UNWINDING REPORT

JUNE 2024

Department of Medicaid

MESSAGE FROM THE DIRECTOR

First, a word of THANKS! The DeWine Administration wishes to acknowledge the incredibly hard work and collaboration from many individuals and stakeholder groups across Ohio. Beginning in the fall of 2020, ODM began to work with stakeholders to prepare for a 'return to normal'. Webinars, discussions and general information sharing began early -- recognizing that the difficult task of reaching every individual served by the Ohio Medicaid program would come. A continuous, open flow of formal and informal communication was established. From community organizations; food banks, homeless shelters, consumer and disability groups, family organizations; every type of health care provider group and associations; behavioral health, hospitals, physicians and more; the County Departments of Job and Family Services, their statewide leadership, and the Ohio Department of Job and Family Services; the Medicaid managed care plans; and a number of state departments across the Cabinet; along with the thoughtful and vigilant interest and monitoring of the Ohio General Assembly, creating an unparalleled collaborative effort focused on meeting the needs of the individual Ohioans.

Sincerely,

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EXECUTIVE SUMMARY

Pursuant to H.B. 33 of the 134th General Assembly, the Ohio Department of Medicaid (ODM) is required to submit a report to the Joint Medicaid Oversight Committee (JMOC) detailing its findings of the process undertaken to unwind from the Public Health Emergency (PHE). This report fulfills this statutory requirement.

"Unwinding" was the federally required process for reviewing eligibility of every enrolled Medicaid member who was maintained on the program during the COVID 19 public health emergency between March 2020 to March 2023. Ohio's unwinding process spanned a twelve-month period between March 2023 and March 2024. Ohio Medicaid reviewed the eligibility of over 3.5 million enrollees during that time. Planning for the unwinding spanned 3 years, involved multiple data and systems vendors, and active engagement of county Departments of Job and Family Services, community and provider stakeholders, and Medicaid managed care plans.

The undertaking was immense, and at points took unexpected turns; but in the end, it was entirely successful. Lessons learned and systems and process improvements made before and during the unwinding have greatly improved the processing of Medicaid eligibility determinations and the state is well situated to maintain an efficient and effective process for the long-term.

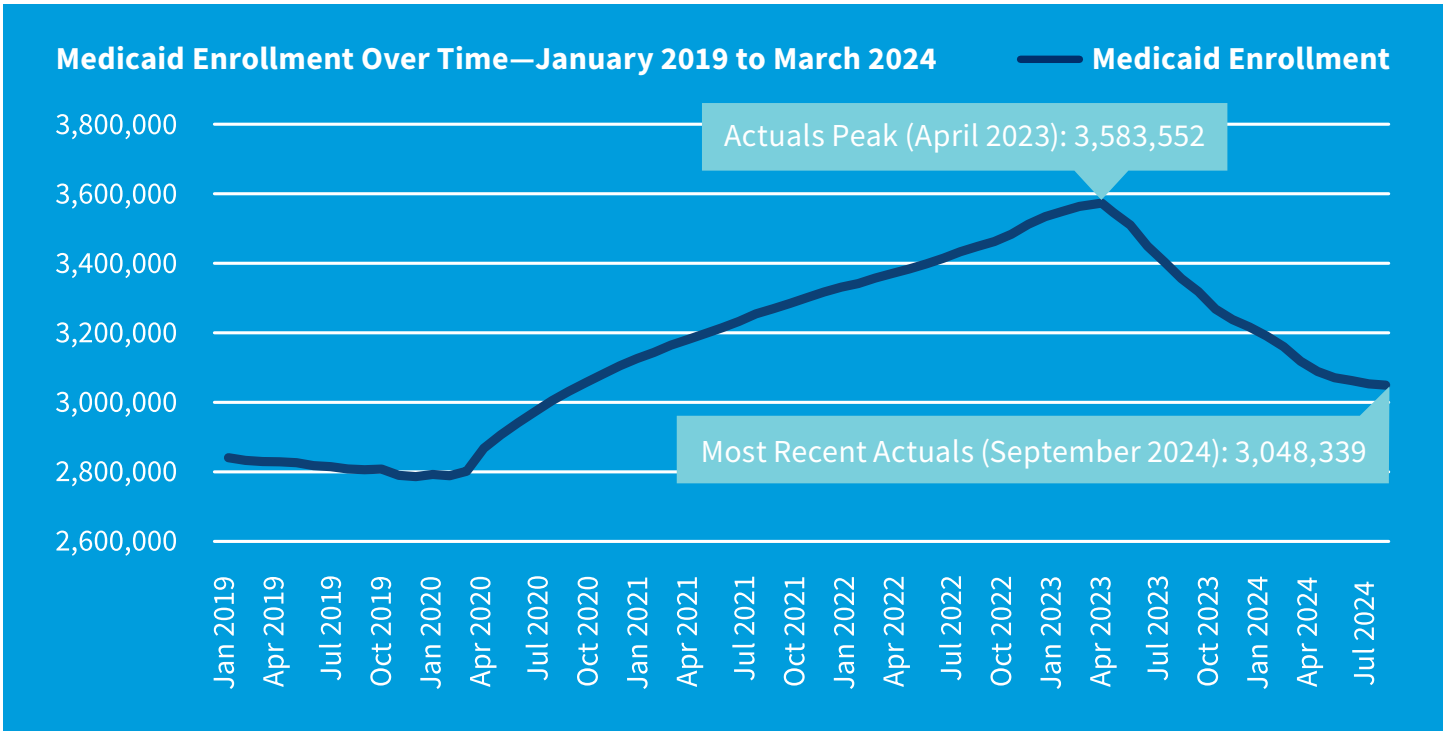
BACKGROUND ON THE PUBLIC HEALTH EMERGENCY

On January 31, 2020, U.S. Secretary of Health and Human Services Alex Azar declared a nationwide public health emergency (PHE) in response to the COVID-19 pandemic. As part of the PHE under the Families First Coronavirus Response Act (FFCRA)[1], states could receive a 6.2 percentage point increase in their federal Medicaid matching rates if certain requirements were met. Ohio received an estimated total of $5,072,013,814 of additional federal funding. In exchange, one requirement of the FFCRA, known as the continuous coverage requirement, required that states could not terminate enrollees' Medicaid coverage unless they asked to be disenrolled, moved out of state, or passed away.[2] States were required to maintain enrollment of nearly all members through March or April 2023; e.g., the end of the month in which the PHE ended.

During the PHE, the State of Ohio implemented numerous federal requirements and some programmatic flexibilities to help ensure that members maintained access to health care services and the Medicaid provider network remained viable. These changes impacted almost all aspects of the State of Ohio's Medicaid delivery system.

Medicaid Enrollment During the PHE

The PHE had a profound impact on Ohio's Medicaid enrollment, which saw a 29% increase of more than 800,000 individuals between March 2020 and February 2023. This explosion in growth resulted



[1] Families First Coronavirus Response Act (116th Congress 2019-2020) Public Law No. 116-127. HR 6201.

[2] For additional information on ODM's Medicaid eligibility processes, please see "Ohio Medicaid's Full Response to the Auditor of the State Report"

in a historic program caseload, exceeding the 3.5-million-member mark.

As Ohio's Medicaid enrollment grew, its composition also changed. After the PHE, Ohio's Medicaid caseload was materially equivalent in terms of eligibility category, race and ethnicity, sex, and broad geography to the pre-PHE caseload. However, there were some eligibility categories that expanded or shrank at greater rates during the PHE. The fastest-growing group was the Expansion population, which increased by approximately 52% during the PHE. Additionally, during the PHE, the enrollment of adults between the ages of 18 and 64 years increased approximately 32% compared to a 12% increase of children and an 21% increase of adults aged 65 years or more.

Additional analysis conducted by the department showed that of those enrolled at the end of the PHE, most (71%) were continuously enrolled since prior to the PHE. The remainder were divided into two categories, as indicated in the chart below, those who were new (referred to as "PHE Joiners") to the program and those who returned to the program after a period of absence (referred to as PHE Re-Joiners).

Percentage of Medicaid Caseload by Enrollment History Group	
Enrollment History Group	**Approximate Percent**
Continuously enrolled since at least February 2020	71%
PHE Joiners *(Current Medicaid recipient who enrolled during PHE and who was not enrolled in 12 months prior to PHE)*	22%
PHE Re-Joiners *(Current Medicaid recipient who enrolled during PHE and who was enrolled at any point in 12 months prior to PHE)*	7%
	100%

Substance Use Disorder Treatment Utilization During the PHE

In terms of utilization of Medicaid services, one of the most notable differences between those continuously enrolled compared to the PHE Joiners and PHE Re-Joiners was for non-acute/non-emergent substance use disorder (SUD) treatment services. The PHE re-joiners used 10.8 SUD non-acute/non-emergent treatment services per 1,000 member months, compared to 7.2 for those who were continuously enrolled, and 7.7 for PHE Joiners. The PHE Re-Joiners used non-acute/non-emergent SUD treatment services at 1.5 times the rate of those who were continuously enrolled.

This usage highlights the widely acknowledged impact of the PHE on mental health and opioid use. Moreover, the difference between those continuously enrolled and those who joined or re-

joined during the PHE emphasizes the important role of Medicaid in addressing this ongoing SUD epidemic.

Utilization of Non-Acute/Non-Emergent SUD Treatment: Patients Per 1,000 Member Months As of November 2022	
Enrollment History Group	**Rate of Utilization**
Continuously enrolled since at least February 2020	7.2
PHE Joiners *(Current Medicaid recipient who enrolled during PHE and who was not enrolled during the 12 month period prior to PHE)*	7.7
PHE Re-Joiners *(Current Medicaid recipient who enrolled during PHE and who was enrolled at any point in 12 months prior to PHE)*	10.8

On December 29, 2022, the Consolidated Appropriations Act of 2023 (CAA, 2023) was signed into law, which delinked the continuous coverage requirement enacted from the continuing requirements of the FFCRA. The continuous coverage requirement expired on March 31, 2023, and states resumed routine Medicaid eligibility operations, or "Unwinding". The CAA, 2023 also phased out the enhanced federal Medicaid matching funds through December 2023.

Enhanced Federal Medical Assistance Percentage (eFMAP) Phasedown

The CAA, 2023 included an eFMAP phase-down over the course of 2023.

- 6.2% through March 30
- 5% through June 30
- 2.5% through September 30
- 1.5% through December 31

The CAA, 2023 also brought with it new federal requirements states mandated as part of their unwinding activities. States found noncompliant could face a myriad of penalties. Examples of the new federal requirements included:

- Comply with all federal requirements relating to redeterminations including renewal strategies authorized under the social security act or other alternative processes and procedures approved by HHS
- Make good faith efforts to maintain up-to-date contact information. Examples of sources include the National Change of Address (NCOA) database and other HHS programs
- Maintain member enrollment on basis of returned mail unless the state also attempts to contact with another modality (e.g., email or phone)
- Report monthly on data elements, in addition to those already required by Centers for Medicare and Medicaid Services (CMS), including the number of ex parte renewals, number of redeterminations, number of terminations for procedural reasons, i.e. failure to complete renewal paperwork, and others

Federal Unwinding Guidance

To support states through the transition, CMS issued guidance to Medicaid programs with details and requirements for Unwinding:

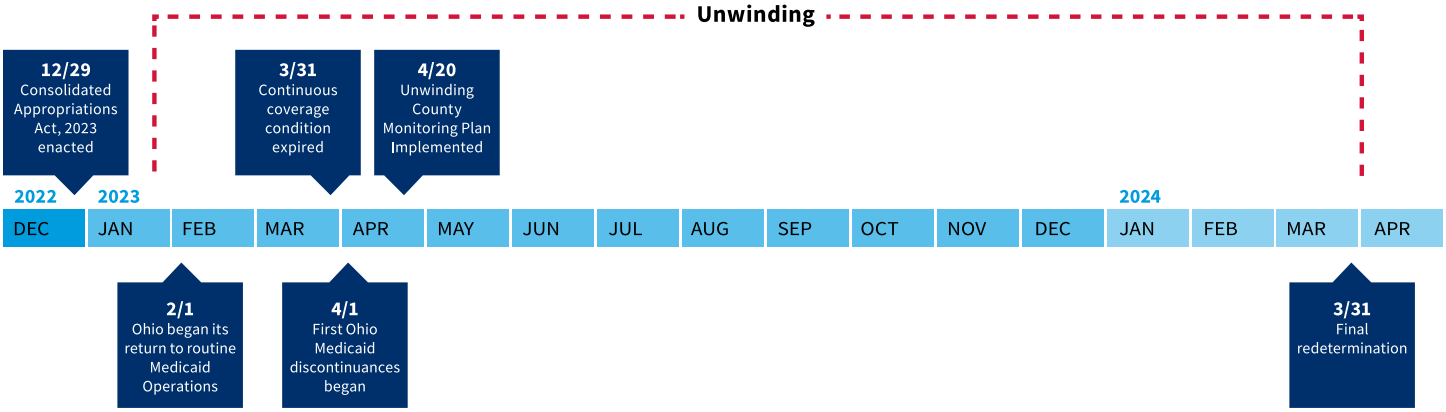
- Published State Health Official (SHO) letters in December 2020, August 2021, and March 2022 setting out federal expectations and requirements related to case processing timelines and member communications for redetermining Medicaid coverage for those

who had their coverage continuously maintained

- Information and resources on federal statutes and federal regulations governing the eligibility determination and renewal process
- Provided tool kits, presentations, and other materials for States
- Hosted numerous webinars and offered individual technical assistance calls
- Guidance and other material relating to Unwinding was posted on the CMS website

PREPARING FOR AND RESUMING ROUTINE MEDICAID ELIGIBILITY OPERATIONS – "UNWINDING"

The Ohio Department of Medicaid (ODM) began Unwinding in April 2023. During the 13 months of Unwinding, more than 3.5 million Ohio Medicaid members had their eligibility reviewed. The enrollments or renewals were conducted either through ex parte renewal or through manual caseworker processing.



ODM adopted the following principles to define their approach to Unwinding.

- Work together with our county partners to redetermine individuals as quickly as possible, balancing the directives of H.B. 110 and federal requirements.
- Keep eligible individuals enrolled and reduce churn
- Identify those 'most likely' to be ineligible and prioritize processing these cases and assist with transitioning to other coverage
- Make efficient, accurate decisions within prescribed timelines and achieve a sustainable renewal schedule
- Maintain timeliness with new applications and change of circumstance; as well as SNAP and other county responsibilities
- Comply with state and federal law and CMS requirements

System Redesign

The state conducted a thorough Eligibility and Enrollment Application (system) redesign, inclusive of enhanced case processing automation for ex parte, document management, case alerts activity, and included ongoing testing and monitoring. All this work was initiated prior to the PHE as a result of the RY2019 Ohio Medicaid and Child Health Insurance (CHIP) Payment Error Rate Measurement (PERM) Cycle 1 findings, and it continued to address needs for work related to Unwinding.

Ex Parte Process

ODM and its partners made significant preparations to meet the demands of Unwinding and position Medicaid eligibility operations and county caseworkers to pre-pandemic status. As part of these preparations, ODM implemented several improvements and automations to streamline the ex parte process, or "automatic" renewal of cases. Ex parte review is a redetermination of eligibility based on reliable, verified information contained in the enrollee's eligibility case or other current information available to the agency, including information accessed through electronic data sources.[3] All cases due for renewal in a given month are evaluated via this process, which begins two months prior to an individual's eligibility renewal date. There are two types of ex parte: automated ex parte and manual ex parte.

The figure below outlines the full end-to-end ex parte process with additional information supplied in the paragraphs below.

Ohio Department of Medicaid Ex Parte Process: End-to-End

Step 1	Step 2	Step 3	Step 4	Step 5
System review of full population	**Ohio Benefits (OB) pings eternal systems**	**PCG data matching and reporting**	**Renewal Received Bot engaged**	**Failed ex parte for both blocs and individuals**
• All cases due for renewal in a given month are evaluated via the ex parte process first • If essential information needed for ex parte approval is missing, the agency is unable to conduct data matching and make a renewal. These cases are sent renewal packets and skip to Step 5.	• The system (OB) reviews income results to determine if individual meets eligibility standards • Individuals not meeting the eligibility standards "fallout" of the ex parte process, an a renewal packet with prepopulated forms are sent to those individuals • A list of "fallout" cases is sent to PCG	• New data is downloaded • Cases are sorted into "eligible," "likely eligible," or "likely ineligible" • "Eligibles" list of individuals sent to Renewal Received Bot	• Bot stops auto-disenrollment regardless of whether or not the renewal packet is returned • All individuals with a PCG "eligible" determination are sent to a caseworker to attempt manual ex parte renewal based on PCG data, known case information, or electronic data sources	• Verifications needed to conduct redetermination • If a renewal application is received, an eligible or ineligible determination will be made • If a renewal application is not received and/or a renewal packet is not returned, coverage will be procedurally terminated

[3]Ex parte is required by 42 CFR 435.916.

Additional Data Exchange and Matching Capability for Unwinding

Step 1: System Review of Full Population

Ohio Benefits is programmed to identify all persons with an eligibility renewal due date two months in advance of that due date. This forward looking programming is designed to enable the system to run an ex parte review, and if that fails, enabling a non ex parte eligibility verification process. The system looks for any missing data elements that would be needed to conduct an ex parte review. If there are data elements missing, an ex parte review is not done, and a renewal packet is produced and mailed to the Medicaid enrollee. Examples of missing data can include, missing or invalid social security numbers, missing or invalid dates of birth, mismatched names or household members, etc.

Step 2: Ohio Benefits (OB) pings external systems

Ohio Benefits then tests each individual against Ohio's eligibility criteria using SWICA, UC, and SSA records as data sources to verify income, household and citizenship. Individuals not meeting the eligibility criteria through an electronic match "fallout" of the ex parte process and a renewal packet is produced and sent to the individual. The renewal packet is a prepopulated form identifying what information is needed to complete the eligibility review. This is also referred to as a verification checklist.

Concurrent with that, a list of the fallout cases would be sent to PCG, the state's third party data vendor.

Step 3: PCG data matching and reporting

Additional data matching functionality was performed by PCG took all of these "fallout" cases and conducted data matching against multiple data sources that the state did not have access to to evaluate eligibility. Based on their data, PCG identified individuals who were "likely ineligible" and "eligible". PCG supplied the information to the County Department of Jobs and Family Services (CDJFS) caseworkers and the source data used to make the designation of "likely ineligible" and "eligible". Individuals with discrepancies on any material eligibility factor, whether by mistake, incompleteness, or misrepresentation, would be marked as "likely ineligible" requiring further follow up by county workers. Using that information, a county caseworker would seek further verification of this information. Under federal law, vendors and contractors are prohibited from making final eligibility determinations themselves

County caseworkers could also take the data provided by PCG to conduct a manual ex parte renewal.

Step 4: Renewal Received Bot Engaged

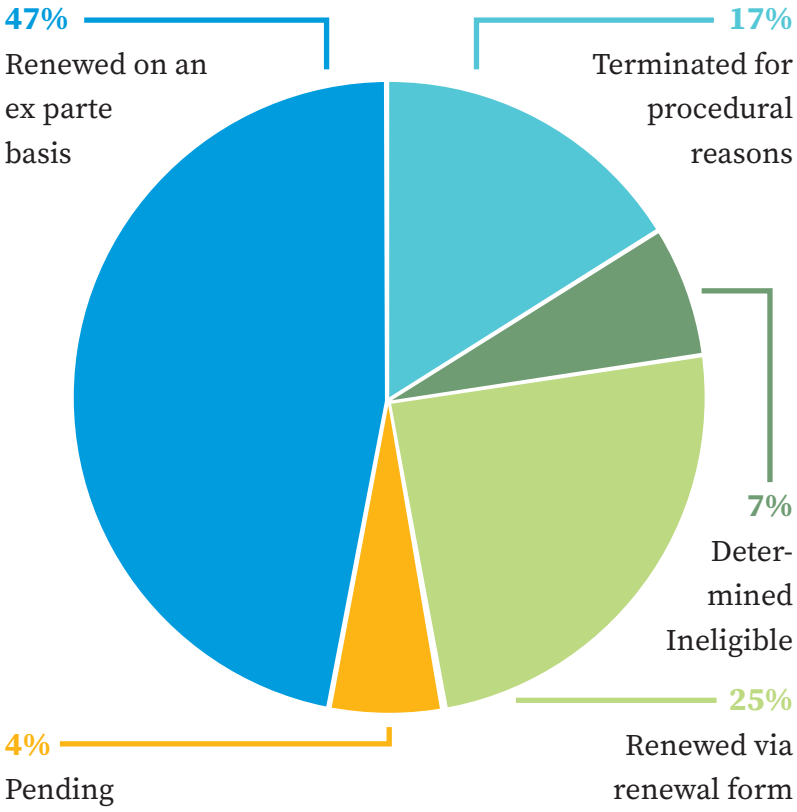
The renewal received bot was programming designed exclusively for unwinding. It was used to prevent incorrect procedural terminations. Ordinarily if a renewal packet is sent and the individual does not respond, the case is auto closed, i.e. terminated, for procedural reasons. During unwinding, PCG data was sufficient in certain cases to conduct a manual ex parte renewal without requiring additional information from the individual. If PCG designated an individual as "eligible", the bot

prevented auto closures of those cases even if the individual didn't respond to a renewal packet. These cases proceeded to county workers to conduct a manual review using the PCG supplied data.

Step 5: Failed ex parte for both blocs and individuals

For cases that are not renewed ex parte either by Ohio Benefits or with county workers using PCG data, the case would require a response from the individual with the requested verifications. If the verifications are provided by the individual, then a case worker can review them and make a final eligibility determination, which could be an approval or a denial. If the individual does not provide the requested verifications, then coverage would be terminated.

Ohio Monthly Outcomes of Unwinding Renewal



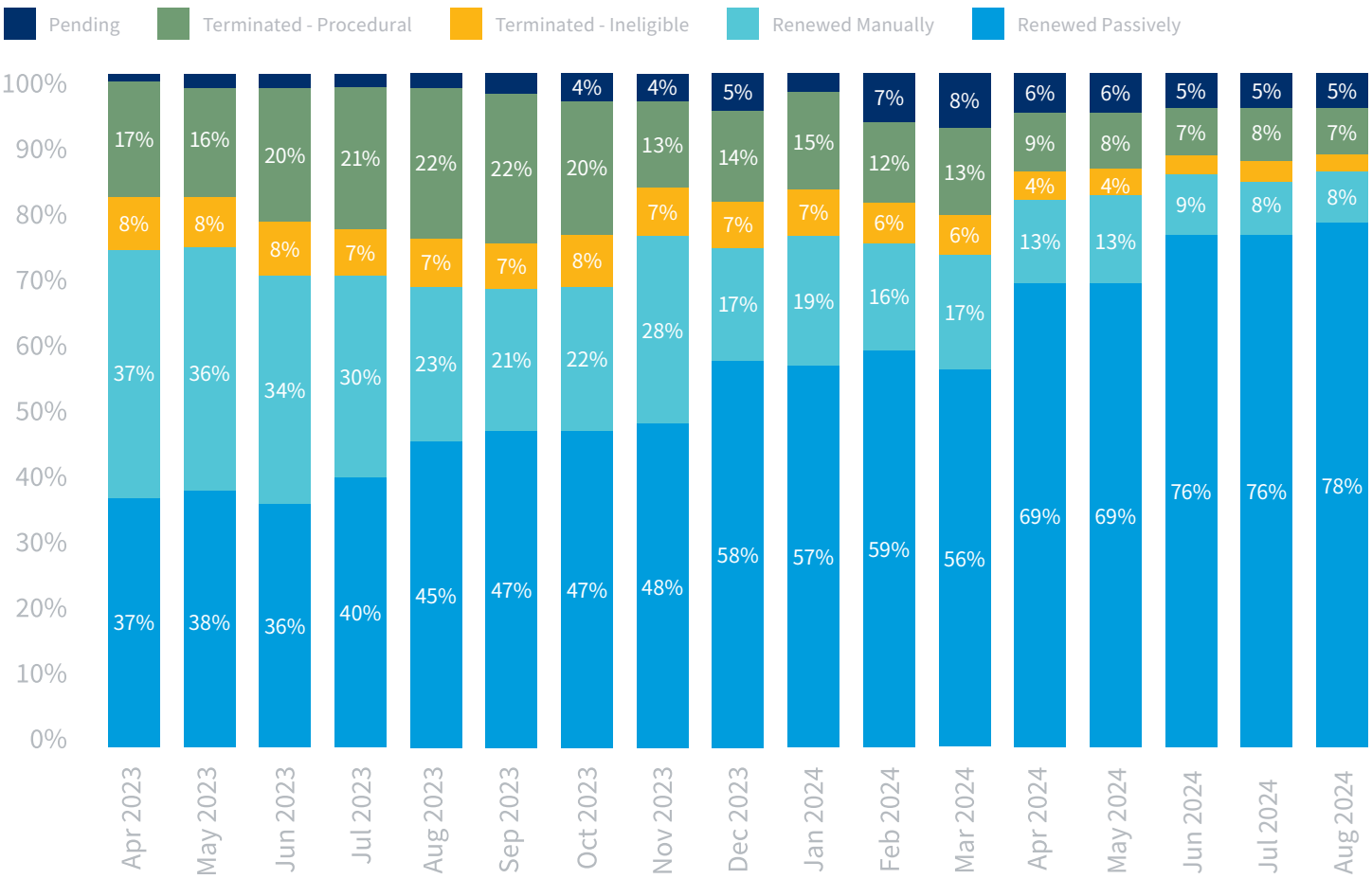
Source: KFF Medicaid Enrollment and Unwinding Tracker
As of May 1, 2024

- In total, ODM 1,497,199 members who "fell out" went through PCG's external data process proccess
- PCG leveraged its system and identified that 863,680 of these members, or 57.7%, were likely eligible for at least one Medicaid category
- Of those 669,017, were ultimately found eligible and retained coverage.

As of March 2024, termination notices were issued for 877,445 enrollees,[4] including 266,280 who were determined ineligible and 611,165 who were terminated for procedural reasons. Of those terminated for procedural reasons, the PCG data flagged almost half as "likely ineligible ."

[4]The term "terminated" refers to the system issuing a notice of termination. This does not mean the individual actually lost coverage. Many responded to the termination notice and had coverage reinstated after the notice was sent. That is in part, why the total decline in enrollment is only approximately 460,000 as of April 2024. https://medicaid.ohio.gov/stakeholders-and-partners/reports-and-research/caseload-reports/2024/04-caseload-2024

Unwinding Renewal Outcomes Per Month



Additional Automations and Systems

ODM developed a variety of automations, or bots, to help streamline and improve the renewal process.

- Fast Lane Bot – This Bot implemented Ohio's 1902(e)(14)(A) SNAP option waiver. The Fast Lane Bot would conduct nightly sweeps to see if any SNAP recertifications had a corresponding Medicaid case. A Medicaid case could be renewed for SNAP participants without conducting a separate MAGI-based income determination

- Renewal Received Bot – This Bot was critical to the ex parte renewal process, as it prevents cases identified as "eligible" by PCG data matching from automatic termination if manual renewal packets have not been received or if a renewal packet is not necessary for certain reasons

- Address Bot – This Bot automated beneficiary contact information changes in Ohio Benefits received from a variety of sources. ODM partnered with Managed Care Organizations (MCO), Automated Health Systems (AHS), and Recovery Management Agencies who submitted any updated contact information to the Bot. The Address Bot also updated member records with addresses obtained from the U.S. Postal Service and the National Change Of Address (NCOA) database

The table below highlights the number of cases reviewed and processed by the Renewal Received Bot and Medicaid Fast Lane Bot. The cases processed reflect action taken by the Bot on the case (i.e., prevented automatic termination and/or renewed based on SNAP eligibility).

Bot Statistics (April 2023 - July 2024)			
Bot Name	**Total Reviewed**	**Processed**	**Processing Rate**
Renewal Received Bot	**378,120**	**283,630**	**75%**
Medicaid Fast Lane Bot	**86,220**	**45,838**	**53%**

The table below highlights the number of cases that were successfully updated with new contact information in Ohio Benefits.

Address Bot Statistics			
Bot Name	**Total Reviewed**	**Processed**	**Processing Rate**
Address Bot (April 2023–July 2024)	**405,744**	**230,516**	**57%**
Address NCOA Bot (April 2023–March 2024)*	**101,674**	**71,693**	**93%**
*1902(e)(14)(A) waiver establishing linkages with the national Change of Address (NCOA) database ended March 2024.			

Additional Communication Efforts During the Unwinding

Leading up to and during Unwinding, ODM made significant efforts to conduct outreach to Medicaid members.

ODM developed an Unwinding webpage that was regularly updated with information and resources, including upcoming events, monthly CMS Unwinding reports, and webinar slides.

ODM also developed and posted a communications Partner Packet. This Partner Packet was widely distributed to stakeholders and partners that engaged with the Medicaid population. It included key messages and sample communications materials (e.g., social media posts, flyers). These key messages included:

- Communicate to Medicaid members the importance of updating their contact information and responding to requests for information
- Share with members the importance of responding to their renewal packets, if applicable

- Ensure Medicaid members take the necessary steps to transition to other coverage if they're no longer eligible for Medicaid
- Communicate that children may be eligible for coverage even if their parent/legal guardian is no longer eligible

Outreach Modalities for "Non-Responders" and for Instances of Returned/Undeliverable Mail

One area not often considered in the context of program integrity, is ensuring consistent communications with the members. Communicating with Medicaid members, and especially those who are low income- as compared to those with a significant disability—is a significant challenge. Accuracy of mailing and contact information, combined with very specific federal requirements for paper communications—that cannot be substituted with electronic communication is key. All states experienced these challenges. Ohio implemented several strategies to comply with the requirements of the CAA, 2023 to ensure ODM had up to date contact information for use in processing renewals and to handle cases where the renewal packet mail was returned as undeliverable.

For cases with returned mail, the counties conducted outreach using multiple modalities in an attempt to obtain current residential and mailing addresses. This included telephone, text message, email, and mail. If returned mail identified a new address, they would send the material to the new address. Each step was preserved in the Ohio Benefits system. For cases without returned mail who did not respond to the initial renewal packet, a follow up reminder notice was mailed out.

Outreach Via IVR and ProComm

Robo-calls and texts were also sent to members via Interactive Voice Response (IVR) at two points in the process. The first outreach occurred when the follow-up reminder notice was mailed. The second was via phone to notify the individual that non-response could result in lost coverage and provided information about other health insurance options. This phone call would occur at least 15 days prior to coverage termination.

In July 2023, Ohio introduced a new communications tool - ProComm (proactive communications) - to conduct texting and calls. This system connects with individuals at four points:

1. ProComm touchpoint 1: One-time welcome message.
2. ProComm touchpoint 2: Sends a text to the member to confirm the address on file is still accurate if the address was not updated within the past month. If the address is not correct, a link and instructions on how to update the address are provided. If the individual does not have a Self-Service Portal account, they are able to set up an account via the link.
3. ProComm touchpoint 3: Informs the individual they will receive a Manual Medicaid Renewal packet in the mail and also provides a link for them to access and complete their renewal online. If the individual does not have a Self-Service Portal account, they are able to set up an account via the link.

4. ProComm touchpoint 4: Sends a renewal reminder to individuals who have not responded to the initial Manual Medicaid Renewal packet. They are provided a link to access and complete the renewal online. If the individual does not have a Self-Service Portal account, they are able to set up an account via the link.

ProComm Statistics (April 2023 - August 2024)	
Campaign Type	Total
One Time Welcome	499,508
Update Contact Info	536,947
Renewal Packet Sent	477,144
Renewal Submission Reminder	324,969

MCO and Other Partner Outreach to Members

During Unwinding, ODM supplied Medicaid MCOs, MyCare plans, and waiver case management entities lists of their members or clients who were not renewed through the ex parte process. These partners conducted outreach to these individuals when renewal packets were being sent and to inform them that they would receive a renewal packet and encourage them to respond promptly. The partners reported at least 1.1 million distinct outreach efforts to nearly 400,000 individuals over the course of the Unwinding. During this outreach, the individual's contact information in Ohio Benefits was confirmed and any address corrections were updated in Ohio Benefits via the Address Bot.

County Oversight, Support, and Training

ODM has divisions that monitor, support, and ensure county compliance in handling eligibility applications and renewals. Those divisions are County Engagement, County Compliance, and County Technical Assistance. Each has a distinct but important role in ensuring the integrity of the renewal process.

The County Engagement division met with all 88 counties at least quarterly but engaged with some counties weekly. This division received monthly reports from the County Compliance division on county case processing statistics for monitoring and intervention as needed. This division also provided post-training "hyper care support" to all counties and additional training session to counties as requested. This additional support helped ensure counties understood training materials and expectations during Unwinding.

The County Compliance Division was responsible for monitoring each county's application and renewal backlog. Activities they performed during Unwinding included developing various caseload reports and statistics that the counties could use to manage their caseloads and track their progress on unwinding.

The County Technical Assistance Division administered Unwinding-specific trainings and provided training materials to counties. Desk aid and other reference materials were developed and shared

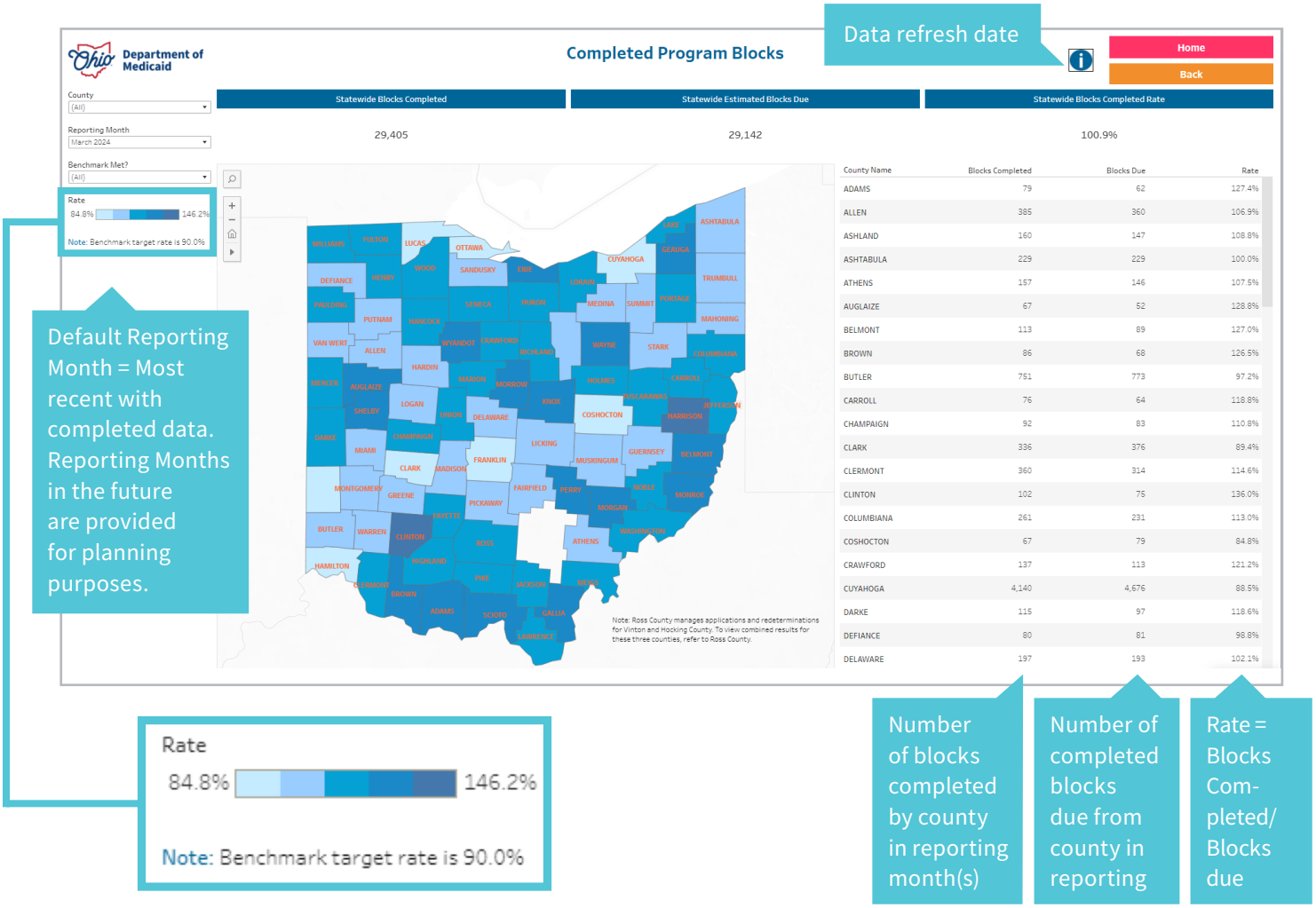
with counties and posted on their County Resources site.

In addition to the ODM trainings, the Ohio Department of Job and Family Services (ODJFS) provided training and support for the counties related to the Income Eligibility Verification System (IEVS). This training included county responsibility, completing IEVS matches, IEVS reports, and safeguarding federal tax information (FTI).

County Activities Dashboard & Monitoring Plan

During Unwinding, the [County Activities Dashboard] reported on metrics relevant to Unwinding and counties' Medicaid application and renewal activities. It allows members, stakeholders, legislators, and partners to view statewide and county-level performance data. It was intended to help counties determine their workload and monitor their monthly performance. Counties could also use the dashboard to look back at historical performance data during Unwinding and track their performance.

County Activities Dashboard

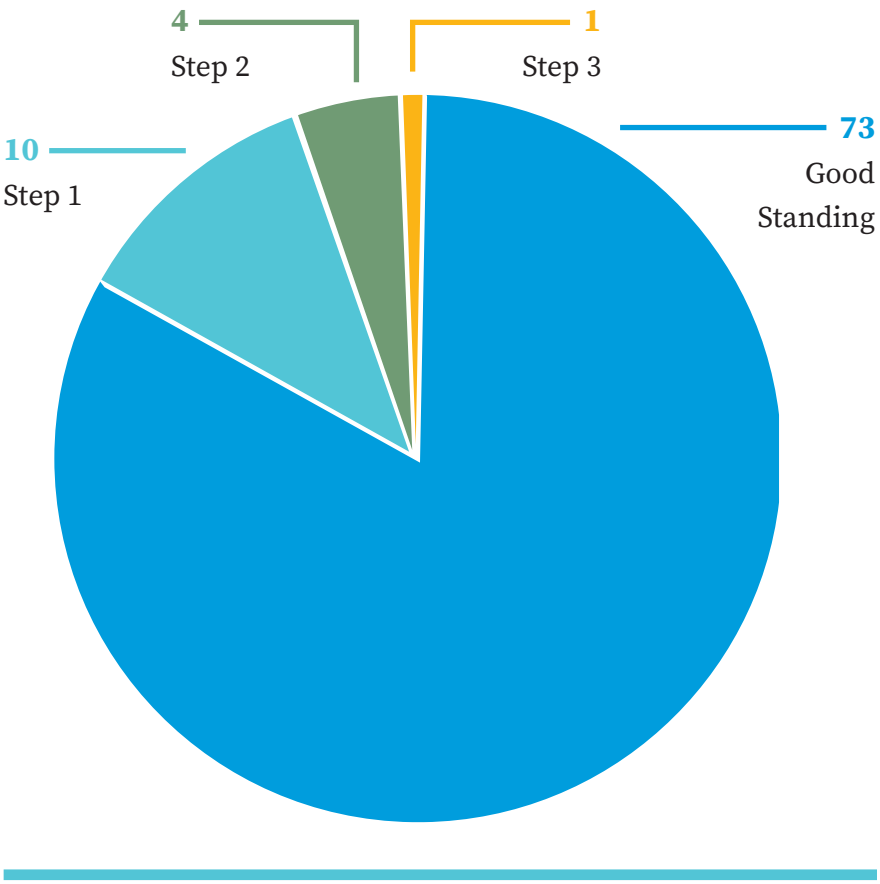


During Unwinding, Ohio counties were expected to complete 90% of cases due for renewal in a given month. Counties who did not meet this 90% benchmark were subject to interventions through the County Monitoring Plan. The County Monitoring Plan consisted of three steps for each month a county did not meet the benchmark. The months did not need to be consecutive.

- Step 1: The first month that the benchmark was missed an email was sent to the county directors and county compliance contacts. The email noted the county's processing rate and advised them that the next month the benchmark was missed, the county would be subject to possible interventions.
- Step 2: The second month the benchmark was missed the county was placed under a Corrective Action Plan throughout the remainder of Unwinding.
- Step 3: The third month the benchmark was missed the county could be subjected to financial consequences.

Intervention Status of All Counties

The number of counties in good standing, step 1, step 2, or step 3 at the end of Unwinding



PROGRAM INTEGRITY: FRAUD, WASTE, AND ABUSE

Program integrity is a bedrock of Ohio's Medicaid program. It is a place the department continues to strengthen and provide resources to ensure maximum transparency and accountability. Here again is another great example of where Ohio's extensive investments in automations and system improvements starting back in 2019 prepared ODM to handle the myriad of federal and state unwinding requirements.

In fact, a recently released federal U.S. Department of Health and Human Services, Office of Inspector General (HHS OIG) audit of Ohio's Unwinding found almost no errors in determinations. Additional information on the HHS OIG audit is provided in Section V.

Throughout the PHE, ODM, Medicaid MCOs, and ODJFS continued to make referrals to prosecutors for cases of alleged fraud. Investigation and prosecution of Medicaid recipient fraud is the responsibility of the county department and the county prosecutors.[6] Termination of Medicaid benefits due to fraudulent representations or verifications has long been part of the Ohio Medicaid programs operations.[7] From 2019 to 2023 MCOs made more than 1,100 referrals for fraud investigation of medicaid enrollees. The most common reasons for referral of enrolled members included enrollment, theft of identification, misuse of benefits and pharmacy or drug related reasons.

ODJFS also receives referrals for alleged fraud and abuse. ODJFS staff screen, log, and forward the complaints (if warranted) to the appropriate county agency for review and potential investigation. ODJFS also produces a monthly report that includes the number of tasks performed that are related to this investigatory work (e.g., phone call, email, referral, etc.).

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[5] Fraud as evidenced by conviction

[6] Ohio Administrative Code 5160:1-2-04

[7] Ohio Administrative Code 5160:1-2-01

FEDERAL MONITORING OF UNWINDING AND HHS OIG UNWINDING AUDIT

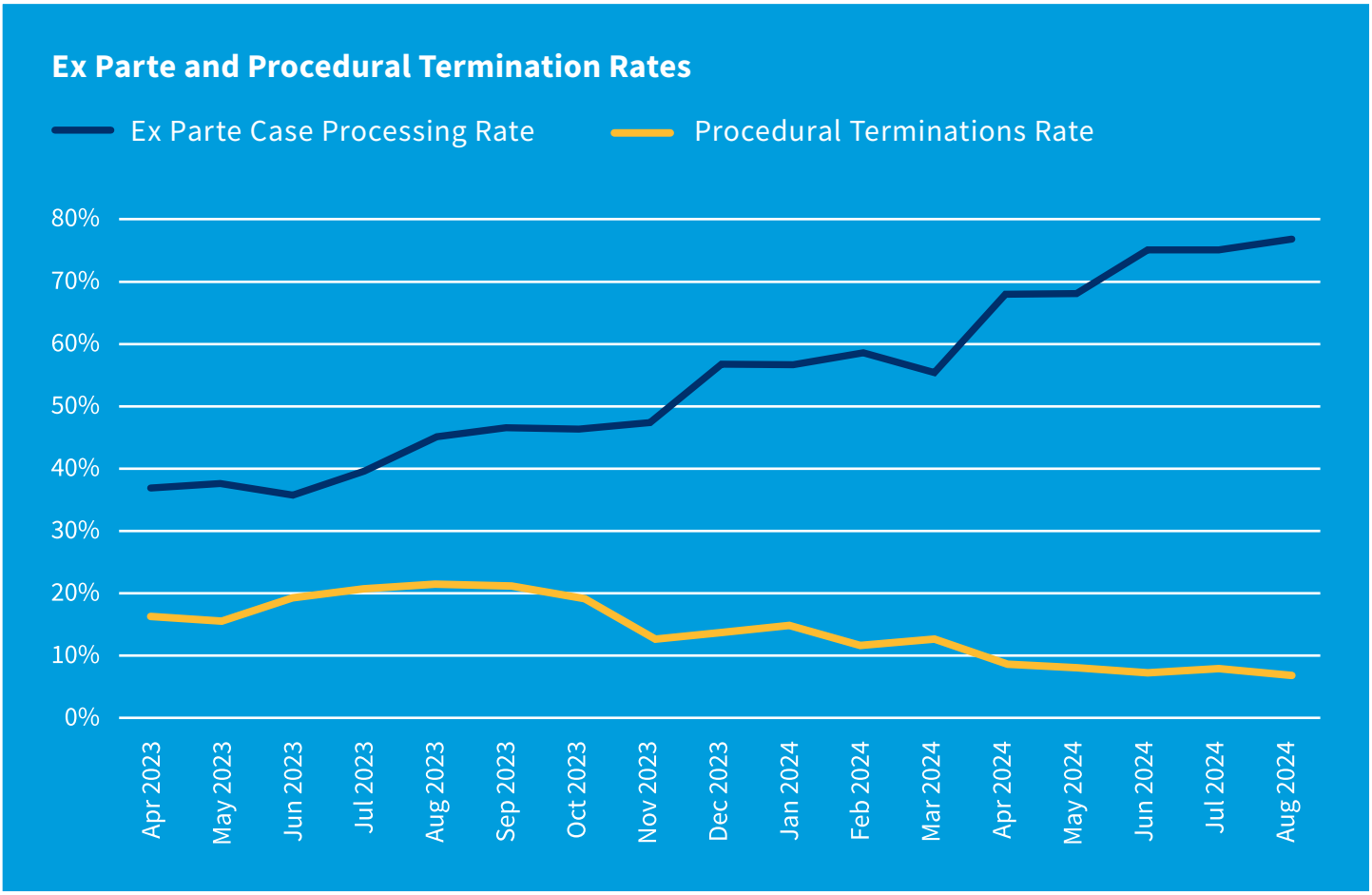
As required by SHO 22-001, and the CAA, 2023, all states were required to submit monthly data for a minimum of 14 months through a CMS-developed reporting template. These metrics were designed to demonstrate states' progress towards restoring timely application processing and completing renewals for all Medicaid and CHIP enrollees. ODM's reports were published monthly on ODM's Unwinding webpage.

On August 24, 2023, the U.S. Department of Health and Human Services, Office of Inspector General initiated an audit to determine whether ODM completed Medicaid eligibility actions in accordance with Federal and State requirements during the Unwinding period following the end of continuous enrollment. The audit included a review of 1,211,991 Ohio Medicaid enrollees who either had their Medicaid enrollment renewed or terminated during the period of April 1 through August 31, 2023. The audit found almost no errors and Ohio had re¬quired corrections. That full report is available on ODM's Unwinding resources web page and can be accessed here: "Ohio Generally Completed Medicaid Eligibility Actions During the Unwinding Period in Accordance with Federal and State Requirements".

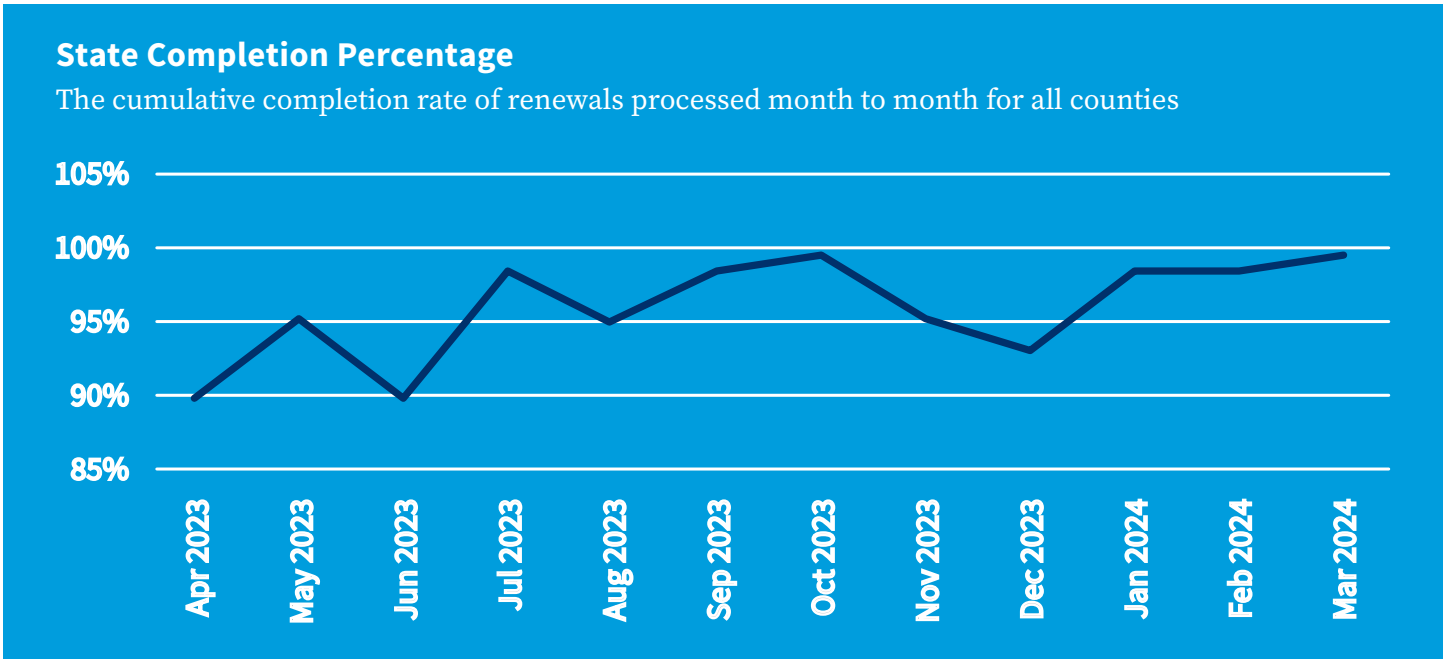
CONCLUSION

In April 2024, Ohio successfully completed its year-long unwinding plan. With unwinding behind us, the state has resumed normal eligibility operations. This was an enormous project for the department and counties, having processed nearly 3.4 million Medicaid cases.

The implementation of improvements and enhancements to the ex parte system led to an increase in cases processed through ex parte automated renewal and an overall decrease in coverage terminated due to procedural reasons (e.g., missing or incorrect paperwork). Nationally, Ohio was a top performing state in preventing terminations that were strictly limited to procedural reasons.



As a result of ODM's support for counties through training, resources, collaboration and data, counties processing rates increased throughout Unwinding. On average, Ohio counties processed **more than 97%** of their renewals due each month. Leveraging funds from H.B. 33, counties received incentive funds for each month they met the minimum standard of 90% caseload processing from September 2023 to March 2024. The amount was allocated by the county's overall Medicaid caseload as a proportion of the counties qualifying for incentives. All 88 counties received a bonus for this incentive.



National Comparison

Collectively, Ohio performed better than most states, even seeing performance improve throughout the PHE as a result of process and systems improvements. Overall:

- Ohio had a better than average retention rate for children,
- Ohio had a lower rate of procedural terminations than most states,
- Ohio had a higher renewal rate than most states,
- Ohio had a better rate of timely processing that most states , and
- By the end of the PHE, Ohio's ex parte rate exceeded 85%.

It is also worth noting that the federal government forced more than 23 states to pause their redeterminations for a variety of reasons.[8] Ohio was not one of these states, and in addition to completing its unwinding on time, received no sanctions and secured the full amount of available federal funds.

In closing, this report has been prepared to archive the incredible work, creativity, and collaboration Ohio showcased during the unwinding.

[8] See GAO, Medicaid: Federal Oversight of State Eligibility Redeterminations Should Reflect Lessons Learned after COVID-19. GAO-24-106883 (Washington, D.C.: Jan. 18, 2024).