Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OHIO GENERALLY COMPLETED MEDICAID ELIGIBILITY ACTIONS DURING THE UNWINDING PERIOD IN ACCORDANCE WITH FEDERAL AND STATE REQUIREMENTS

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Inspector General

April 2024
A-05-23-00019

Office of Inspector General

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REPORT HIGHLIGHTS

April 2024 | A-05-23-00019

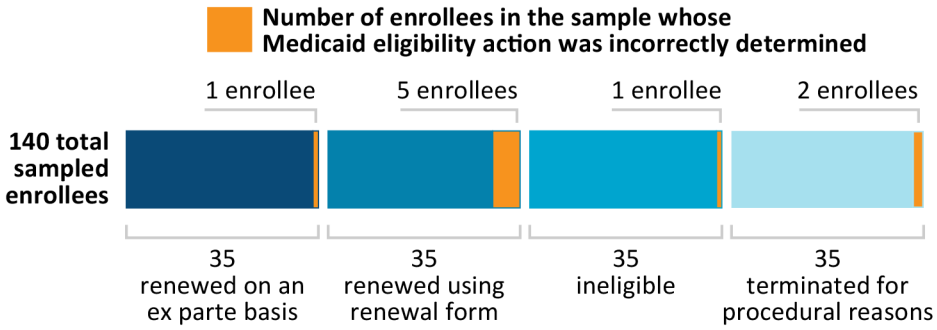
Ohio Generally Completed Medicaid Eligibility Actions During the Unwinding Period in Accordance With Federal and State Requirements

Why OIG Did This Audit

- In March 2020, Congress enacted the Families First Coronavirus Response Act in response to the COVID-19 public health emergency, which required States to ensure most individuals were continuously enrolled for Medicaid benefits (enrollees).
- The Consolidated Appropriations Act, 2023, ended the continuous enrollment condition. As a result, States had to conduct renewals, post-enrollment verifications, and redeterminations (Medicaid eligibility actions) for all enrollees, including disenrolling individuals who were no longer eligible.
- This audit is part of a series that examined whether Ohio completed Medicaid eligibility actions during its unwinding period in accordance with Federal and State requirements.

What OIG Found

Of the 1,211,991 enrollees covered under our audit period (April 1 through August 31, 2023), we sampled 140 enrollees and determined that 9 enrollees had their Medicaid enrollment incorrectly determined.



On the basis of our sample results, we estimated that Ohio either incorrectly renewed or terminated Medicaid eligibility for 78,486 of the 1,211,991 Medicaid enrollees during our audit period.

What OIG Recommends

We recommend that Ohio:

1. take appropriate action with respect to the incorrect Medicaid eligibility determinations identified in our sample,
2. provide periodic training to caseworkers about verifying and documenting enrollees' income during the renewal process, and
3. provide additional training to caseworkers about using current information when conducting enrollee eligibility determinations.

Ohio concurred with all our recommendations and described actions that it has taken or plans to take in response to our recommendations.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS AUDIT

On January 31, 2020, the Department of Health and Human Services (HHS) declared a public health emergency (PHE) for COVID-19.[1] In March 2020, Congress enacted the Families First Coronavirus Response Act (FFCRA) in response to the PHE.[2] The FFCRA provided States with a temporary increase of 6.2 percentage points to their regular Federal medical assistance percentage (FMAP) rates. To receive the increased FMAP, the FFCRA required, among other conditions, States to ensure that most individuals who were enrolled for Medicaid benefits (enrollees) as of or after March 18, 2020, were continuously enrolled through the end of the month in which the PHE ended (continuous enrollment condition). These enrollees should have remained enrolled for Medicaid, unless the enrollee requested a voluntary termination of eligibility, ceased to be a resident of the State, or died.

The Consolidated Appropriations Act, 2023 (CAA) amended the expiration of the continuous enrollment condition to March 31, 2023.[3] As a result, States had to conduct renewals, post-enrollment verifications, and redeterminations (Medicaid eligibility actions) for all enrollees. In accordance with guidance issued by the Centers for Medicare & Medicaid Services (CMS), States have up to 12 months to initiate and an additional 2 months to complete Medicaid eligibility actions for all enrollees (unwinding period). States were able to begin their unwinding period as early as February 1, 2023, and could begin terminating Medicaid enrollment on or after April 1, 2023, for individuals who were no longer eligible.[4]

The COVID-19 pandemic created extraordinary challenges for the delivery of health care and human services to the American people. As the oversight agency for HHS, the Office of Inspector General (OIG) oversees HHS's COVID-19 response and recovery efforts. This audit is part of OIG's COVID-19 response strategic plan.[5] This audit of the Ohio Department of Medicaid (State agency) is one in a series of reports related to States' unwinding periods.

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[1] Administration for Strategic Preparedness & Response, "Determination That A Public Health Emergency Exists." Available online at https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx. Accessed on Feb. 12, 2024. (The PHE ended on May 11, 2023.)

[2] The Families First Coronavirus Response Act (P.L. No. 116-127) (Mar. 18, 2020).

[3] Division FF, section 5131, Consolidated Appropriations Act (P.L. No. 117-328) (Dec. 29, 2022).

[4] CMS State Health Official (SHO) Letter No. 23-002 (issued on Jan. 27, 2023).

[5] OIG's COVID-19 response strategic plan and oversight activities can be accessed at HHS-OIG's Oversight of COVID-19 Response and Recovery | HHS-OIG.

OBJECTIVE

Our objective was to determine whether the State agency completed Medicaid eligibility actions in accordance with Federal and State requirements during its unwinding period following the end of the continuous enrollment condition.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). The Federal and State governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although each State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Federal Government pays its share of a State's medical assistance costs based on the FMAP, which varies depending on the State's per capita income.[6] Although FMAPs are adjusted annually for economic changes in the States, Congress may increase or decrease FMAPs at any time.

Federal Requirements and CMS Guidance Related to the Continuous Enrollment Condition and the Unwinding Period

In March 2020, Congress enacted the FFCRA in response to the COVID-19 PHE. Section 6008 of the FFCRA provided a temporary increase of 6.2 percentage points to each qualifying State's FMAP effective January 1, 2020. To qualify for the increased COVID-19 FMAP, States were required to ensure that most individuals who were enrolled for Medicaid benefits as of or after March 18, 2020, were continuously enrolled through the end of the month in which the PHE ended.

Title 42, section 433.400(d) of the Code of Federal Regulations (CFR), effective November 2, 2020, interprets and implements FFCRA section 6008(b)(3). The CFR outlines exceptions to the continuous enrollment condition requirement. A State could terminate an enrollee's Medicaid enrollment during the PHE if:

- the enrollee or the enrollee's representative requests a voluntary termination of eligibility,

[6] The Act § 1905(b).

- the enrollee ceases to be a resident of the State, or

- the enrollee dies.

The CAA, enacted on December 29, 2022, included significant changes to the FFCRA's continuous enrollment condition. The CAA addresses the end of the continuous enrollment condition, the phase down and end of the temporary FMAP increase, and the unwinding process. Under section 5131 of the CAA, the end of the continuous enrollment condition and receipt of the temporary FMAP increase are no longer linked to the end of the PHE. The CAA amended section 6008(b)(3) of the FFCRA to end, on March 31, 2023, continuous Medicaid enrollment as a condition for claiming the temporary FMAP increase. Further, the FFCRA's temporary FMAP increase gradually phased down beginning April 1, 2023, and ended on December 31, 2023. The CAA required States to initiate all eligibility actions for all enrollees when the continuous enrollment condition ended.

In accordance with CMS issued guidance, in preparation for and at the end of the continuous enrollment condition:

- States could begin their unwinding period as early as February 1, 2023, but were required to begin initiating eligibility actions no later than April 30, 2023.

- For States that initiated renewals prior to April 1, 2023, terminations of Medicaid eligibility could not be effective earlier than April 1, 2023.

- States must initiate renewals for all individuals enrolled in Medicaid within 12 months of the beginning of the State's unwinding period and must complete renewals for all individuals within 14 months of the beginning of the State's unwinding period.[7]

Monthly Reporting Requirements for States During the Unwinding Period

In March 2022, CMS announced that States would be expected to submit data demonstrating progress in completing the required eligibility and enrollment actions during the unwinding period.[8] Subsequently, the CAA required States to report and CMS to publicly report on a broad set of metrics, including some of the specific metrics described in CMS's monthly *Unwinding Eligibility and Enrollment Data Reporting Template* (unwinding data report).[9, 10] These metrics in the monthly unwinding data reports are designed to demonstrate the State's

[7] SHO Letter No. 23-002.

[8] SHO Letter No. 22-001.

[9] Division FF, section 5131(b), Consolidated Appropriations Act (P.L. No. 117-328) (Dec. 29, 2022).

[10] As of Dec. 6, 2023, this process is further outlined under 42 CFR § 435.927 and 42 CFR § 435.928.

progress toward restoring timely application processing and initiating and completing renewals of eligibility for all Medicaid and Children's Health Insurance Program (CHIP) enrollees. The categories of metrics that are reported monthly by the States are:

- application processing (i.e., pending applications that were received during the continuous enrollment condition),
- renewals initiated,
- renewals and outcomes, and
- Medicaid fair hearings.

States must report on the number of applications processed and pending, renewals initiated, renewals and outcomes, and Medicaid fair hearings in the unwinding data reports. This audit focuses on the renewals of enrollees and the outcomes in the April through August 2023 reporting periods. The renewals and outcomes are defined as follows:

- enrollees renewed and retained, which includes:
    - enrollees renewed on an ex parte basis[11] and
    - enrollees renewed using a renewal form;
- enrollees determined to be ineligible; and
- enrollees terminated for procedural reasons (i.e., failure to respond).

Ohio's Medicaid Program

The State agency provides health care coverage to more than 3 million Ohio enrollees through a network of more than 165,000 providers. The State agency is responsible for the administration and oversight of the Medicaid program in Ohio. The State agency uses County Departments of Job and Family Services (County agencies) caseworkers to review Medicaid applications and make Medicaid program eligibility determinations. Ohio Benefits is the statewide eligibility determination system the State agency utilizes to process renewals for enrollees.[12] Additionally, the State agency uses the Electronic Document Management System (EDMS) as a central repository to store documentation supporting Medicaid eligibility. EDMS allows the State agency staff and caseworkers to view enrollees' documentation online. The

[11] An ex parte renewal is any renewal that is completed without contacting the enrollee for information or verification (42 CFR § 435.916(a)(2)). The State agency refers to ex parte renewals as "passive" (i.e., completed all electronically) or "manual" (i.e., involving some caseworker intervention).

[12] Ohio Benefits is also referred to as the Ohio Integrated Eligibility System.

Ohio Administrative Code (OAC) describes the eligibility criteria that apply to Ohio's Medicaid program.[13]

State Agency Oversight of County Operations During the Unwinding Period

The State agency has four divisions that monitor, support, and ensure County agencies' compliance in handling eligibility applications and renewals. According to Ohio's *Medicaid Plan For Resuming Normal Operations* (published on February 23, 2023) and in preparation for the end of the unwinding period, the State agency took several steps to ensure that renewal determinations for enrollees were conducted timely and accurately, including:

- improved automation of processing of eligibility renewals using an ex parte process,
- enhanced oversight of the County agencies and processing of cases by the State agency,
- financial incentives for counties to manage assigned caseloads within required time frames,
- enhanced monitoring of county performance against the timeliness standards, and
- State agency intervention and penalties for any county failing to meet performance standards.

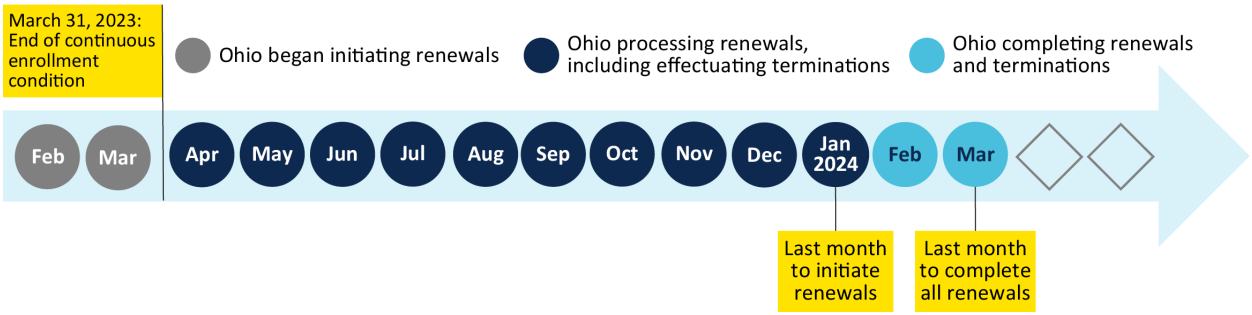
State Agency's Unwinding Process for Renewing Medicaid Eligibility

The State agency began initiating unwinding-related renewals in February 2023, 2 months prior to the end of the continuous enrollment condition. In April 2023, the State agency began processing renewals, including terminations of eligibility. The State agency had until January 2024 to initiate all renewals and an additional 2 months to complete renewals during the unwinding period, ending March 2024.

Figure 1 illustrates the State agency's renewal process timeline during its 14-month unwinding period.

[13] OAC 5160:1.

Figure 1: Ohio's Unwinding Timeline



Ohio Benefits is designed to begin processing renewals 2 months in advance of a renewal due date. A renewal is considered initiated when the State agency begins the passive ex parte process.

To verify the accuracy of enrollees' eligibility information during the passive ex parte process, Ohio Benefits uses multiple electronic data sources, including sources available through the State Wage Information Collection Agency (SWICA), State Unemployment Compensation (UC), and Federal Data Services Hub (Data Hub). The Social Security Administration (SSA) and Department of Homeland Security, among others, provide the data sources available through the Data Hub.[14]

Ohio Benefits sends an electronic request to the Data Hub for each eligibility factor requiring verification. The Data Hub provides an electronic response to Ohio Benefits indicating whether the data match was successful. If Ohio Benefits is able to electronically verify the information, then the enrollee's eligibility can be renewed on a passive ex parte basis.

According to the State agency's internal processes during the unwinding period, if an enrollee's eligibility cannot be renewed using the passive ex parte process, the State agency will send the enrollee a prepopulated renewal form. Outside of Ohio Benefits, the enrollee's record will be compared to third-party external data sources using the Public Consulting Group's (PCG's) Instant Eligibility Verification System (IEVS).[15] The automated eligibility check will result in an IEVS report that lists the enrollee's potential eligibility status for various categories, including income, residency, and household composition. The information from IEVS is considered verified if the effect on the enrollee's eligibility is neutral (no change) or positive. For example, if the enrollee's income listed on the IEVS report is less than or equal to the income in Ohio

[14] States are required to request financial information from other agencies, such as SWICA, SNAP, SSA, and UC, to the extent the agency determines such information is useful for verifying the financial eligibility of an individual (42 CFR § 435.948). Additionally, the State agency received waiver authority from CMS under section 1902(e)(14)(A) of the Act to renew Medicaid eligibility during the unwinding period for individuals receiving SNAP benefits without conducting a separate MAGI-based income determination (effective July 1, 2022).

[15] The State agency contracted with PCG to conduct third-party data matching against multiple data sources to evaluate enrollees' potential eligibility status.

Benefits, the income is considered verified. If the information from IEVS will negatively impact the enrollee's eligibility, the caseworker must verify that information before a Medicaid eligibility action can occur.

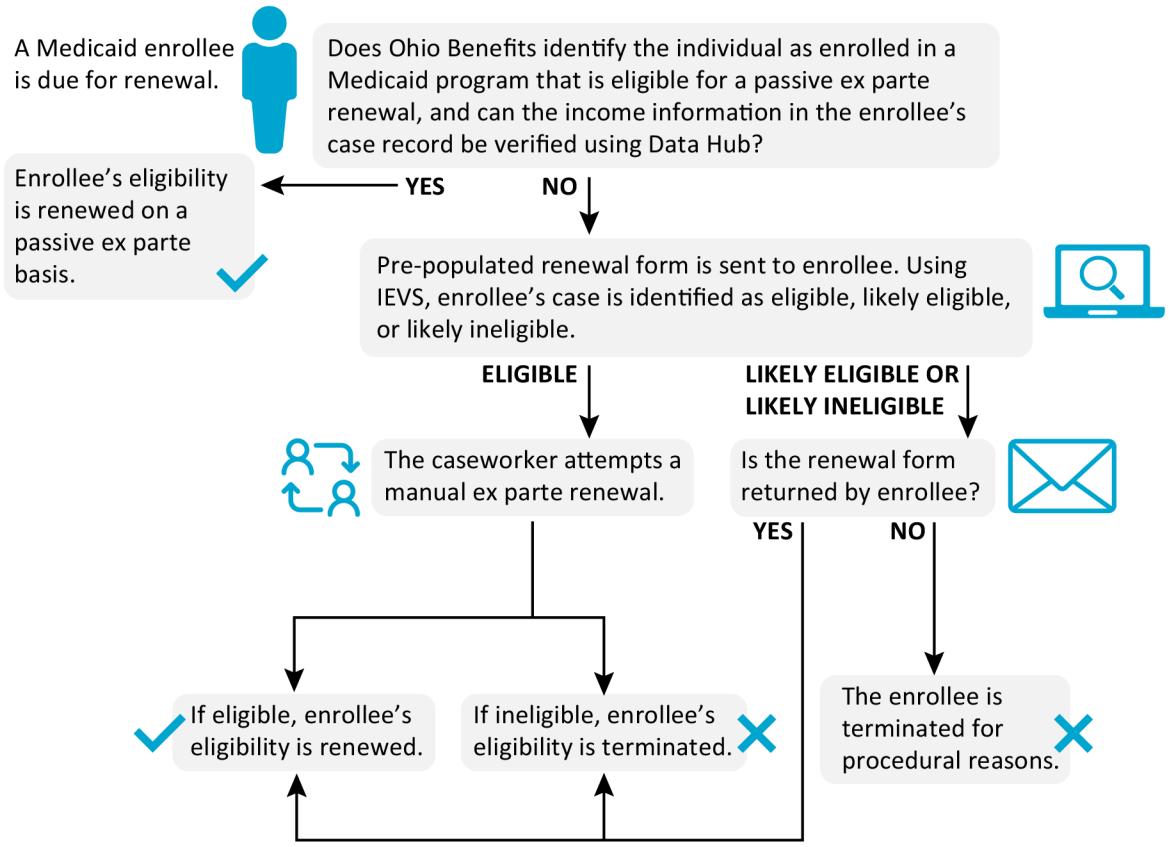
The IEVS report identifies the enrollee's potential eligibility status. The outcome designations are "eligible," "likely eligible," or "likely ineligible."[16] If the IEVS designation is eligible and the IEVS information is comparable to information in Ohio Benefits, then the caseworker can process the renewal using a manual ex parte process (i.e., without contacting the enrollee). If the enrollee cannot be renewed using manual ex parte process, the renewal is completed using the information provided by the enrollee (i.e., returned renewal form, pay stubs, or bank records). If the enrollee returns the renewal form, including any supporting documentation, the caseworker processes the renewal using the returned information along with the IEVS information and other electronic verifications to determine whether the enrollee is eligible. If the renewal form is received as returned mail,[17] the caseworker contacts the enrollee using two different modalities of communication in an attempt to obtain updated information from the enrollee prior to discontinuance of eligibility. The permissible methods of communication include mail, telephone, and email. If no response is received, the caseworker may terminate the enrollee's eligibility.

Figure 2 illustrates the State agency's renewal process for enrollees during the unwinding period.

[16] The designation of "likely eligible" was added to IEVS in August 2023.

[17] Returned mail may include returned with no forwarding address, a forwarding address, or an out-of-State forwarding address.

Figure 2: Ohio's Medicaid Eligibility Process During Unwinding



HOW WE CONDUCTED THIS AUDIT

Our audit covered 1,211,991 enrollees[18] listed on Ohio's monthly unwinding data reports who had their Medicaid enrollment either renewed or terminated during April 1 through August 31, 2023 (audit period),[19] following the end of the continuous enrollment condition. Of the 1,211,991 enrollees whose Medicaid enrollment was either renewed or terminated, we identified:

- 575,568 enrollees whose enrollment was renewed on an ex parte basis,[20]
- 326,768 enrollees whose enrollment was renewed using a renewal form,[21]

[18] This audit excludes CHIP enrollees.

[19] Our period covered the monthly unwinding data reports that were available when we began audit fieldwork.

[20] The State agency only reports "passive" ex parte renewals in the ex parte renewal outcome category on the unwinding data reports.

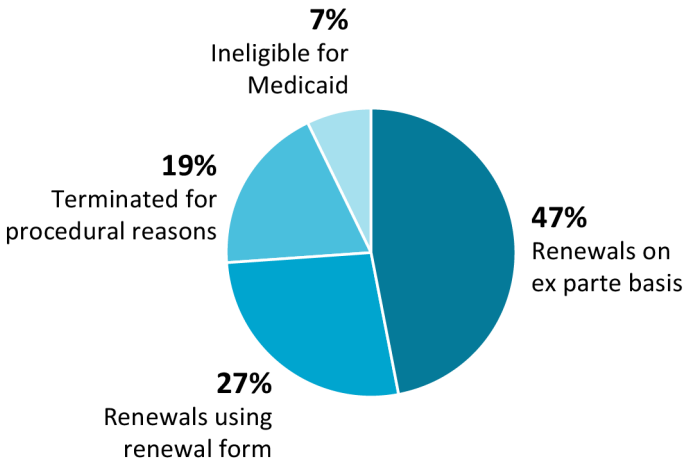
[21] The State agency reports "manual" ex parte renewals in the renewal form outcome category.

- 81,692 enrollees who were determined to be ineligible for Medicaid, and

- 227,963 enrollees whose enrollment was terminated for procedural reasons (i.e., failure to respond).

See Figure 3 for the percentage of Medicaid eligibility actions taken by the State agency for enrollees during our audit period.

Figure 3: Medicaid Eligibility Actions Taken by the State Agency for Ohio Enrollees Following the End of the Continuous Enrollment Condition (April Through August 2023)



We reviewed the documentation in Ohio Benefits and EDMS for the Medicaid eligibility actions made by the State agency for a stratified random sample of 140 enrollees:

- 35 enrollees who were listed on the unwinding data reports as renewed on an ex parte basis,

- 35 enrollees who were listed on the unwinding data reports as renewed using a renewal form,

- 35 enrollees who were listed on the unwinding data reports as ineligible for Medicaid, and

- 35 enrollees who were listed on the unwinding data reports as terminated for procedural reasons (i.e., failure to respond).

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, and Appendix B contains the details of our statistical sampling methodology.

FINDINGS

The State agency generally completed Medicaid eligibility actions in accordance with Federal and State requirements during the unwinding period following the end of the continuous enrollment condition. Of the 140 sampled enrollees, we determined that 9 enrollees had their Medicaid enrollment either incorrectly renewed or terminated during our audit period. Specifically, we determined the following:

- Of the 35 enrollees listed on the unwinding data reports as renewed on an ex parte basis, the Medicaid eligibility action was incorrectly determined for 1 enrollee.

- Of the 35 enrollees listed on the unwinding data reports as renewed using a renewal form, the Medicaid eligibility actions were incorrectly determined for 5 enrollees.

- Of the 35 enrollees listed on the unwinding data reports as ineligible, the Medicaid eligibility action was incorrectly determined for 1 enrollee.

- Of the 35 enrollees listed on the unwinding data reports as terminated for procedural reasons, the Medicaid eligibility actions were incorrectly determined for 2 enrollees.

Additionally, we identified errors that caseworkers made during the redetermination process that did not affect enrollees' eligibility determinations, including incorrect manual income calculations, income that was incorrectly included or excluded from total income, and not acting on a Public Assistance Reporting Information System (PARIS) Interstate Match alert.[22] Although these errors did not affect eligibility determinations, similar errors could potentially cause Medicaid eligibility actions to result in improper renewals or improper terminations for other enrollees.

These deficiencies occurred because caseworkers failed to use information that was available, made mistakes while completing manual income calculations, or did not follow internal policies and procedures. As a result, the State agency could not always be assured that Medicaid eligibility actions taken by caseworkers were completed in accordance with Federal and State requirements and certain enrollees' eligibility was incorrectly renewed or terminated during the unwinding period following the end of the continuous enrollment condition.

[22] A PARIS Interstate Match alerts States when they may be making payments on behalf of enrollees with concurrent enrollment in another State.

On the basis of our sample results, we estimated that the State agency either incorrectly renewed or terminated Medicaid eligibility for 78,486 of the 1,211,991 enrollees during our audit period.[23] We estimated that eligibility for 63,126 enrollees was incorrectly renewed on an ex parte basis or incorrectly renewed using a renewal form.[24] We have chosen not to report the estimates of incorrect terminations because of the low number of enrollees in our sample who were incorrectly determined to be ineligible or incorrectly terminated for procedural reasons.

Appendix C contains our sample results and estimates.

RENEWALS OF MEDICAID ELIGIBILITY ON AN EX PARTE BASIS

In accordance with Federal and State requirements, the State agency must make a redetermination of Medicaid eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency.[25] During the unwinding period, a renewal is considered initiated when the State begins the renewal process by attempting to renew eligibility on an ex parte basis. If Ohio Benefits can electronically verify the enrollee's eligibility information with the Data Hub, then the enrollee's eligibility can be renewed on a passive ex parte basis. When eligibility cannot be renewed on an ex parte basis, then the State must request information from the enrollee.[26]

Of the 35 enrollees listed on the unwinding data reports as renewed on an ex parte basis, eligibility for 34 enrollees was correctly renewed. However, the State agency incorrectly determined eligibility for one enrollee. Specifically, we found that the State agency did not consider updated income reported by the enrollee. This action was not in accordance with Federal and State requirements, and related processes in place during the unwinding period.

The following examples describe enrollees whose eligibility was renewed on an ex parte basis.

Example 1:
Enrollee whose eligibility was correctly renewed on an ex parte basis.

For an enrollee in our sample (8-year-old child), the State agency listed the individual on the July 2023 unwinding data report as having their eligibility renewed. In May 2023, the individual's renewal was initiated through the ex parte process. For the ex parte renewal, the State agency processed the renewal

[23] The lower and upper limit at the 90-percent confidence level is 33,660 and 123,313, respectively.

[24] The lower and upper limit at the 90-percent confidence level is 21,032 and 105,220, respectively.

[25] 42 CFR § 435.916(a)(2). See also the process for verifying financial information under OAC 5160:1-2-10(B)(8)(a).

[26] 42 CFR § 435.916(a)(3). OAC 5160:1-2-01(H).

using the income data in the case record indicating that the child's parent had no income. This information was also substantiated through a letter from a prior employer that the parent submitted to the caseworker in March 2023, indicating that the prior employment had ended.

Example 2:
Enrollee whose eligibility was incorrectly renewed on an ex parte basis because the individual was over the income limit.

For an enrollee in our sample (adult), the State agency listed the individual on the July 2023 unwinding data report as having their eligibility renewed. In May 2023, the individual's renewal was initiated through the ex parte process. For the ex parte renewal, the State agency processed the renewal using income data in the case record that was previously verified in 2021 and indicated a monthly income of $1,814. Determining eligibility using the 2021 income data would have made the enrollee eligible for Medicaid coverage. However, the enrollee reported updated income in May 2023, prior to the completion of the ex parte renewal. On a Supplemental Nutrition Assistance Program (SNAP) application, the individual stated they worked 40 hours a week at $18.25 an hour, for a total of $3,139 per month. The income limit for the enrollee's household size was $2,186 per month. Had the caseworker input the self-reported income from the SNAP application, the enrollee would have exceeded the income limit and should not have been renewed prior to income verification.

RENEWALS OF MEDICAID ELIGIBILITY USING A RENEWAL FORM

When an enrollee's eligibility cannot be renewed using a passive ex parte renewal, the enrollee's information must be verified with other electronic sources through the manual ex parte process, or directly with the enrollee using a prepopulated renewal form.[27] According to the State agency's internal processes during the unwinding period, after the State agency sends an enrollee the renewal form, the enrollee may renew their eligibility by completing the renewal form, by contacting their caseworker by telephone or in person, or by using Ohio Benefits' online self-service portal. Caseworkers are responsible for documenting the latest information reported by the enrollee in their case record, including additional information reported by the enrollee based on followup requests, such as pay stubs or employment verification. Caseworkers are also able to access a database of income and employment data from employers across various industries to verify income and employment. Additionally, in the enrollee's case record, caseworkers must document current household living arrangements that could affect their eligibility.[28]

[27] 42 CFR § 435.916(a)(2)-(3).

[28] See also OAC 5160:1-2-01(H) and OAC 5160:1-2-10(B)(8)(a).

Of the 35 enrollees listed on the unwinding data reports as renewed using a renewal form, eligibility for 30 enrollees was correctly renewed.[29] However, the State agency incorrectly determined eligibility for five enrollees. Specifically, we identified incorrect income calculations, incorrect household size, and unverified income discrepancies for four enrollees. For the remaining enrollee, an unauthorized individual who was not related to the enrollee sought to renew the enrollee. These actions were not in accordance with Federal and State requirements and related processes in place during the unwinding period.

The following are examples of enrollees whose eligibility was renewed using a renewal form.

Example 3:
Enrollee whose eligibility was correctly renewed with a renewal form.

For an enrollee in our sample (dependent adult), the State agency listed the individual on the May 2023 unwinding data report as having their eligibility renewed. In March 2023, the individual's renewal was initiated through the ex parte process; however, the ex parte process failed because the income could not be verified. The State agency sent the enrollee's parent a renewal form in April 2023 requesting income verification. The enrollee's parent returned the renewal form along with pay stubs by the due date. The caseworker added the newly verified income to the case record, found the household remained eligible for Medicaid, and correctly renewed the enrollee's Medicaid coverage.

Example 4: Enrollee was incorrectly renewed without verifying income from SWICA.

For an enrollee in our sample (adult), the State agency listed the individual on the August 2023 unwinding data report as having their eligibility renewed. When the renewal process was initiated in June 2023, the individual's income in Ohio Benefits was listed as $0; however, SWICA indicated potential monthly income of $1,331. On June 24, 2023, electronic income verification failed, and a renewal form was sent to the enrollee on June 29, 2023. There was no evidence the caseworker verified the enrollee's income discrepancy identified through the SWICA match. In addition, a subsequent SWICA alert from August 14, 2023, identified potential monthly income to be $2,284. The case was incorrectly renewed using $0 income. Specifically, there was no evidence the individual wasn't employed at the time of renewal or of the caseworker following up on the discrepancy with the income reported in SWICA.

[29] The State agency refers to manual renewals during the unwinding period as using renewal forms or renewals using the manual ex parte process (i.e., without contacting the enrollee).

ENROLLEES DETERMINED TO BE INELIGIBLE FOR MEDICAID

In accordance with Federal and State requirements, prior to making a determination of ineligibility, the State agency must consider all bases of eligibility for other medical assistance categories. Additionally, State requirements describe the criteria that apply to all medical assistance programs, how the State agency verifies eligibility criteria, and when an individual is asked to provide manual verification.[30] The State agency must deny an application for Medicaid for an individual who does not meet the conditions of eligibility.[31]

If an individual is no longer eligible for a category of Medicaid and termination from that category is being considered, the caseworker must explore eligibility for any other Medicaid category, known as a pretermination review.[32] If there are no other Medicaid assistance options available for the enrollee, then the Medicaid coverage must be terminated. Individuals must be given prior notice of the termination and allowed due process and hearing rights.[33]

Of the 35 enrollees listed on the unwinding data reports as ineligible, 34 enrollees were correctly determined to be ineligible. However, the State agency correctly terminated coverage and then incorrectly renewed the eligibility for one enrollee during the same month. This action was not in accordance with Federal and State requirements and related processes in place during the unwinding period.

The following are examples of enrollees who were determined to be ineligible for Medicaid.

Example 5:
Enrollee who became ineligible for Medicaid and was correctly terminated.

For an enrollee in our sample (adult), the State agency listed the individual on the August 2023 unwinding data report as being ineligible. In August 2023, the enrollee reported new income on their renewal form. The newly reported income was over the income limit for the household size. The caseworker added the newly provided income to the case record, found the household was ineligible for Medicaid, and correctly terminated the enrollee's Medicaid coverage.

[30] OAC 5160:1-2-10.

[31] 42 CFR § 435.916(f). Specifically, under OAC 5160:1-2-01(I)(4)(d) the State may deny an application for Medicaid if an individual, among other reasons, fails to cooperate with the application or determination process or fails to provide all necessary verifications, or does not meet all conditions of eligibility for any medical assistance category.

[32] OAC 5160:1-1-01(B)(68).

[33] 42 CFR § 435.916(a)(2) and (a)(3)(i)(C).

Example 6:
Enrollee whose coverage was correctly terminated but then incorrectly renewed during the same month.

For an enrollee in our sample (adult), the State agency listed the individual on the April 2023 unwinding data report as being ineligible. However, the enrollee left the household on the sampled case and their eligibility was renewed on another case during the same month. While completing the redetermination on the other case, the caseworker used $0 income to determine eligibility and did not use the income information that was available for the enrollee, which indicated that the enrollee's income exceeded the limit. The State agency could not provide support for the $0 income that was used. We determined that the enrollee's eligibility should have remained terminated and not renewed for Medicaid coverage.

ENROLLEES' ELIGIBILITY TERMINATED FOR PROCEDURAL REASONS

In accordance with the State requirements, in determining an enrollee's eligibility, the State agency must deny Medicaid coverage if the individual fails to cooperate with the determination process or fails to provide all necessary verifications.[34] Starting in April 2023, a State must attempt to update contact information for an individual for whom it conducts an eligibility redetermination.[35] For compliance with this condition, the types of contact information a State must attempt to update include the enrollee's mailing address, phone number, and email address. States can use multiple data sources and/or adopt multiple strategies to update all types of contact information. In addition, States were required to document strategies and processes for obtaining updated contact information for enrollees in order to demonstrate compliance.[36] In Ohio's unwinding operational plan, the State agency described its strategies, including obtaining updated address information from the Medicaid managed care plans and the National Change of Address database with the U.S. Postal Service.[37, 38]

[34] OAC 5160:1-2-01(I)(4)(d)(iii).

[35] CAA § 5131(a).

[36] SHO Letter No. 23-002.

[37] Ohio submitted its "State Report on Plans for Prioritizing and Distributing Renewals Following the End of the Medicaid Continuous Enrollment Provisions" to CMS on Dec. 20, 2022, which is referred to as Ohio's unwinding operational plan throughout this report.

[38] The State agency received waiver authorities from CMS under section 1902(e)(14)(A) of the Act for obtaining address information from the Medicaid managed care plans and the National Change of Address database (effective July 1, 2022).

Ohio's unwinding operational plan describes the following strategies to minimize Medicaid coverage losses for procedural reasons:

- coordinating with Medicaid managed care plans for outreach to enrollees,
- accepting updated address information from Medicaid managed care plans,
- developing a PHE Unwinding Communications Partner toolkit,[39] and
- utilizing an automated telephone and text messaging system to gather and update address information directly from enrollees and sending reminder notifications.

Further, Federal and State requirements are in place for determinations upon a reported change from an enrollee who is discontinued for not cooperating with the renewal process or providing verifications requested. A State agency must accept the renewal or verifications without requiring a new application if the missing verifications are provided within 90 calendar days, or a longer period determined by the State, from the termination date.[40]

Of the 35 enrollees listed on the unwinding data reports as terminated for procedural reasons, eligibility for 33 of the enrollees was correctly terminated. However, the State agency made incorrect renewal determinations for two enrollees. For one enrollee, Medicaid coverage was incorrectly terminated for procedural reasons, and the coverage should have been renewed. Additionally, for one enrollee, Medicaid coverage was initially terminated for procedural reasons. However, the enrollee later returned the renewal form, and their Medicaid coverage was reinstated pending asset verification, despite being over the income limit. The caseworker did not terminate the enrollee's Medicaid coverage as required. These actions were not in accordance with Federal and State requirements, and related processes in place during the unwinding period.

The following are examples of enrollees who were terminated for Medicaid for procedural reasons.

Example 7:
Child whose Medicaid eligibility was correctly terminated for procedural reasons due to returned mail.

For an enrollee in our sample (6-year-old child), the State agency listed the child on the July 2023 unwinding data report as being terminated for procedural reasons. On May 31, 2023, the enrollee's parent was sent a renewal form to be

[39] The State agency's *COVID-19 Public Health Emergency Unwinding Communications Partner Packet* (accessed on Feb. 12, 2024).

[40] 42 CFR § 435.916(a)(3)(iii). OAC 5160:1-2-01(H)(5)(c).

completed by June 30, 2023. That renewal form was sent back by the United States Postal Service on June 11, 2023, as returned mail with no forwarding address. The State agency sent a reminder letter to the same address as the renewal form on June 20, 2023, and it was also sent back as returned mail on June 27, 2023. When a renewal form is sent back as returned mail, the caseworker must attempt to contact the enrollee using a second modality.[41] The caseworker documented in the case file that they attempted to use a second contact modality, called two different phone numbers associated with the account, and could not reach anyone within the household. The case record did not have a forwarding address or an email address associated with it. The caseworker followed the proper procedures to notify the enrollee that their coverage would end effective August 1, 2023, because the household did not complete the renewal process.

Example 8:
Child whose Medicaid eligibility was incorrectly terminated for procedural reasons.

For an enrollee in our sample (1-year-old child), the State agency listed the child on the May 2023 unwinding data report as being terminated for procedural reasons. Specifically, the case record in Ohio Benefits indicated the child's Medicaid eligibility was terminated because the case holder (parent) failed to verify income. However, there was documentation in Ohio Benefits and EDMS that the parent had been responsive to requests for documentation. Additionally, Ohio Benefits listed the case holder's (parent) eligibility as renewed in May 2023 due to a pregnancy with another child, but the Medicaid eligibility of the child in our sample was incorrectly terminated for procedural reasons (i.e., failure to respond). As a result of our audit, in October 2023, the State agency reinstated the child for retroactive Medicaid coverage.

ERRORS MADE BY CASEWORKERS THAT DID NOT AFFECT THE INITIAL MEDICAID ELIGIBILITY ACTION FOR ENROLLEES

Modified Adjusted Gross Income (MAGI) is used to determine financial eligibility for Medicaid, CHIP, and premium tax credits and cost sharing reductions available through the health insurance marketplace. When calculating enrollees' MAGI, caseworkers are required to consider all sources of income, including tips.[42]

[41] Division FF, section 5131, Consolidated Appropriations Act (P.L. No. 117-328) (Dec. 29, 2022) requires States to make a good faith effort to contact, using more than one modality, any enrollee who is determined ineligible based on returned mail prior to discontinuing coverage for that enrollee. SHO Letter No. 23-002 further interprets the "good faith" effort standard in CAA's section 5131.

[42] 42 CFR § 435.603(e). OAC 5160:1:4:01.

As a condition of receiving Medicaid funding for their automated data systems, the State agency is required to have an eligibility determination system that provides data matching through PARIS.[43] In accordance with State agency procedures, when the State agency receives a PARIS Interstate Match alert, a contact letter is system generated from Ohio Benefits and mailed to the enrollee's address of record. If the enrollee responds and verifies Ohio residency, eligibility is continued. If the response indicates an out-of-State residency, eligibility is terminated as of that date. If the enrollee does not respond to the contact notice within 10 days, a verification notice with a 10-day deadline is then mailed to the enrollee. If there is no response after the second verification notice, the caseworker should terminate eligibility.

The State agency did not always complete Medicaid eligibility actions in accordance with requirements and procedures during the unwinding period following the end of the continuous enrollment condition, but some errors did not adversely impact the Medicaid eligibility actions taken on enrollees. Specifically, we identified some errors that were made by the caseworkers during the redetermination process that did not affect the enrollee's eligibility outcomes, including incorrect manual income calculations, income that was incorrectly included or excluded from total income, and not acting on a PARIS Interstate Match alert. Although these errors did not affect eligibility determinations, similar errors could potentially cause Medicaid eligibility actions to result in improper renewals or improper terminations for other enrollees.

The following are examples of errors made by caseworkers that did not affect the eligibility outcome for the enrollees.

Example 9:
Child whose Medicaid eligibility was correctly renewed, but the caseworker used an incorrect income amount for a subsequent renewal.

For an enrollee in our sample (11-year-old child), the State agency listed the child on the April 2023 unwinding data report as being renewed on an ex parte basis. In a subsequent renewal, the caseworker input a biweekly income amount of $455 in the case record, instead of the correct monthly income amount of $978, supported by the income information available. Even if the caseworker had used the correct monthly income amount, the child's case would still have been under the income limit. Therefore, we determined the error made by the caseworker did not affect the enrollee's eligibility determination.

Example 10:
Enrollee whose coverage was properly terminated but income was incorrectly excluded.

For an enrollee in our sample (adult), the State agency listed the individual on the June 2023 unwinding data report as having their eligibility terminated. While

[43] 42 CFR § 435.945(d). OAC 5160:1-1-06.

completing the redetermination, the caseworker did not include tips when calculating the monthly income for the individual. The correct income that should have been used was still over the income limit threshold, so the enrollee was still ineligible for Medicaid coverage. Therefore, we determined the error made by the caseworker did not affect the enrollee's eligibility determination.

Example 11:
PARIS alerts were not acted upon by the caseworker after the enrollee's eligibility was renewed.

For an enrollee in our sample (adult), the State agency listed the individual on the April 2023 unwinding data report as having their eligibility renewed on an ex parte basis. In February 2023, the individual's renewal was initiated through the ex parte process and properly renewed. However, beginning in June 2023, Ohio began receiving PARIS Interstate Match alerts indicating potential residence in Florida. Although the February renewal was processed correctly on an ex parte basis, we found no evidence that a caseworker acted on the PARIS Instate Match alerts to verify the enrollee remained a resident of Ohio. As a result of identifying this during our audit, the State agency terminated the enrollee's Medicaid coverage in December 2023.

RECOMMENDATIONS

We recommend that the Ohio Department of Medicaid:

- take appropriate action with respect to the incorrect Medicaid eligibility determinations identified in our sample,
- provide periodic training to caseworkers about verifying and documenting enrollees' income during the renewal process, and
- provide additional training to caseworkers about using current information when conducting enrollee eligibility determinations.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency concurred with our recommendations and described the actions that it has taken or plans to take to address them. The State agency's actions include: (1) working with County agencies to correct eligibility determinations identified in our sample, (2) revising the income processing training that will be presented live in April 2024 and available online for caseworkers, and (3) refreshing the eligibility renewal training that will be conducted in July 2024. The State agency's comments are included in their entirety as Appendix D.

CMS also provided written technical comments on the draft report, which we addressed as appropriate.

We recognize the actions that the State agency has taken or plans to take to implement our recommendations. These actions should assist the State agency with addressing the deficiencies identified during our audit.

OTHER MATTERS

Although we used the unwinding data reports as the basis for identifying enrollees who were renewed or terminated during the unwinding period, we note that those reports represent activity as of a specific point of time and are not updated if other Medicaid eligibility actions occur after the earlier reports were published. Accordingly, we identified instances where Medicaid eligibility actions were correctly overturned in subsequent months for sampled enrollees. Of the 70 sampled enrollees who were listed as renewed on the monthly unwinding reports, we determined that one enrollee was later terminated when the child was placed in the custody of a county's children services agency. Of the 35 sampled enrollees who were listed as ineligible for Medicaid, we determined Medicaid coverage was reinstated for 5 enrollees. Of the 35 sampled enrollees who were listed as being terminated for procedural reasons, we determined Medicaid coverage was reinstated for 10 enrollees.

We found these subsequent Medicaid eligibility actions occurred for a variety of reasons, including children's cases that were transferred to another parent's case, loss of employment, providing eligibility verifications after the initial Medicaid eligibility actions, and reinstatement of children's Medicaid coverage due to the continuous eligibility requirement.[44] The subsequent Medicaid eligibility actions after the initial determinations for the enrollees created discrepancies between the monthly unwinding data reports and final Medicaid eligibility actions taken during the unwinding period following the continuous enrollment condition. Although many enrollees were listed as terminated on the unwinding data reports, we identified enrollees who were later renewed for coverage.

[44] Previously, under section 1902 (e)(12) of the Act, 42 CFR §435.926, and 42 CFR § 457.342, States had the option of providing 12-month continuous eligibility coverage to children in Medicaid and CHIP through a State plan amendment. Ohio provides 12 months of continuous eligibility to children in Medicaid.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 1,211,991 enrollees listed on Ohio's monthly unwinding data reports who had their Medicaid enrollment either renewed or terminated during April 1 through August 31, 2023 (audit period), following the end of the continuous enrollment condition. We reviewed the Medicaid eligibility actions made by the State agency for a stratified random sample of 140 enrollees as described in Appendix B.

We assessed internal controls and compliance with laws and regulations necessary to satisfy the audit objective. In particular, we assessed the design, implementation, and operating effectiveness of the State agency's: (1) control activities, (2) information and communication, and (3) monitoring during the unwinding process. As part of our internal control assessment, we reviewed the State agency's policies and procedures for processing eligibility renewal actions during the unwinding period. However, because our review was limited to the processes in place during the unwinding period, it may not have disclosed all internal control deficiencies that may have existed. Any internal control deficiencies we found are discussed in this report.

We conducted our audit from August 2023 through February 2024.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- met with State agency officials to gain an understanding of the electronic systems used in Ohio's Medicaid program and Ohio's unwinding process;
- obtained and reviewed the State agency's policies and procedures covering Ohio's unwinding process;
- obtained Medicaid data supporting what Ohio reported to CMS in its April to August 2023 unwinding data reports;
- identified 1,211,991 enrollees who were either renewed or terminated during April to August 2023;
- selected a stratified random sample of 140 enrollees (see Appendix B);
- reviewed eligibility documentation associated with the 140 sampled enrollees;

- on the basis of our sample results, estimated:
    - the total number of enrollees in the sampling frame whose eligibility was incorrectly renewed on an ex parte basis or incorrectly renewed using a renewal form and
    - the total number of enrollees in the sampling frame whose eligibility was either incorrectly renewed or terminated; and
- discussed the results of our audit with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of an Access database that contained 1,211,991 Ohio enrollees who had their Medicaid enrollment either renewed or terminated during our audit period, following the end of the continuous enrollment condition.

SAMPLE UNIT

The sample unit was an enrollee.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample containing four strata. Stratum 1 contained enrollees whose eligibility was renewed on an ex parte basis. Stratum 2 contained enrollees whose eligibility was renewed using a renewal form. Stratum 3 contained enrollees who were determined to be ineligible for Medicaid. Stratum 4 contained enrollees whose eligibility was terminated for procedural reasons (i.e., failure to respond).

Table 1: Sample Design and Size

Stratum	Medicaid Eligibility Actions	Frame Size (Enrollees)	Sample Size
1	Renewals on Ex Parte Basis	575,568	35
2	Renewals Using Renewal Form	326,768	35
3	Terminated Due to Ineligibility Determination	81,692	35
4	Terminated for Procedural Reasons	227,963	35
Total		**1,211,991**	**140**

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG Office of Audit Services (OIG/OAS) statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We sorted the items in each stratum by recipient identification number (smallest to largest) and then consecutively numbered the items in each stratum in the sampling frame. After generating the random numbers for each of these strata, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate: (1) the total number of enrollees in the sampling frame whose eligibility was incorrectly renewed and (2) the total number of enrollees in the sampling frame whose eligibility was either incorrectly renewed or terminated. We calculated the point estimate and the corresponding two-sided 90-percent confidence interval for each of these estimates.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

ENROLLEE CHARACTERISTICS FOR ESTIMATION

Incorrect Eligibility Renewals: enrollee's eligibility was incorrectly renewed on an ex parte basis or incorrectly renewed using a renewal form.

Incorrect Eligibility Terminations: enrollee's eligibility was incorrectly determined to be ineligible for Medicaid or incorrectly terminated for procedural reasons.

Incorrect Medicaid Eligibility Actions: enrollee's eligibility was either incorrectly renewed or terminated.

Table 2: Sample Results

Stratum	Frame Size (Enrollees)	Sample Size	Incorrect Eligibility Renewals	Incorrect Eligibility Terminations	Incorrect Medicaid Eligibility Actions
1	575,568	35	1	N/A	1
2	326,768	35	5	N/A	5
3	81,692	35	N/A	1	1
4	227,963	35	N/A	2	2
Total	**1,211,991**	**140**	**6**	**3**	**9**

Table 3: Estimates for Each Characteristic in the Sampling Frame
(Limits Calculated at the 90-percent Confidence Level)

Attribute	Statistical Estimates		
	Point Estimate	Lower Limit	Upper Limit
Incorrect Eligibility Renewals	63,126	21,032	105,220
Incorrect Eligibility Terminations	N/A	N/A	N/A[45]
Incorrect Medicaid Eligibility Actions	78,486	33,660	123,313

[45] We have chosen not to report the estimated number of Incorrect Eligibility Terminations in the sampling frame because of the low number of enrollees in our sample who were incorrectly determined to be ineligible or incorrectly terminated for procedural reasons.

Department of Medicaid
Medicaid.Ohio.gov
Mike DeWine, *Governor* Jon Husted, *Lt. Governor* Maureen M. Corcoran, *Director*

March 12, 2024

Ms. Sheri Fulcher
Office of Inspector General
Office of Audit Services, Region V
233 North Michigan, Suite 1360
Chicago, IL 60601

RE: Report Number: A-05023000019

Dear Ms. Fulcher:

Thank you for the opportunity to respond to the draft report issued by the Department of Health and Human Services, Office of Inspector General (OIG) titled *Ohio Generally Completed Medicaid Eligibility Actions During the Unwinding Period in Accordance With Federal and State Requirements*.

The Ohio Department of Medicaid's (ODM) informal comments are as follows:

Recommendation 1
Take appropriate action with respect to the incorrect Medicaid eligibility determinations identified in our sample.

Management Response
ODM concurs with HHS OIG's recommendation 1 and will continue to work with county agencies to correct eligibility determinations. Five cases have been corrected and four are in the process of being corrected.

Recommendation 2
Provide periodic training to caseworkers about verifying and documenting enrollees' income during the renewal process.

Management Response
ODM concurs with HHS OIG's recommendation. Ohio's eligibility system contains Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), Medicaid and Childcare programs. For that reason, income processing trainings are conducted jointly with the Ohio Department of Job and Family Services (ODJFS) and require coordination to develop and present to the county agencies. Income processing training was conducted during the public health emergency in 2/2022 and 3/2022. This training is currently being revised and will be presented in three parts in April 2024. The first training in the series will include a policy overview, review of income types, frequencies and reviewing verifications. Part two will include entering income into Ohio Benefits for an intake, income inheritance between programs and verifying income electronically. In the third part of the series, the focus will be on case maintenance while processing reported changes. In addition to being offered live, the sessions will be recorded and available online for caseworkers to view at their convenience.

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Recommendation 3
Provide additional training to caseworkers about using current information when conducting enrollee eligibility determinates.

Management Response
ODM concurs with HHS OIG's recommendation. ODM Technical Assistance provided a Ramping Up to Renewals training in May and July 2023. Topics included a high-level overview of the renewal process, renewal processing timelines, types of renewals received, identifying valid renewal signatures, processing Medicaid renewals, including obtaining updated information, updating data collection pages in Ohio Benefits, redetermining eligibility and completing pre-termination reviews when discontinuing benefits. This training and all materials are currently available on the OB Resources portal. ODM is planning to refresh this training and conduct a repeat of the session in July 2024.

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

Sincerely,

[redacted]

Maureen M. Corcoran, Director