB systems determination for eligibility is incorrect. The OB system incorrectly determines eligibility for a number of reasons, such as incorrect calculations for long-term care benefits.

Chart 10 shows the trend of overrides in the OB system between SFY2015 and SFY2019. As illustrated, although overrides were somewhat level between SFY2017 and SFY2018, there has been an overall increase in the number.

Chart 10: Overrides in State Fiscal Years 2015 through 2019

Source: ODAS

Almost all of the 27 counties interviewed indicated that caseworkers are able to perform an override in the system. A few indicated that supervisors are involved in the process but due to the number of overrides needed, most did not require this level of oversight. Feedback from the county respondents included concerns about the number of workarounds and processes that do not occur once an override is completed on a case stating "once broken, always broken." Batch processing (an automated system wide update) generally results in cases where an override had previously been completed to fall out which then necessitates manual intervention by a caseworker.
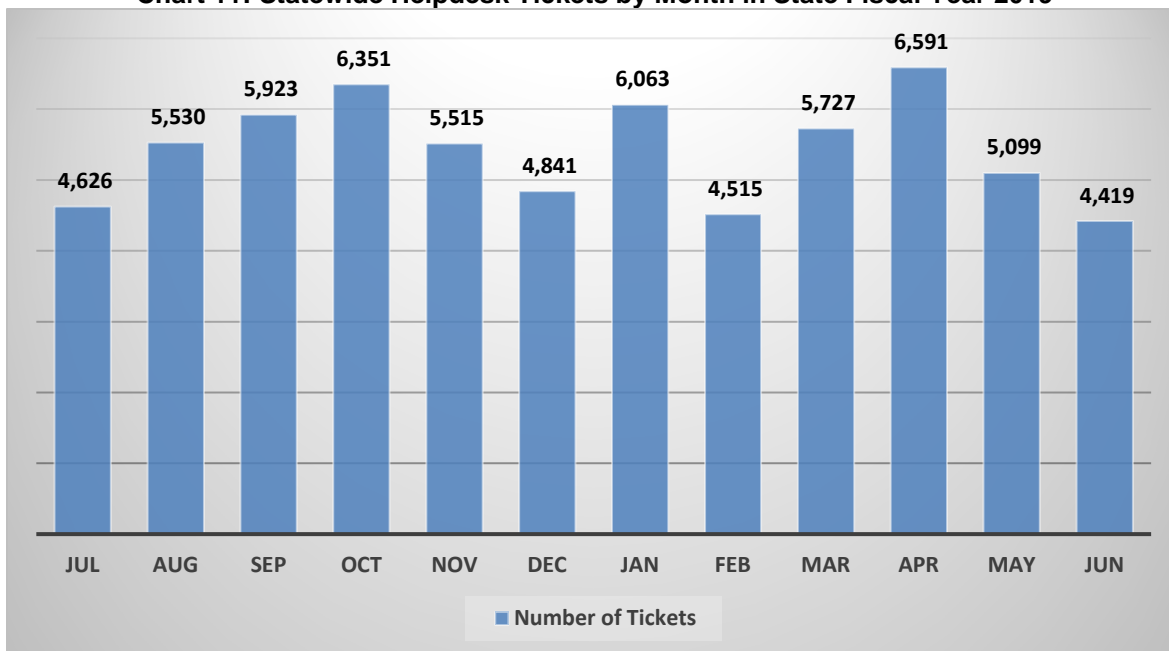
G. Ohio Benefits System Helpdesk Tickets

> **Key Points**
>
> There is a helpdesk system for counties to report issues with a case or with the functioning of the OB system. The helpdesk tracks these reports (tickets). Excluding tickets related to password or log-in errors, the helpdesk received over 55,000 tickets in SFY2019; however, based on feedback from the counties the number of issues being experienced may be under-reported. ODM indicates it monitors the tickets to identify issues and if the tickets are under-reported, this could lead to issues going unaddressed.

When a county cannot resolve an issue, it submits a ticket to the helpdesk. In addition some of the workarounds instruct the caseworker to send a ticket. Tickets may be submitted via phone or email. Tickets submitted via email go to a dedicated mail box that is monitored by ODAS staff. The Remedy system is used to track resolution, closure times, notes and action taken for all tickets. ODM has access to Remedy and reported that they meet weekly with the helpdesk. The staff involved perform root cause analysis to determine if the system is working correctly. Additional guidance is provided to counties when common issues are identified.

A total of 65,200 tickets were submitted in SFY2019, an average of 5,433 per month. Of these, over 9,800 were due to password, access and/or log in errors. The number of tickets statewide are usually higher at the start of second, third and fourth quarters, with the months of October, January, and April having over 6,000 tickets each. **Chart 11** show statewide tickets by month for SFY2019.

Chart 11: Statewide Helpdesk Tickets by Month in State Fiscal Year 2019

Source: ODAS
Note: Original data provided by ODAS included entries labeled "misdirected call". According to ODAS these are incidents that are not expected to be handled by the helpdesk; the most common being a customer calling the helpdesk instead of ODM's vendor. The misdirected calls were removed from the data for this chart.

A number of concerns were noted by the county respondents regarding tickets. While a few counties indicated receiving timely responses, more often counties expressed concerns with timeliness and quality of the response. It should be noted that this feedback seemed to be reflective of concerns over a longer period than SFY2019 and many counties noted that the system has improved over time. Feedback from counties included:

- at times instructed to do what county reported it already did;
- late response or no response;
- frustration because it does not appear the ticket was fully read, so counties have to send it a second time;
- tickets marked "urgent" do not get addressed timely;
- at times one issue is corrected but this action results in a different problem being created; and
- most cases on the pending report are waiting on ticket responses.

Based on feedback from the counties, the number of tickets may be under-reported. Respondents stated they generally do not send tickets after performing a known work around ("why tell them what they already know") and they prefer to trouble shoot with CSS partners due to lack of consistency and timeliness from the help desk. This limits the ability to use the ticket data to monitor the OB system and make improvements.

H. Ohio Benefits System Alerts

Key Points

The OB system includes alerts that notify the counties of a potential change in a customer's circumstance that may impact Medicaid eligibility. This important control is not effective due to the number and duplication of the alerts being generated – in SFY2019 there were approximately 11.8 million alerts. Counties described alerts as time consuming, a low priority, out of control and a never-ending cycle.

The OB system generates alerts for interface outputs/updates, batch outputs or other triggers in the system. Alerts are given a priority indicator of low, medium or high and inform caseworkers of updates to the system and/or an action that needs to be taken. Examples include an IEVS alert which is generated when income from outside sources does not agree to the OB system. Another alert generates notifications regarding third-party insurance and Medicare. See **Appendix 2** for list of alerts generated in the OB system and corresponding action steps.

In SFY 2019, there were 4,416,781 Medicaid IEVS alerts and 7,346,955 statewide Medicaid non-IEVS alerts, for a total of 11,763,736. This equates to an average of 133,679 per county. The IEVS alerts increased by 41 percent in comparison to SFY2018. It should be noted that counties also receive alerts for other programs that they process such as SNAP and TANF. The total of all alerts for all programs in SFY2019 was just under 17 million.

Interviews with the 27 counties identified alerts as a significant issue. Comments indicated that the alerts are numerous and repetitive; for example, one county reported receiving 5,000 alerts in one day. Another county noted that alerts are hard to understand and staff are confused on how to address them. Some counties have developed an internal system to track alerts to help manage this workload while others indicated the volume is too high to be manageable and they acknowledged that significant alerts may be missed.

One specific concern expressed by counties was related to the Territory Beneficiary Query (TBQ) alert. They indicated that changes are made to customer's eligibility for Medicare Premium Assistance Program in which Medicaid pays Medicare premiums on behalf of a customer. Due to a system glitch, a customer's status is changed and the premiums are deducted from their social security check. Often multiple months are deducted at the same time leaving the customer in financial distress. According to county interviews, the county is generally not aware of this change until the affected customer contacts them in a crisis mode. While the county caseworkers can correct the customer's status in OB, it may take months before the funds are returned from Social Security leaving the customer to struggle for this period of time.

Findings regarding the alerts have been raised by the Auditor of State (AOS) in prior reports. These reports have repeatedly noted that ODM did not have controls and procedures in place to monitor IEVS alerts. The 2018 State of Ohio Single Audit noted that 41.6 percent of the IEVS alerts sent to the counties during the SFY2018 were not cleared within 45 days as required. The alerts were cleared between one and 502 days beyond the 45-day requirement. AOS has identified additional weaknesses with alerts, highlighting the volume of alerts, multiple and repetitive alerts, irrelevant alerts, and difficulties in the steps required to complete alerts.

I. Ohio Benefits Updates and Releases

Key Points

Updates are made to the OB system to improve the functionality of the system. Many of these updates result in changes to how caseworkers process cases. In SFY2019 there were 654 changes to the OB system and these involved 533 changes in how caseworkers perform their work. Despite the many updates to improve the system, the counties report significant issues continue to exist.

The OB project web-site provides monthly release notes giving a summary of fixes and enhancements in the OB system organized by the program(s) impacted by the release (change may impact Medicaid only, SNAP/TANF only, or all programs). The release notes are organized by the categories of retired workarounds, new functionality, enhancement or system improvement and describes the case worker impact, if applicable. Examples from the release notes include:

- new functionality - the interface to National Technology Information Services with a caseworker impact of creating a new alert;

Ohio's Medicaid Eligibility Determination Process

- system improvement - gave caseworkers the capability to centrally reprint an award notice; and
- enhancement - updating the no touch process so that unknown or absent parent records are automatically created if not present in the application and the impact was an improvement to the caseworker's experience.

Table 9 shows changes and impacts to caseworkers in SFY2018 and SFY2019 for Medicaid only or shared by all programs. The category of System Changes includes functionality changes, system enhancements, improvements and workarounds. This data shows that both the number of changes and the impacts to caseworkers increased by approximately 70 percent in this period.

Table 9: Ohio Benefit System Changes

Time Period	System Changes	System Changes that Impacted Caseworkers
SFY2018	385	316
SFY2019	654	533
Percent Change SFY2018 to SFY2019	70%	69%

Source: Ohio Benefits Portal

County interviews highlighted numerous concerns with the OB system. Issues identified by multiple counties include:

- The caseworker identifier is not always accurate (e.g. one caseworker pings hub but a different caseworker name is populated as performing the task).
- Data disappears, the OB system shuts down frequently or times out and caseworkers lose work and general system slowness.
- The EDBC will run and budgets are often not correct and require an override.
- The automated mass change and batch processes cause cases to fall out and require a caseworker to manually update.
- The OB system renews people it should not.
- The OB system does not calculate household size correctly and if the household size is too large, the system will time out.
- Caseworkers cannot remove retroactive months.
- Customers are put into wrong aid category.
- It is difficult to remove a child from case.
- Term life insurance does not work correctly.
- The pending citizenship screen requires a work around.
- Award notices (NOAs) are not being generated properly.
- No interface with the My Care Ohio program.
- If a rule is not implemented in the OB system correctly it does not generate the expected results.
- Error code "9500" pops up when a caseworker clicks on something too fast.
- It is not always possible to the see needed history on a case.

During fieldwork for this audit, changes were made to address some of these issues. In addition, the number of system enhancements and improvements made in SFY2018 and SFY2019 demonstrates efforts to improve the OB system. We did note that at times one county indicated that there was an issue while another county indicated that there was a "fix" for the same problem. This would indicate that there is a gap in knowledge between counties and their staff on some of the system enhancements and improvements.

Accuracy of Eligibility Determinations

We selected customers from each county using a random stratified sampling approach. We identified four strata for our samples: aged, blind and disabled (ABD), Group VIII Expansion[9], covered families and children (CFC) and Other (i.e. pregnant mothers, deemed newborns). We selected four customers from the ABD and CFC strata; three customers from the Group VIII Expansion strata, and one customer from the Other strata for each of the 27 counties. In total we selected 12 customers from each county resulting in a sample of 324 customers. Because a customer could have moved from one aid category to another during SFY2019, customers were duplicated in the entire population but were not duplicated within a strata.

Using information in the OB system and supporting documentation maintained in EDMS, we redetermined eligibility for each selected customer. After our initial testing, we sent a list of potential non-compliance to the applicable county and to ODM and requested any additional information that could address the initial result. We updated our results for the additional information received.

We identified a customer as non-compliant if we could not determine eligibility due to lack of information, if renewals were not processed timely and if the customer was ineligible for benefits based on the documented facts. For customers in which we could not verify eligibility or who were determined to be ineligible, we identified an improper payment for the effected months. We did not identify improper payments for customers with renewals that were not processed timely but were later processed and the customer was found to be eligible.

Results

We found 41 of the 324 (12.7 percent) of the Medicaid customers tested were non-compliant. Of these, 16 customers (4.9 percent) were determined to be ineligible to receive benefits during all or a portion of SFY2019. These errors resulted in improper payments of $39,135. This amount was calculated by adding all capitation and fee for services payments made on behalf of the customer during the period of ineligibility. We determined the remaining 25 noncompliant cases were likely eligible based on subsequent renewals or other information.

Applying the ineligible error rates found in each strata, the potential loss to the program is over $455 million. For many of the sampled cases, the system lacked the necessary historical information to identify edited, overridden, or information written over by a county caseworker. This contributed to difficulties in determining how the caseworker verified eligibility at the time of the determinations.

Table 10 shows the results of the redeterminations by strata. See **Appendix 5** for results by county.

Table 10: Sample Results by Strata

Strata	Sample Size	Non-Compliant Customers	Ineligible Customers	Ineligible Rate	Overall Error Rate	Improper Payments	Potential Program Loss
ABD	108	8	2	1.9%	9.2%	$3,556	$12,503,736
CFC	108	3	7	6.5%	9.2%	$8,987	$157,746,595
Group VIII Expansion	81	13	5	6.2%	22.2%	$24,685	$236,293,587
Other	27	1	2	7.4%	11.1%	$1,907	$48,723,549
Totals	**324**	**25**	**16**	**4.9%**	**12.7%**	**$39,135**	**$455,267,467**

Source: AOS

---

[9] Group VII are individuals covered by the expansion option included in the Affordable Care Act.

Aged, Blind and Disabled Sample

Two of 108 (1.9 percent) ABD customers selected for testing were not eligible to receive benefits during all or a portion of SFY2019. These errors resulted in an improper payment of $3,556. Applying the error rate to the population indicates a potential loss to the program of $12.5 million.

For one error, the OB system closed the case due to the customer being over income but the case remained open in MITS for an additional 21 months and payments continued to be made on behalf of the customer during that entire period. We also noted eight renewals that were processed from three to 17 months late.

Covered Families and Children Sample

Seven of 108 (6.5 percent) CFC customers selected for testing were not eligible to receive benefits during all or a portion of SFY2019. These errors resulted in an improper payment of $8,987. Applying the error rate to the population indicates a potential loss to the program of over $157.7 million. In addition to the ineligible customers, we noted two customers included in an incorrect aid category and one renewal that was processed two months late.

Group VII Expansion Sample

Five of 81 (6.2 percent) Group VII Expansion customers selected for testing were not eligible to receive benefits during all or a portion of SFY2019. These errors resulted in an improper payment of $24,685. Applying the error rate to the population indicates a potential loss to the program of approximately $236.3 million.

In addition to the ineligible customers, we noted the following errors:

- two customers who reported zero income but there was information contradicting that and the caseworker did not request verification;
- two customers included in an incorrect aid category; and
- nine renewals processed late including one that was processed 20 months late.

In one of the instances of zero reported income, the customer was an adult, stated he lived with his parents, had no income and worked at a café owned by his parents for room and board. State wage information reports indicated considerable taxable income from that café during each quarter of the year which should have been included in the budget.

Other Sample

Two of 27 (7.4 percent) Other Medicaid customers selected for testing were not eligible to receive benefits during all or a portion of SFY2019. These errors resulted in an improper payment of $1,907. Applying the error rate to the population indicates a potential loss to the program of over $48.7 million. In addition, we noted one customer included in an incorrect aid category.

AOS Experience with the OB System

ODM provided us access to the OB system in order to redetermine eligibility for the selected customers in our samples. In performing these redeterminations, we identified concerns with how the OB system functioned and many of our experiences mirrored the information provided by the county staff interviewed.

There was an insufficient audit trail as the system lacked the necessary historical information to identify edited, overridden, or information written over by a county caseworker. For example, we found different screens reported different amounts for income; however, we were not able to see if a screen had been overridden or if there was a write over performed by a caseworker. This information would have been helpful in determining why income amounts were different, or if the income on the different screens are reported for different periods, employers, or other case members.

Ohio's Medicaid Eligibility Determination Process

The system generated numerous error messages and would time out frequently, necessitating additional log in steps. We constantly re-entered dates, as different screens require dates be in a different format and the system requires dates to be entered again when you advance to a screen and then return to the previous screen. There were instances where the Medicaid History Screen would give dates when redeterminations were completed but the EDBC list would not have run dates that matched the completion dates. Verifications within the OB system do not seem to remain consistent between the different screens. This made it almost impossible to determine how the caseworker verified eligibility at the time of the determination.

ODM's 2020 CAP stated, "our findings regarding the backlogs revealed that the processes and technology intended to enable effective and efficient processing of applications were instead creating a laborious and ineffective eligibility system". During this work we also discovered potentially significant shortcomings in the eligibility and enrollment processes which resulted in missing records and data, and incorrect eligibility determinations. The CAP went on to address three key issues contributing to the identified errors and strategies and milestones for obtaining compliance including:

- significant ongoing and persistent delays in the State's ability to complete determinations of eligibility at application, resulting in sizable backlogs and applications pending;
- failure to conduct timely renewals of eligibility resulting is sizable backlogs and renewals pending beyond the timeframe permitted; and
- failure to promptly redetermine eligibility between regular renewals of eligibility whenever the agency receives information about a change in a beneficiaries circumstances that may affect eligibility.

In addition to the samples, we obtained information on the Medicaid Eligibility Quality Control program at ODM which is a federally mandated process for states to test accuracy of eligibility determinations. We reviewed results of Ohio's most recent PERM audit completed by CMS which includes testing of eligibility determinations. We also obtained data on appeals filed by customers in regards to their eligibility determination along with information on training and resources for counties completing this work.

Medicaid Eligibility Quality Control Program

CMS requires states to implement Medicaid Eligibility Quality Control (MEQC) programs which are designed in part to reduce erroneous expenditures by monitoring eligibility determinations. Required reviews include:
- active cases (excluding Social Security Income cases, foster care and adoption assistance cases and cases that are 100 percent federally funded);
- negative cases;
- erroneous payments; and
- verification of eligibility status.

In addition, the state must take action to correct any active or negative case action errors found in the sample, take administrative action to prevent or reduce the incidence of those errors and submit a report to CMS on its error rate and a corrective action plan. We obtained ODM's MEQC activity reports for SFY2016 through SFY2019. There are no results for SFY2018 as CMS performed a Payment Error Rate Measurement Program (PERM) for that period. **Table 11** shows the results of the MEQC reviews.

Table 11: Medicaid Eligibility Quality Control Program Data

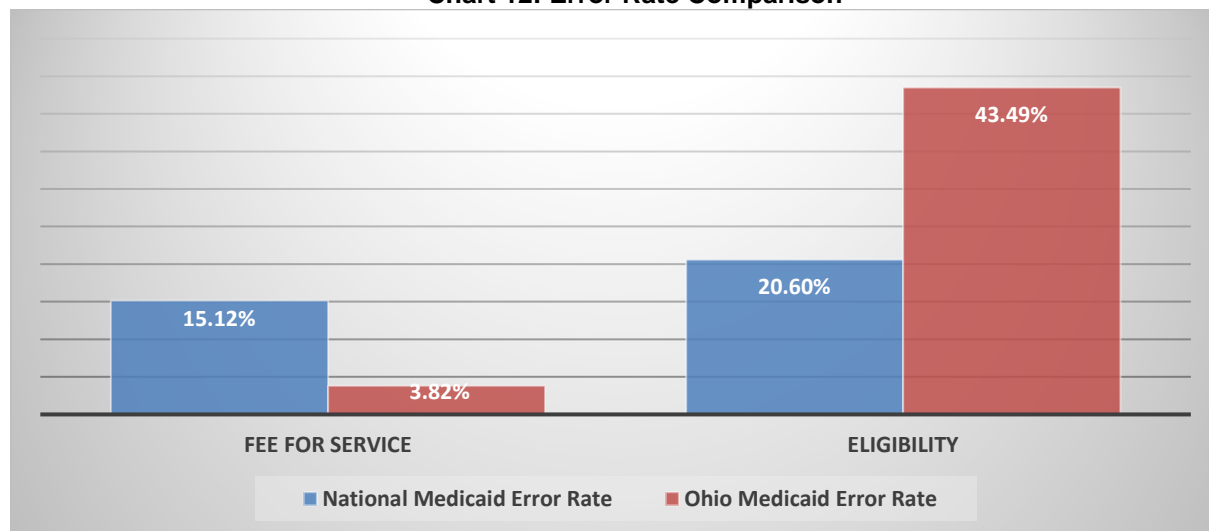| State Fiscal Year	Cases Reviewed	Number of Errors	Error Rate
2016	240	17	7%
2017	159	12	8%
2019	143	12	8%

Source: ODM

Payment Error Rate Measurement (PERM) Program

The PERM program is used by CMS to measure Medicaid improper payments and are conducted annually, with 17 states per cycle resulting in each state being reviewed every three years. PERM reviews three components: fee for service (based on payments made to providers), managed care data processing errors (based on capitation payments to managed care plans) and eligibility errors (based on eligibility determinations).

CMS issued its FY2019 report findings for Ohio's Medicaid program on November 26, 2019[10]. **Chart 12** compares Ohio's error rate to the national rate[11].

Chart 12: Error Rate Comparison

Source: CMS PERM report

While Ohio had an 11 percent lower error rate than the national error rate for fee for service payments, it had a 23 percent higher error rate than the national average for eligibility determinations. In addition, CMS reported the following breakdown of Ohio's eligibility errors:

- 122 errors due to documentation to support eligibility determination not available to auditors;
- 69 errors due to determination/renewal not conducted timely (deemed ineligible by auditors);
- 55 errors due to incomplete verification and/or documentation; and
- 15 errors due to other miscellaneous errors.

Appeal of Result of Eligibility Determination

If customers believe the determination of eligibility is in error, they may file for an appeal. The ODJFS has responsibility for the state hearings requested by customers which can be related to a denied application, an application acted upon erroneously, not acted upon with reasonable promptness or in response to a proposal to reduce, suspend or terminate benefits. The ODJFS must receive a hearing request within 90 days of the mailing date of the notice. Coverage will continue through the appeal process if a customer requests a hearing within 15 days of receiving the notice to terminate benefits.

We obtained statewide data on SFY2017 through SFY2019 hearings from ODJFS related to the Medicaid program. As shown in **Chart 13**, the percentage of hearings overturned remained relatively stable during

---

[10] Note the FY 2019 cycle reviews payments made in SFY2018 can include eligibility records one year prior (July 1, 2016 to June 30, 2017). Ohio Medicaid must reimburse federal Medicaid dollars for claim errors identified in the sample data collected for the 2019 PERM review.

[11] The rates for managed care data processing errors were both zero percent and are not reflected.

that period, while the overall number of hearings increased by 49 percent between SFY2017 and SFY2019. While the number of applications increased during this period which could account for the increase (see **Chart 3**), this data warrants continued monitoring.

Chart 13: Medicaid Appeal Hearings

Source: ODJFS

Ohio's use of a county administered system necessitates that a sound training program is available that meets the needs of all 85 county offices. In addition, the errors in eligibility determination identified in multiple audits and reviews and the increasing number of state hearings points to the need to further evaluate how training is being conducted and how the State can better support the county staff in this important work.

Training and Ohio Benefits Project Website

During interviews with the 27 counties, issues with staff turnover differed between counties as did their approach to training new staff. Some counties reported having no new staff in years or that they hire staff from other counties so training is not necessary. Other counties differ in terms of the length of training and whether it includes classroom training or only on-the-job training.

Counties have access to the Ohio Benefits Project web-site that includes training materials, resources and other information related to the OB system. The website contains training material organized by benefit type that includes MAGI-Medicaid, PE, Non-MAGI (ABD/LTC) and other programs (i.e. SNAP/TANF). Training course materials included participant guides, materials from other instructor based training, web-based training, and video conferences.

Training topics provided during 2019 included aid codes, overrides, income and resource verification and change processing. ODM reported the following trainings and technical assistance for counties:

- quarterly regional operational support county meetings (started during 2019);
- monthly ODM technical assistance video conference;
- quarterly ODM/ODJFS joint video conference (started during 2019);
- bi-weekly operational webinars specific to system topics (started in 2019); and
- new caseworker Medicaid policy training conducted quarterly via webinar.

Ohio's Medicaid Eligibility Determination Process

The project website also includes job aides on specific topics and content on workarounds. The job aides' purpose is to provide processing information and address requests on specific topics. Workarounds generally indicated the user should create a help desk ticket or provided steps to resolve an issue. Release notes are also available on the OB project web-site and provide a monthly summary of OB system upgrades, fixes and enhancements.

County interviews indicated that most have supervisors and/or select staff participate in trainings and then disseminate information internally and that they use other resources such as job aides and policy bulletins available on the OB web-site. Although the majority indicated that they use the site, concerns included that the web site is hard to navigate, has outdated information, and is only used as a last resort. Other issues include training not being proactive, instead taking place after the system change. Some counties have developed an internal process to streamline the information on the web-site into more useful format that better meets their needs. Some counties noted the benefit of regions sharing training resources.

AOS Experience with the Resource Web-Site

Through reviewing and researching resources on the OB project site, we noted outdated training information was included along with the current information and was not organized in chronological order so the most current and relevant information could be accessed first. We found it difficult to navigate the site to find information on specific topics and went through multiple links and files to find relevant information on topics researched. **Table 12** shows the number of resources by topic found on the OB project site (not including SNAP or TANF information).

Table 12: Ohio Benefit System Resources

Category	Workarounds	Job Aids	Training Course	Video Conferences
MAGI	18	108	12	26
Presumptive Eligibility	4	45	11	10
ABD/LTC	58	134	24	23
Totals	**80**	**287**	**47**	**59**

Source: https://ohiobenefitsproject.ohio.gov/Training/Training-Materials-by-Benefit-Program-Type

The following print screen shows an example of the layout on the OB project web-site.

Source: OB project website

While there are numerous materials available on the website, 473 items as shown in **Table 12,** the feedback from the counties and the auditor's experience with the website indicate this is an area for improvement.

Counties shared recommendations for improvement including hands-on training on the OB system, training on how to use the system to process long-term care cases and improved interaction and communication between policy and system staff. In Ohio's CAP, strategies included using subject matter experts to provide training to county staff.

Stakeholder Feedback

Medicaid Managed Care Organizations

The majority of customers enrolled in Ohio's Medicaid program are enrolled with one of the State's managed care organizations (MCOs): Buckeye Health Plan, CareSource, Molina Health Care, Paramount Advantage, and United Healthcare Community Plan. We sent questionnaires to each of the MCOs to obtain an understanding of their interaction with counties regarding the Medicaid eligibility determination process.

The responses indicated that MCOs typically use ODM redetermination files to identify renewal dates and send reminders of renewal dates via post cards or phone calls to their customers. Three of the five MCOs reported having minimal interaction with counties. The interaction that occurs is usually to ensure newborns are added appropriately and to resolve eligibility discrepancies. The other two MCOs indicated more frequent interaction with county offices with one MCO reporting participation in community/public meetings and coalition sessions.

All MCOs reported that their customer provided feedback indicated that interaction and communication with counties could be improved. Identified concerns include long phone wait times and difficulty getting to speak with a person on the phone. All MCOs had customers indicate problems with how documentation and information is handled at county offices, including issues with paperwork being lost, information not processed or processed incorrectly, and information having to be submitted more than once. Strengths of the system included the use of different methods to reach customers. Many noted that communication has improved over time.

<div style="border: 1px solid black;">

MCOs identified the following recommendations for improvement:

- Improve the experience of customers in renewing Medicaid eligibility.
- Improve/reduce hold times experienced by customers.
- Give health plans the ability to assist members with obtaining Medicaid eligibility.
- Develop better ways to inform MCOs of eligibility status at the same time as the customer.
- Offer renewal events partnering with both community and faith based organizations.
- Have community navigators assist with the renewal process.
- Ensure data is correct, specifically addresses, phone numbers, date of birth, date of death, and newborn data.
- Review how customer demographic information is being updated by each county, communicated to the ODM and then passed to the MCOs.
- Ensure that the Ohio Benefits number is functional for all customers and the hours the number is being staffed.
- Add the option of texting by the county.

</div>

Long-Term Care Facilities

A long-term care facility is defined as a nursing facility, intermediate care facility for individuals with intellectual disabilities, or medical institution with respect to whom payment is made based on a level-of-care provided in a nursing facility. The comprehensive care includes room and board.

Ohio's Medicaid Eligibility Determination Process

We used the Ohio Department of Aging's website to identify nursing facilities in the state to interview regarding their interaction with counties. We haphazardly selected 50 nursing facilities from the 27 counties selected for testing. Of the 50 facilities contacted, 35 responded to our request.

Interview responses indicated interaction with counties involved new applications, redeterminations, and notification of income changes. Overall, respondents indicated frequent interaction with counties with communication most commonly occurring on a daily or weekly basis. Twenty-six of the 35 reported that the facility is assigned a primary county caseworker. Some facilities in larger metropolitan counties indicated that a team of caseworkers respond to their inquiries.

Twenty of the 35 respondents reported no issues with the counties in regard to the eligibility determination process. Others did report issues with timeliness of the process. For example, one facility interviewed in November 2019 reported having 10 applications and six redeterminations waiting on approval since February 2019. Other issues noted involved the customer or representative experiencing difficulty obtaining the required documents such as life insurance and bank statements.

Recommendations from the long-term care facilities include:

- Have regular representative meetings.
- Simplify the renewal process.
- Train staff involved with eligibility determinations and/or family members on long-term care requirements, including income and other financial requirements.
- Allow more time to obtain records from external entities.
- Improve communication between counties and facilities during redetermination and application process so processes are understood and cases are not incorrectly closed and can be processed in a timely manner.
- Provide more timely response and improved customer service from the call center.

Recommendations

---

1. OB System

Despite efforts by ODM and other state agencies, significant issues continue to impact the State's Medicaid eligibility determination process. These issues, compounded with the complexity of the program, the use of a county administered system, and the multiple avenues for information to be submitted, have resulted in confusing rules, system errors, human errors, and communication difficulties. The consequence is that it is difficult to see how eligibility is determined and to verify its accuracy.

Updates are continually made to improve the functionality of the OB system. Many of these updates result in changes to how caseworkers process cases. In SFY 2019 there were 654 changes to the OB system and these involved 533 changes in how caseworkers perform their work. Despite the many updates, the counties report significant issues continue.

The 2019 State of Ohio Single Audit noted system issues including the lack of a system warning or other control in place to identify or prevent caseworkers from overwriting data when new information is identified instead of adding the new information, as intended. Another system defect prevents caseworkers from viewing the previous case information.

In its response, ODM indicated it was working with its vendor to establish a plan to address system design weaknesses, defects and the number of alerts and workarounds. Additionally, in its 2020 CAP, ODM acknowledged numerous issues with the OB system and outlined a number of activities to address these issues including:
- evaluate and re-design the alert system;
- joint new user training and regional long term care training;
- reducing and monitoring the backlog of applications and renewals;
- addressing the lag in receiving applications from the federal market place and social security;
- improved reporting system to aid counties; and
- increased staffing at ODM and funding to counties to address backlog.

We recommend that ODM implement the corrective action steps identified in its response to the 2019 audit and release progress reports on system and process improvements and issues impacting Medicaid eligibility. These mechanisms could be a combination of a committee comprised of stakeholders meeting on a regular basis (i.e. quarterly) and frequent communication to the public via web-site, newsletters, or other means. Regular reporting on the process and system issues improves accountability for how public funds are spent and transparency on how the Medicaid program determines and processes Medicaid eligibility. Information reported could include, but is not limited to, timeliness of processing application and renewals, backlog status, OB system changes, application procedures, feedback from counties and customers (i.e. surveys), rule changes, and state and federal audit results.

In addition, ODM has indicated that it will be contracting for an external review of the system. We recommend ODM ensure that this review include an evaluation of the effectiveness of the identified corrective action steps. Monitoring and evaluating the OB systems' effectiveness and other processes and structures for determining Medicaid eligibility are critical to reduce the backlog of renewals and applications, to accurately determine Medicaid eligibility and to ensure a vulnerable populations' interaction with the Medicaid system is positive and efficient. Implementing recommendations to improve how Medicaid eligibility is processed through the OB system is essential to increase the confidence of the public and to ensure eligibility is determined according to standards and best practices.

ODM's Response: ODM reported that it posted a request for applications in September 2020 to procure services of an independent IT vendor to evaluate the OB system with the tentative project timeline of March 2021 – June 2022. In addition, the last four updates (releases) for the OB system completed in April, May,

July and August 2020 have addressed defects in various functional areas and made enhancements to the system. ODM indicated it intends to continue communicating with stakeholders to explain progress with system and process improvements.

2. Medicaid Eligibility Determinations

We found 41 of the 324 (12.7 percent) of the Medicaid customers tested in this audit were non-compliant. Of these, 16 customers (4.9 percent) were determined to be ineligible to receive benefits during all or a portion of SFY2019. These 16 customers resulted in improper payments of $39,135. Applying the ineligible error rates found, the overall potential loss to the program is over $455 million. For many of the sampled cases, the system lacked the necessary historical information to identify edited, overridden, or written over information. This contributed to difficulties in determining how the caseworker verified eligibility at the time of the determinations.

Similar results were identified in the 2019 State of Ohio Single Audit which noted that for 10 percent of the Medicaid customers selected for testing, a systemic issue within Ohio Benefits existed that impacted the eligibility process and/or eligibility determination. The 2019 audit recommended that ODM identify and coordinate program changes to address identified system design weaknesses/defects, including the issues with overwriting data and ensuring all data stored in the system is available/viewable by users.

We recommend that ODM evaluate the results for the 41 non-compliant customers and reimburse federal Medicaid dollars for the 16 ineligible customers identified in the sample. We also recommend that ODM address the system issues that contribute to the identified eligibility errors, develop accurate and timely reports that provide necessary data to monitor the work performed by the counties, and improve training for counties. (See recommendations on Data Governance Structure, Alerts in the OB System and Training Resources below.) In addition, we recommend that ODM regularly evaluate selected benefit payments to verify the customer's eligibility, verify the customer information entered into the OB System is accurate, and the information is being maintained to support the eligibility decision.

ODM's Response: ODM reviewed the 41 non-compliant eligibility determinations identified, including the 16 identified as not eligible, and agrees that 12 are either not eligible or lack documentation to determine their eligibility. In addition, ODM indicated that, per CMS, financial recoveries based on eligibility errors can only be pursued when identified by programs operating under CMS' Payment Error Rate Measurement (PERM) program, under section 1903(u) of the Social Security Act and regulations at 42 CFR Part 431, Subpart Q and as such ODM will not return the federal share previously claimed for these 41 individuals, unless or until CMS directs otherwise.

AOS Conclusion: In its response, ODM gave no basis for its disagreement with four of the recipients determined to be ineligible and we maintain that our results are valid.

3. **Data Governance Structure**

We experienced issues in obtaining reliable and consistent OB system data and reports. There were instances in which we had to request reports multiple times because the original report did not contain all the data requested. For some of our requests, we received a revised report we could use for analysis, but in other instances we were unable to use the reports provided, or the data was never provided. We did not receive reports in a timely fashion. For example, we requested several reports in November 2019, and although we received various reports in the interim months, we did not receive many of the reports until early March 2020.

In our limited use of the EDMS system to view documents used to support eligibility determinations, we found it to be slow, documents were difficult to locate (multiple years of support in a single folder, inconsistency in what a single scan may include, applications and renewal forms in the same folder, etc.) and found instances in which documents were scanned under the incorrect social security number and therefore not in the correct folder.

Ohio's Medicaid Eligibility Determination Process

To ensure consistency and reliability of data, we recommend that ODM work with ODAS to emphasize and evaluate a data governance structure. Data governance is the process of managing the usability, reliability, availability and security of an organization's data. Focusing on effective data governance improves data quality and reliability of data used for analytical decision making by identifying and fixing errors before sharing information with other agencies and using for auditing purposes.

The 2019 State of Ohio Single Audit also recommended ODM and ODAS consider developing a data governance structure that includes subject matter expert at each agency to be accountable for the quality of data generated and shared.

According to the Data Governance Institute, eight principles are at the center of all successful data governance and stewardship programs:

- All data governance participants must have integrity in their dealings with each other. They must be truthful and forthcoming in discussing the drivers, constraints, options, and impacts for data-related decisions.
- Data governance and stewardship processes require transparency. It must be clear to all participants and auditors how and when data-related decisions and controls were introduced into the processes.
- Data-related decisions, processes, and controls subject to data governance must be auditable. They must be accompanied by documentation to support compliance-based and operational auditing requirements.
- Data governance must define who is accountable for cross-functional data-related decisions, processes, and controls.
- Data governance must define who is accountable for stewardship activities that are the responsibilities of individual contributors and groups of data stewards.
- Data governance will define accountabilities in a manner that introduces checks-and-balances between business and technology teams, and between those who create/collect information, those who manage it, those who use it, and those who introduce standards and compliance requirements.
- Data governance will introduce and support standardization of enterprise data.
- Data governance will support proactive and reactive change management activities for reference data values and the structure/use of master data and metadata.

ODM's Response: ODM agreed with the assessment in this recommendation that a more robust data governance structure is needed to enhance Ohio Benefits and reported that a Technical Data Governance Committee will be created by December 31, 2020. This committee will include operational, IT security and infrastructure, and governance officers and one of its first actions will be to develop data governance goals.

4. **OB System Alerts**

The OB system includes alerts that notify the counties of a potential change in customer circumstance that may impact Medicaid eligibility. This important control is not effective due to the number and duplication of the alerts being generated – in SFY2019 there were approximately 11.8 million alerts. Counties described alerts as time consuming, a low priority, out of control and a never-ending cycle. The 2019 State of Ohio Single Audit identified various system design weaknesses or defects in the OB system including multiple and repetitive alerts. The 2019 report notes that due to the system issues identified there is an increased risk that benefits paid on behalf of customers will be inaccurate or unallowable and recommended redesigning the alert process to be more effective and efficient. This could include a more centralized evaluation of alert activity and/or better use of automated tools to vet and prioritize items requiring follow-up.

In its response to the State of Ohio Single Audit, ODM indicated it is evaluating and redesigning the alert structure, improving reporting capabilities, and enhancing controls to require alerts to be addressed before benefits are calculated. In addition, ODM added 25 staff for trouble shooting and technical assistance.

We recommend ODM continue to design and implement appropriate control procedures for monitoring IEVS and non-IVES alerts generated and processed in the OB system to help ensure the counties are completing them properly and timely. These monitoring procedures should be performed frequently, include

appropriate follow up with the county if alerts are not being completed properly and timely, and be documented. Management should periodically review this documentation to ensure the control procedures are being performed as intended.

ODM's Response: ODM and ODJFS began meeting in April 2020 to review alerts currently generated in Ohio Benefits. Once all system alerts are reviewed, recommendations are to be presented to the vendor for system improvements. ODM indicated it will engage counties regarding improvements for alert functionality and has been in communication with its vendor to begin identifying potential solutions to identified issues.

5. **Training Resources**

Ohio is one of only 10 states that has a decentralized county or local administered program. County staff process Medicaid applications and renewals, conduct quality assurance activities, obtain documentation to support eligibility decisions, address complaints, provide information for appeals, and are the primary users of the state system used to determine eligibility for Medicaid and other public assistance programs. Ohio's use of a county administered system necessitates that a sound training program is available that meets the needs of all 85 county offices. In addition, the errors in eligibility determination identified in multiple audits and reviews and the increasing number of state hearings point to the need to further evaluate how training is being conducted and how ODM can better support the county staff in this important work.

The 2019 State of Ohio Single Audit recommended that ODM mandate initial and on-going training on the OB system to ensure staff are knowledgeable on how to collect, enter, and verify information in the system to accurately and efficiently determine Medicaid eligibility. In addition, implementing an in-depth IEVS training for county caseworkers would ensure they have the knowledge to properly document and resolve IEVS alerts generated by the OB system. In its response, ODM indicated it is working with ODJFS to develop a New User Training program along with a Train-the-Trainer program. In addition, attendance at mandatory trainings will be tracked and reported back to ODM at the caseworker level.

We recommend that ODM enhance its methods to train county staff on the OB system by better organizing information on the Ohio Benefits project website. Methods that could enhance how information is presented on the site include organizing information using drop-down menus where the most recent information is easily identified and accessible and older information archived or deleted. In addition, the training should incorporate information for effective operations of a call center. We found that the county offices are adjusting from a service delivery model in which they met face to face with customers to operating a call center. The interaction now with customers is almost all via phone or through electronic forms of communication such as emails and faxes. Counties responded in interviews that OB training could be improved by ODM offering more hands-on training and additional training resources on how to process long term care applications.

ODM's Response: ODM stated it will work with counties to obtain feedback and recommendations for improvements to the Ohio Benefits project website and that the new Technical Data Governance Committee will be helpful to facilitate this work.

6. County Models

Ohio uses a county administered process to enroll most customers in the Medicaid program. While the eligibility rules are consistent across the state and the OB system provides a statewide platform, there are differences in how counties are organized and the processes used to complete the enrollment process. See **Appendix 7** for practices implemented by the 27 counties interviewed for this audit. These differences are due to various factors such as county size, the county's participation in a CSS region, and variations in county administration and management. As a result, a customer's experience with this statewide program will vary based on county of residence. Due to issues with the OB system highlighted in this report, we were unable to draw any conclusions as to the efficiency or effectiveness of any particular model or practice at the county level.

Ohio's Medicaid Eligibility Determination Process

We recommend that after addressing system issues, alerts, training and data governance, ODM should conduct a formal program evaluation to identify best practices regarding the models used by the counties to administer Medicaid eligibility. In ODM's 2020 CAP, ODM stated it collected best practices through visits to seven counties; however, ODM staff indicated this was an "informal process".

From interviews with counties, we found examples of different methods counties use to administer Medicaid eligibility, including casebank model, CSS call center, quality assurance to review accuracy, and different OB system and/or internally developed reports to monitor alerts, backlog, and timeliness of application and renewals. So although one practice may not be implemented the same in every county, an evaluation could give strategies for measuring the effectiveness of models and what model works best under certain circumstances.

This evaluation should address questions including:

- What are the best practices a CSS call center should use to provide customer service, accurately process Medicaid eligibility, reduce wait times and measure performance?
- Are there QA practices counties should consider to effectively reduce error rates for eligibility determinations and avoid escalation to hearing?
- What types of reports are available or are needed to effectively monitor alerts, backlog, and timeliness of processing application and renewals?
- Is the casebank model used by counties effective for processing Medicaid eligibility?

ODM's Response: In addition to the external review of Ohio Benefits, ODM stated it will continue to support county best practices through its training and county engagement work. ODM plans to continue this work to support the counties while it makes the system and process improvements recommended by the Auditor of State and discussed in its response. When that work is further along, ODM will determine whether a formal program evaluation to address county best practices is necessary or helpful.

See Appendix 8 for ODM's complete response to this report.

Appendix 1: Medicaid Eligibility Standards (as of January 2019)[12]

Category Needy - Aged, Blind and Disabled (ABD)	Income Standard*	Resource Standard
Single	$771	$2,000
Couple	$1,157	$3,000

* Income standard based on the Federal Benefit Rate (FBR)

LTC (Nursing Home/Waiver)	Income Standard 300% (FBR)	Resource Standard
Special Income Level (SIL)	$2,313	* Same as ABD Category

* Resource standard for Category Needy (ABD) would apply for LTC

Monthly Federal Poverty Level (FPL) Income Guidelines for MAGI Based Programs						
Family Size	Individuals Age 19 or 20 44%	Parent or Caretaker Relative 90%	MAGI Adults 133%	Coverage for Children 156%*	Pregnant Women 200%	Coverage for Children 206%**
1	$458	$937	$1,385	$1,624	$2,082	$2,145
2	$621	$1,269	$1,875	$2,199	$2,819	$2,903
3	$783	$1,600	$2,365	$2,773	$3,555	$3,662
4	$945	$1,932	$2,854	$3,348	$4,292	$4,421
5	$1,107	$2,263	$3,344	$3,923	$5,029	$5,180
6	$1,269	$2,595	$3,834	$4,497	$5,765	$5,938

*This standard is used for children without creditable insurance.
**This standard is used for children with creditable insurance.

Medicare Premium Assistant Program Income Standards	Single	Couple
Qualified Medicare Beneficiary (QMB) 100% FPL	$1,041	$1,410
Specified Low-Income Medicare Beneficiary (SLIMB) 120% FPL	$1,249	$1,691
Qualified Individual-1 (QI-1) 135% FPL	$1,406	$1,903
Qualified Disabled and Working Individual (QDWI) 200% FPL	$2,082	$2,819

Medicare Premium Assistant Program Resource Standard	Amount
Single	$11,600
Couple	$7,730

Monthly FPL Income Guidelines for Premium Calculation (MBIWD) 250% FPL ($2,603) beginning 03/01/19 to qualify for the program		
Family Size	MBIWD 150%	MBIWD 450%
1	$1,562	$4,684
2	$2,114	$6,342
3	$2,667	$7,999
4	$3,219	$9,657
5	$3,772	$11,314
6	$4,324	$12,972

[12] Appendix 1 focuses on standards for ABD category needy, LTC, MAGI, Medicare Premium Assistance Program and MBIWD, and would not include all income and resource standards for Other covered groups. **Source**: ODM.

Appendix 2: Types of Alerts

The following appendix describes types of alerts, how many are contained for the type, and caseworker action example[13].

Type	Number	Purpose	Caseworker Action Example
E-Verify Interface Alerts	44	Alerts inform worker on updates in information for interfaces such as Bendix-SSA, PARIS, SDX-SSI.	SDA-SSI pending medical condition alert requires worker to review pending medical condition record, verify new record, complete review history and journal entry, and clear alert.
Mass Change Alerts	15	Alerts generated at regular time intervals, when changes occur or action needed related to mass change. Example of alerts include document uploaded from self-service portal, notice of inter-county transfer, and pregnancy due date reminder.	The document uploaded from self-service portal requires the worker to view alerts, verify the document was uploaded, and clear the alert.
Miscellaneous Alerts	15	Various types of alerts of which examples include state residency fall-out and SSA death indicator.	State residency fall-out alert requires the worker to review the residency page, add a residency record, run EDBC, and clear alert.
SETS Alerts	14	Alerts notify workers of updates to child support orders and information.	The 700 paternity established alert requires the worker to review interface detail page, update absent parent record, run EDBC, create journal entry and clear alert.
IEVS Alerts	10	Alerts inform worker on discrepancies in income or unemployment insurance. Examples of IEVS alerts include SWICA income comparison and unemployment compensation discrepancy alert.	SWICA unemployment compensation discrepancy requires worker check SWICA income in E-verify, income detail screen, and determine if update or additional verification is needed. Run EDBC again if necessary. Clear alert.
LTC Alerts	8	Alerts to inform caseworkers long-term care records have been created or updated.	The creation of long-term detail record alert requires the worker to initiate long-term financial eligibility, update LTC/additional services detail screen and clear the alert.
HATSx Alerts	8	Alerts notify of updates associated with hearings.	HATSx compliance approved alert requires the worker to review compliance e-mail from HATSx, update data collection page, rerun EDBC, update

---

[13] Although not listed in Medicaid alerts spreadsheet, there is also a TBQ alert, which notifies a worker of updates to Medicare information has been provider through the TBQ interface and the worker would review the Medicare Detail Screen. This TBQ alert was added to TPL count in Medicaid Alerts Inventory

Type	Number	Purpose	Caseworker Action Example
			compliance documents in HATSx, clear alert.
Age related alerts	7	These alerts are generated when certain different ages are reached for MAGI population to explore potential eligibility.	The customer in adult MAGI turns 65 alert requires the worker to explore eligibility options, check any pending medical conditions, resources, AVS if application, run EDBC and clear alert.
Buy-In Alert	5	Alerts inform worker that buy-in has started or error or update with CMS.	Buy-in information rejected due to error alert requires the worker check other sources of Medicare information such as Bendix, confirm information such as dates and premiums, review demographic screen, and re-run EDBC.
TPL Alerts	5	Alerts generate notifications about third-party insurance and Medicare.	The TPL – update to Medicare Detail alert requires the worker confirm Medicare detail screen, re-run EDBC, and check eligible and ineligible/overridden budget detail screens. Clear the alert.
Benefit Recovery Alerts	4	Alerts inform benefit recovery workers on updates to recovery accounts.	The benefit recovery response deadline exceeded alert requires the worker to view alert, update status, re-run EDBC, complete journal entries and clear alert.
AVS alerts	2	Alerts notify workers on updates for asset detection and verification.	The asset verification response alert requires the worker to navigate to the AVS page, review information, contact customer if necessary, update liquid resource detail page, and clear alert.
Verification alerts	2	Alerts notify works when verifications are overdue.	The verification request list items past due alert requires the worker to explore options for eligibility, review medical condition, run EDBC and clear alert.
SRS Alerts	2	Alerts to inform caseworkers SRS records have been created or updated.	The SRS eligibility impact update alert requires the worker to check LTC detail/additional services screen, run EDBC and clear alert.
Healthchek Alerts	2	Alerts generate notifications about pregnancies	Healthchek/PRS follow-up alert requires the worker to confirm if second attempt is made, if form not sent back by customer e-mail or call, update journal entries and clear alert.
ROP alerts	2	These alerts are generated through the ROP 30-day notification batch process	The 30-day ROP 30 day reminder alert requires the worker to follow up with household according to policy,

Type	Number	Purpose	Caseworker Action Example
			enter data, run EDBC and clear alert.
SACWIS	2	Alerts generated for updates in child custody status.	The child taken into custody alert requires the worker to review alert, update the data collection page, run EDBC, add journal entry and clear alert.

Source: OB project website - Medicaid Alerts Spreadsheet V2.3.4 updated March 2019

Appendix 3: Sources of Electronic Verification

Verification Interfaces	Description
Beneficiary and Earning Data Exchange (Bendex)	Used to verify social security numbers (SSN) and other information from SSA such as medical condition.
Beneficiary and Earning Data Exchange (BEER)	Provides quarterly data such as SSNs and wage data for customers receiving Title II and Title XVI benefits.
Bureau of Vital Statistics (IPHIS)	Used to verify vital statistics records, such as data of death and births.
Child/Spousal Support (SETS)	Used to verify child support and enforcement collection and payment records.
Department of Rehabilitation and Correction (DRC)	Used to verify incarceration information and update living arrangement in OB.
Department of Youth Services (DYS)	Provides records on incarcerated youth.
Electronic Disqualified Recipient System (eDRS)	Interface with data on disqualified household members receiving SNAP benefits.
Enumeration Verification System (EVS)	Ensures that the state of Ohio obtains valid SSNs of customers applying for federally funded income and/or health maintenance programs.
Public Assistance Reporting Information System (PARIS)	Federal database used to match information on federal wages, veterans benefits, and benefits received in another state.
Federal Office of Child Support Enforcement (National New Hire Database)	Developed to assist states in locating parents to support child support order. Contains wage and employment information.
Medicaid Buy-In For Workers with Disabilities (MBIWD)	Interface with ODM vendor that will exchange information with MBIWD.
National Crime Information Center (NCIC)	Electronic database of crime data maintained by the FBI.
Nurture Ohio (PRAF)	Nurture Ohio system has pregnancy related information.
State Data Exchange (SDX)SSI	Provides benefit updates and creates e-application for customers approved for SSI.
State On-Line Query (SOLQ)	Used to verify income, SSNs, Medicare, and other information.
State Verification and Exchange System (SVES)	Information from SSA proving verification of social security numbers and citizenship through Title II and Title IVI data.
State Wage and Information Collection Agency (SWICA)	Used as additional income verification source, specifically regarding state earned income.
Statewide Automated Child Welfare Information System (SACWIS)	Case management system for Ohio's state and local child welfare agencies.
Unemployment Compensation Benefits (UCB)	Sends unemployment information to OB which will be used as a source for unearned income verification.

Source: OB project website

Appendix 4: Ohio Benefits System Reports

Authorized users with proper roles and responsibility have the ability to run reports in the OB system to monitor the status of applications and redeterminations for eligibility. Many of these reports can be run on-demand, while others can be scheduled, or run monthly or when a batch run is performed. Some of the county respondents indicated they use pending application reports, re-determination reports, backlog reports, delinquencies and alerts. The following list includes examples of reports available to county workers for processing eligibility determinations.

- Applicant Timeliness Report –calculates and displays the number of days it takes for an initial eligibility determination (approved/denied) for customers within a selected county for a given reporting period.
- Application Pending Report –tracks at the application level, the number of days (within a time range) that an application has been pending, and displays the total number of applications by Caseworker's Assigned County.
- County Redetermination Report –provides details about cases which are due for renewal, also called redetermination.
- No Touch - Fall Out Report –calculates and displays the total number and percent of customers that go through the No Touch process or Fall Out, as well as the total number of customers per fall out point within a specified county and reporting period.
- The Phone Applications Report –tracks pending phone applications with ODM's vendor.
- Recipients by LTC Facility Report –will show individual Medicaid customers who are located at LTC facilities.

The following state level reports are used to meet federal reporting requirements:

a) The Medicaid Quality Control Report – this is designed to randomly sample determinations made on customers who applied for or are receiving Medicaid. This report will be used by ODM Quality Control team to fulfill federal reporting requirements.

b) CMS Performance Indicators Report – this report provides important information to CMS that allows it to share data publicly on state program performance. Indicators include the following:

- number of applications received;
- number of electronic accounts transferred;
- number of renewals;
- total enrollment;
- number of customers determined eligible;
- number of customers determined ineligible;
- number of pending applications or determinations; and
- processing time for determinations.

Appendix 5: Accuracy of Eligibility Determinations by County

County	Strata	Customers in Strata Population	Total Amount Paid for Population	Finding Amount of Sample	Potential Financial Impact
Butler	ABD	12,684	$52,075.02	$0.00	$0.00
Butler	CFC	58,147	$7,581.51	$0.00	$0.00
Butler	Group VIII Expansion	28,054	$8,660.43	$0.00	$0.00
Butler	Other	7,514	$196.95	$0.00	$0.00
Butler Subtotals		**106,399**	**$68,513.91**	**$0.00**	**$0.00**
Cuyahoga	ABD	77,109	$58,346.84	$0.00	$0.00
Cuyahoga	CFC	209,767	$14,160.57	$407.90	$21,390,990.00
Cuyahoga	Group VIII Expansion	124,458	$4,554.31	$0.00	$0.00
Cuyahoga	Other	31,580	$1,539.65	$1,539.65	$48,622,147.00
Cuyahoga Subtotals		**442,914**	**$78,601.37**	**$1,947.55**	**$70,013,137.00**
Defiance	ABD	1,311	$11,050.13	$0.00	$0.00
Defiance	CFC	5,950	$14,328.98	$0.00	$0.00
Defiance	Group VIII Expansion	2,407	$15,813.07	$0.00	$0.00
Defiance	Other	839	$913.10	$0.00	$0.00
Defiance Subtotals		**10,507**	**$42,105.28**	**$0.00**	**$0.00**
Franklin	ABD	49,911	$27,206.89	$0.00	$0.00
Franklin	CFC	221,417	$6,712.22	$1,872.72	$103,663,011.00
Franklin	Group VIII Expansion	95,565	$9,108.13	$7,072.16	$225,283,657.00
Franklin	Other	35,294	$8,353.43	$0.00	$0.00
Franklin Subtotals		**402,187**	**$51,380.67**	**$8,944.88**	**$328,946,668.00**
Hamilton	ABD	37,052	$107,802.32	$0.00	$0.00
Hamilton	CFC	130,264	$10,552.70	$0.00	$0.00
Hamilton	Group VIII Expansion	67,011	$8,868.46	$0.00	$0.00
Hamilton	Other	17,927	$920.15	$0.00	$0.00
Hamilton Subtotals		**252,254**	**$128,143.63**	**$0.00**	**$0.00**
Henry	ABD	648	$71,016.45	$0.00	$0.00
Henry	CFC	2,952	$12,136.59	$0.00	$0.00
Henry	Group VIII Expansion	1,340	$16,020.04	$0.00	$0.00
Henry	Other	414	$1,033.44	$0.00	$0.00
Henry Subtotals		**5,354**	**$100,206.52**	**$0.00**	**$0.00**
Highland	ABD	2,048	$105,702.85	$0.00	$0.00
Highland	CFC	8,956	$8,668.12	$0.00	$0.00
Highland	Group VIII Expansion	4,235	$16,998.80	$0.00	$0.00
Highland	Other	1,342	$44.00	$0.00	$0.00
Highland Subtotals		**16,581**	**$131,413.77**	**$0.00**	**$0.00**

Ohio's Medicaid Eligibility Determination Process

County	Strata	Customers in Strata Population	Total Amount Paid for Population	Finding Amount of Sample	Potential Financial Impact
Hocking	ABD	1,359	$40,252.84	$0.00	$0.00
Hocking	CFC	5,820	$13,629.89	$0.00	$0.00
Hocking	Group VIII Expansion	2,911	$7,556.11	$0.00	$0.00
Hocking	Other	818	$66.14	$0.00	$0.00
Hocking Subtotals		**10,908**	**$61,504.98**	**$0.00**	**$0.00**
Lorain	ABD	11,154	$29,879.93	$0.00	$0.00
Lorain	CFC	42,471	$7,115.77	$0.00	$0.00
Lorain	Group VIII Expansion	20,628	$17,959.67	$0.00	$0.00
Lorain	Other	5,513	$10,290.57	$0.00	$0.00
Lorain Subtotals		**79,766**	**$65,245.94**	**$0.00**	**$0.00**
Lucas	ABD	26,661	$46,741.06	$0.00	$0.00
Lucas	CFC	79,896	$21,446.83	$0.00	$0.00
Lucas	Group VIII Expansion	39,716	$12,684.50	$0.00	$0.00
Lucas	Other	11,907	$5,978.89	$0.00	$0.00
Lucas Subtotals		**158,180**	**$86,851.28**	**$0.00**	**$0.00**
Mahoning	ABD	14,168	$75,787.71	$0.00	$0.00
Mahoning	CFC	42,638	$17,913.67	$2,197.56	$23,424,891.00
Mahoning	Group VIII Expansion	25,087	$11,263.20	$0.00	$0.00
Mahoning	Other	5,380	$2,261.12	$0.00	$0.00
Mahoning Subtotals		**87,273**	**$107,225.70**	**$2,197.56**	**$23,424,891.00**
Monroe	ABD	571	$31,427.59	$0.00	$0.00
Monroe	CFC	2,157	$6,150.81	$0.00	$0.00
Monroe	Group VIII Expansion	1,147	$24,419.03	$3,373.80	$1,289,916.00
Monroe	Other	274	$57.76	$0.00	$0.00
Monroe Subtotals		**4,149**	**$62,055.19**	**$3,373.80**	**$1,289,916.00**
Montgomery	ABD	26,502	$57,533.60	$0.00	$0.00
Montgomery	CFC	89,171	$5,628.60	$0.00	$0.00
Montgomery	Group VIII Expansion	46,582	$20,036.75	$0.00	$0.00
Montgomery	Other	14,258	$1,634.55	$0.00	$0.00
Montgomery Subtotals		**176,513**	**$84,833.50**	**$0.00**	**$0.00**
Noble	ABD	471	$48,136.48	$0.00	$0.00
Noble	CFC	1,795	$6,274.68	$0.00	$0.00
Noble	Group VIII Expansion	1,005	$15,118.28	$0.00	$0.00
Noble	Other	276	$734.80	$367.40	$101,402.00
Noble Subtotals		**3,547**	**$70,264.24**	**$367.40**	**$101,402.00**
Paulding	ABD	551	$35,702.55	$0.00	$0.00
Paulding	CFC	2,644	$15,555.04	$1,591.11	$1,051,724.00

County	Strata	Customers in Strata Population	Total Amount Paid for Population	Finding Amount of Sample	Potential Financial Impact
Paulding	Group VIII Expansion	1,064	$22,291.68	$3,833.61	$1,359,654.00
Paulding	Other	390	$8,814.60	$0.00	$0.00
Paulding Subtotals		**4,649**	**$82,363.87**	**$5,424.72**	**$2,411,378.00**
Pike	ABD	2,109	$24,851.16	$0.00	$0.00
Pike	CFC	7,206	$10,724.15	$0.00	$0.00
Pike	Group VIII Expansion	3,686	$16,078.87	$0.00	$0.00
Pike	Other	1,007	$1,595.83	$0.00	$0.00
Pike Subtotals		**14,008**	**$53,250.01**	**$0.00**	**$0.00**
Preble	ABD	1,239	$15,190.53	$0.00	$0.00
Preble	CFC	6,122	$6,239.46	$0.00	$0.00
Preble	Group VIII Expansion	2,967	$12,406.56	$0.00	$0.00
Preble	Other	846	$75.05	$0.00	$0.00
Preble Subtotals		**11,174**	**$33,911.60**	**$0.00**	**$0.00**
Ross	ABD	4,756	$76,397.95	$0.00	$0.00
Ross	CFC	17,523	$13,731.38	$1,296.29	$5,678,722.00
Ross	Group VIII Expansion	8,655	$24,682.04	$1,793.23	$3,880,101.00
Ross	Other	2,385	$15,345.85	$0.00	$0.00
Ross Subtotals		**33,319**	**$130,157.22**	**$3,089.52**	**$9,558,823.00**
Sandusky	ABD	1,952	$25,047.97	$0.00	$0.00
Sandusky	CFC	8,350	$14,367.68	$0.00	$0.00
Sandusky	Group VIII Expansion	3,696	$13,387.16	$0.00	$0.00
Sandusky	Other	1,682	$841.97	$0.00	$0.00
Sandusky Subtotals		**15,680**	**$53,644.78**	**$0.00**	**$0.00**
Seneca	ABD	1,859	$36,372.76	$0.00	$0.00
Seneca	CFC	8,088	$5,479.23	$449.30	$908,485.00
Seneca	Group VIII Expansion	3,552	$5,545.88	$0.00	$0.00
Seneca	Other	1,124	$870.25	$0.00	$0.00
Seneca Subtotals		**14,623**	**$48,268.12**	**$449.30**	**$908,485.00**
Stark	ABD	15,931	$24,523.10	$0.00	$0.00
Stark	CFC	54,158	$8,920.73	$0.00	$0.00
Stark	Group VIII Expansion	28,172	$5,753.02	$0.00	$0.00
Stark	Other	8,373	$86,259.95	$0.00	$0.00
Stark Subtotals		**106,634**	**$125,456.80**	**$0.00**	**$0.00**
Summit	ABD	24,230	$43,722.17	$2,021.81	$12,247,114.00
Summit	CFC	78,290	$10,719.48	$0.00	$0.00
Summit	Group VIII Expansion	46,691	$6,590.61	$0.00	$0.00

County	Strata	Customers in Strata Population	Total Amount Paid for Population	Finding Amount of Sample	Potential Financial Impact
Summit	Other	9,986	$9,131.06	$0.00	$0.00
Summit Subtotals		**159,197**	**$70,163.32**	**$2,021.81**	**$12,247,114.00**
Trumbull	ABD	10,019	$118,431.81	$0.00	$0.00
Trumbull	CFC	33,932	$8,207.30	$0.00	$0.00
Trumbull	Group VIII Expansion	19,350	$14,051.15	$0.00	$0.00
Trumbull	Other	4,677	$12,604.03	$0.00	$0.00
Trumbull Subtotals		**67,978**	**$153,294.29**	**$0.00**	**$0.00**
Tuscarawas	ABD	3,528	$31,313.61	$0.00	$0.00
Tuscarawas	CFC	12,446	$6,179.90	$0.00	$0.00
Tuscarawas	Group VIII Expansion	5,970	$14,591.20	$3.23	$6,428.00
Tuscarawas	Other	2,192	$93.14	$0.00	$0.00
Tuscarawas Subtotals		**24,136**	**$52,177.85**	**$3.23**	**$6,428.00**
Vinton	ABD	783	$38,837.03	$0.00	$0.00
Vinton	CFC	3,174	$4,763.50	$0.00	$0.00
Vinton	Group VIII Expansion	1,559	$15,673.88	$8,609.04	$4,473,831.00
Vinton	Other	365	$12.45	$0.00	$0.00
Vinton Subtotals		**5,881**	**$59,286.86**	**$8,609.04**	**$4,473,831.00**
Williams	ABD	1,101	$47,907.89	$0.00	$0.00
Williams	CFC	5,558	$6,135.47	$1,172.20	$1,628,772.00
Williams	Group VIII Expansion	2,454	$5,742.52	$0.00	$0.00
Williams	Other	767	$21.48	$0.00	$0.00
Williams Subtotals		**9,880**	**$59,807.36**	**$1,172.20**	**$1,628,772.00**
Wyandot	ABD	669	$74,231.23	$1,534.36	$256,622.00
Wyandot	CFC	2,535	$7,846.26	$0.00	$0.00
Wyandot	Group VIII Expansion	1,095	$7,156.87	$0.00	$0.00
Wyandot	Other	374	$4,108.82	$0.00	$0.00
Wyandot Subtotals		**4,673**	**$93,343.18**	**$1,534.36**	**$256,622.00**
Total All Counties		**2,228,364**	**$2,153,471.24**	**$39,135.37**	**$455,267,467.00**

Source: Quality Decision Support System[14] for number of customers in each strata; MITS for payment information; overpayments based on ineligible customers for ineligible months in samples

---

[14] The Quality Decision Support System is software program used by the state for the enterprise-wide analysis of the Ohio Medicaid program.

Appendix 6: Data for the 27 Sampled Counties

County	Medicaid Enrollment (Enrollment as Percent of County Population)	Applications	Renewals	Alerts	Total Applications on July 1, 2019 (Percent Pending More than 45 days)
Butler	84,220 (22%)	35,481	17,195	334,273	3,167 (66%)
Cuyahoga	372,497 (30%)	147,068	62,396	1,547,256	6,683 (36%)
Defiance/ Paulding	11,306 (20%)	4,111	4,203	46,417	301 (67%)
Franklin	329,037 (25%)	136,047	47,721	1,461,088	7,277 (31%)
Hamilton	201,009 (25%)	89,272	60,618	808,687	3,094 (35%)
Henry	4,085 (15%)	1,907	1,326	17,505	54 (19%)
Highland	13,031 (30%)	4,248	3,349	56,171	328 (52%)
Hocking/ Ross/Vinton	36,686 (31%)	12,274	11,846	156,746	617 (46%)
Lorain	63,708 (21%)	25,058	20,452	281,212	1,660 (38%)
Lucas	130,895 (30%)	46,577	25,576	548,049	4,071 (64%)
Mahoning	73,235 (32%)	21,253	17,095	299,186	2,056 (72%)
Monroe	3,404 (25%)	945	1,249	11,825	62 (69%)
Montgomery	143,135 (27%)	68,443	30,939	638,251	6,279 (60%)
Noble	2,708 (19%)	922	1,116	10,452	30 (47%)
Pike	10,627 (38%)	3,582	3,830	46,086	109 (7%)
Preble	8,651 (21%)	2,906	3,325	34,542	90 (16%)
Sandusky	12,292 (21%)	7,055	4,025	60,096	224 (20%)
Seneca	11,393 (21%)	4,807	3,231	48,150	131 (15%)
Stark	86,725 (23%)	33,305	27,225	388,400	1,107 (19%)

Ohio's Medicaid Eligibility Determination Process

County	Medicaid Enrollment (Enrollment as Percent of County Population)	Applications	Renewals	Alerts	Total Applications on July 1, 2019 (Percent Pending More than 45 days)
Summit	130,201 (24%)	46,364	35,431	581,849	2,482 (35%)
Trumbull	55,242 (28%)	20,024	16,111	239,966	994 (49%)
Tuscarawas	19,089 (21%)	9,590	6,421	89,248	292 (27%)
Williams	7,396 (20%)	4,064	1,807	32,701	108 (8%)
Wyandot	3,594 (16%)	1,698	1,156	16,148	40 (25%)
Totals	1,814,166 (26%)	727,001	407,643	7,754,304	41,256 (46%)

Sources: ODAS for applications and alerts; ODM for Medicaid enrollment and applications in process

Appendix 7: Practices Implemented by the 27 Sampled Counties

County	Case Assignment Process	QA and Productivity Standards	Training - New Hires
Butler	case load	pay for performance model, QA pull cases to review	uses peer support and monitoring, first 90 days reduced intake
Cuyahoga	casebank	review 2 cases per worker per month	onboarding, shadowing, 98% accuracy standard
Defiance/ Paulding	initial applications round robin then case load	QA review	uses mentoring then are given a caseload
Franklin	2 large casebanks & smaller bank for specialized cases	on phone 4 hours/day; process 6 calls and 10 touches on cases per day; supervisors review cases	12-week program: on-the-job and classroom, review until 10 cases in a row are error free
Hamilton	casebank - assigned to worker until complete then back to bank	supervisors review 5 cases per month, benchmark - 12 renewals per day	observed by supervisors; initially 100% review
Henry	case load; new applications assigned round robin	cases reviewed during complaint process, QA review on new hires	on the job and one on one, observe interactions
Highland	casebank- assigned round robin	3 intakes day per worker	mentoring, use ODM training materials and job aides
Hocking/ Ross/Vinton	casebank except LTC	QA selects 5 cases per worker per month	classroom training 8-12 weeks then mentoring or shadowing, 100% case check
Lorain	casebank except LTC	supervisors review 35 cases per month (3 per worker), expected error rate of 10-15%	train internally - groups of 6 - 8. Review 100% through most of probation
Lucas	casebank	QA reviews 2 cases per month per worker	4-8 weeks training, classroom, and OJT
Mahoning	casebank	every caseworker reviewed weekly	9 month training
Monroe	casebank	no formal QA; reviews based on supervisor case load	mentoring; team determine when ready to perform independently
Montgomery	caseloads round robin distribution specialized unit uses hybrid of mini casebank and caseload	12 cases quarterly by supervisors and team leads for accuracy and timeliness; for new or promoted staff - 3 levels of reviews	10-11 weeks of classroom then job shadowing, on the job training, independent casework and 3 levels of QA case reviews

Ohio's Medicaid Eligibility Determination Process

County	Case Assignment Process	QA and Productivity Standards	Training - New Hires
			(additional training for specialized units)
Noble	casebank	supervisor checks while resolving case issues	no formal training
Pike	round robin, case load	supervisory reviews	training manual, supervisors train employees
Preble	round robin, casebank	no formal QA; work alerts and help with hearings	CSS has a training group
Sandusky	casebank	reviewer randomly selects cases on a monthly basis new hires reviewed for accuracy for the first year	6 -8 weeks with the new hire (includes bookwork, hands on practice and observation), 96% accuracy standard
Seneca	round robin, case load	lead reviews 2 cases per worker per week, 90% accuracy; 95% timeliness	no formal process / packet of information and interview template
Stark	casebank (units have bank and a main bank for cases in between needed actions)	4 cases per month per employee reviewed, new hires expectation is 90% accuracy	classroom based training/ testing/ quality reviews
Summit	casebank, LTC case load	spot check phone records and reports, QA review 15 CM1 cases per month, till 80% accuracy; 50 CM2 cases till 80% accuracy	12 weeks; LTC additional 4-6 weeks; Trainers mentor as begin processing cases
Trumbull	casebank with alpha & numerical rotation	QA reviews random sample of cases; errors to supervisor, monthly report	classroom for 4.5 months learning all programs then 4.5 months OJT training; reviews all cases
Tuscarawas	casebank except specialized units	QC reviews state hearing cases, supervisor reviews apps on 30 day list; EDMS workers are expected to review 24 documents per day	4-6 months; trainer determines when ready to begin processing cases
Williams	round robin, case load	supervisors review cases on an as needed basis	no formal process; front desk is 3 to 4 weeks ; caseworkers is 6 to 8 months
Wyandot	round robin, case load	2 cases per caseworker per month	no program for training - try to hire from other counties

Source: AOS interviews with 27 counties

This page intentionally left blank.

Ohio | Department of Medicaid

Mike DeWine, Governor
Jon Husted, Lt. Governor

Maureen M. Corcoran, Director

November 9, 2020

Keith Faber, Auditor of State of Ohio
Attn: Kristi Erlewine, Chief Auditor
Medicaid/Contract Audit Section
88 East Broad Street, 4th Floor
Columbus, Ohio 43215

Dear Auditor Faber:

Thank you for the opportunity to respond to the draft report issued by the Auditor of State regarding the review of the Medicaid Eligibility Determination Process. The Ohio Department of Medicaid's (ODM) offers the following response.

PART I: BACKGROUND

A. INTRODUCTION

Ohio Benefits (OB) is a system used by the Ohio Department of Medicaid and the Ohio Department of Job and Family Services (ODJFS) to manage healthcare, childcare, food and cash benefits for eligible Ohioans. As a system, Ohio Benefits is intended to centralize enrollment and benefits administration, simplifying the application process for consumers seeking assistance across multiple benefit programs. The centralized solution also provided administrative efficiencies to the state and its county partners.
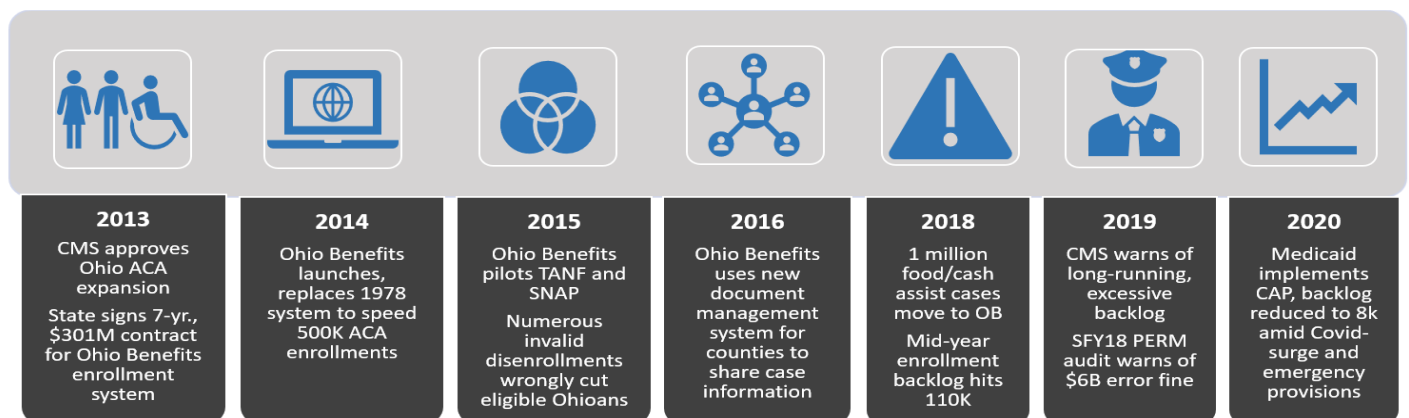
Within the first week of taking office, CMS notified Director Maureen Corcoran that the eligibility backlog in Ohio, which included over 53,000 applications not processed 45 days after submission, was unacceptable and longstanding, requiring the federal agency to take further action. CMS released another audit—the Payment Error Rate Measurement (PERM) audit for state fiscal year 2018 (July 1, 2017 – June 30, 2018) that revealed significant issues with OB and Medicaid's eligibility processes. Fortunately, ODJFS programs, such as SNAP and TANF, do not appear to be experiencing the difficulties encountered by Medicaid within Ohio Benefits.

The PERM audit showed Ohio as performing among the worst in its class with Overall Payment Error Rates of 44.28% for the Medicaid population and 55.41% for the Children's Health Insurance Program (CHIP) population. These error rates are not necessarily overpayments.

Rather, they classify transactions that lack the statutory, regulatory, administrative, or other legally applicable requirements that results from missing or partial documentation and record-keeping, data entry error, and the like. They may represent overpayments or underpayments. Along with other operational concerns, these eligibility issues were identified in a year-end report from Director Corcoran to Governor DeWine dated January 13, 2020.

While working to immediately address the situation, ODM discovered that many of the PERM audit errors were caused by process and information technology system defects in the OB system, which manages online applications for various benefits, including Medicaid eligibility. System defects included unintended data overrides, peculiar data overwriting problems, untraceable decision making related to eligibility determinations, and an overwhelming number of alerts. Alerts – an automated electronic signal generated by the system to notify caseworkers of an exception – are intended to quickly and easily gain the attention of county caseworkers of a potential change in a recipient's circumstance that may impact her Medicaid eligibility. The defects, innumerable alerts, and the host of manual "work-arounds" related to known defects created enhanced risk of eligibility-documentation error and added substantial time to day-to-day program operations for case workers.

The following is a brief chronology of the development of the Ohio Benefits system. ODM is not diminishing the importance of the findings identified in the AOS audit report. We appreciate the report acknowledging the complexity of Ohio's system – indeed the complexity of *any* state Medicaid eligibility system. We also welcome comments recognizing ODM's attention to and progress with improvements to the system.

2013	2014	2015	2016	2018	2019	2020
CMS approves Ohio ACA expansion	Ohio Benefits launches, replaces 1978 system to speed 500K ACA enrollments	Ohio Benefits pilots TANF and SNAP	Ohio Benefits uses new document management system for counties to share case information	1 million food/cash assist cases move to OB	CMS warns of long-running, excessive backlog	Medicaid implements CAP, backlog reduced to 8k amid Covid-surge and emergency provisions
State signs 7-yr., $301M contract for Ohio Benefits enrollment system		Numerous invalid disenrollments wrongly cut eligible Ohioans		Mid-year enrollment backlog hits 110K	SFY18 PERM audit warns of $6B error fine	

ODM is committed to improving and repairing the overall eligibility process. It introduced extensive remediation efforts to correct errors within the OB system, a robust training program to improve data accuracy and compliance with county caseworkers, and formalized a multi-agency workgroup to align resources and vendors and correct high-impact system flaws contributing to excessive backlogs and errors.

B. ODM WORK COMPLETED AND PLANNED

ODM developed and began implementing corrective action plans (CAP) in response to the PERM and Single State Audits. Regular interagency leadership meetings are ongoing. ODM's corrective actions include county caseworker training, OB system improvements, issues monitoring, and reporting. These efforts will improve service to individuals, increase the accuracy of ODM's Medicaid eligibility determinations, and provide more accountability for taxpayer dollars.

ODM created a new web application to track and report eligibility error trends identified by its Medicaid Eligibility Quality Control unit, increased training and engagement of county partners, and issued an RFP for a technical and code review of OB.

Strengthening county partner training and engagement for Income and Eligibility Verification System (IEVS) Monitoring.

ODM made improvements to IEVS monitoring through process changes and new training for counties. The Ohio Department of Job and Family Services (ODJFS) leads training curriculum and development. The agency also updated its IEVS processing guide. This training reached county departments of job and family services (CDJFS) on October 20, with a repeat session held October 28.

ODJFS currently reviews IEVS processing completed by the CDJFSs through a formal triad review process that examines three areas—claims management and recipient integrity; IEVS alert processing; and federal tax information safeguards—that interact directly and reciprocally with another.

ODM's Eligibility Compliance office meets monthly with ODJFS to review these reports and share results with ODM's County Engagement team. Additionally, ODM's Medicaid Eligibility and Quality Control (MEQC) unit will continue to review IEVS processing in its eligibility reviews and whether the alert was processed timely. Findings are shared with the counties that processed the application, and with ODM's Eligibility Compliance and County Engagement sections.

Redesigning the alert process.

The Ohio Benefits systems was designed to administratively streamline decision making to simplify the user experience and safeguard against caseworker errors. Alerts were incorporated in the architecture to proactively notify caseworkers of potential mistakes, data discrepancies or pending timelines as a means to strengthen eligibility oversight and controls. For example, an alert can notify a caseworker when a beneficiary has a change in circumstance that may affect his/her eligibility. Though the feature is valuable in notifying workers of significant life changes, such as births or deaths, or a resident's moves to another state, the system generates an inordinate volume of alerts that caseworkers find difficult to manage.

- ODM and ODJFS began meeting bi-weekly in April 2020 to review every alert generated in Ohio Benefits to determine what information is communicated, how often the alert is generated, whether the alert was customized for Ohio's programs, and any state and federal mandates govern the frequency and nature of alert requirements. Analysis prioritizes high volume alerts, errors or defects for upcoming releases. Once all system alerts are evaluated, the group will present recommendations for vendor corrective action. During this process, ODM communicates discoveries to the vendor, enabling it to investigate and implement fixes when possible. As an example, a county workgroup request to remove outstanding alerts on closed cases was addressed and enhanced to automatically clear alerts for denied and discontinued Medicaid blocks without losing the record of the alert. This functionality was implemented in Release (R) 3.6.3 (August 2020).
- ODM improved the visibility of alerts for caseworkers through several system enhancements; allowing them to more quickly address potential changes in an individual's eligibility. In R3.6.3 (August 2020) the vendor introduced a new Alert and Task dashboard to the Case Summary page enabling caseworkers to identify pending and overdue alerts quickly and easily. The dashboard also provides hyperlinks to alerts that need worked to expedite caseworker review and response. Seventeen corrections to defects associated with alert functionality are complete and new alert reports have been developed and piloted with several counties. ODM is working with the Ohio Department of Administrative Services (DAS) to make these reports available to all 88 counties.
- ODM and ODJFS are evaluating the feasibility of enhancing Ohio Benefits to force alerts to be worked before the Eligibility Determination and Benefit Calculation (EDBC) is run. Many alerts are shared and contain information requiring follow-up but may delay eligibility determination with other benefit programs. The joint workgroup will assess possible system enhancements while remaining compliant with CMS, United States Department of Agriculture (USDA) Food and Nutrition Service (FNS), Ohio Administrative Code (OAC) and Ohio Revised Code (ORC) requirements.

ODM also works with DAS and its contractor to strategically schedule system improvements in Ohio Benefits, sorting each by functional group. Alerts are prioritized by functional group 1(b) as described below.

Prioritizing efforts to remedy issues within the OB system.

ODM incorporated the recommendations provided by the Auditor of State (AOS) in our Single State Audit into our system corrections plan. ODM also worked with the vendor for capacity planning to determine implementation fixes, record corrections made, and provide insight into upcoming enhancements planned for release.

ODM strengthened the approach to prioritize and include defects and enhancements in periodic updates of OB. The new approach classifies all changes based on functional areas. This allows the team to evaluate defects in relation to the broader system implications rather than as separate,

unrelated changes. This approach allows ODM to group all related defects or enhancements together in targeted releases. Functional areas are identified by impact on eligibility, as follows:

1a.   Eligibility Rules
1b.   Alerts
1c.   Overwrites and View History
2.   Renewals (Passive and Manual)
3.   Change Reporting
4.   Self-Service Portal
5.   Notices
6.   Document Management EDMS
7.   County Shared Services/Interactive Voice Response
8.   Signatures for Renewals
9.   Electronic Verification Audit Trail
10.   No Touch Initial Application
11.   Reporting

This approach enabled defect corrections and system enhancements to be implemented in the last four releases (R3.6 April 2020; R3.6.1 May 2020; R3.6.2 July 2020; R3.6.3 August 2020). The chart at the bottom of page 8 shows the functional areas where the defect corrections and enhancements have occurred.

Contracting an independent vendor to strengthen system assessments.

In November 2019, ODM collaborated with DAS and ODJFS to develop a request for proposal (RFP) for a third-party vendor assessment to identify the root cause of underlying problems previously identified. The review will evaluate the design and code of the system and identify issues which may cause risk to performance, capacity, master data management and/or data integrity. The vendor will complete an in-depth data model review of the system and its component databases, including business intelligence, operational data store, and the master client index functions. Also, an in-depth review of project management, operational workflows and hardware infrastructure will be assessed. Once complete, ODM will evaluate the findings and take action as needed should results show a correlation between system performance and the effectiveness of ODM's Independent Verification and Validation vendor.

The RFP was posted in September 2020, and upon completion of the procurement process, the awarded vendor will be onboarded with tentative project timeline of March 2021 – June 2022. During the project time period, recurring meetings will be held with the vendor, ODM, ODJFS, and DAS and reports provided related to the assessment, and its findings. The state agencies will use this information to determine the stability, gaps, and proposed improvements of the system.

Improving eligibility training and technical assistance.

ODM provides and will continue to provide new worker training for all Medicaid programs, including long-term care. ODM, in collaboration with ODJFS, created a statewide Medicaid, SNAP, TANF (MST) New Worker Training. This training is offered quarterly and is currently delivered virtually until in-person training held regionally can resume. The training covers program policy and system basics for new workers for all three programs.

45	New virtual training sessions introduced for all county workers
44	Virtual training sessions are available on demand
3	Average number of trainings held for each county office

Separately, a Medicaid Long-Term Care training has been developed for workers new to long-term care. The pilot class was launched in October 2020 virtually for a one-week instructor-led session. Material for both trainings is maintained and facilitated by ODM and ODJFS, but once in-person sessions can resume, the training will be presented by existing county trainers in regionally located CDJFS offices. ODM and ODJFS provide ongoing policy and technical support for the sessions.

Ohio has completed some enhanced technical assistance and training to all 88 counties on a variety of joint system and policy topics as identified by the Auditor of State, with more planned in the coming months. Most trainings will be presented again once the public health emergency ends. Topics include:

1. Income processing procedures
2. Resource processing
3. Categorically needy processing checklist
4. Alert processing and prioritization
5. Common Medicaid household formation errors including proper completion of tax filing details

Attachment A to this response provides further detail of all trainings provided by ODM to the CDJFS contacts since June 2019.

The ODM Compliance Unit works with counties weekly to address application intake and renewal backlogs.

Beginning May 21, 2019, ODM started an initiative to support counties with the highest number of past due applications. This effort included weekly phone calls with the specified counties to:

- Identify ways to reduce application backlogs
- Troubleshoot applications that had system issues
- Review emerging and outstanding policy questions

Additionally, each county receives weekly reports identifying past due applications. Phone calls with counties continued through February 2020 but were paused as COVID-related work demands took priority.

Nevertheless, despite the public health emergency, weekly reports identifying backlog applications continued to be sent to counties. This initiative resulted in a significant improvement in Ohio's application timeliness. On January 7, 2019, Ohio had 53,392 Medicaid applications pending for more than 45 days. On October 26, 2020, that number has been reduced to 6,109 applications pending for more than 45 days.

On March 2, 2020, ODM changed the focus of its efforts from pending applications to pending renewals and started a new initiative to support counties with the highest number of past-due renewals. Weekly phone calls with the specified counties identified ways to reduce their renewal backlogs and troubleshoot cases with system issues or outstanding policy questions. In addition to weekly reports, counties received reports identifying past-due renewals. Due to the COVID-19 public health emergency, weekly phone calls with counties regarding renewals were suspended from April 2020 through September 2020 as renewal processing had been suspended in keeping with CMS's requirements for receiving enhanced federal funding during the crisis. Weekly reports continued to be sent and the full effort resumed in October.

As part of this effort, ODM's Central Processing Unit is reviewing the oldest pending applications to identify next steps to complete the eligibility determination. This information is shared with the county to aid with processing.

Improving county relationships and promoting best practices.

To build stronger relationships with the CDJFS agencies, ODM created a County Engagement unit in March 2020. This unit consists of five engagement managers assigned to approximately 17 counties each. The managers act as the county's primary point of contact and direct inquiries, suggestions, or issues from the county to the appropriate contacts within ODM. They also answer detailed and case-specific policy and system questions and follow unresolved system problems through appropriate escalations to ensure satisfactory and timely resolutions.

Engagement managers meet quarterly with all 88 counties to discuss a variety of topics, including identifying issues or barriers with determining eligibility, reviewing application/renewal timeliness reports, discussing any backlogs, identifying best practices the county may have to share with other county agencies as well as current hot topics and walk-on items. In addition, for Medicaid eligibility-related issues, engagement managers provide hyper-care support services following technical assistance training, as requested. To date, most engagement managers have contact with each of their counties on a weekly basis by phone or email and maintain an open line of communication.

ODM is improving the way the MEQC unit works with other program areas to proactively identify and remedy eligibility issues.

ODM's MEQC unit in the Bureau of Program Integrity reviews a broad spectrum of new cases and works in tandem with the ODM County Technical Assistance Unit to identify common caseworker errors, address trending system anomalies and errors, and identify training needs quickly. Additionally, as mentioned above, ODM's MEQC unit worked with ODM Information Technology Services group to build an online application to effectively review and report eligibility error trends internally and to county partners. The MEQC unit began assisting with Medicaid application processing at the start of the public health emergency but in October, the group started reviewing cases and reporting quarterly to ODM's Technical Assistance Unit regarding errors identified. This work allows ODM and the CDJFSs to analyze error trends and continue to identify system fixes or training needs to address those errors.

In 2019, ODM invited several experienced county workers to meet with ODM and discuss their concerns with Ohio Benefits. The county workers spent time walking through eligibility processing and explained common issues that they encountered while processing applications. They explained that system issues created the need for time-consuming manual "work arounds." ODM was able to learn from this meeting and to use the expressed concerns to understand and focus on areas of remediation.

With this work in mind, ODM responds to the Auditor of State's recommendations below.

PART II: ODM RESPONSES TO THE AUDITOR OF STATE RECOMMENDATIONS

RECOMMENDATION 1 (OB SYSTEM)

We recommend that ODM implement the corrective action steps identified in its response to the 2019 audit and release progress reports on system and process improvements and issues impacting Medicaid eligibility; and ODM ensure that this review include an evaluation of the effectiveness of the identified corrective action steps, as ODM has indicated that it will be contracting for an external review of the system.

MANAGEMENT RESPONSE

Status Updates

ODM provides status updates system and process improvements in OB to stakeholders through multiple venues. These include:

- Daily – Status emails are sent to all users of the system if there are any issues with the system including CSS/IVR, EDMS and/or Ohio Benefits.
- Weekly – Status Report and meeting managed by the vendor with representation from all vendors for the Ohio Benefits Program, DAS, ODJFS and ODM that reports the status of releases as well as the health of the system. This report is shared with our CMS representative also.
- Release Notes – Sent to all users of the system after changes to the system are implemented. The Release Notes include added/changed functionality, defect fixes and impacted work arounds.
- Operational Webinars – held twice monthly and include system updates or awareness issues for county workers, including training on system functionality. The Operational Support teams from ODJFS and ODM also hold Microsoft Teams events for system releases prior to go-live. Additional Teams events are added as needed for in-depth topics.
- Monthly status reports are created specifically for ODM's CMS representative that summarizes the status of all releases as well as any special projects, i.e. COVID-19.
- Corrective Action Plans – Provide remediation updates on previous audit findings to CMS, U.S. Department of Health and Human Services Office of Inspector General (HHS/OIG), and AOS on a regular basis.

Communication: ODM 2019 Year-End Memo to Governor DeWine and Submission of CMS Corrective Action Plan (CAP)

As noted, regular discussions with CMS began in early February 2019. This included submission of a CAP. Along with other operational concerns, these Ohio Benefit and PERM issues were identified in a year-end report from Director Corcoran to Governor DeWine and shared with stakeholders, the Ohio General Assembly and the public.

Discussions were held with the CDJFS leadership early in the discussions between ODM and CMS, with periodic leadership meetings and updates. Understanding the importance of ensuring visibility and transparency in these critical areas, ODM came forward with a formal statement to Ohio news media, highlighting PERM finding, but more importantly, assuring Ohioans that ODM's leadership were committed to correcting backlog and eligibility imperfections. Interviews were conducted with 10 news outlets (Dispatch, Plain Dealer, Dayton Daily News, Gongwer, Hannah, Statehouse News Bureau, Toledo Blade, Cincinnati Enquirer, Associated Press, Bloomberg News) and nearly 50 Ohio media contacts received communications or a news release.

ODM intends to continue communicating with stakeholders in the manner described above to explain progress with system and process improvements.

Independent Assessment

ODM posted an RFA in September 2020 to procure services of an independent IT vendor to evaluate the OB system. Upon completion of the procurement process, the awarded vendor will be onboarded with tentative project timeline of March 2021 – June 2022. During the project time period, recurring meetings will be held with the vendor, ODM, ODJFS and DAS and the vendor will provide reports related to the assessment and its findings. This information will be used to determine the stability, gaps and proposed improvements of the system.

System Enhancements and Defect Corrections

Progress improvements to date are shown below.

The following functional areas have had defects corrected and enhancements implemented in the last four releases (R3.6 April 2020; R3.6.1 May 2020; R3.6.2 July 2020; R3.6.3 August 2020):

Functional Group	Defects Corrected	Enhancements
1A- Rules	263	25
1B- Alerts	17	3
1C-Income Overwrites View History	33	7

Functional Group	Defects Corrected	Enhancements
2-Renewal Passive and Manual	15	1 ** Entire overhaul of Passive Renewal Process tentatively planned for February 2021.
3-Change Reporting- New Indicator	10	3
4-SSP Look and Feel	16	
5-NOAs	12	2
6-Documument Management	1	1
7-CSS/IVR		
8-Signatures		
9-Electronic Verification Audit Trail	11	
10-Intake No Touch	12	
11-Reports	22	2

ODM identified functional areas by their impact on eligibility; please see the descriptions below.

1a. Eligibility Rules
- OB uses a 'rules engine' to apply state and federal policy to information individuals supply on the Medicaid application.
- Any defect in the 'rules engine' logic could result in an incorrect eligibility determination by the system.
- Caseworkers must 'override' the incorrect eligibility determination made by the system due to these defects.
- System overrides are time consuming, error prone and have a negative impact on system batch processes.
- Correcting these defects results in accurate eligibility determinations, fewer overrides and more productive batch processing.

1b. Alerts
- OB signals caseworkers of potential changes which may impact an individual's eligibility through automated electronic notifications generated within the system.
- Alert defects include missed or inaccurately timed alerts that may trigger caseworker action that's unnecessary or erroneously applied.
- The current alert design was based on the alert design contained in the legacy system which OB replaced. The alert volume is an identified major concern as caseworkers are unable to manage the workload.
- To address this, ODM and ODJFS meet bi-weekly to review every alert currently generated in Ohio Benefits to determine what information is communicated, how often the alert is generated, whether the alert was customized for Ohio (to determine why it is generated) , and whether there are any state and/or federal mandates for the alert.
  - Analysis began with the alerts representing the highest volume and the most error prone. Those identified were then prioritized for upcoming releases as capacity allowed.
  - ODM and ODJFS continue to meet bi-weekly to analyze the remaining alerts. Once all system alerts are reviewed, the group will present recommendations to the vendor for overall system alert improvements.

1c. Overwrites and View History
- OB should keep a history/audit trail of all actions on the data collection screens.
- Defects in this area prevent auditors from seeing information used in past eligibility determinations.
- Enhancements are required to retain the Federal Data Services Hub ping results and not allow workers to update. Electronic data sources 'pinged' during passive renewal include the Social Security Administration (SSA), Unemployment Compensation (UC), and State Wage Information Collection Agency (SWICA).

2. Renewals (Passive and Manual)
- Defects with passive renewal impact the success rate. Passive renewal is the term used in Ohio to describe renewals on the basis of information available to the agency. States are required to use information within their eligibility systems (previously reported income, etc.) as well as information that's available via electronic data sources to attempt a renewal of Medicaid before reaching out to the individual to request information or verification. Renewals which fall out of passive renewal require manual processing by counties, thus a higher fallout rate results in a higher volume of work for the counties.
- Defects with the renewal dates (RE) impact future renewal batches. Cases that are not updated appropriately by the system may be overlooked in future renewal cycles.
- Eight 'high' defects related to passive renewal are slotted for correction in the November 2020 release. In addition, ODM has collaborated with Kansas to review that state's passive

renewal process, which has a much higher success rate. ODM will pursue enhancements to our passive renewal process based on identified best practices, including the following:

- o Eliminate reverification of Social Security Administration (SSA) income types. The passive renewal process should use the Social Security income on the individual's case, so this reverification is not necessary.
- o Revise calculation for how the income tolerance value is calculated to ensure the reasonable compatibility (RCD) threshold logic is correct and renewals with reasonably compatible income are successfully processed through the passive renewal process.
- o Include additional income types so that the rate of successful passive renewal is increased for individuals in receipt of Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI).

3. Change Reporting
- Individuals can report changes through the self-service portal (SSP). These changes must be processed timely to ensure potential eligibility impacts are processed.
- Defects associated with 'New' indicators impact caseworkers' ability to process changes timely.
- Enhancements are required to provide a 'reject' option for counties for duplicate 'New' indicators (scheduled to be implemented in November 2020).

4. Self-Service Portal
- Individuals can apply for benefits online via the SSP.
- Defects with the SSP impact the ability of individuals to apply for Medicaid and/or impact information being transferred from the SSP to OB. This results in additional work for counties and applicants.

5. Notices of Action (NOAs)
- State and federal regulations require ODM to notify individuals of actions taken on their case.
- Defects with NOAs (i.e. not generating, not containing correct information) results in additional work for counties to generate manual NOAs and could have state hearing impacts for consumers.
- Enhancements are required to update the NOA logic and make changes to the verbiage.

6. Document Management /EDMS
- Documents can be uploaded into OB by consumers via the SSP. All documents should be viewable by the worker.

- Defects in the area may impact the ability to view PDFs within OB. If workers cannot view the document, they need to reach out to the applicant or request verifications, creating more work for the caseworker and duplication by the individual.
- ODM will propose enhancements to address issues with viewing documents.

7. County Shared Services/Interactive Voice Response
- Though not every county utilizes County Shared Services, counties have the option to work on cases across county lines. This can speed up case processing in the event one county falls behind.
- Multiple enhancements are proposed to improve this process for both counties and applicants.

8. Signatures for Renewals
- Counties participating in County Shared Services (CSS) can collect audio signatures for renewal applications. ODM is working with Automated Health Systems (AHS) to allow it to collect audio signatures for non-CSS counties.
- Enhancements are planned to implement a 'combined audio signature' by the end of 2020. This will allow individuals applying for multiple programs to listen to one set of rights and responsibilities instead of separate recordings for each program (Medicaid, Cash, SNAP).

9. Electronic Verification Audit Trail
- Similar to 1c., OB must be able to retain an audit trail for electronic verifications which is viewable for all caseworkers and auditors without vendor intervention.
- Defects in this area result in auditors not being able to see what information was used in past eligibility determinations.
- Enhancements are required to retain all electronic verification records and maintain a viewable history which cannot be changed by a worker.

10. No-Touch Initial Application
- OB should allow for applications to be processed via No-Touch – without additional worker intervention.
- Defects in this area cause applications to 'fall out' and require manual intervention by workers.
- Enhancements are required to improve the No-Touch success rate. Enhancements to the passive renewal process will also have a positive impact on this area.

11. Reporting
- Counties rely on reports pulled from OB to assist them with monitoring and prioritizing their work, i.e. pending applications, outstanding alerts, etc.

- Defects in this area such as inaccurate reports, reports with gaps, reports that time out and won't complete result in counties not being able to get the information they need to manage their work.
- Self Service Reporting (SSR) was implemented in late 2019 which improved the data available to counties. Additional enhancements are required to add additional Medicaid reporting to this tool.

RECOMMENDATION 2 (MEDICAID ELIGIBILITY DETERMINATIONS)

We recommend ODM evaluate the results for the 41 non-compliant customers and reimburse federal Medicaid dollars for errors identified in the sample. We also recommend that ODM address the system issues that contribute to the identified eligibility errors, develop accurate and timely reports that provide necessary data to monitor the work performed by the counties, and improve training for counties; and ODM regularly evaluate selected benefit payments to verify the customer's eligibility, verify the customer information entered in the OB System is accurate, and the information is being maintained to support the eligibility decision.

MANAGEMENT RESPONSE

ODM leadership and program staff take very seriously our responsibility as stewards of every dollar taxpayers contribute to this vital program. Financial oversight; protection against fraud, waste and abuse; and program transparency are paramount to the agency's ability to support Ohioans who rely on Medicaid for their health coverage.

The AOS's selected sample cases are for the time period SFY 2019 (July 1, 2018 – June 30, 2019). ODM reviewed the 41 non-compliant eligibility determinations identified by the state auditor, including the 16 identified as not eligible, and agrees that 12 are either not eligible or lack documentation to determine their eligibility. It should be noted that all of these do not necessarily represent expenses that should not have occurred but, for some, represent only determinations without sufficient documentation available to support an eligibility determination. This also holds true for the extrapolated numbers that the AOS projected as potential program loss.

Director Corcoran's 2019 year-end letter to Governor DeWine recognized that OB allowed overwriting of eligibility data and documentation which eliminates the historical record necessary to prove that member eligibility was proper established.

Additionally, when reviewing previous AOS findings related to eligibility, CMS informed ODM that financial recoveries based on eligibility errors can only be pursued when identified by programs operating under CMS' Payment Error Rate Measurement (PERM) program, under section 1903(u) of the Social Security Act and regulations at 42 CFR Part 431, Subpart Q. Adhering to CMS's direction means ODM will not return the federal share previously claimed for these 41 individuals, unless or until CMS directs ODM otherwise.

It should also be noted that CMS clarified that improper payment rates are not necessarily indicative of or measures of fraud. Instead, improper payments are payments that did not meet statutory, regulatory, administrative, or other legally applicable requirements and may be overpayments or underpayments.

ODM will continue to address the OB system remediation as described in the introduction and is moving forward with the external review of OB as described in the response to Recommendation 1.

ODM's county training and engagement work to address this recommendation includes:
- The Joint New Worker Training Program pilot class began in July 2020. Two classes for the second offering began October 2020. This training program covers system and policy basics on Medicaid, TANF and SNAP and includes both an Ohio Benefits Basics core module and a Case Maintenance (combined programs) core module. In addition, ODM developed a long-term care (LTC) training for new LTC workers which will be full-time instructor led class instruction for a week. The pilot class begins late October 2020.
- The ODM Technical Assistance team has provided a variety of trainings as a result of audit findings since August 2019. These efforts continue and many topics will be repeated annually to accommodate staffing changes at the counties. Topics include income processing, change processing, renewal processing, a variety of long-term care topics, override training and dual eligibility for Medicare recipients.
- ODM created a County Engagement unit in March 2020 which consists of five engagement managers assigned to be the ODM point of contact for about 17 counties each. Engagement managers meet quarterly with all 88 counties to discuss a variety of topics including: identifying any issues or barriers they may be having in determining eligibility, reviewing application/renewal timeliness reports, and discussing any backlogs as well as identifying best practices to be shared. Engagement managers also provide hyper-care support following a training, if requested, to provide 1:1 support with the county. Most engagement managers have contact with all of their counties on a weekly basis.

Additionally, as mentioned above, ODM's MEQC unit worked with ODM ITS to build an online application for reviewers to work in that will allow us to better review and report eligibility error trends internally and to county partners. The MEQC unit started to assist with Medicaid application processing at the start of the public health emergency, but in October started reviewing cases and reporting quarterly to ODM's Technical Assistance Unit regarding errors identified. This work allows ODM and the CDJFSs to analyze error trends and continue to identify system fixes or training needs to address those errors.

RECOMMENDATION 3 (DATA GOVERNANCE STRUCTURE)

We recommend that ODM work with ODAS to emphasize and evaluate a data governance structure, to ensure consistency and reliability.

MANAGEMENT RESPONSE

ODM and DAS agree with the assessment in Recommendation 3 that a more robust data governance structure is needed to enhance Ohio Benefits. The preface to the recommendation highlights some challenges with the Ohio Benefits system, namely that the table structure and the interaction with system interfaces is extremely complex and not well documented. These challenges impact programmatic outcomes, table structures, and ad hoc data requests.

A Technical Data Governance Committee will be created by December 31, 2020, and membership will be comprised of individuals from ODM, DAS, ODJFS and Accenture to ensure the whole system maintains a high level of data integrity and control. This committee will include operational, IT security and infrastructure, and governance officers from each participating agency. One of the first actions of this committee will be to develop Data Governance Goals as well as a RACI chart which will designate which agencies and individuals will be responsible, accountable, consulted, and informed. This committee will meet and do its work, in addition to the regular meeting of the DAS, ODM and ODJFS Department directors and senior deputies that have been meeting since early last year.

RECOMMENDATION 4 (OB SYSTEM ALERTS)

We recommend ODM continue to design and implement appropriate control procedures for monitoring IEVS and non-IVES alerts generated and processed in the OB system to help ensure the counties are completing them properly and timely.

MANAGEMENT RESPONSE

- ODM continues working collaboratively with ODJFS to improve the alert process. To evaluate and redesign alert structure and priority, ODM and ODJFS began meeting bi-weekly in April 2020 to review every alert currently generated in Ohio Benefits to determine the information communicated, the frequency in which the alert is generated, the reasoning or history behind the alert type and the state and regulatory mandates directing the use of the alert. This review prioritized high volume, error-prone alerts and identified those planned for upcoming releases as capacity allowed. ODM and ODJFS continue to meet bi-weekly to analyze the remaining alerts. Once all system alerts are reviewed, the group will present recommendations to the vendor for overall system alert improvements.
- Several system enhancements have been made to improve the visibility of alerts for caseworkers and are referenced above. In R3.6.3 (August 2020) functionality was implemented which modified the Case Summary page (which is typically the first screen accessed by case workers) to include a new Alert and Task Dashboard. This dashboard displays the number of pending and overdue alerts as well as hyperlinks for caseworkers to access. In addition, 17 outstanding defects associated with alert functionality have

been corrected in 2020. New reports for outstanding alerts have been developed and piloted with several counties. ODM is working with DAS to make these reports available to all 88 counties.

- Once the ODM and ODJFS internal review is complete and information known for all alerts, we will engage counties again regarding improvements that can be made to the system for alert functionality. ODM has been in communication with the vendor about this overhaul to begin identifying potential solutions to issues called out by the ODM and ODJFS work groups.

- An outstanding county workgroup enhancement request to remove alerts on closed cases was expanded to automatically clear alerts for denied and discontinued Medicaid blocks and insert a Journal entry (information associated with the alert remains, the alert is just cleared). This functionality was implemented in R3.6.3 (August 2020).

- ODM and ODJFS are evaluating the feasibility of enhancing Ohio Benefits to force alerts to be worked before a caseworker runs EDBC. Many of the alerts are shared between public benefits programs but, for certain programs, may only require follow-up rather than review before approving eligibility. The ODM and ODJFS workgroup will assess what system enhancements can be made to achieve this goal while remaining compliant with CMS, FNS, OAC and ORC regulations.

- Once these changes have been identified, ODM and ODJFS will pursue the needed enhancements.

RECOMMENDATION 5 (TRAINING RESOURCES)

We recommend that ODM enhance its methods to train county staff on the OB system by better organizing information on the Ohio Benefits project website.

MANAGEMENT RESPONSE

The project website is vendor owned. However, ODM reviews desk aids that the vendor creates or revises. Because of the interest we have in ensuring optimum user performance, ODM will work with counties to obtain feedback and recommendations for site improvements. The new Technical Data Governance Committee will be helpful to facilitate this work.

In addition, the county agencies have access to the Medicaid Resources page on the ODJFS Innerweb - site not accessible by the public. The Medicaid Resources page includes ODM-created desk aids and training materials for all Medicaid categories. Materials on this page are specific to Medicaid policy and procedures and this page is maintained by ODM staff.

RECOMMENDATION 6 (COUNTY MODELS)

We recommend that after addressing system issues, alerts, training and data governance, ODM should conduct a formal program evaluation to identify best practices regarding the models used by the counties to administer Medicaid eligibility.

MANAGEMENT RESPONSE

Ohio is committed to improving its eligibility processing system, including addressing system issues, alerts, training, and data governance. Many of the steps Ohio is taking are described in the responses to Recommendations One through Five in this report. However, Ohio will need a substantial amount of time to solve these problems, given their scale and competing priorities, including a public health emergency.

As a result, we believe it is premature to introduce a formal program evaluation of county best practices. That said, ODM will continue dialogue with CDJFS leadership and practices currently implemented to identify and share best practices with CDJFSs as part of the agency's regular support and outreach efforts. As this work continues, it may make a formal program evaluation less necessary once the previous eligibility system challenges are addressed.

As described above, ODM is contracting for an external review of the OB system. The RFP was posted in September 2020 and upon completion of the procurement process, the awarded vendor will be onboarded with tentative project timeline of March 2021 – June 2022. During the project time period, recurring meetings will be held with the vendor, ODM, ODJFS and DAS and the vendor will provide reports related to the assessment and its findings. This information will be used to determine the stability, gaps and proposed improvements of the system.

In addition to the external review of OB, ODM will continue to support county best practices through its training and county engagement work. This includes:

- The Joint New Worker Training Program pilot class began in July 2020. Two classes for the second offering began October 2020. This training program covers system and policy basics of Medicaid, TANF and SNAP and includes both an Ohio Benefits Basics core module and a Case Maintenance (combined programs) core module. In addition, ODM developed a long-term care training for new LTC workers which will be full-time instructor led class instruction for a week. The pilot class begins in October 2020.
- The ODM Technical Assistance team has provided a variety of trainings as a result of audit findings since August 2019. These efforts continue and many topics will be repeated annually to accommodate staffing changes at the counties. Topics include income processing, change processing, renewal processing, a variety of long-term care topics, override training and dual eligibility for Medicare recipients.
- ODM created a County Engagement unit in March 2020 which consists of five engagement managers assigned to be the ODM point of contact for about 17 counties each. Engagement managers meet quarterly with all 88 counties to discuss a variety of topics

including: identifying any issues or barriers they may be having in determining eligibility, reviewing application/renewal timeliness reports, and discussing any backlogs as well as identifying best practices to be shared. Most engagement managers have contact with all of their counties on a weekly basis.

- On May 21, 2019, ODM started an initiative with counties that had the highest number of past due applications. Weekly phone calls were held with the specified counties to identify ways to reduce the counties' application backlogs and to troubleshoot applications that had system issues or outstanding policy questions. Additionally, all counties were sent reports each week that identified past due applications that remained pending in their counties. Phone calls with counties continued through February 2020 and weekly reports identifying backlog applications continue to be sent to counties today. This initiative resulted in a significant improvement in Ohio's application timeliness.

- On March 2, 2020, ODM changed the focus of its efforts from pending applications to pending renewals and started a new initiative with counties that had the highest number of past due renewals. Weekly phone calls were held with the specified counties to identify ways to reduce the counties' renewal backlogs and to troubleshoot cases that had system issues or outstanding policy questions. In addition to the weekly report that all counties received with their application backlogs, they were also sent reports each week that identified past due renewals in their counties. Due to the COVID-19 public health emergency, weekly phone calls with counties regarding renewals were suspended from April 2020 through September 2020 as renewal processing had been suspended. Weekly reports continued to be sent and the full effort has resumed October 2020.

- ODM's Central Processing Unit is reviewing the oldest pending applications to identify next steps to complete the eligibility determination. This information is shared with the county to aid in processing.

ODM will continue this work to support the counties while it makes the system and process improvements recommended by the Auditor of State and discussed here. When that work is further along, ODM will determine whether a formal program evaluation to address county best practices is necessary or helpful.

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

Sincerely,

Maureen M. Corcoran, Director

Title	Description	Date(s)		Type
PARIS Alerts Processing (future)	Training on the types of PARIS alerts received, follow up alerts, how to research and resolve	11/9/2020		Webinar
ABD Case Processing plus Processing Guide	Training on ABD case processing including policy references and system guidance	8/31/2020	10/6/2020	Webinar
Qualified Income Trust Basics	Policy training on QITs for long-term care	9/10/2019		Webinar
Alerts and eVerify Interface	Alerts, their meaning and how to resolve and processing eVerify matches	6/6/2019		Webinar
MAGI Case Processing	Training on MAGI case processing, including policy references and system guidance	8/28/2020	10/5/2020	Webinar
Renewal Processing	Review of the renewal process, processing paper, phone and SSP applications, tips and tricks	10/26/2020		Webinar
Returned Mail Processing (future)	Training on how to process returned mail with or without a forwarding address	11/16/2020		Webinar
Zero Income	How to process a case when someone reports having zero income. Includes prolicy and system information	2/5/2020		Monthly Video Conference
CHIP Child versus MAGI Child	Understanding the difference between the two and how third party liability affects it	3/4/2020		Monthly Video Conference
EDMS Scanning and Indexing Tips	Instruction on proper scanning and indexing of documents in the electronic data management system	8/5/2020		Monthly Video Conference
Trusts	Various types of trusts and how Medicaid policy looks at them. How to enter into the system.	10/20/2019		Webinar
Long-Term Care Changes, Part 1	Processing various changes that affect long-term care cases	12/10/2019		Webinar
Long-Term Care Changes, Part 2	A continuation of processing various changes that affect long-term care cases	1/28/2020		Webinar
Processing Unpaid Past Medical Bills	Policy and system guidance on how to process unpaid past medical bills for use in long-term care share of cost budgets	11/25/2019		Webinar
Processing Applications for Instittionalized Children	How to process an application for a child applying for waiver or in an institution	3/28/2019		Webinar

RSS Refresher	A refresher for all case workers on the RSS program with system and policy guidance	10/23/2019		Webinar
SRS Basics and Refresher	A refresher on the Specialized Recovery Services Program policy and system guidance	8/23/2019		Webinar
Authorized Representatives, Power of Attorneys and Guardians	The differences and considerations around these three types of designations	7/10/2019		Webinar
Alert Processing Training (future)	Alerts broken down in groups - description of the alert, how to process and resolve. Includes system and policy guidance	3/2021, 6/2021 and 9/2021		Webinar
MAGI New Worker Training (completed quarterly - began in 2018)	Policy training for new workers on MAGI Medicaid household formation, budgeting, tax filing status, etc.	3/2/2020	6/22/2020	Webinar
ABD New Worker Training (completed quarterly - began in 2018)	Policy training for new workers on ABD Medicaid including budgeting, resource tests and household formation	3/4/2020	6/23/2020	Webinar
Resources for New Workers (completed quarterly - began in 2018)	Policy training for new workers on applying resources properly for Medicaid programs with a resource test	3/5/2020	6/23/2020	Webinar
Long-Term Care Financiel for New Workers (completed quarterly - began in 2018)	Policy training for new workers on financial/income/budgeting guidance as it applies to institutionalization	3/9/2020	6/24/2020	Webinar
Long-Term Care Community Spouse Resource Assessment for New Workers (completed quarterly - began in 2018)	Policy training on how to complete a spousal resource assessment when exploring eligibility for long-term care (waiver and facility)	3/11/2020	6/25/2020	Webinar
Long-Term Care Post-Eligibility Treatment of Income for New Workers (completed quarterly - began in 2018)	Policy training on how to calculate a share of cost for institutionalized individuals	3/13/2020	6/26/2020	Webinar
Long-Term Care New Worker Training (system and policy)	Integrated system and policy training which includes required pre-requisites and a one-week instructor led classroom training (currently conducted virtually)	Completed pilot class 10/30/2020	TBD	Instructor Led

New Worker Training OB Basics (joint with JFS)	Integrated system and policy training which includes required pre-requisites and a one-week instructor led classroom training (currently conducted virtually). Entire course includes SNAP and TANF as well and **takes 12 weeks to complete**.	Completed pilot class 09/22/2020	Two classes began 10/20/2020 and 10/27/2020	Instructor Led
New Worker Training MAGI (joint with JFS)	Integrated system and policy training which includes required pre-requisites and a one-week instructor led classroom training (currently conducted virtually). Entire course includes SNAP and TANF as well and takes **12 weeks to complete.**	Completed pilot class 09/22/2020	Two classes began 10/20/2020 and 10/27/2020	Instructor Led
New Worker Training ABD (joint with JFS)	Integrated system and policy training which includes required pre-requisites and a one-week instructor led classroom training (currently conducted virtually). Entire course includes SNAP and TANF as well and takes 12 weeks to complete.	Completed pilot class 09/22/2020	Two classes began 10/20/2020 and 10/27/2020	Instructor Led
New Worker Training Case Maintenance (joint with JFS)	Integrated system and policy training which includes required pre-requisites and a one-week instructor led classroom training (currently conducted virtually). Entire course includes SNAP and TANF as well and takes **12 weeks to complete.**	Completed pilot class 09/22/2020	Two classes began 10/20/2020 and 10/27/2020	Instructor Led
County Reports from ODM	Review of various reports counties may receive from ODM, why they receive them, what they can do to prevent receiving them and how to resolve them when they do receive them	8/24/2020		Webinar
SSI Auto Enrollment Process	Instruction on the SSI auto enrollment process	3/4/2020		Webinar
Eligibility Overrides	Proper reasons to complete overrides in the system, common errors	3/4/2020		Webinar
MIA Hardship	When and how to grant a hardship on the maintance income allowance when processing long-term care cases for individuals with a spouse	3/4/2020		Webinar

Renewal Reports	Review of renewal reports available to counties and how to use them	3/4/2020		Webinar
Processing Renewals during COVID	Reminders on how to process renewals with consideration given to the requirements during the public health emergency	9/4/2020		Webinar
Presumptive Eligibility Fallout	Training on a system enhancement to prevent Qualified Entities from creating duplicate individuals but requires worker intervention	10/7/2020		Webinar
Non Citizenship versus AEMA Eligibility	Explaining the differences between eligibility an individual may have as a legal non-citizen or through AEMA eligibility, how to process in the system and the accompanying policy	10/7/2020		Webinar
Properly Removing RMCP	System training on how to process a restricted Medicaid penalty period once one was completed but determined incorrect	10/7/2020		Webinar
Signature Requirement for Medicaid Renewals (new)	Training on the upcoming change to policy requiring signatures at renewal	11/4/2020		Webinar
Processing Applications	Special considerations for how to process applications when an individual is ineligible in the application month but eligible ongoing	11/4/2020		Webinar
Small Bites: Researching the OAC	Shortened recorded training on researching the OAC to properly research medicaid eligibility policy	1/1/2020		Webinar
Small Bites: Medicaid for Former Foster Care Children	Shortened recorded training on how to properly determine eligibility (system and policy) for former foster care youth	1/1/2020		Webinar
Small Bites: Transitional Medicaid Assistance	Shortened recorded training on TMA eligibility	1/1/2020		Webinar
Small Bites: MAGI Households	Shortened recorded training on forming correct MAGI Medicaid households	1/1/2020		Webinar

Small Bites: MPAP versus Buy-in	Policy and system information on the differences and similarities between Medicare Premium Assistance Programs and the State Buy-in Program	1/1/2020		Webinar

This page intentionally left blank.

OHIO AUDITOR OF STATE
KEITH FABER

OHIO'S MEDICAID ELIGIBILITY DETERMINATION PROCESS

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 11/19/2020