



Ohio Department of
Medicaid

Performance Audit

October 2026



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

The Auditor of State's Office recently completed a performance audit for the Ohio Department of Medicaid (ODM or the Department). This review was conducted by the Ohio Performance Team and provides an independent assessment of operations within the Next Generation of Medicaid. This service to ODM and to the taxpayers of the State of Ohio is being provided at the request of the General Assembly.

This performance audit report contains recommendations, supported by detailed analyses, to enhance the overall efficiency, effectiveness, and transparency of the Department and its operations. This report has been provided to ODM and its contents have been discussed with the appropriate staff and leadership. The Department is reminded of its responsibilities for public comment, implementation, and reporting related to this performance audit per the requirements outlined under Ohio Revised Code § 117.461 and § 117.462. In future compliance audits, the Auditor of State will monitor implementation of the recommendations contained in this report, pursuant to the statutory requirements.

It is my hope that ODM will use the results of the performance audit as a resource for improving transparency, operational efficiency, and overall effectiveness. The analyses contained within are intended to provide leadership with information to consider while making decisions about their operations.

This performance audit report can be accessed online through the Auditor of State's website at <http://www.ohioauditor.gov> and choosing the "Search" option. Additional resources related to performance audits are also available on the Ohio Auditor of State's website.

KEITH FABER
Ohio Auditor of State

Tiffany L. Ridenbaugh, CPA, CFE, CGFM
Chief Deputy Auditor

October 15, 2026

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Ohio Department of Medicaid

Performance Audit Summary

WHAT WE LOOKED AT

The Ohio Department of Medicaid (ODM or the Department) is the designated single state agency responsible for the administration and oversight of Ohio's Medicaid program. In Ohio, there are more than 3 million individuals enrolled in Medicaid that receive free or low-cost healthcare. This program has more than \$40 billion in annual expenditures and accounts for approximately 43 percent of the state's annual operating budget. These expenditures include the state and federal share of the cost of administering the program along with payments related to healthcare services. Although ODM works with several other state agencies, local governments, and third-party vendors, the Department is ultimately responsible for the efficiency, effectiveness, and transparency of Medicaid in Ohio.

The Department is in the midst of a multi-year project to update and modernize systems and operations commonly referred to as the Next Generation initiative. In House Bill 96 of the 136th General Assembly, the Auditor's office was tasked with conducting a fiscal and performance audit of the Department's Next Generation system. Based on the requirements identified in the legislation, this performance audit reviewed the Department's strategic planning and performance evaluation, county oversight, contract management, and provider claim processing. These areas were identified to provide the Department with analyses that could improve overall operational performance.

WHAT WE FOUND

Medicaid is a large, complex program requiring the coordination of multiple organizations. Clear and consistent management practices and communication across the Department would be expected for effective operations and program outcomes. However, throughout the audit we encountered poor management practices including nonexistent overarching strategic and operational plans, minimal program evaluation practices, inconsistent contract management practices, inadequate utilization of data for performance improvement purposes, limited oversight over the County Departments of Job and Family Services that process Medicaid applications, and ineffective stakeholder engagement.

To facilitate the audit, the Department filtered information through an audit coordination group. While this is a normal function of large state agencies that undergo several audits, this group filtered all information rather than allowing AOS direct access to subject matter experts

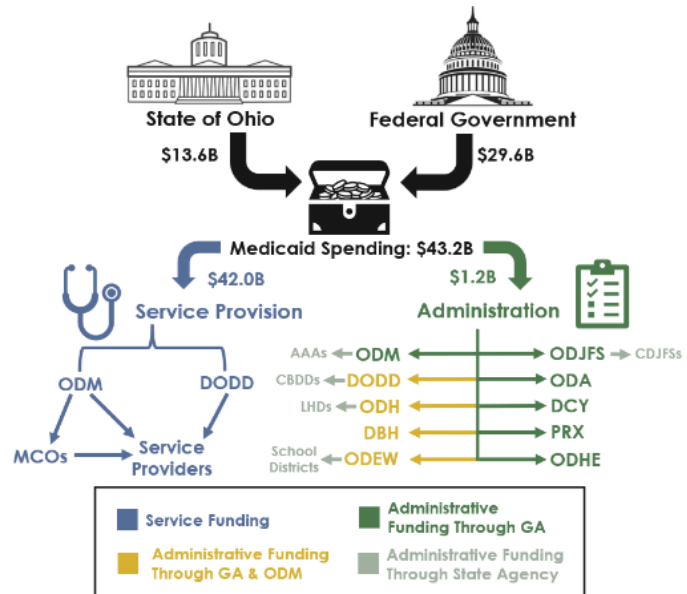
within ODM once the appropriate parties were identified. The interference from the audit coordination group at times led to delays in obtaining information and made it difficult to clarify issues through follow-up conversations. Through our interviews with other key stakeholders, we found this behavior of limiting access to information and creating additional work to obtain answers to questions an issue that permeated the Department.

Our audit found several areas where the Department can take steps to improve overall operations and increase transparency. Centralized strategic planning efforts can assist in aligning Department goals with operational management and performance evaluation efforts, which are currently not occurring on a consistent basis. Improved contract management efforts can help the Department to avoid costly overruns related to systems used in Next Generation. Data collection efforts beyond minimum requirements would allow ODM to proactively manage the Department's performance and respond to concerns in a more effective manner by providing detailed information to stakeholders. Enhancing ODM's oversight of the County Departments of Job and Family Services and collaboration with other state agencies overseeing public assistance programs would improve the timeliness and accuracy of application processing. In total, we made nine recommendations for the Department to implement and had one issue for further study for it to consider.

KEY OBSERVATIONS

Key Observation 1: Overall, we found that the Department operates on a culture of compliance, rather than one that is concerned with improving and optimizing program outcomes. In several instances we found that ODM was conducting the minimally required activity needed to meet federal and state guidelines. However, these minimum requirements often fall short of providing the information necessary to effectively review program outcomes and devise improvement plans. For example, the Department conducts a review of a sample of 800 Medicaid eligibility determinations on a triennial basis to identify the accuracy of the decisions. In 2025, the most recent year the Department conducted this review, there were approximately 850,000 Medicaid applications processed in Ohio. This quality control effort reflects a review of less than one percent of applications processed in a given year.

Key Observation 2: Medicaid is a \$40 billion program in Ohio, however not all of these funds flow through ODM. Although ODM is the single state agency responsible for oversight of Medicaid, there are seven other state agencies along with local entities and third-party vendors involved in Medicaid administration. Funding can go directly to other entities without passing through ODM, resulting in a funding structure that is complex and can result in confusion regarding responsibility.



Key Observation 3: We noted a lack of institutional knowledge throughout the audit process. While there was no evidence of turnover at higher rates than peer agencies, ODM staff members who were identified as subject matter experts were unable to answer questions about programs. In particular, several individuals that were identified as owning a program were generally unable to speak to the evaluation and measurement of outcomes of the program.

SUMMARY OF RECOMMENDATIONS

Strategic Planning and Management

Recommendation 1: ODM does not have organization-wide strategic, operational, or staffing plans in place to articulate the Department's goals and identify the activities and programs in place to achieve these goals. Strategic planning and program evaluation efforts for ODM's major programs are fragmented across multiple offices, with significant variation in the efficacy and intentionality of practices utilized by these offices. As a result, the divisions and offices within ODM are not operationally aligned, have institutional knowledge gaps, functional silos, and information retention issues. This makes it difficult for ODM to properly evaluate the effectiveness of programs and ensure that the program is effective and efficient. ODM should align strategic plans and program evaluation efforts throughout the Department with operational strategies. This will improve the overall operation of the Department as well as the delivery and efficiency of Medicaid programs.

Recommendation 2: ODM creates a biennial Medicaid Caseload and Expenditure Forecast Report in collaboration with the Office of Budget and Management that projects two years of

Medicaid enrollment and expenditures. This forecast is used in the development of Ohio's biennial budget to ensure that an appropriate amount of funding is allocated for the provision of healthcare services to Medicaid recipients. The Department considers a variety of factors in its forecast, including recipient characteristics, economic indicators, and population trends. ODM's forecasting process is largely aligned with best practices identified by the GFOA, except for ensuring the public transparency of forecast materials. While the Medicaid Caseload and Expenditure Forecast Report is publicly available on the Office of Budget and Management's website, ODM does not publish this report, instead producing monthly Budget Variance Reports comparing forecasted values to actual enrollment and expenditures. Additionally, none of these reports are accompanied by detailed forecast assumptions. The Department should enhance the transparency of its enrollment and financial forecasting process by publishing the forecast report and an accompanying public narrative in a central location.

Recommendation 3: Ohio's Medicaid program is facilitated by several third-party vendors that the Department contracts with for various functions, including information systems and managed care plans. These contracts represent a large portion of ODM's total spending. In SFY 2025, the Department spent 41.4 percent (\$253.4M) of its administrative expenditures on contracted services and 66.5 percent (\$27.9B) of its service expenditures on managed care, which is provided by contracted entities. We reviewed six of ODM's contracts that are critical to the "Next Generation" initiative and modularization of OMES. Half of the contracts with cost proposals had significant discrepancies between the planned costs and actual spending on the contracted service, amounting to over \$145 million in unplanned expenses. When comparing ODM's contract procurement and management efforts to best practices, we identified many opportunities for improvement. These opportunities varied from being unique to individual contracts we reviewed to being consistent across all contracts reviewed. The most significant deficiencies we observed were related to strategic planning, vendor references, stakeholder communication and engagement, training of contract managers, and documentation of review processes. ODM should utilize best practices to improve its contract management practices, which may result in fewer unplanned expenses, enhanced service delivery, and more comprehensive stakeholder engagement.

Recommendation 4: Healthcare providers are paid for services provided to Medicaid recipients through claims submitted to ODM. There are federal and state requirements that set timeframes in which claims must be processed and paid. The federal requirements are set through statute, while the state requirements are set through contracts with MCOs and the contractor for the Fiscal Intermediary, the system that processes fee-for-service claim payments. While our review of claim payment timeliness was limited in scope due to data availability, it indicated that the Department has been largely compliant with federal statutory requirements, while contracted entities have varying levels of compliance with the more stringent state contractual requirements. Additionally, we were unable to identify any systemic

changes in the timeliness of claim payments over the past five years for the points in the process where data was available. There may have been changes in timeliness associated with the process steps where data was not available, but we were not able to evaluate this.

The claim payment timeliness metrics currently collected, aggregated, and monitored by ODM are categorized into broad timeframes. These broadly categorized metrics do not allow for in-depth tracking of changes to claim payment timeliness over time or an adequate evaluation of contractor performance because the vast majority of claims are paid within the shortest timeframe measured. The Department should collect more detailed claim payment metrics and utilize it to effectively monitor and manage contractor performance over time, adjust contractual timeliness benchmarks, and improve the public transparency of the claim payment process.

County Oversight

Recommendation 5: In Ohio, public assistance programs are overseen by multiple state agencies, while the day-to-day processes relating to applications and eligibility determinations are the responsibility of County Departments of Job and Family Services (CDJFS agencies). Individuals who receive public assistance often qualify for and receive benefits from multiple programs; however, each state agency that oversees the programs has its own procedures and requirements for the application and renewal process. This can result in the CDJFS requiring multiple documents for the same basic information, such as income verification or residency. ODM should work with ODJFS and DCY to improve collaboration regarding the oversight of public assistance programs in Ohio. This could include aligning policies and procedures where possible and collaborating on training and guidance to reduce duplication of efforts.

Recommendation 6: Ohio Benefits is Ohio's eligibility and enrollment system for Medicaid and other public benefit programs. CDJFS caseworkers utilize this system to process applications and renewals, verify information, and make eligibility determinations and redeterminations. All of the counties we interviewed reported experiencing issues with Ohio Benefits. Over 20 common issues were pervasive among the respondents related to general functionality, determination accuracy, alerts, automation, and the self-service portal. ODM should work with ODJFS, which is responsible for managing Ohio Benefits, and CDJFS agencies, who are the primary users of the system, to identify and develop solutions for issues with Ohio Benefits. Doing so will improve application timeliness, determination accuracy, and the experiences of caseworkers and beneficiaries.

Recommendation 7: Medicaid applications are required by law to be processed within a certain number of days. Ohio has historically failed to meet this requirement and falls below the national average for processing timelines. While this information shows an opportunity and

need for improvement, ODM does not currently utilize appropriate county-level data that would allow it to comprehensively evaluate the performance of CDJFS agencies or identify the root causes of timeliness issues. ODM should enhance the collection of application processing timeliness data and use this information to identify issues delaying application processing and develop process improvements or other solutions accordingly. This should be done in conjunction with CDJFS agencies to ensure that solutions are appropriate and feasible.

Recommendation 8: As the state agency overseeing Medicaid in Ohio, ODM is responsible for ensuring the accuracy of Medicaid eligibility determinations and redeterminations, which are primarily made by CDJFS agencies. Once every three years, the Department conducts 800 case reviews over a 12-month period in compliance with federal minimum standards for the Medicaid Eligibility Quality Control (MEQC) program. This represents less than one percent of the total number of applications and renewals processed in Ohio. In MEQC off-years, ODM conducts additional, less standardized case reviews. The limited and inconsistent data obtained through current quality control efforts cannot be used to confirm the accuracy or effectiveness of CDJFS operations across the state. Further, this information cannot be reliably used for year-over-year comparisons or performance management efforts. In addition, ODM does not effectively communicate the results of comprehensive quality control case reviews to the counties, which limits the ability of CDJFS agencies to use this information to improve internal operations or performance management. ODM should expand, standardize, and communicate quality control efforts to improve the accuracy of eligibility determinations and redeterminations throughout the state.

Issue for Further Study 1: The State is required to conduct eligibility redeterminations for all Medicaid recipients each year and renew coverage for recipients who are still eligible. These renewals can be completed manually, in which recipients fill out a renewal form and CDJFS caseworkers process the renewal, or passively, in which the Ohio Benefits system processes the renewal automatically using electronic data sources. Having a passive ex parte renewal process is important for reducing application processing times, reducing CDJFS workloads in some cases, and reducing rates of procedural disenrollment. However, improper passive ex parte renewals also come at a cost to taxpayers. Several CDJFS agencies we spoke to expressed concerns that individuals they know are not eligible for Medicaid have been passively renewed without any way to for the CDJFS to discontinue their enrollment. In some cases, CDJFS agencies discussed how the recipients themselves were not aware they were still enrolled in Medicaid. Given Ohio's use of managed care, this means Ohio may be paying capitation rates for individuals who are not eligible for Medicaid.

Stakeholder Engagement

Recommendation 9: During our audit, we observed a significant variation in the use and efficacy of stakeholder engagement efforts across the Department. This includes not engaging with key stakeholders during procurement processes, failing to successfully engage with partner agencies conducting eligibility application processing, and not publishing critical data and narratives that would inform public understanding of the program. Additionally, ODM does not have public guidance for engaging in the rulemaking process posted in the Register of Ohio, which is in violation of ORC § 119.0311. ODM also lacked proper stakeholder identification. This resulted in limited public engagement for the one rule change we reviewed. This lack of standardized stakeholder engagement across Department can be attributed to the absence of any overarching operational plans and stakeholder-focused leadership. ODM should develop and utilize a stakeholder engagement plan to standardize and improve stakeholder engagement efforts throughout the Department.

FOR EXECUTIVE CONSIDERATION

The audit work contained in this report highlights key management issues with a large state agency, consistent with the findings of previous audit work of specific aspects of the Medicaid program. For more information on those prior audit findings, visit the Ohio Auditor of State's [Medicaid Audits page](#). As one of the largest state agencies, even small changes in efficiency and effectiveness can lead to dramatic programmatic savings for Ohio's taxpayers.

Several areas identified in this audit are multi-agency issues that therefore concern the Governor's office. The governor appoints agency directors, and is ultimately responsible for agency operations within the state. The gubernatorial administration that takes office in 2027 could utilize these recommendations and their executive direction to facilitate improvements to areas impacting multiple agencies. This includes the alignment of eligibility policies and procedures where possible, collaborative training opportunities, and improvements to Ohio Benefits. Having support for the associated improvements not just from the relevant agencies but also clear directive from the Governor's office to work together can aid in implementing the recommendations with fidelity.

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Dear Fellow Ohioans –

For the past eight years, my office has examined Ohio's Medicaid program and identified weaknesses that threaten taxpayer dollars, undermine accountability, and create unnecessary challenges for those who rely on the system.

Our latest performance audit of the Ohio Department of Medicaid's Next Generation initiative confirms that these are longstanding management and oversight problems, not isolated failures, in one of Ohio's largest and most expensive programs.

Medicaid spends more than \$40 billion annually, approximately 43 percent of Ohio's operating budget. Yet our audits have found deficiencies in eligibility verification, unresolved alerts involving recipients potentially enrolled in multiple states, inadequate documentation supporting provider payments, and persistent problems with the Ohio Benefits system. One audit found that 59 percent of reviewed interstate eligibility alerts were not properly addressed; another identified more than 124,000 individuals enrolled in both Ohio Medicaid and another state's program for at least three consecutive months.

Our latest audit found that ODM lacks comprehensive strategic and operational plans, relies on limited performance measures, and inconsistently manages contracts. Among the contracts reviewed, discrepancies between planned and actual spending exceeded \$145 million. We also found inadequate oversight of county eligibility operations and ongoing communication problems among agencies, providers, and stakeholders.

These findings reflect a culture that too often prioritizes minimum compliance over meaningful results. Our recommendations call for clear management and performance expectations; stronger eligibility and payment verification; better coordination among state and county agencies; greater transparency in spending and contracting; and regular reporting on corrective actions and outcomes.

Sustained leadership from the next administration and continued legislative oversight will be essential. Additional technology and spending alone will not resolve problems in anchored in management and accountability.

Ohioans deserve a Medicaid program that provides necessary care to eligible recipients while protecting public resources. After eight years of findings and recommendations, the question is if not now, then when, will changes be made that protect services for our most vulnerable populations?

I believe this report and our previous audits provide a roadmap for effective change.

Sincerely,

Keith Faber
Ohio Auditor of State

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Introduction

Medicaid is a nationwide governmental health insurance program designed to provide free or low-cost health coverage for eligible low-income individuals. Established federally in 1965 and adopted by Ohio in 1968, Medicaid is jointly funded by federal and state governments, along with local funding in some states. State governments are responsible for the administration of the Medicaid program, in accordance with the requirements and regulations set by the federal government. As a part of this responsibility, states are able to establish eligibility standards, determine which services are covered, and set the rates of payment for these services within the confines of federal requirements. The federal government is charged with monitoring the administration, performance, and outcomes of state Medicaid programs, as well as providing the majority of the funding. This duty is the responsibility of the federal Centers for Medicare and Medicaid Services (CMS).

Medicaid vs Medicare

Medicaid and Medicare both provide health insurance to eligible individuals. **Medicaid** provides coverage to low-income individuals and is administered by state governments. **Medicare** provides coverage to individuals over the age of 65 and is administered by the federal government.

This report focuses on the administration of Medicaid in Ohio. However, there are individuals that are eligible for both programs (dually eligible individuals).

Services covered by Medicaid, both on a state and national level, span a wide range of healthcare needs, including preventative care, vision, dental, behavioral health, pregnancy, prescription drugs, medical equipment, inpatient and outpatient hospital services, emergency room visits, family planning, vaccinations, and professional medical services. These services are provided free of charge, or for a small co-pay, to individuals that meet income and citizenship or residency requirements or fall within other qualifying populations. These populations include low-income pregnant women, infants, children, older adults, and individuals with disabilities.

When Medicaid was first established, it was designed to serve certain low-income populations, specifically children and their caretakers, older individuals, and individuals with disabilities. Over time, the populations served and low-income requirements have expanded through various programs and legislation, including the Children's Health Insurance Program (CHIP) for additional low-income children and the Affordable Care Act (ACA) for low-income adults.¹ The ACA expanded Medicaid eligibility to include all adults under the age of 65 that meet low-income requirements. However, a 2012 Supreme Court ruling gave states discretion in adopting

¹ Other groups include women with breast or cervical cancer and individuals in home or community-based care settings. For a full description of eligible populations, see [Eligibility](#) section.

this expanded eligibility.² Ohio, along with 25 other states and the District of Columbia, adopted expanded eligibility in CY 2014. Since then, an additional 14 states have done the same, leaving only 10 states not participating in the optional eligibility expansion. See [Appendix B](#) for a list of expansion and non-expansion states, as well as more information about Medicaid's history. In Ohio, adults enrolled in Medicaid under this expanded eligibility requirement is referred to as Group VIII.³

Medicaid has costs associated with the administration of the program and the provision of healthcare services. Federal and state governments share the costs associated with providing Medicaid services, while administrative costs are shared between federal, state, and local governments. The federal share of Medicaid expenditure is provided to states in the form of reimbursements for qualifying Medicaid expenditures. The level of reimbursement each state receives is dictated by a match rate called the Federal Medical Assistance Percentage (FMAP), which is the percentage of Medicaid spending that is covered by the federal government. This rate is updated annually by the U.S. Department of Health and Human Services. The FMAP rate is primarily based on each state's per capita income compared to the national average, resulting in states with a lower per capita income receiving a higher match rate. All states receive an FMAP rate of at least 50 percent. For more information on Ohio's FMAP rates, see the [Financial Background](#).

In order to be eligible for federal reimbursement, there are certain federal requirements that states must meet. First, states must provide Medicaid coverage to mandatory populations, including low-income pregnant women, children, people with disabilities, and older adults.⁴ Second, this Medicaid coverage must include certain mandatory benefits including hospital, physician, and nursing home services. States are able to receive federal reimbursements for services and populations outside of these requirements with federal approval, but must cover mandatory populations and services to receive federal matching funds.

The Ohio Department of Medicaid (ODM or the Department) is the single state agency responsible for the administration and oversight of Ohio's Medicaid program. ODM accomplishes this responsibility with the assistance of other state agencies and local governments. Approximately one in four Ohioans receive health insurance coverage through Medicaid, which, in Ohio, is over 3 million individuals. Specifically, Medicaid covers about 38 percent of children and 63 percent of nursing home residents in Ohio. With annual

² National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012).

³ This title is a reference to the section of the Social Security Act that created the new adult group: 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

⁴ Low-income older adults who are enrolled in both Medicaid and Medicare are considered dually eligible. ODM utilizes the MyCare program to coordinate services for dually eligible individuals.

expenditures of more than \$40 billion, Medicaid is the largest single state program on an all funds basis and accounted for approximately 43 percent of Ohio's total operating budget in State Fiscal Year (SFY) 2026.⁵

⁵ The annual expenditure for Ohio's Medicaid program accounts for about five percent of Ohio's gross domestic product, according to the Legislative Service Commission's Greenbook for ODM.

Audit Methodology

In House Bill 96 of the 136th General Assembly, the Ohio legislature mandated that the Ohio Auditor of State complete a performance and financial audit of the Ohio Department of Medicaid in accordance with Chapter 117 of the Ohio Revised Code (ORC). This bill specifically prescribed that these audits would focus on the Department’s “Next Generation” initiative, which represents ODM’s plans to modernize Medicaid operations in Ohio. For the full bill language, see [Appendix C](#).

The Ohio Auditor of State, through its Ohio Performance Team (OPT), is required by ORC § 117.46 to complete at least four performance audits of state agencies or, at its discretion, institutions of higher education during each biennium.⁶ In August 2025, OPT initiated a performance audit of the Ohio Department of Medicaid in accordance with House Bill 96. The audit was designed to provide insight into the overall efficiency, effectiveness, and transparency of the Department’s operations. Specific scope areas included reviews of the Department’s strategic planning and performance evaluation, the Department’s program and financial forecasting, county performance variation, the Department’s contract management practices, and the Department’s provider claim processing and interactions.⁷ This review did not include examination of Medicaid fraud or the validity of the Department’s financial reporting, which are conducted by the Auditor of State’s Medicaid Contract Audit and Financial Audit Divisions.⁸ This report contains findings from our audit and recommendations which will assist organizational leadership and policymakers in improving program operations.

ODM’s “Next Generation”

“Next Generation” is an ODM initiative that began in 2019 to implement new information systems, revise managed care plans, and adjust the provider experience. ODM’s goals for this initiative are listed below.

- Improve wellness and health outcomes;
- Emphasize a personalized care experience;
- Support providers in better patient care;
- Improve care for children and adults with complex needs; and,
- Increase program transparency and accountability.

⁶ Performance audits are conducted according to Generally Accepted Government Auditing Standards, see [Appendix A](#) for additional details.

⁷ See [Appendix A](#) for a full listing of audit objectives.

⁸ For additional reports regarding these and other topics reviewed by the Medicaid Contract Audit and Financial Audit Divisions, visit the Ohio Auditor of State’s [Audit Search](#).

A Note on Fiscal Years

Financial data is often reported on a fiscal year basis rather than on a calendar year basis. Ohio operates on a different fiscal year from the federal government, while counties typically follow the standard calendar year. The calendar year (CY) begins on January 1 and ends on December 31. The State Fiscal Year (SFY) begins on July 1 and ends on June 30 of the following year, identified by the year end in June. The Federal Fiscal Year (FFY) begins on October 1 and ends on September 30 of the following year, identified by the year end in September.

Ohio Department of Medicaid

The Ohio Department of Medicaid (ODM or the Department) is the single state agency responsible for the administration of Medicaid in Ohio. This means that the Department is federally accountable for implementing Ohio’s Medicaid program, even when other entities perform specific functions. To accomplish this, ODM facilitates the transfer of funds from the federal and state government to healthcare providers and county governments, and is responsible for overseeing the operations of these entities to ensure funds are spent appropriately. The Department also develops and maintains information systems used for Medicaid administration, monitors eligibility and enrollment processes to identify inconsistencies and fraud, and devises strategies to ensure access and improve the quality of care provided to Medicaid enrollees. As a cabinet agency, ODM’s Director is appointed by the Governor, with the consent of the Senate, and serves in the Governor’s cabinet.

The state agency tasked with administering Medicaid in Ohio has changed several times since the program was enacted in Ohio in 1968. In 2006, the Ohio Medicaid Administrative Study Council released a report recommending the establishment of a new cabinet-level agency to optimize the program’s fiscal and operational goals. In 2014, the Ohio Department of Medicaid was established as a standalone cabinet agency. For a full history of the state agencies that have administered Medicaid in Ohio, see [Appendix B](#).

Structure and Organization

There are two primary models for the administration of Medicaid eligibility determinations. The first is referred to as “state-administered” and the second is referred to as “state-supervised, county-administered.” These administrative models are defined in the graphic below. Various models for the provision of Medicaid services are outlined in the [Service Provision](#) section.

Administrative Models for Medicaid Eligibility Determinations

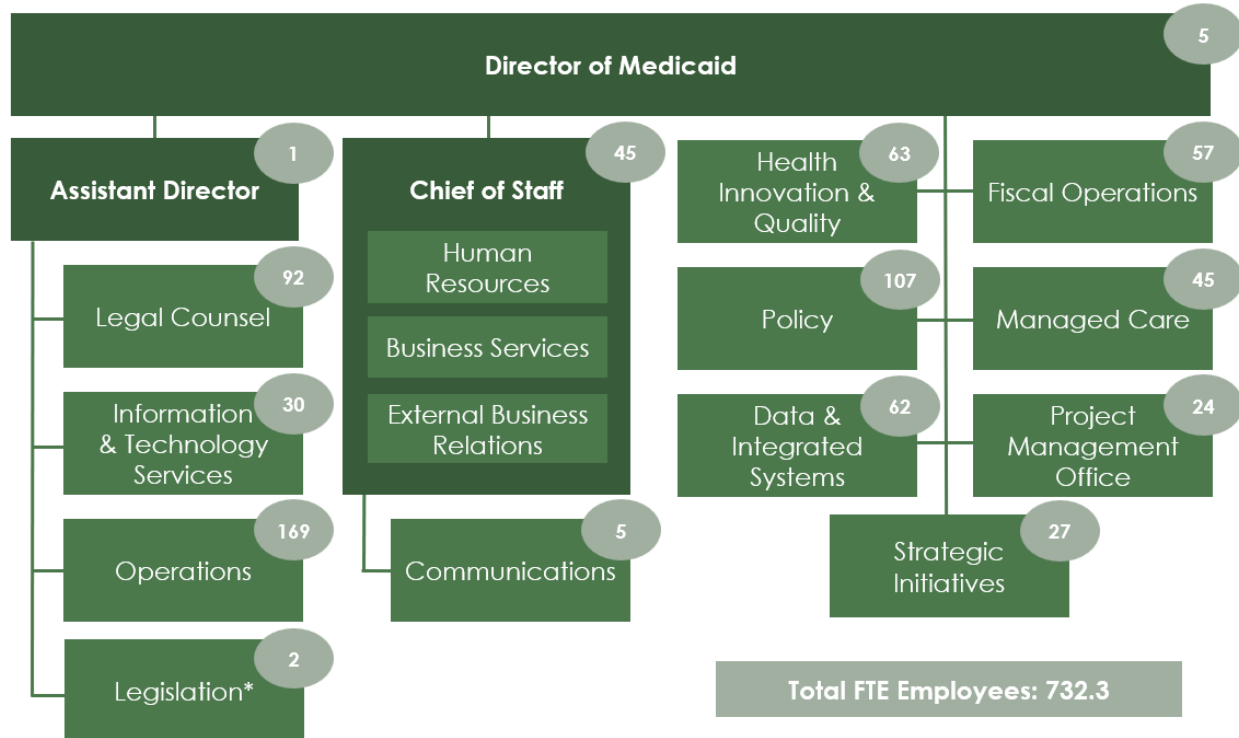
State-Administered	State-Supervised, County-Administered
<u>State</u> administers all aspects of Medicaid, including application processing, eligibility determination, and enrollment of recipients.	<u>State</u> provides guidance, training, and funding to local government entities. <u>Local</u> government entities are responsible for application processing, eligibility determination, and enrollment of recipients.
40 states & D.C.	10 states

Efficient • Effective • Transparent

Ohio is one of only ten states that utilizes the state-supervised, county-administered model for the determination of eligibility for Medicaid and other social services. The local entities responsible for processing Medicaid applications and documentation, determining eligibility, and enrolling individuals to receive benefits in Ohio are county governments, specifically the county departments of job and family services (CDJFS agencies) through a Memorandum of Understanding with the Ohio Department of Job and Family Services (ODJFS). As a result, the majority of the staff responsible for Medicaid eligibility determinations are employed at the county level. ODM provides county staff with guidance, training, and technological infrastructure to enable them to perform these duties and ensure consistency across the state. The ODJFS provides funding to CDJFS agencies for this purpose, along with the funding provided for the social support programs that ODJFS oversees.

In order to accomplish its wide range of responsibilities, ODM is organized into a variety of sub-units referred to as departments, bureaus, or offices. In SFY 2025, the Department employed a total of 732.3 full-time equivalent (FTE) employees. This does not include the county staff employed at CDJFS agencies who are responsible for determining Medicaid eligibility. The majority of ODM's employees are based in Columbus, although a few employees work at regional offices located in Cincinnati, Cleveland, and Mansfield. The organizational chart on the following page shows the primary departments within ODM and the number of FTE employees working in each.

SFY 2025 ODM Table of Organization⁹



Source: OAKS & ODM Table of Organization

*There were multiple vacancies within Legislation in SFY 2025.

Note: Assistant Director does not have staff outside of the four offices, while the Chief of Staff does. FTE counts are calculated by taking the average of three points in time within SFY 2025. Individual departments' FTEs are rounded and therefore do not sum to the total FTE. The counts in this graphic represent actual average FTE rather than approved headcounts.

Most of the primary departments displayed in the table of organization above are broken down into subunits with specific purposes. In total, ODM has 42 subunits within these primary departments, some of which are broken down even further into bureaus or divisions. The three largest primary departments, their purposes, and some of their subunits are described below. For a full breakdown of the Department's subunits, see [Appendix D](#).

The largest office within ODM is Operations, with 169.2 FTE employees in SFY 2025. This office focuses on provider and eligibility operations, including Business Operational Supports, Claims Operations, Network Management, and the Ohio Benefits System. Business Operational Support is responsible for overseeing and communicating with counties, which includes providing in-person and online trainings and resources for CDJFS case workers, monitoring the

⁹ A new Director of Medicaid was appointed in October 2025.

accuracy of eligibility determinations, issuing guidance related to new rules and regulations, and assisting counties with questions, technical issues, or business processes. Claims Operations runs the third-party liability program and the Medicaid Buy-In program. Network Management is responsible for all provider network requirements, including enrollment, credentialing, oversight, and compliance. The Ohio Benefits system team works with the Ohio Department of Administrative Services (DAS) to design, plan, and execute federal eligibility rules within the Ohio Benefits system.

The second largest office within ODM is Policy, with 107.0 FTE employees in SFY 2025. This office is responsible for all of Ohio's Medicaid policies that are not related to Managed Care Entities.¹⁰ This includes the administrative rules and regulations for providers of long-term healthcare, behavioral healthcare, hospital services, and other medical services provided to Medicaid recipients outside of Managed Care Entities, many of which are necessitated by federal policy changes. These rules and regulations are often codified in the Ohio Administrative Code (OAC). The office additionally oversees the Medicaid State Plan and various waiver programs. Administrative rules and regulations for Managed Care Entities specifically are handled by ODM's Managed Care office.

The third largest office within ODM is Legal Counsel, with 92.0 FTE employees in SFY 2025. In general, the functions of the office include providing legal guidance, coordinating litigation affecting the Department, preparing and processing contracts and procurements, and ensuring the Department meets all privacy standards. Additionally, this office houses the Bureau of Program Integrity, a subsection that works to detect and prevent fraud, waste, and abuse.

While these three offices contain approximately 50.3 percent of ODM's FTE, there are ten other offices that contribute to the Department's overall operations. See [Appendix D](#) for more information about the Department's structure and operations, including descriptions for other offices.

¹⁰ Managed Care Entity (MCE) is the overarching name for entities which includes Managed Care Organizations (MCOs), Primary Care Case Management, Prepaid Inpatient Health Plan, and Prepaid Ambulatory Health Plan. While ODM has responsibilities that include all of these MCEs, the focus within this report will be on MCOs, which are discussed further in the following section.

Additional Contributors

In addition to ODM employees, numerous other entities have employees that play a role in the administration of Ohio's Medicaid program. This includes 86 CDJFS agencies, as previously mentioned,¹¹ which employ clerical staff and caseworkers to process applications and make eligibility determinations, as well as seven managed care organizations (MCOs), which employ staff to facilitate the provision of services to Medicaid recipients and payments to providers for these services. It also includes the entities that ODM contracts with for information systems, the other state agencies that have administrative responsibilities for the program, and additional local entities that receive Medicaid funding. For more information on these entities, see the [Entities Involved in Medicaid Administration](#) section. Due to the number of entities involved in Medicaid administration in Ohio, it is difficult to accurately quantify the total number of staff contributing to the program. Therefore, accurately comparing Ohio's total staffing resources to that of other states in order to understand efficiency is not possible.

Service Provision

Services covered by Medicaid span a wide range of healthcare needs, including preventative care, vision, dental, behavioral health, pregnancy, prescription drugs, medical equipment, inpatient and outpatient hospital services, emergency room visits, family planning, vaccinations, and professional medical services. The federal government requires states to cover some of these services, while others are optional and covered at each state's discretion.

Ohio provides Medicaid healthcare coverage through one of two models: managed care organizations (MCOs) or fee-for-service (FFS). Within FFS, there is another category referred to as limited coverage. In these models, Medicaid pays for the majority of medical costs either directly to providers or indirectly through third-party organizations. These costs are referred to as service expenditures. In addition to service expenditures paid with federal and state funding, select medical services require Medicaid enrollees to pay co-payments to health care providers at the time of service.

MCO: The majority of Ohio's Medicaid enrollees receive benefits through MCOs, which are privately-operated health insurance companies. The Department selects and contracts with MCOs, which in turn develop a network of providers to deliver services to enrollees. ODM pays the MCOs a monthly premium for each enrollee, called a capitation payment. In return, MCOs pay for all of the healthcare services required by their enrollees. The intent of this model is to improve budget predictability for ODM by shifting the financial uncertainty associated with the

¹¹ Hocking County, Ross County, and Vinton County are combined into one CDJFS agency referred to as South Central.

variation in medical services needed by Medicaid recipients onto the MCOs. The model is also intended to outsource administrative responsibility and improve health outcomes. Since it was first introduced in the 1970s, the State of Ohio has been expanding its use of managed care by shifting more populations into this model, which is aligned with national Medicaid enrollment trends. The current statewide managed care program, which was introduced in 2005, is mandatory for certain populations. MCO enrollment has continued to increase over the past 10 years, with 87.2 percent of Ohio’s Medicaid recipients enrolled in an MCO in SFY 2025.

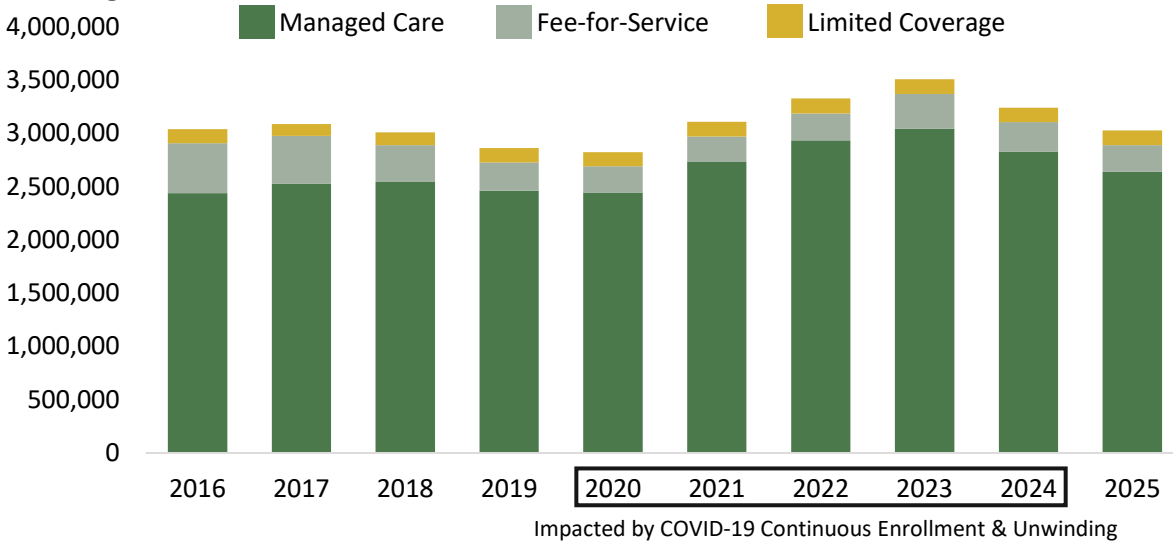
FFS: Under the more traditional model, FFS, Medicaid providers are paid directly by ODM for each service provided. The rates of payment are outlined in the Ohio Administrative Code (OAC). A much smaller portion of Medicaid enrollees receive services through this model. The largest populations of enrollees in this model are individuals with developmental disabilities in need of long-term care, individuals that are dually eligible for Medicaid and Medicare, and newly enrolled individuals that have not yet been enrolled in an MCO. FFS enrollment has declined over the past ten years, with 8.1 percent of Ohio’s Medicaid recipients enrolled in FFS in SFY 2025. This decline has likely been impacted by the introduction of MyCare, a managed care program specifically for dually eligible individuals.

Limited Coverage: The final portion of Medicaid recipients in Ohio are those enrolled in specific eligibility groups that are provided limited healthcare services on a fee-for-service basis. This includes the Medicare Premium Assistance Program, which helps low-income older adults pay for the premiums, deductibles, and copays associated with Medicare. It also includes the Refugee Medical Assistance Program, which provides temporary health coverage to low-income refugees who are ineligible for Medicaid during their first eight months in the United States. The final group in this category is presumptive eligibility, which allows uninsured residents to get immediate access to Medicaid services without waiting for their application to be processed, if they meet certain criteria. Once these individuals are determined eligible, they are shifted into the appropriate eligibility group and corresponding service delivery model. In SFY 2025, only 4.7 percent of Medicaid enrollees received limited coverage, a level of enrollment that has increased slightly over the past ten years.

The graph on the following page shows the breakdown of full-year equivalent (FYE)¹² Medicaid enrollees between these three service delivery categories over the past ten SFYs.

¹² FYE enrollment is calculated by taking the average of each month’s Medicaid enrollment headcount.

SFY 2016-2025 Medicaid FYE Enrollment by Service Delivery Category



Source: ODM Caseload Reports

Over this ten-year period, Ohio's Medicaid enrollment peaked in SFY 2023 with 3.5 million enrollees. The increase in enrollment from SFY 2020 to SFY 2023 can be largely attributed to the mandatory continuous enrollment of Medicaid recipients during the COVID-19 pandemic. During this time period, the federal government provided additional Medicaid funding to states and required states to maintain the enrollment of nearly all Medicaid enrollees, regardless of their eligibility status. When the continuous enrollment provision ended in SFY 2023, states had to redetermine eligibility of all Medicaid enrollees, leading to a decrease in enrollment in SFY 2024 to 3.2 million enrollees and SFY 2025 to 3.0 million enrollees. This process has been referred to as unwinding.

*Eligibility*¹³

To be eligible for Medicaid coverage in Ohio, applicants must generally be an Ohio resident and meet citizenship and financial requirements.¹⁴ Additionally, each program within Medicaid has its own specific requirements that applicants must meet to enroll. While almost all Medicaid recipients must be low-income, each program has a specific income requirement that

¹³ This section is intended to provide broad background information regarding eligibility in Ohio and should not be used for determining your own eligibility. To check your eligibility for Medicaid and other benefits, utilize the [Ohio Benefits Self-Assessment](#) or contact your local County Department of Job and Family Services office.

¹⁴ Non-United States citizens must meet non-citizen requirements outlined in OAC Rule 5160:1-2-12.

applicants must meet. The methodology used to calculate income varies based on applicant type. A Modified Adjusted Gross Income (MAGI) is used for most applicants, while an alternative methodology based on the income calculation for Supplemental Security Income (SSI) is used for applicants over the age of 65 and individuals applying on the basis of disability or blindness. This alternative methodology is referred to as Non-MAGI. Some programs may also have asset limitations.¹⁵ Programs that are intended to serve special populations typically have medical need or demographic requirements. More information about these special populations, programs, and eligibility requirements is available on the Department's [website](#). Those who meet eligibility requirements are broadly categorized into four overarching Medicaid eligibility groups. These groups are shown and defined in the graphic below.

Medicaid Eligibility Groups

Aged, Blind, and Disabled (ABD)	Covered Families and Children (CFC)	Group VIII	Other
Individuals that are dually eligible for Medicaid and Medicare Individuals with disabilities Individuals that are eligible for SSI Individuals enrolled in Medicaid Buy-In for Workers with Disabilities	Low-income families, children, and pregnant women Includes individuals enrolled in Medicaid and CHIP programs	Low-income adults that are eligible to receive services due to Medicaid expansion Includes individuals between the ages of 19 and 64 who do not qualify under other eligibility categories	Individuals enrolled in the Medicare Premium Assistance Program Individuals enrolled through Presumptive Eligibility Individuals enrolled in the Refugee Medical Assistance Program

Source: ODM Caseload Reports, Health Policy Institute of Ohio

Note: Individuals enrolled through Presumptive Eligibility can fall into any MAGI eligibility category. They are captured in the Other category until their eligibility determination is finalized.

¹⁵ In regard to Medicaid eligibility, "income" means cash, in-kind income, or something of value which is received, available, and attributable to an individual. "Assets" means all income and resources of the individual and of the individual's spouse. See OAC Rule 5160:1-1-01 for more information.

The ABD and Other categories have multiple separate programs that fall within them. Medicaid Buy-In for Workers with Disabilities, which falls within ABD, is a program designed to enable Ohioans with disabilities to work while still keeping their Medicaid coverage. The Medicare Premium Assistance Program (MPAP), Presumptive Eligibility, and Refugee Medical Assistance Program (RMAP) all fall within Other.¹⁶

Each of these eligibility groups have different levels of income required to be eligible for Medicaid. Income requirements are determined by taking a percentage of the Federal Poverty Level (FPL). The FPL is updated annually by the U.S. Department of Health and Human Services. As a result, the income requirements for Medicaid in Ohio change each year. However, the FPL percentages have not changed since CY 2014, when Ohio adopted expansion. The table below displays the income requirements for each of the four overarching eligibility groups in CY 2025.

Ohio Medicaid Eligibility Groups and Income Thresholds

Eligibility Group	Who?	FPL Percentage	Income Level for One Person in FFY 2025
Covered Families and Children (CFC)	Families	90%	\$14,085
	Pregnant Women	200%	\$31,300
	Children	206%	\$32,239
Group VIII	Adults under age 64	138%	\$21,597
Aged, Blind, and Disabled (ABD)	ABD – Single Individuals*	74%	\$11,604*
	ABD – Married Individuals*	82%	\$17,400*
	MBIWD	250%	\$39,125
Other	MPAP	100-135%	\$15,650-\$21,128
	RMAP	100%	\$15,650

Source: ODM & U.S. Department of Health and Human Services

*ABD eligibility is determined based on monthly income per SSI eligibility criteria. This table displays this income annually for comparison to other eligibility groups. ABD – Single Individuals represents the income for a family of one, while ABD – Married Individuals represents the income for a family of two.

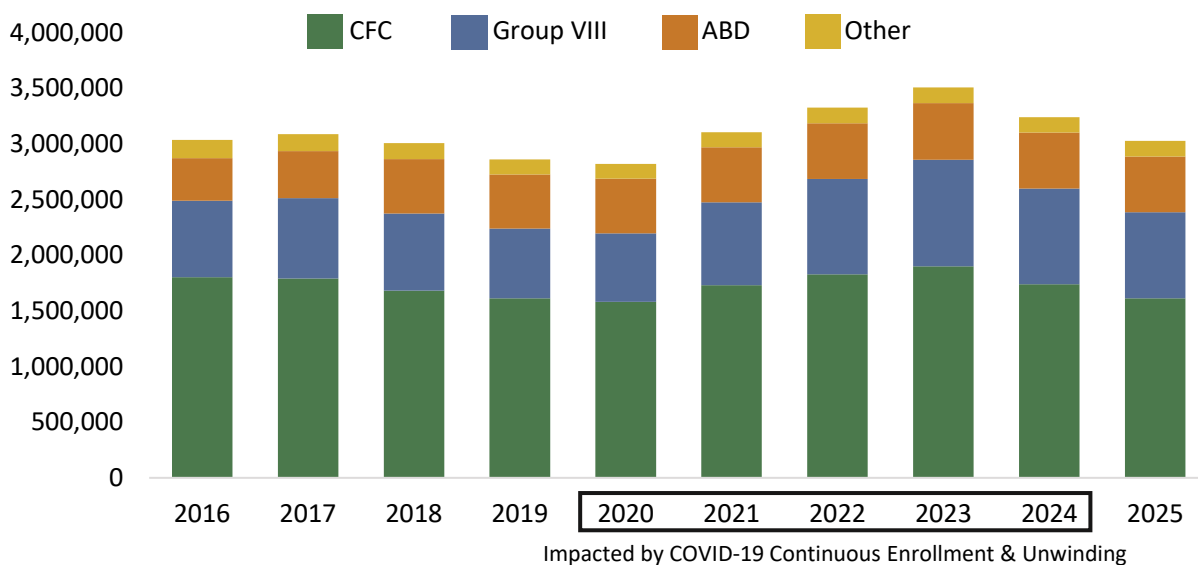
Note: This table does not include asset requirements for Non-MAGI eligibility groups or medical need requirements. Presumptive Eligibility income requirements vary based on what other eligibility group an applicant falls into. MPAP income requirements vary based on specific program.

¹⁶ See the Ohio Auditor of State's [Medicaid Audits](#) for a recent audit of the ABD population.

In addition to the requirements listed previously, the federal budget reconciliation bill signed July 4, 2025 included significant changes to Group VIII eligibility requirements. This bill implements work requirements for Group VIII. The work requirement indicates that adults in this group must be working or participating in qualifying activities for at least 80 hours per month, with the exception of parents with children under the age of 13 and medically frail individuals. This bill also introduced additional administrative requirements, including conducting eligibility redeterminations every six months for Group VIII. For more information about these and other recent federal changes, see the [Federal Budget Reconciliation Bill](#).

Despite recent eligibility changes, these broad eligibility groups have remained consistent over the past decade. The graph below shows Medicaid enrollment broken down by the four eligibility groups displayed on the previous page over the past ten SFYs. As previously discussed, total Medicaid enrollment increased significantly from SFY 2020 to SFY 2023 due to the continuous enrollment requirement and suspension of eligibility redetermination during the COVID-19 pandemic. This requirement was lifted in SFY 2023, leading to a decrease in enrollment as a result of redeterminations from SFY 2023 to SFY 2025.¹⁷

SFY 2016-2025 Medicaid FYE Enrollment by Eligibility Group



Source: ODM Caseload Reports

¹⁷ Redetermination outcomes include renewal of coverage due to eligible determination, disenrollment due to ineligible determination, and procedural disenrollment. Procedural disenrollment occurs when individuals do not complete the administrative tasks required for the redetermination process, such as not returning the renewal packet or requested documentation.

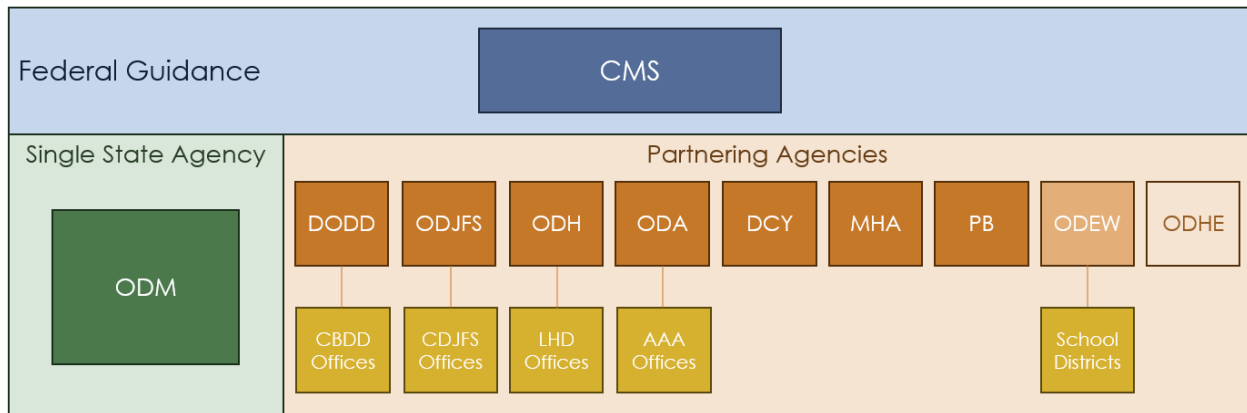
Overall, Medicaid enrollment in Ohio has decreased by 0.3 percent from SFY 2016 to SFY 2025, while the state's population has increased by 2.2 percent over the same time period. CFC has historically been the largest eligibility group in Ohio, with over 1.6 million enrollees in SFY 2025. While this has remained the largest eligibility group, it has also seen a 10.5 percent decrease since SFY 2016. The second largest group, Group VIII, has seen a 12.7 percent increase over the same time period. While ABD was the third-largest eligibility group in SFY 2025, it has seen the fastest relative growth over the last decade, increasing by 30 percent. This increase was likely driven by Ohio's transition to accepting Supplemental Security Income (SSI) eligibility as automatic eligibility for Medicaid, which occurred in SFY 2017. This transition increased the income and asset thresholds for ABD eligibility, therefore increasing the population that was eligible. Other enrollment has declined by 14.5 percent, the most over this time period.

Entities Involved in Medicaid Administration

While ODM is the single state agency responsible for the administration of Medicaid, this responsibility is accomplished with the assistance of other state agencies, county governments, and contractors. Nine other state agencies in Ohio assisted in the facilitation of specific Medicaid programs in SFY 2025, although only seven will be involved in Medicaid administration moving forward.¹⁸ These state agencies, as well as the entities they oversee, are displayed in the visual on the following page.

¹⁸ The Ohio Department of Education and Workforce (ODEW) and the Ohio Department of Higher Education (ODHE) will not be involved in Medicaid administration moving forward. ODEW administrated the Medicaid Schools Program, but this responsibility was transferred to ODM in SFY 2026. ODHE assisted with administering Home and Community Based Services provider relief payments in SFY 2024 and SFY 2025, but this responsibility was associated with one-time federal funding and will not be needed moving forward.

Governmental Entities Involved in Medicaid Administration



Source: Ohio Medicaid State Plan, Legislative Service Commission's HB 96 Greenbooks, OAKS GL-0028s

Note: The Department of Education and Workforce's oversight of the Medicaid Schools Program is transitioning to ODM. The Ohio Department of Higher Education (ODHE) received Medicaid funding in SFY 2024 and SFY 2025 to assist in administering Home and Community Based Services provider relief payments. However, ODHE is not anticipated to participate in Medicaid spending in future years and received no appropriations for SFY 2026 or SFY 2027.

While all of these state agencies assist in the administration of Medicaid, they have varying levels of involvement and expenses associated with their specific responsibilities. The Ohio Department of Developmental Disabilities (DODD) is the only other state agency with service expenditures coded in their financial reports. DODD administers and pays for care provided through Medicaid waiver programs for individuals with developmental and/or intellectual disabilities, state developmental centers, private intermediate care facilities, and services provided by county boards of developmental disabilities. However, in Ohio, local governments contribute more funding for these developmental disability services than the State does, often generated through local developmental disability levies. This local funding in the developmental disability space is not common in other states.

With coordination from the Ohio Department of Job and Family Services (ODJFS), ODM utilizes CDJFS agencies to handle the majority of Medicaid eligibility determinations, enrollment, and redeterminations. As a result of this model, CDJFS offices serve as the primary point of contact for individuals applying to or enrolled in Medicaid. ODJFS receives a portion of the State's Medicaid funding to distribute to CDJFS agencies as a reimbursement for providing these services. While the expenses associated with these administrative services are partially reimbursed by ODJFS, county governments are responsible for a portion of the administrative costs associated with Medicaid, as well as other social services. The portion that counties are responsible for is referred to as their Medicaid mandated share and is dictated by the formula in ORC § 5101.16. CDJFS agencies are also responsible for providing or coordinating non-emergency medical transportation services to Medicaid enrollees, which are fully reimbursed with state and federal funding.

The other state agencies listed on the previous page are responsible for specific duties, programs, or information systems associated with Medicaid. The Ohio Department of Health (ODH) surveys and certifies healthcare facilities participating in the Medicaid program to ensure compliance with state and federal regulations. The Ohio Department of Behavioral Health (DBH) works with local behavioral health service boards to ensure the provision of mental health and addiction services and conducts Pre-Admission Screening and Resident Reviews (PASRR) for individuals seeking institutional placements. The Ohio Department of Aging (ODA) administers Medicaid home and community-based service programs for older Ohioans in collaboration with local partner entities, including PASSPORT, Assisted Living, and PACE.¹⁹ Both DBH and ODA are also involved in Preadmission Screening and Resident Review.²⁰ The Ohio Department of Children and Youth (DCY) provides support to residential infant care centers and Medicaid eligible adoptive children. The State Board of Pharmacy (PRX) uses Medicaid funding for the Ohio Automated Rx Reporting System, which tracks the controlled prescription drugs provided to patients across the state. Finally, the Ohio Department of Education and Workforce (ODEW) administers the Medicaid Schools Program, which provides school districts with funding for in-school services provided to Medicaid-eligible students, such as speech and occupational therapy.²¹

In addition to these public entities, the Department contracts with several private entities for service provision, information systems, external quality review, actuarial services, and research. As previously discussed, contracted service providers include MCOs as well as individual healthcare providers for enrollees on FFS or limited coverage plans. The information systems contracted for include, but are not limited to:

- Ohio Benefits, the system used to process applications;
- Fiscal Intermediary, which is used to process FFS claims, payments, and prior authorizations;
- Electronic Data Interchange, which is used to transmit data between systems and trading partners for all claims-related activities; and,
- Provider Network Management, which is a centralized portal for provider certification.

¹⁹ PASSPORT is the Pre-Admission Screening System Providing Options and Resources Today, a Medicaid waiver program that helps Medicaid-eligible older Ohioans obtain long-term healthcare services and supports in their homes or communities. Assisted Living is also a Medicaid waiver program, which pays for the cost of care in assisted living facilities. PACE is the Program for All-Inclusive Care of the Elderly, which is a comprehensive home and community-based care model for older Ohioans.

²⁰ Preadmission Screening and Resident Review is a federal requirement that all individuals seeking admission to a Medicaid-certified nursing facility be assessed for serious mental illness and/or developmental disability.

²¹ The administration of this program is in the process of being transferred to ODM.

ODM also contracts for a Single Pharmacy Benefit Manager (SPBM). These contracts are managed by various employees across ODM's organizational structure, although they all go through a procurement process handled by the legal department. Additionally, while these information systems are contracted, there are also technical staff working at ODM to help manage the systems. For more information on ODM's contract management processes, see [Recommendation 3](#).

Financial Background

Ohio's Medicaid program is jointly funded by federal, state, and local governments. Federal Medicaid funding is provided to the state through a reimbursement process, covering approximately 70 percent of annual Medicaid expenditures. The federal reimbursement process uses Federal Medical Assistance Percentage (FMAP) rates, which are determined annually by the U.S. Department of Health and Human Services. Ohio's standard FMAP rate is 64.85 percent as of FFY 2026, meaning that for every dollar Ohio spends on standard Medicaid services, it receives approximately 65 cents from the federal government. While 64.85 percent is Ohio's standard FMAP rate, reimbursement rates are also impacted by the type of expenditure, population served, and service provided. Generally, most administrative expenses are reimbursed at a lower rate than service expenses.²²

There are enhanced FMAP rates for services provided to children through the Children's Health Insurance Program (CHIP), as well as Group VIII adults. The graph below displays Ohio's FMAP rates for these categories in FFY 2026.

A Note on Financial Data

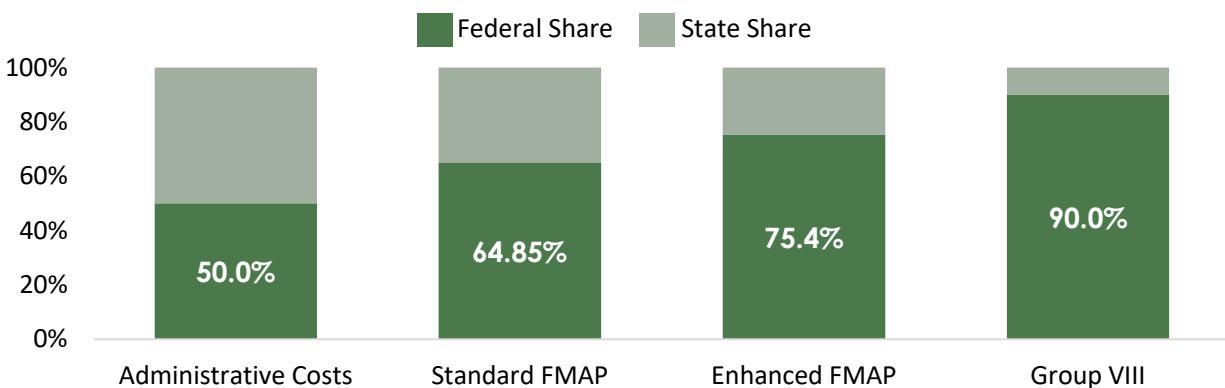
Given the interconnected nature of Medicaid program delivery in Ohio, there are different levels of financial views that are appropriate. The following labels will be used for graphs to demonstrate the entities included in the views. All three of these views include both state and federal funds.

Statewide: Includes all state agencies and counties.

All Agency: Includes all state agencies but excludes county funds.

ODM: Financial information that is exclusive to ODM.

FFY 2026 FMAP Rates for Ohio



Source: Social Security Administration, Health Policy Institute of Ohio

Note: Enhanced FMAP rate is used for specific populations, including CHIP and the Breast and Cervical Cancer Project.

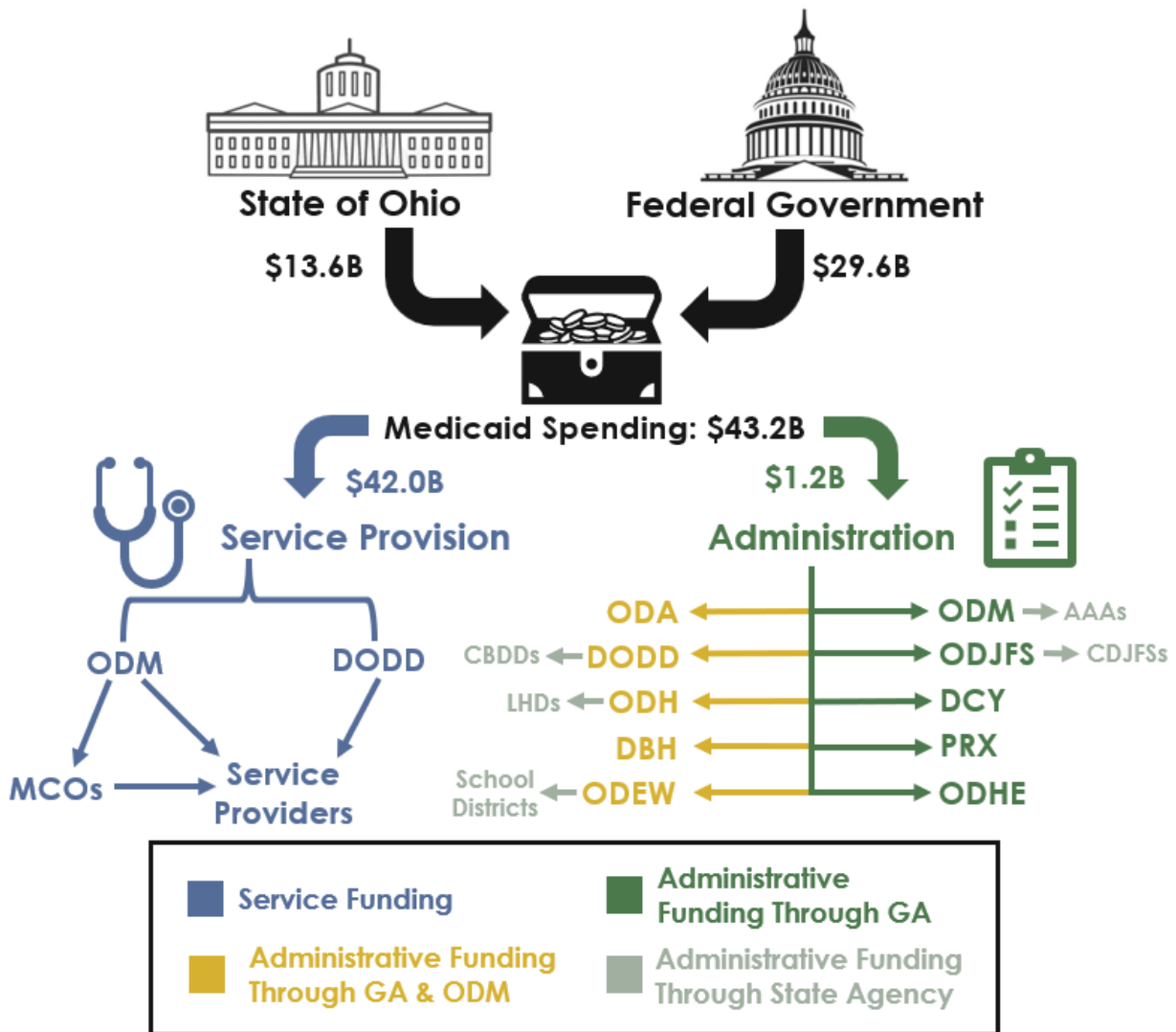
²² Some administrative expenses, such as upgrades to health information technology systems, are reimbursed at a higher rate.

The remaining 30 percent of Medicaid expenditures are paid for by the State. This funding comes from the State General Revenue Fund (GRF), as well as several Dedicated Purpose Funds. These Dedicated Purpose Funds include revenue from fees charged to MCOs, nursing homes, and long-term care facilities, hospital assessments, prescription drug rebates, and third-party liability recoveries.

Additionally, county governments are required to pay for a portion of administrative expenditures associated with Medicaid eligibility determinations, referred to as the County Medicaid Mandated Share. In SFY 2025, county governments contributed a total of approximately \$17.0 million to Medicaid administrative expenditures through their mandated share. Counties may expend additional local resources. For more information on this contribution, see the [County Oversight](#) section.

Excluding county funding, the General Assembly appropriated a total of \$44.5 billion of state and federal funding for Medicaid in SFY 2025, mostly for the provision of services. ODM received 87.8 percent of this appropriation, which was approximately \$39.1 billion. DODD received 11.4 percent, and the remaining less than one percent is split between other state agencies. This flow of funds is displayed in the graphic on the following page.

SFY 2025 Flow of State and Federal Medicaid Funds



Source: Ohio Medicaid State Plan, Legislative Service Commission's HB 96 Greenbooks, OAKS GL-0028s

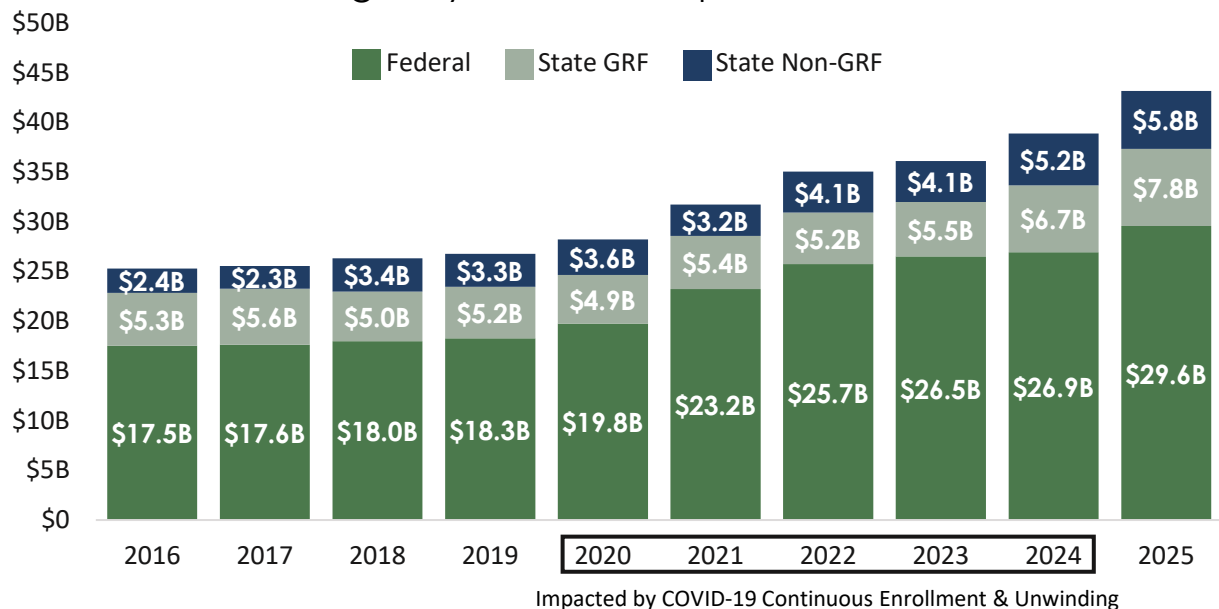
Note: The Department of Education and Workforce's (ODEW) oversight of the Medicaid Schools Program is transitioning to ODM. The Ohio Department of Higher Education (ODHE) received Medicaid funding in SFY 2024 and SFY 2025 to assist in administering Home and Community Based Services provider relief payments. However, ODHE is not anticipated to participate in Medicaid spending in future years and received no appropriations for SFY 2026 or SFY 2027.

Expenditures

In SFY 2025, the State of Ohio spent \$43.2 billion in federal and state funding on Medicaid. Of this total, \$37.6 billion was expended by ODM. The remaining funds were expended by a variety of other state agencies that assist with Medicaid program delivery in Ohio. Due to this interconnected nature, all agency expenditures are shown below.

Over the past decade, Medicaid expenditures have been growing steadily in Ohio and nationwide. From SFY 2016 to SFY 2025, Ohio's Medicaid expenditures have increased by 70.7 percent. This growth is displayed in the graph below.

SFY 2016-2025 All Agency Medicaid Expenditures



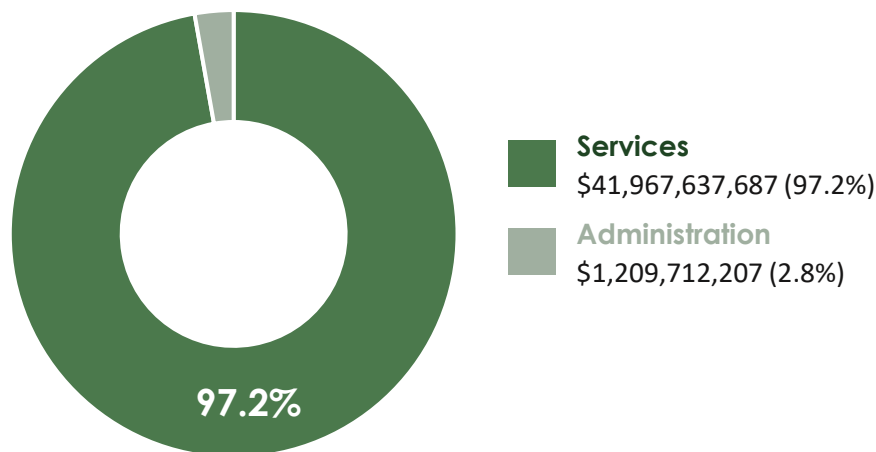
Source: ODM Budget Variance Reports

Over this time period, the most substantial increase occurred from SFY 2020 to SFY 2023. This is likely due to the continuous enrollment requirement during the COVID-19 pandemic, as discussed in the Service Provision section. The increase from SFY 2023 to SFY 2025 can be attributed to an increase in FFS reimbursement rates that was approved by the State of Ohio in the SFY 2024-2025 budget bill. The overall increase in Ohio's all agency Medicaid expenditure is slightly below the national average.²³

Medicaid expenditures can be broken into services and administration. Services include all expenses related to the provision of healthcare to Medicaid enrollees. Administration includes expenses related to the facilitation of Medicaid programs including eligibility determination, enrollment, claims payments, information systems, and program management. The split in expenditures between these two categories is shown below.

SFY 2025 Medicaid All Agency Expenditure

Total: \$43,177,349,894



Source: ODM Budget Variance Reports

In SFY 2025, 97.2 percent of expenditures were for services, while 2.8 percent were for administration. Due to the sizeable difference between service and administrative expenditures, we examined the expenditures within each of these categories separately.

²³ From CY 2016 to CY 2024, national Medicaid expenditures increased by 65.5 percent. From SFY 2016 to SFY 2024, Ohio's Medicaid expenditures increased by 53.7 percent. Due to data lag, we do not have information on the national expenditures in CY 2025.

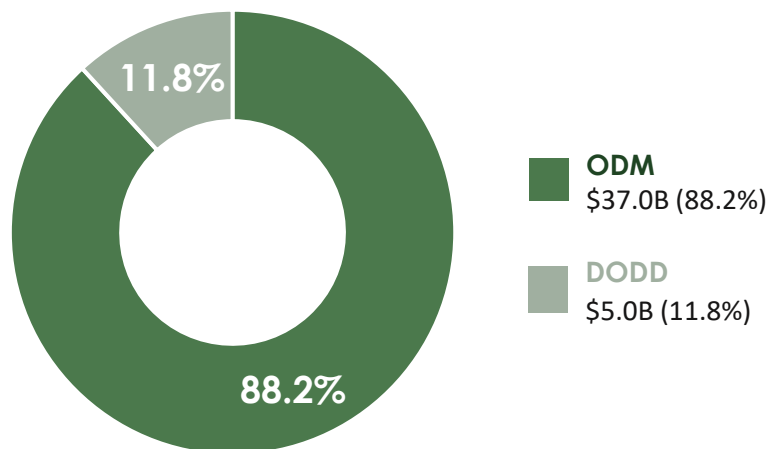
Services

Service expenditures made up the vast majority of Medicaid spending in SFY 2025, at approximately \$42.0 billion. This includes all funding that is used to pay healthcare providers for services provided to Medicaid enrollees. This payment is given to service providers either directly by a state agency or indirectly through MCOs. Healthcare services paid for with these funds include inpatient and outpatient hospital services, preventative healthcare, professional medical services, long-term care, medical equipment, vision and dental care, behavioral healthcare, pregnancy related services, and prescription drugs.

ODM and DODD spent the entirety of service expenditures in SFY 2025, as these are the only two state agencies responsible for paying healthcare providers for services delivered to Medicaid enrollees. The other state agencies that receive Medicaid funding assist with Medicaid in an administrative capacity only. ODM's service expenditures were approximately 88.2 percent of the total in SFY 2025, primarily including payments to service providers and MCOs. DODD's service expenditures were the remaining 11.8 percent of the total in SFY 2025, including payments for waiver services, targeted case management services, and services provided to individuals in developmental centers and intermediate care facilities. The graph below shows the breakdown of service expenditure between ODM and DODD.

SFY 2025 All Agency Medicaid Service Expenditures

Total: \$42.0B

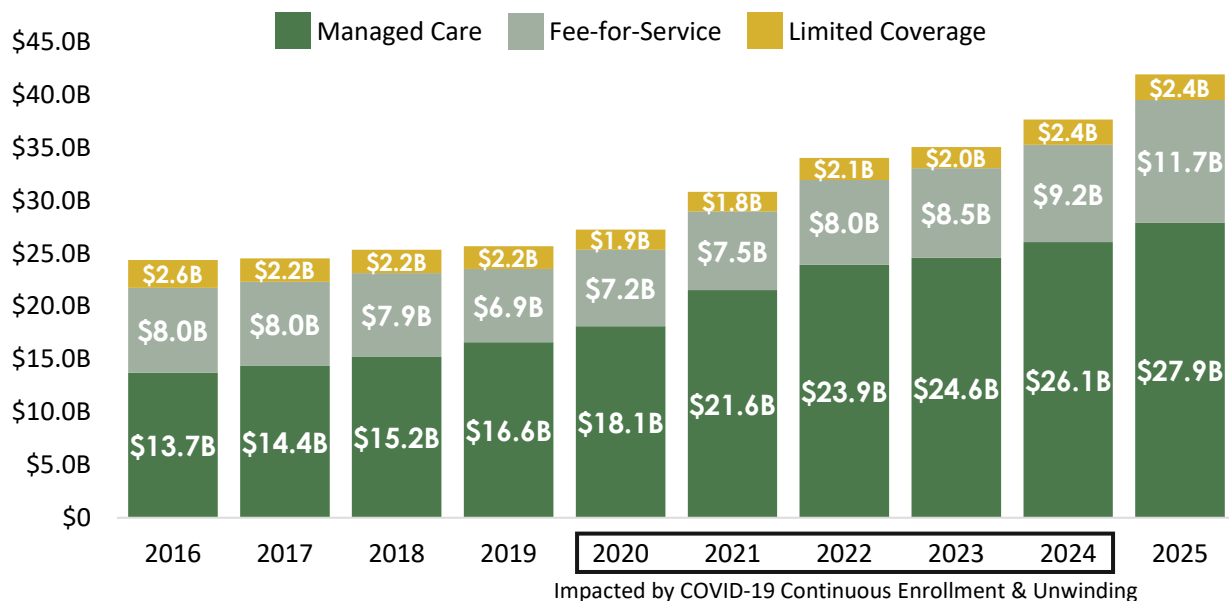


Source: ODM Budget Variance Reports

As the majority of Ohio's Medicaid enrollees receive healthcare through an MCO, the majority of service expenditures fall into this category as well. In SFY 2025, 66.5 percent of service expenditures were for managed care plans, 27.8 percent were for fee-for-service plans, and the

remaining 5.7 percent were for limited coverage plans. The graph below shows the expenditures in these three categories over the past ten SFYs.

SFY 2016-2025 All Agency Medicaid Service Expenditures by Delivery Category



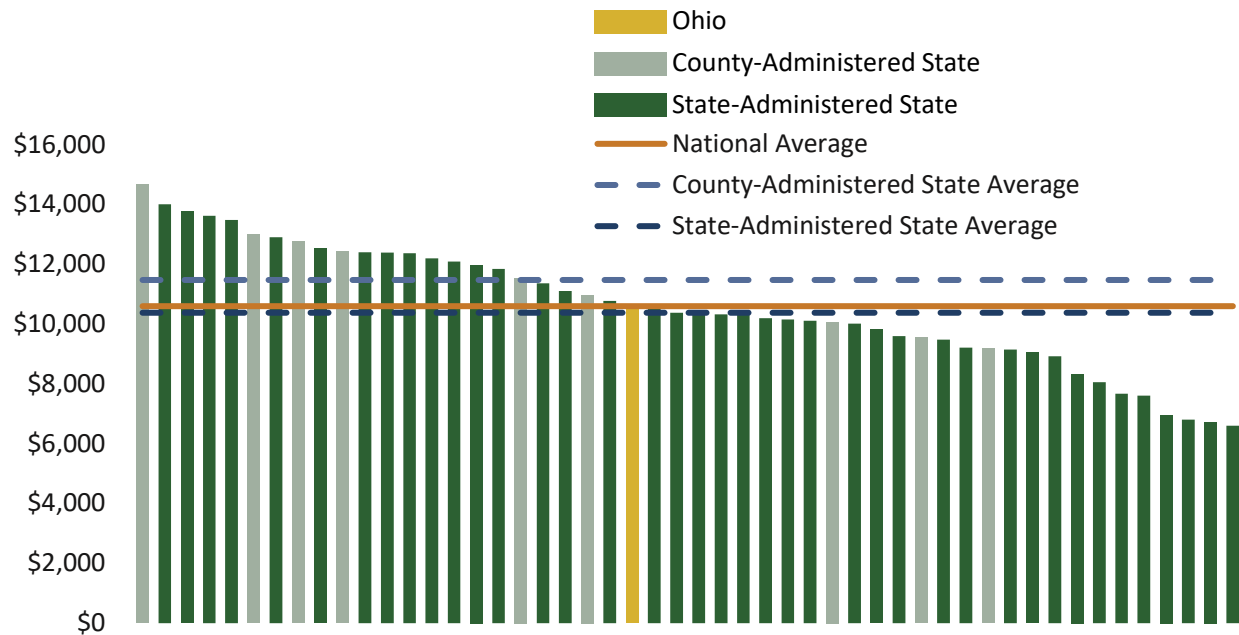
Source: ODM Budget Variance Reports

Note: Limited coverage expenditures include the Hospital Care Assurance Program, which offers help with unpaid hospital bills to low-income Ohioans who are not eligible for Medicaid.

Notably, managed care accounts for a smaller portion of expenditures than it does enrollment, with almost 90 percent of Medicaid recipients enrolled in a managed care plan. However, individuals with significant medical needs, including individuals with disabilities and older individuals, are more likely to be enrolled in the FFS model or limited coverage category. As a result, these service delivery models have higher expenditures on a per-person basis.

Overall, Ohio's spending on Medicaid services is in line with the national average. In FFY 2024, Ohio spent approximately \$10,600 per FYE enrollee on Medicaid services, which is exactly in line with the national average and below the county-administered state average of \$11,500. Ohio's spending on Medicaid services in comparison to other states as reported by the Medicaid and CHIP Payment and Access Commission (MACPAC) is shown in the graph on the following page.

FFY 2024 Total Benefit Spend per FYE Enrollee



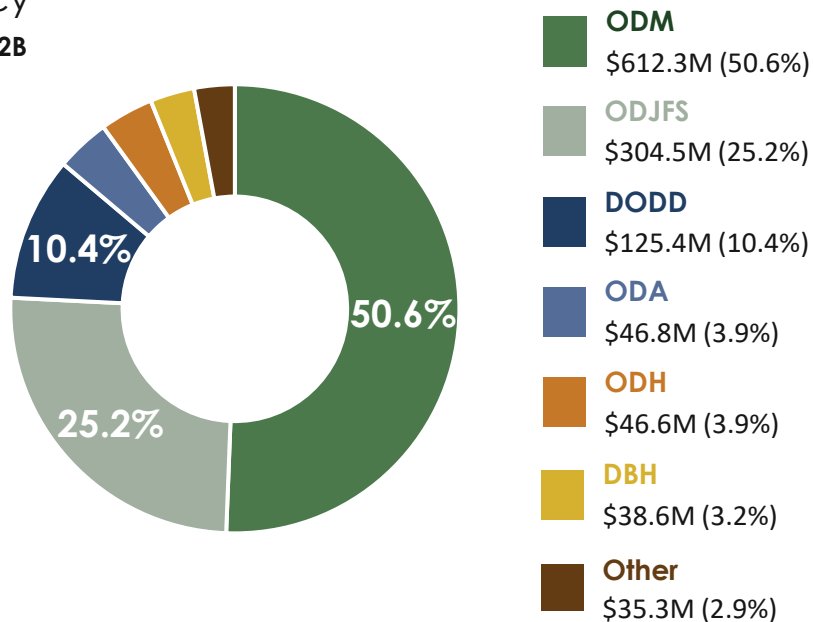
There are many factors that impact a state's Medicaid spending, such as the FMAP rate, expansion status, service delivery model, population demographics, and health care infrastructure. For further information on how Ohio's spending on Medicaid services compares to other states, including a distribution of spending by service delivery category and eligibility groups, see [Appendix F](#).

Administration

Administrative expenditures made up approximately \$1.2 billion of Ohio's statewide Medicaid spending in SFY 2025. Despite being responsible for the majority of Medicaid service provision, ODM only accounts for approximately half of these administrative expenditures. The remaining half is spent by a combination of state agencies that assist ODM with the administration of the State's Medicaid program. The graph on the following page displays the breakdown of administrative Medicaid spending by state agency.

SFY 2025 All Agency Medicaid Administrative Expenditures by Agency

Total: \$1.2B



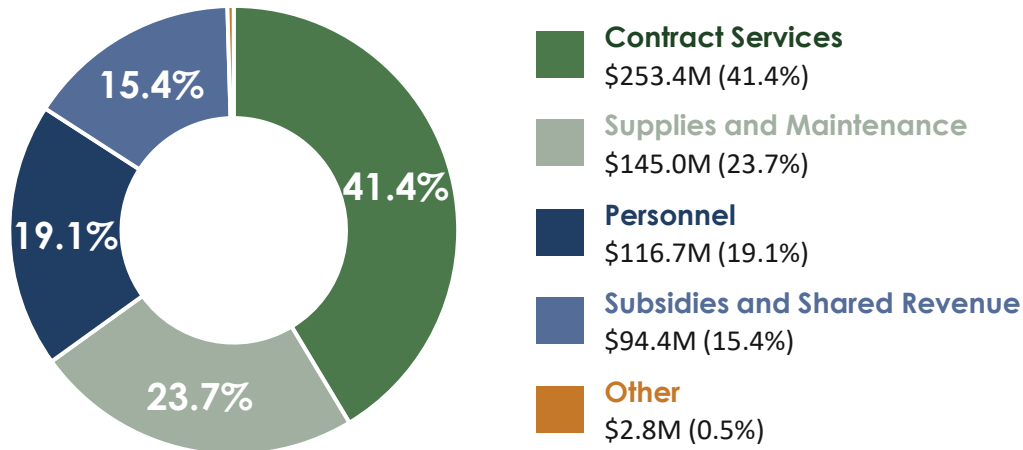
Source: ODM Budget Variance Reports

Note: Other includes ODHE, DCY, State Board of Pharmacy, and ODEW.

Of the state agencies involved with Medicaid administration, ODM has the highest administrative expenditure. This is spent on contracted services, information systems, personnel, supplies, and payments to other state entities. The graph on the following page displays the breakdown of ODM's administrative expenditure. ODJFS has the second highest administrative expenditure, approximately 90 percent of which is distributed to counties to support CDJFS eligibility determination and enrollment processes for Medicaid. DODD has the third highest expenditure, which is spent on the administration of its Medicaid waiver programs, targeted case management services, and services for individuals in developmental centers and intermediate care facilities.

SFY 2025 ODM Administrative Expenditures by Category

Total: \$612.3M



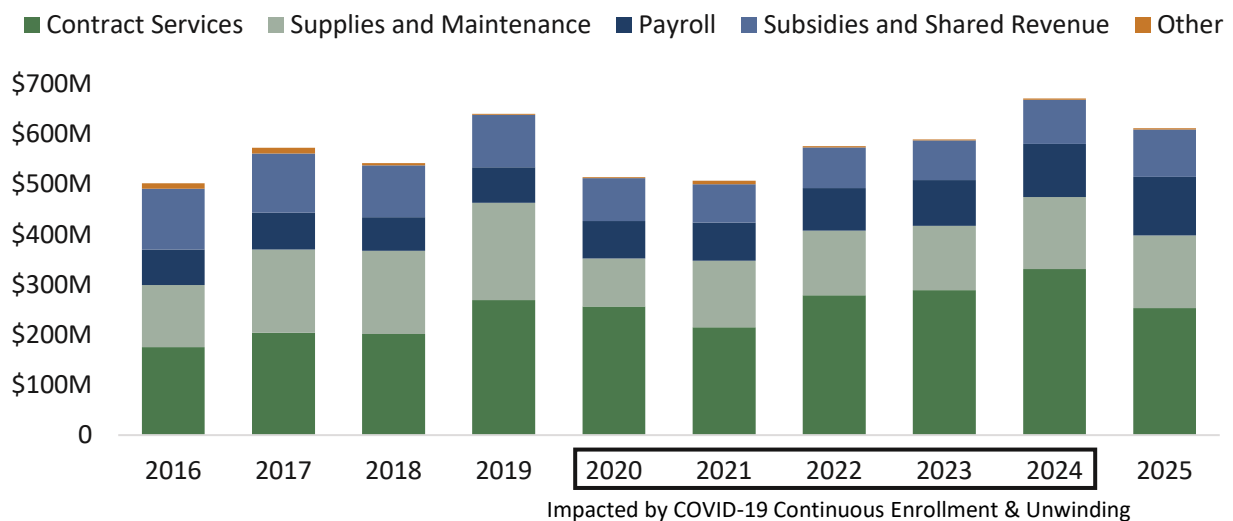
Source: OAKS BI GL-0028

Note: Other includes transfers, non-expense items, equipment, judgements, settlements, and bonds.

Within ODM's administrative spending, there are four primary categories. The largest is contract services, which was approximately 41.4 percent of the Department's administrative expenditures in SFY 2025. This category includes expenses associated with ODM's contracts for information technology and network services, research services, and medical services. Specifically, these expenses include cost of the contracts themselves, as well as requests for contract proposals, contract management, and legal consultations. The second largest category is supplies and maintenance, at approximately 23.7 percent of administrative expenditures. The vast majority of this category is attributed to intrastate transfers, which were ODM's payments to other state agencies for goods and services provided such as administrative services, arbitration fees, and audits. Additional items within this category include postage, office supplies, and facility rentals. The third largest category is personnel, at 19.1 percent, which includes the salaries, wages, and benefits for ODM's staff. The smallest primary category is subsidies and shared revenue, at 15.4 percent. This category is composed of the various grants that ODM distributes, primarily to Area Agencies on Aging (AAAs), a contractor, and a higher education institution for administration and research.

Over the past six years, ODM’s administrative expenditures have increased by approximately 21.8 percent. The only primary expenditure category that decreased over this time period was subsidies and shared revenues, which decreased by 22.5 percent. Payroll increased by 65.5 percent, contracted services increased by 44.2 percent, and supplies and maintenance increased by 17.1 percent. The graph below shows these trends. Notably, this does not include administrative costs for MCOs, CDJFS agencies, or other state agencies therefore it does not capture the entire cost of the administration of Ohio’s Medicaid program.

SFY 2016-2025 ODM Administrative Expenditures

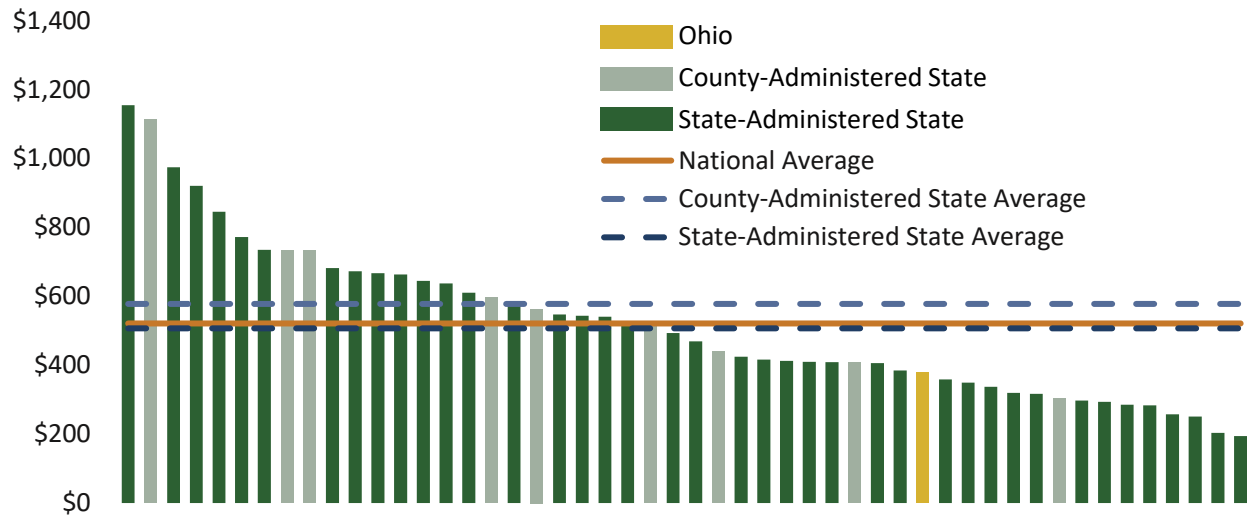


Source: OAKS BI GL-0028

As shown in the chart above, there were substantial increases in administrative expenditures in SFY 2019 and SFY 2024, followed by decreases in the subsequent years. From SFY 2019 to SFY 2020, the decrease was primarily seen in the supplies and maintenance category. Within this category, the decrease can be attributed to two account codes: software licenses and intrastate transfers. The variation from SFY 2023 to SFY 2025 was primarily seen in the contracted services category, specifically related to information technology, personal services, medical services, unemployment compensation, and training.

Overall, Ohio’s reported administrative spending is lower than the national average. In FFY 2024, Ohio spent approximately \$380 on Medicaid administrative expenses per FYE enrollee. This falls below both the national average, at approximately \$520 per FYE enrollee, and the county-administered state average, at approximately \$580 per FYE enrollee. Ohio’s spending on Medicaid administration in comparison to other states as reported by MACPAC is shown in the graph on the following page.

FFY 2024 Total Administrative Spend per FYE Enrollee



Source: MACPAC

Although Ohio's administrative spending per enrollee is lower than the national average, as previously discussed, local governments contribute funding to Medicaid administration in Ohio. This local funding contribution is not captured in this state-level data and may or may not occur in other states, which likely impacts Ohio's below average administrative spending. MCOs additionally take on some of the administrative expenses associated with service delivery through managed care, which further reduces Ohio's administrative spending.

Summary of Audit Results

Our audit reviewed several operational areas and analyzed the Department's policies and procedures and compared them to best practices and industry standards. Specific areas of review for this audit included strategic planning and program evaluation, program and financial forecasting, contract management, county oversight, and claim payment timeliness.

Our audit identified nine recommendations and one issue for further study across these areas of review that can assist the Department in improving overall efficiency and effectiveness. The audit, and the associated recommendations, will provide transparency to stakeholders and allow ODM to implement improvements that will benefit Medicaid recipients, partner agencies, providers, and taxpayers.

Strategic Planning and Management

Recommendation 1: ODM does not have organization-wide strategic, operational, or staffing plans in place to articulate the Department's goals and identify the activities and programs in place to achieve these goals. Strategic planning and program evaluation efforts for ODM's major programs are fragmented across multiple offices, with significant variation in the efficacy and intentionality of practices utilized by these offices. As a result, the divisions and offices within ODM are not operationally aligned, have institutional knowledge gaps, functional silos, and information retention issues. This makes it difficult for ODM to properly evaluate the effectiveness of programs and ensure that the program is effective and efficient. ODM should align strategic plans and program evaluation efforts throughout the Department with operational strategies. This will improve the overall operation of the Department as well as the delivery and efficiency of Medicaid programs.

Recommendation 2: ODM creates a biennial Medicaid Caseload and Expenditure Forecast Report in collaboration with the Office of Budget and Management that projects two years of Medicaid enrollment and expenditures. This forecast is used in the development of Ohio's biennial budget to ensure that an appropriate amount of funding is allocated for the provision of healthcare services to Medicaid recipients. The Department considers a variety of factors in its forecast, including recipient characteristics, economic indicators, and population trends. ODM's forecasting process is largely aligned with best practices identified by the GFOA, except for ensuring the public transparency of forecast materials. While the Medicaid Caseload and Expenditure Forecast Report is publicly available on the Office of Budget and Management's website, ODM does not publish this report, instead producing monthly Budget Variance Reports comparing forecasted values to actual enrollment and expenditures. Additionally, none of these reports are accompanied by detailed forecast assumptions. The Department should enhance

the transparency of its enrollment and financial forecasting process by publishing the forecast report and an accompanying public narrative in a central location.

Recommendation 3: Ohio’s Medicaid program is facilitated by several third-party vendors that the Department contracts with for various functions, including information systems and managed care plans. These contracts represent a large portion of ODM’s total spending. In SFY 2025, the Department spent 41.4 percent (\$253.4M) of its administrative expenditures on contracted services and 66.5 percent (\$27.9B) of its service expenditures on managed care, which is provided by contracted entities. We reviewed six of ODM’s contracts that are critical to the “Next Generation” initiative and modularization of OMES. Half of the contracts with cost proposals had significant discrepancies between the planned costs and actual spending on the contracted service, amounting to over \$145 million in unplanned expenses. When comparing ODM’s contract procurement and management efforts to best practices, we identified many opportunities for improvement. These opportunities varied from being unique to individual contracts we reviewed to being consistent across all contracts reviewed. The most significant deficiencies we observed were related to strategic planning, vendor references, stakeholder communication and engagement, training of contract managers, and documentation of review processes. ODM should utilize best practices to improve its contract management practices, which may result in fewer unplanned expenses, enhanced service delivery, and more comprehensive stakeholder engagement.

Recommendation 4: Healthcare providers are paid for services provided to Medicaid recipients through claims submitted to ODM. There are federal and state requirements that set timeframes in which claims must be processed and paid. The federal requirements are set through statute, while the state requirements are set through contracts with MCOs and the contractor for the Fiscal Intermediary, the system that processes fee-for-service claim payments. While our review of claim payment timeliness was limited in scope due to data availability, it indicated that the Department has been largely compliant with federal statutory requirements, while contracted entities have varying levels of compliance with the more stringent state contractual requirements. Additionally, we were unable to identify any systemic changes in the timeliness of claim payments over the past five years for the points in the process where data was available. There may have been changes in timeliness associated with the process steps where data was not available, but we were not able to evaluate this.

The claim payment timeliness metrics currently collected, aggregated, and monitored by ODM are categorized into broad timeframes. These broadly categorized metrics do not allow for in-depth tracking of changes to claim payment timeliness over time or an adequate evaluation of contractor performance because the vast majority of claims are paid within the shortest timeframe measured. The Department should collect more detailed claim payment metrics and utilize it to effectively monitor and manage contractor performance over time, adjust

contractual timeliness benchmarks, and improve the public transparency of the claim payment process.

County Oversight

Recommendation 5: In Ohio, public assistance programs are overseen by multiple state agencies, while the day-to-day processes relating to applications and eligibility determinations are the responsibility of County Departments of Job and Family Services (CDJFS agencies). Individuals who receive public assistance often qualify for and receive benefits from multiple programs; however, each state agency that oversees the programs has its own procedures and requirements for the application and renewal process. This can result in the CDJFS requiring multiple documents for the same basic information, such as income verification or residency. ODM should work with ODJFS and DCY to improve collaboration regarding the oversight of public assistance programs in Ohio. This could include aligning policies and procedures where possible and collaborating on training and guidance to reduce duplication of efforts.

Recommendation 6: Ohio Benefits is Ohio's eligibility and enrollment system for Medicaid and other public benefit programs. CDJFS caseworkers utilize this system to process applications and renewals, verify information, and make eligibility determinations and redeterminations. All of the counties we interviewed reported experiencing issues with Ohio Benefits. Over 20 common issues were pervasive among the respondents related to general functionality, determination accuracy, alerts, automation, and the self-service portal. ODM should work with ODJFS, which is responsible for managing Ohio Benefits, and CDJFS agencies, who are the primary users of the system, to identify and develop solutions for issues with Ohio Benefits. Doing so will improve application timeliness, determination accuracy, and the experiences of caseworkers and beneficiaries.

Recommendation 7: Medicaid applications are required by law to be processed within a certain number of days. Ohio has historically failed to meet this requirement and falls below the national average for processing timelines. While this information shows an opportunity and need for improvement, ODM does not currently utilize appropriate county-level data that would allow it to comprehensively evaluate the performance of CDJFS agencies or identify the root causes of timeliness issues. ODM should enhance the collection of application processing timeliness data and use this information to identify issues delaying application processing and develop process improvements or other solutions accordingly. This should be done in conjunction with CDJFS agencies to ensure that solutions are appropriate and feasible.

Recommendation 8: As the state agency overseeing Medicaid in Ohio, ODM is responsible for ensuring the accuracy of Medicaid eligibility determinations and redeterminations, which are primarily made by CDJFS agencies. Once every three years, the Department conducts 800 case reviews over a 12-month period in compliance with federal minimum standards for the

Medicaid Eligibility Quality Control (MEQC) program. This represents less than one percent of the total number of applications and renewals processed in Ohio. In MEQC off-years, ODM conducts additional, less standardized case reviews. The limited and inconsistent data obtained through current quality control efforts cannot be used to confirm the accuracy or effectiveness of CDJFS operations across the state. Further, this information cannot be reliably used for year-over-year comparisons or performance management efforts. In addition, ODM does not effectively communicate the results of comprehensive quality control case reviews to the counties, which limits the ability of CDJFS agencies to use this information to improve internal operations or performance management. ODM should expand, standardize, and communicate quality control efforts to improve the accuracy of eligibility determinations and redeterminations throughout the state.

Issue for Further Study 1: The State is required to conduct eligibility redeterminations for all Medicaid recipients each year and renew coverage for recipients who are still eligible. These renewals can be completed manually, in which recipients fill out a renewal form and CDJFS caseworkers process the renewal, or passively, in which the Ohio Benefits system processes the renewal automatically using electronic data sources. Having a passive ex parte renewal process is important for reducing application processing times, reducing CDJFS workloads in some cases, and reducing rates of procedural disenrollment. However, improper passive ex parte renewals also come at a cost to taxpayers. Several CDJFS agencies we spoke to expressed concerns that individuals they know are not eligible for Medicaid have been passively renewed without any way to for the CDJFS to discontinue their enrollment. In some cases, CDJFS agencies discussed how the recipients themselves were not aware they were still enrolled in Medicaid. Given Ohio's use of managed care, this means Ohio may be paying capitation rates for individuals who are not eligible for Medicaid.

Stakeholder Engagement

Recommendation 9: During our audit, we observed a significant variation in the use and efficacy of stakeholder engagement efforts across the Department. This includes not engaging with key stakeholders during procurement processes, failing to successfully engage with partner agencies conducting eligibility application processing, and not publishing critical data and narratives that would inform public understanding of the program. Additionally, ODM does not have public guidance for engaging in the rulemaking process posted in the Register of Ohio, which is in violation of ORC § 119.0311. ODM also lacked proper stakeholder identification. This resulted in limited public engagement for the one rule change we reviewed. This lack of standardized stakeholder engagement across Department can be attributed to the absence of any overarching operational plans and stakeholder-focused leadership. ODM should develop and utilize a stakeholder engagement plan to standardize and improve stakeholder engagement efforts throughout the Department.

Strategic Planning and Management

The Department has recently undergone multiple changes with the goal of modernizing its operations. Many of these changes are related to ODM's "Next Generation" initiative, which includes the implementation of new information systems, revisions of managed care plans, and adjustments to the provider experience. Given the size and complexity of Ohio's Medicaid program, intentional strategic planning and management are essential for general operations and significant operational changes, such as the "Next Generation" initiative. We evaluated multiple program and functional areas to assess the effectiveness of ODM's strategic planning and management practices, including program evaluation, forecasting, contract management, and data utilization.

ODM's "Next Generation" initiative has the following goals: improve wellness and health outcomes, emphasize a personalized care experience, support providers in better patient care, improve care for children and adults with complex needs, and increase program transparency and accountability. To accomplish these goals, ODM is utilizing managed care entities to deliver healthcare services and has contracted with third-party vendors to make updates to the Ohio Medicaid Enterprise System (OMES). OMES is the information system used by ODM to manage, monitor, and administer the Medicaid program in Ohio, such as facilitating claim payments.

Managed Care Entities

The managed care entities ODM is utilizing for the delivery of the "Next Generation" of Medicaid fall into the following four program areas.

- **Managed Care Organizations (MCOs):** ODM provides MCOs with a monthly capitation payment for each Medicaid recipient enrolled in a managed care plan. In turn, MCOs contract with healthcare providers to provide services to Medicaid recipients.
- **MyCare:** A specialized managed care plan designed for individuals receiving both Medicaid and Medicare benefits. This program is intended to coordinate comprehensive healthcare services between the two benefits to more adequately meet the needs of dually eligible individuals.
- **Ohio Resilience through Integrated Systems and Excellence (OhioRISE):** A specialized managed care plan for children and youth with complex behavioral health needs. This program is intended to coordinate services and resources from multiple community systems, including juvenile justice, child protection, developmental disabilities, schools, mental health and addiction, and more.

- **Single Pharmacy Benefit Manager (SPBM):** A third-party administrator contracted by the State to manage prescription drug coverage for all Medicaid recipients.

All four of these program areas were included in our review of the Department’s strategic planning and program evaluation efforts, based on ODM’s indication that these were major programs. The MCOs and SPBM were additionally included in our evaluation of the Department’s contract management practices. This breakdown is displayed in the visual below.

Managed Care Entities Inclusion in Analyses

Managed Care Organizations	MyCare	OhioRISE	SPBM
• Strategic Planning and Performance Evaluation • Contract Management	• Strategic Planning and Performance Evaluation	• Strategic Planning and Performance Evaluation	• Strategic Planning and Performance Evaluation • Contract Management

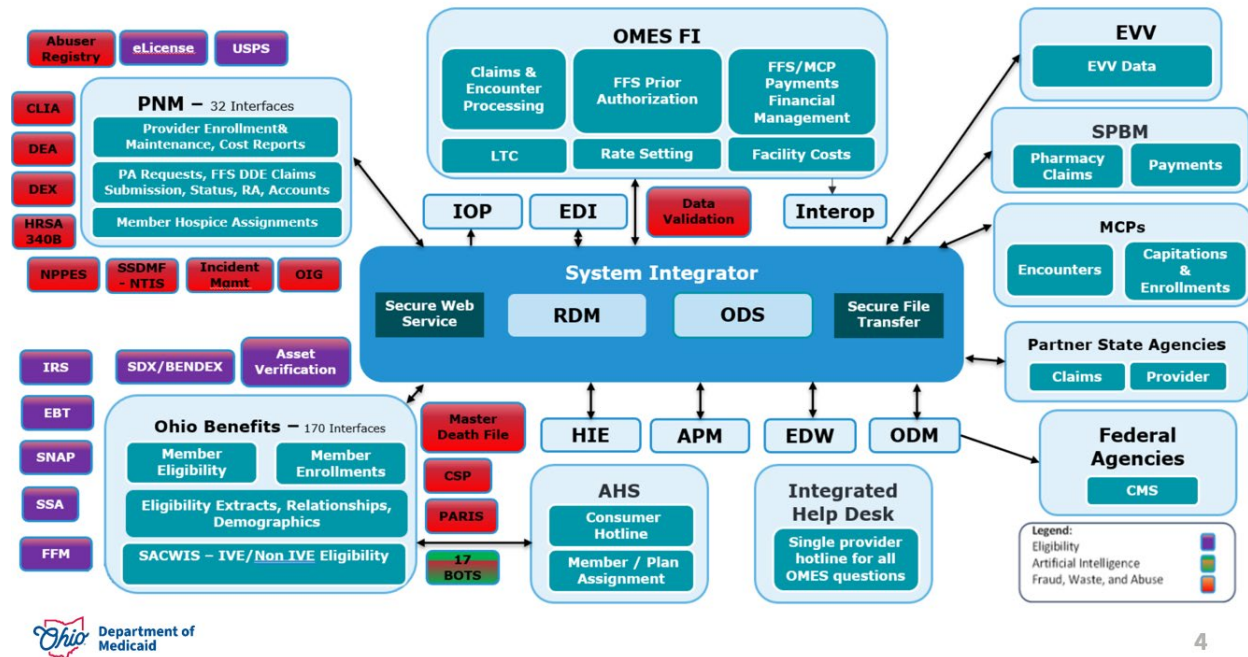
Source: ODM, OPT

Ohio Medicaid Enterprise System

Another change that ODM has been implementing over the past few years is the modularization of its information systems. Currently, the Department uses the Ohio Medicaid Enterprise System (OMES) to manage, monitor, and administer Medicaid in Ohio. Prior to this, ODM used the Medicaid Information Technology System (MITS) for this purpose. OMES was implemented to replace and modernize most of the functionalities within MITS.

Following guidance from CMS in 2016, Ohio was one of the first states to implement a modular Medicaid enterprise system. Modularization is the process of dividing a system into functionally distinct modules to improve flexibility and interchangeability. OMES is made up of many modules, each of which has a different function in the administration of Ohio’s Medicaid program. These modules were created based on CMS guidance and state-level policy decisions. ODM titled the primary modules as the Fiscal Intermediary, Electronic Data Interchange, Provider Network Management, System Integrator, Electronic Data Warehouse, Ohio Benefits, and SPBM. Each of these modules are displayed in the graphic on the following page, which was provided by ODM.

OMES Modules Diagram Provided by ODM



Source: ODM

Federal and state governments each provide a share of administrative funding used for the development and implementation of Medicaid information systems like OMES. In FFY 2025, Ohio spent a total of \$252.5 million on OMES, including both the state and federal share, which is in line with national trends. OMES spending began in approximately SFY 2019, when the first contracting for the first OMES module began. In Ohio, this funding is primarily spent on the third-party vendors that develop and operate the individual modules. Due to this high level of spending on systems contracts, we evaluated the Department's contract management practices for the SPBM, Fiscal Intermediary, System Integrator, Electronic Data Interchange, and Provider Network Management modules. Our review of ODM's strategic planning and management practices resulted in four recommendations related to program evaluation, financial forecasting, contract management, and provider claim payment timeliness.

Recommendation 1: Align Strategic Plans and Program Evaluation Efforts with Operational Strategies to Improve Agency Outcomes

ODM does not have organization-wide strategic, operational, or staffing plans in place to articulate the Department's goals and identify the activities and programs in place to achieve these goals. Strategic planning and program evaluation efforts for ODM's major programs are fragmented across multiple offices, with significant variation in the efficacy and intentionality of practices utilized by these offices. As a result, the divisions and offices within ODM are not operationally aligned, have institutional knowledge gaps, functional silos, and information retention issues. This makes it difficult for ODM to properly evaluate the effectiveness of programs and ensure that the program is effective and efficient. ODM should align strategic plans and program evaluation efforts throughout the Department with operational strategies. This will improve the overall operation of the Department as well as the delivery and efficiency of Medicaid programs.

Impact

Consistent strategic and operational planning across ODM will improve departmental operations, which may improve service delivery and result in more efficient use of financial and other resources. The development and utilization of an organization-wide operational plan would ensure all ODM offices are adhering to similar best practices. This would reduce the misalignment of strategic planning and program evaluation efforts between ODM's offices and help to ensure resources are prioritized appropriately. It would also improve the transfer of institutional knowledge across offices and throughout employee turnover, ensure information is retained properly, and reduce the siloed nature of the Department's functions.

Comprehensively developing and evaluating all programs through standardized processes will enable the Department to monitor the performance of its programs and identify opportunities for improvement, such as deploying resources where they have the greatest impact. Continuous improvement of Medicaid programs is critical to ensure that services are benefiting Ohio's population and taxpayer dollars are being spent effectively.

Background

While some Medicaid recipients receive services through a fee-for-service (FFS) model, in which the State pays healthcare providers directly for services provided to beneficiaries, the majority of Ohio's Medicaid recipients are enrolled in a managed care plan. Under a managed care plan, the state pays managed care entities (MCEs) a capitation payment for each enrollee, and the MCEs contract with healthcare providers to provide services to Medicaid recipients. Within this broad structure, there are MCOs, which provide healthcare services to the majority of Medicaid enrollees, as well as a few specialized programs targeting particular populations or healthcare services.

The first specialized program is MyCare, which is a managed care plan designed for individuals receiving both Medicaid and Medicare benefits. This program is intended to coordinate comprehensive healthcare services between the two benefits to more adequately meet the needs of dually eligible individuals. The second is Ohio Resilience through Integrated Systems and Excellence (OhioRISE), which is a specialized managed care plan for children and youth with complex behavioral health needs. This program is intended to coordinate services and resources from multiple community systems, including juvenile justice, child protection, developmental disabilities, schools, mental health and addiction, and more. The final program is the Single Pharmacy Benefit Manager (SPBM), which is a third-party administrator contracted by the State to manage prescription drug coverage for all Medicaid recipients.

The Department identified five major programs that encompass the majority of ODM's work, including Managed Care, MyCare, OhioRISE, and SPBM. The fifth program identified is Health Innovation and Quality, which is intertwined with all four of these programs. Health Innovation and Quality is an office within ODM responsible for initiatives to improve the quality of care and health outcomes across Ohio's Medicaid population. This office works with MCEs, providers, and other offices within the Department to assist in the evaluation and improvement of Medicaid services and programs. These five major programs are those that were evaluated during the course of the audit with respect to strategic planning initiatives.

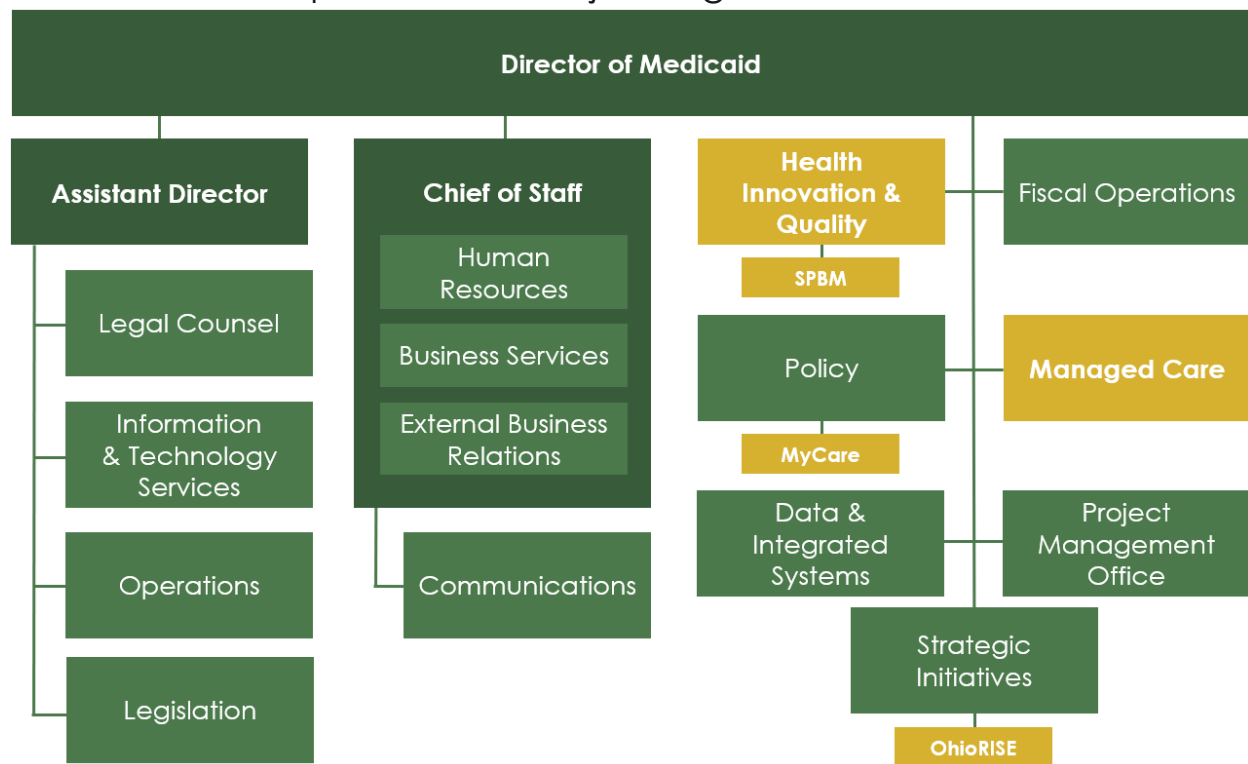
Methodology

We interviewed staff from multiple offices within ODM to develop an understanding of the Department's strategic planning efforts, as well as program development and evaluation practices. Following these interviews, we requested and reviewed ODM's documentation supporting these efforts. We obtained best practices for strategic planning and program evaluation, then compared the practices and documentation for each office to these criteria. As a result, we observed significant variation between offices, which led us to review the Department's overall operational alignment in comparison to best practices.

Analysis

There are separate offices responsible for each of the five major programs identified by the Department and described previously. The offices for Managed Care and Health Innovation and Quality are directly under the Medicaid Director. The Pharmacy Office, which is responsible for the SPBM, is under Health Innovation and Quality. The office for OhioRISE is within Strategic Initiatives and the office for MyCare is within the Long-Term Services and Supports Office under Policy. These offices are colored yellow in the organizational chart below.

ODM Offices Responsible for Major Programs



Source: ODM Table of Organization

Due to this organizational structure, each of these offices is responsible for some level of strategic planning and program evaluation for its particular program. While ODM does not have a Department-wide strategic plan or program evaluation standard, it does have a managed care quality strategy and quality review structure for MCOs as required by the federal government. CMS requires states contracting with MCOs to submit a quality strategy every three years to define their population health and quality improvement priorities, articulate their vision for health delivery reform, and provide a road map for how to achieve these goals. In addition, MCOs must be reviewed annually by an External Quality Review Organization. CMS

recommends that states align these strategies with other performance improvement and quality assessment efforts.

ODM's current managed care quality strategy is largely related to the goals and strategies of the Department's "Next Generation of Managed Care" initiative. The goals of this initiative include the following.

- Improve wellness and health outcomes;
- Emphasize a personalized care experience;
- Support providers in better patient care;
- Improve care for children and adults with complex needs; and,
- Increase program transparency and accountability.

The Department's strategies to achieve these goals include contractual requirements for MCOs and the development of specialized programs, such as those described previously. As ODM identified specialized programs as a piece of its quality strategy, we examined the strategic planning and program evaluation efforts of the individual offices responsible for the major specialized programs. For more information on the contractual management piece of the Department's quality strategy, see [Recommendation 3](#).

Operational Alignment

In our review of strategic planning and program evaluation efforts, which will be discussed in detail in the following pages, we noticed significant variation in the efficacy and intentionality of practices utilized by different offices within ODM. While some offices are fully aligned with best practices, other offices are missing critical elements of effective strategic planning and program evaluation. This suggests a potential misalignment between ODM's overall vision and individual program management. We evaluated Department-wide operational plans and performance management practices to identify opportunities for improving the alignment between offices within ODM.

The National Performance Management Advisory Commission (NPMAC) has *A Performance Management Framework for State and Local Government* (2010) which offers guidance for governmental entities initiating and sustaining performance management practices. In this framework, NPMAC emphasizes the importance of an organization articulating its vision and mission, establishing organization-wide objectives and priorities, and identifying strategies to achieve these objectives. When asked for a Department-wide vision or mission, ODM referred to the Population and Health Quality Strategy, which describes the Department's goals for the improvement of health and wellness outcomes amongst Medicaid recipients, as well as the programs and activities planned or in progress to achieve these goals. While these goals are

extremely important for Ohio’s overall health outcomes, this is only a small portion of ODM’s actual operations. The strategy is specific to managed care programs and does not describe how other aspects of the Department’s operations, such as fiscal operations or communications, are contributing to these goals. It also does not outline operational goals specific to non-managed care divisions of ODM. As a result, the strategy is not applicable to the duties of approximately 490 of the Department’s 732 employees. Additionally, while ODM also has the “Next Generation” initiative which includes five overarching goals for Ohio’s Medicaid program, there is not formal documentation connecting those goals to components typically found in strategic planning efforts. Due to absence of comprehensive planning documentation, the Department does not have an organization-wide articulation of vision or goals to guide operations.

NPMAC also recommends that organizations utilize operational plans to translate high-level objectives typically identified in a strategic plan into policies, programs, services, and activities to achieve these objectives. Operational plans typically cover a two- or three-year period and clearly explain the connection between activities planned and desired results, as well as outlining the specific measures that will be utilized to evaluate progress. ODM could not provide an operational plan, business plan, staffing plan, or any other documentation translating goals into planned activities. The Department cited recent leadership changes as the reason for its inability to provide this documentation.

An operational, business, or staffing plan would be particularly useful for ODM due to the fragmentation of strategic planning, performance management, and program evaluation across various offices within the Department. As outlined previously, there are five offices involved in the strategic planning and evaluation of specialized managed care programs. Additionally, ODM has a Project Management Office and Continuous Improvement Unit, which are meant to assist other areas of the Department with business improvement initiatives. However, these divisions were not mentioned during our interviews with program management staff when discussing the development and evaluation of programs; but were rather included in a request for information that asked for an overview of ODM’s business improvement processes and personnel included. As a result of this fragmentation, there are gaps in institutional knowledge between offices, functional silos, and a lack of information retention. In interviews, some ODM staff members were unable to answer questions about their program areas and pointed to other offices, most frequently Health Innovation and Quality, when asked about methods to evaluate program effectiveness. We also received conflicting information from staff in different offices on multiple occasions and the Department was unable to provide certain pieces of information or data that we requested. NPMAC describes the importance of all employees having a thorough understanding of the end-to-end process to encourage institutional knowledge retention and reduce functional silos.

The Society for Human Resource Management (SHRM) and Milliman, an actuarial and consulting firm, have reports detailing the value of an organizational staffing plan, which ODM does not have. Milliman specifically indicates that state Medicaid agencies may not be able to fully address staff capacity challenges through additional hiring due to inefficient internal processes, such as the lack of institutional knowledge and information retention we observed at ODM. SHRM outlines the steps to creating a staffing plan, which can be used to strategically hire and organize staff to assist an organization in achieving its vision and goals, as well as improving operational alignment across an organization. ODM could achieve improved efficiency and effectiveness across the Department by adopting and utilizing an operational plan and a staffing plan.

Strategic Planning

The Government Finance Officers Association (GFOA) defines strategic planning as the act of articulating an organization's vision for the future and identifying goals and objectives to achieve the vision. This vision can then be used to align budgeting with organizational priorities. The GFOA outlines eight steps in the strategic planning process.

Department-Wide Strategic Planning

- The Department lacks an organization-wide articulation of vision or goals to guide operations. Additionally, it does not have an operational, business, or staffing plan.
- None of the programs were able to provide a comprehensive document that addressed all components of the criteria for their program.

We compared the strategic planning practices of the offices responsible for the five major programs to these steps to identify any opportunities for improvement. This comparison is displayed in the table on the following page.

ODM Strategic Planning Compared to Best Practices

	Health Innovation and Quality	Managed Care	MyCare	OhioRISE	SPBM
Initiate strategic planning					
Analyze and assess the environment					
Define the problem(s)					
Develop a vision to address each problem					
Develop strategies to realize your visions and implement strategies using tactics					
Obtain approval of the plan					
Execute and monitor tactics					
Evaluate and reassess					



Generally Aligned



Partially Aligned



Not Aligned

Source: GFOA and ODM

As shown in the table above, Health Innovation and Quality, OhioRISE, and SPBM are generally aligned with all eight steps outlined in the GFOA criteria. MyCare is generally aligned with seven of the eight and Managed Care is generally aligned with six of the eight. Both of these programs are only partially aligned with the third step of defining the problem(s), and Managed Care is only partially aligned with the seventh step of executing and monitoring tactics. Both offices failed to provide documentation of analyzing the environment to identify the most critical issues for the organization and the community. The Managed Care and MyCare offices require MCOs to identify risks for their members based on characteristics and health needs. However, the offices did not have any documentation of risk identification for their internal operations.

Efficient



Effective



Transparent

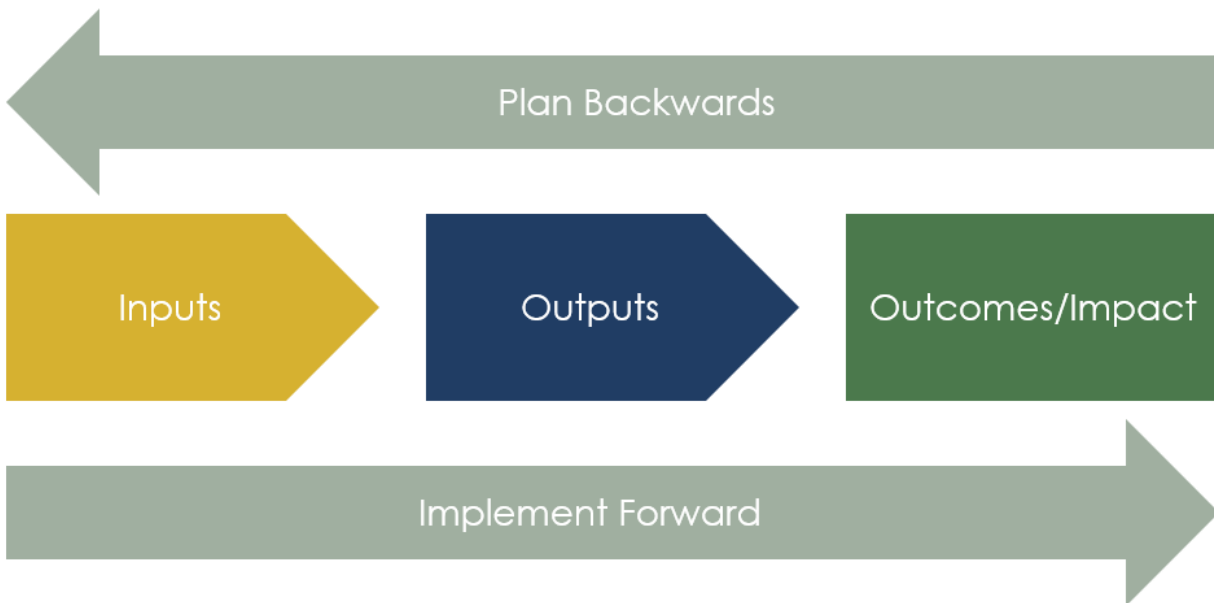
Additionally, the Managed Care Office was not able to provide documentation of monitoring or evaluation of cost and tactic effectiveness, or how this information is utilized in the budget process, while other program offices were able to. This is despite the Department sending \$10.9 billion in capitation payments to these MCOs in CY 2025, and these payments being a significant portion of the Department’s biennial Medicaid Caseload and Expenditure Forecast Report, which is used as part of the state budget process. While these caseloads and expenditures are monitored as part of the forecasting process, program managers should be aware as these are important figures for performance management. For further information on this criteria and the alignment of various offices, see [Appendix G](#).

It is important to note that while the GFOA outlines these steps for strategic planning as a comprehensive process, none of the programs were able to provide a comprehensive document that addressed all components of the criteria. Instead, when program managers could articulate how a process worked and shared documentation, the component was considered generally aligned. Formalizing strategic planning processes as part of operational alignment will allow for these steps to be followed more closely in practice and result in better documentation.

Program Evaluation

Program evaluation is a way for an organization to understand and identify success and opportunities for improvement. One method of program evaluation is through the use of logic models, which are a visual representation of the relationship between inputs, activities, and expected outcomes of a quality improvement program or initiative. This approach is helpful to identify the resources and actionable steps an organization could utilize to measure performance and improve outcomes. Battelle’s Partnership for Quality Management (PQM), which is sponsored by CMS and the U.S. Department of Health and Human Services, provides guidance on the evaluation and enhancement of healthcare provider and system performance. In *Logic Model Guidance for the Endorsement and Maintenance of Clinical Quality Measures* (2025), PQM identifies guiding principles for the use of logic models in healthcare quality measurement. A simplified version of a logic model is visually represented on the following page.

Simplified Version of a Logic Model



Source: Adapted from the University of Wisconsin-Madison's Enhancing Program Performance with Logic Models

While logic models were not specifically used in the development of ODM's programs, and there was not one document that communicated the entirety of a program's inputs, outputs, outcomes, and impact, we still considered programs generally aligned if they were able to communicate and document how they completed each step, even if it was done in a non-formal process. PQM outlines logic models as a way to guide design and planning, clarify objectives, assess impact, enable communication, and center equity. Formalizing program development and evaluation processes as part of operational alignment will allow for the Department and its stakeholders to better understand the relationship between a program's inputs, outputs, outcomes, and impacts. Understanding the relationship between these areas will allow for improved program evaluation and the most impactful leveraging of Ohio's resources. The table on the following page shows a comparison of each office's program evaluation practices to PQM's guiding principles.

ODM Program Evaluation Compared to Best Practices

	Health Innovation and Quality	Managed Care	MyCare	OhioRISE	SPBM
Engage interested parties early and often					
Use evidence-based information					
Revisit the completed logic model frequently					
Evaluate selected indicators in context					
Balance comprehensiveness with parsimony					
Incorporate feedback mechanisms					

 Generally Aligned
  Partially Aligned
  Not Aligned

Source: PQM and ODM

As shown in the table above, Health Innovation and Quality, SPBM, and OhioRISE are generally aligned with all of the guiding principles. MyCare is generally aligned with three and Managed Care is only generally aligned with one. This partial alignment with many of the guiding principles is largely due to a lack of documentation to support the practices that staff described in interviews. Given conflicting testimonial evidence provided by different areas of the Department as well as testimonial evidence from stakeholders we interviewed, we required documentary evidence to show that the Department was generally aligned with best practices. This requirement was explained to the Department in several meetings and written requests. Additionally, when the Department responded to our questions for Managed Care and MyCare in this area, they often included the same response when the programs are serving different populations. For an in-depth discussion of this criteria and the alignment of various offices, see [Appendix G](#).

As a result of the absence of a Department-wide strategic, operational, or staffing plan, there is significant variation in the strategic planning and program evaluation efforts throughout ODM. Despite some individual program efforts being in line with best practices, the lack of consistency across programs reduces the overall efficacy of these efforts. Additionally, there is

a significant number of divisions and employees within the Department that are not considered in any of ODM's current strategic planning practices.

Conclusion

ODM should utilize operational management best practices to improve the alignment of strategic planning and program evaluation efforts across the Department. The current lack of an organization-wide strategic plan, operational plan, and staffing plan causes these planning efforts to be fragmented across multiple offices within the Department. Based on our review of strategic planning and program evaluation practices across five ODM offices, there is significant variation in the adequacy of these practices between offices. This fragmentation and variation creates institutional knowledge gaps and functional siloes, which negatively impacts the Department's overall operational effectiveness.

*In ODM's review of the report draft, it indicated that the audit team failed to include the Department's Project Management Office (PMO) and Human Resources (HR) in this analysis. As noted in the **Performance Audit Summary**, ODM utilizes an Audit Coordination Group that controlled all communication that we had with the Department and attended every meeting. Before the review of the draft, this group did not indicate that we should talk to the PMO or HR, nor did they include staff from these offices in our meetings with the Department regarding strategic planning efforts. While these areas were not mentioned by any program managers during interviews, we did due diligence to ensure there were no other plans outside these areas that would be relevant to this analysis. As part of our review, we requested any operational plans the Department had, giving examples of business plans, staffing plans, or any other documentation that translate high-level organizational goals into policies, procedures, and services. ODM only provided two examples, which were both for the SPBM. Additionally, as part of this review, we requested an overview of ODM's business improvement process. ODM provided an outline of these activities, which included the activities of one unit within the PMO. However, they failed to provide any supporting documentation of these activities, nor were these efforts highlighted by program managers during relevant conversations.*

While ODM may have PMO and HR, these offices appear to be ineffective at supporting operational alignment across the Department, as evidenced by the siloes noted throughout the audit and a lack of consistent standards and plans.

Recommendation 2: Enhance Transparency of Caseload and Financial Forecasting Materials

ODM creates a biennial Medicaid Caseload and Expenditure Forecast Report in collaboration with the Office of Budget and Management that projects two years of Medicaid enrollment and expenditures. This forecast is used in the development of Ohio's biennial budget to ensure that an appropriate amount of funding is allocated for the provision of healthcare services to Medicaid recipients. The Department considers a variety of factors in its forecast, including recipient characteristics, economic indicators, and population trends. ODM's forecasting process is largely aligned with best practices identified by the GFOA, except for ensuring the public transparency of forecast materials. While the Medicaid Caseload and Expenditure Forecast Report is publicly available on the Office of Budget and Management's website, ODM does not publish this report, instead producing monthly Budget Variance Reports comparing forecasted values to actual enrollment and expenditures. Additionally, none of these reports are accompanied by detailed forecast assumptions. The Department should enhance the transparency of its enrollment and financial forecasting process by publishing the forecast report and an accompanying public narrative in a central location.

Impact

The biennial Medicaid Caseload and Expenditure Forecast Report is publicly available on the Office of Budget and Management's website, but is not accessible through ODM's website. ODM publishes monthly Budget Variance Reports comparing forecasted values to actual enrollment and expenditures for the Medicaid program on its website. This accessibility helps the public and stakeholders better understand enrollment and the associated costs. However, these reports are not in a centralized location and the accompanying assumptions used to develop the forecast are not included in these documents. For a forecast to be comprehensively and effectively understood, forecast assumptions are needed to provide context and support. Without these forecast assumptions, the public may misunderstand the reasons for historical variations or future trends and come to incorrect or incomplete conclusions. While the forecasting team noted being willing to discuss forecasting assumptions with interested parties, not having the information posted publicly introduces an administrative barrier. Making the comprehensive forecast narrative publicly available in a centralized location and explaining how the assumptions impact the forecast will improve the public understanding of Medicaid funding and forecasting, foster public trust in the Medicaid program, and enable public participation in Medicaid decision-making.

Background

With an appropriation of over \$45 billion, Medicaid spending accounted for approximately 43 percent of Ohio's total operating budget in SFY 2026. Due to the amount of the State's budget that is allocated to the program, accurate forecasts of Medicaid enrollment and expenditures are critical to the state's financial health and ability to provide healthcare services to all Medicaid beneficiaries. Even slight variations between the Medicaid forecast and actual spending can have a significant impact on the State budget, including impacts on the many other programs that the State funds. According to The Art and Science of Medicaid Budget Forecasting as published by the National Association of Medicaid Directors, challenges in forecasting typically fall into three categories: new policy, unprecedented public health events, and aggregating data timely and effectively.

Ohio law requires the Office of Budget and Management to submit a Medicaid Caseload and Expenditure Forecast Report to the Governor's Office at the beginning of each calendar year. This forecast is prepared in consultation with ODM, which begins to prepare forecast materials for this purpose each fall. The Legislative Service Commission (LSC) additionally creates a revenue and expenditure forecast prior to each fiscal biennium, utilizing a third-party actuary to determine the medical inflation rate. These forecasts are used by the Governor and legislature in the creation and passage of the biennial budget bill.

After the budget bill is passed, ODM's fiscal operations team reviews the budget and actual spending frequently, publicly issuing two monthly Budget Variance Reports, one on forecasted versus actual enrollments and one on forecasted vs actual expenditures. The team also updates the forecasts as needed for internal monitoring and management. Actual enrollment and expenditure information is also displayed in ODM's Demographic and Expenditure Dashboard and OBM's Monthly Financial Reports on Ohio's overall economic and budget performance. In addition to these forecasts, ODM is also required by federal law to submit quarterly estimates of expenditures and actual expenditure reports to CMS. A summary of the documents produced by ODM and OBM related to Medicaid forecasting is displayed on the following page.

Medicaid Forecasting Documents

Report Name	Description	Location
Medicaid Caseload and Expenditure Forecast Report	A biennial report created by ODM and OBM that provides detailed information on current and projected Medicaid enrollment and expenses.	OBM Website Archives
Budget Variance Enrollment Report or Monthly Medicaid Caseload Report	A monthly report created by ODM comparing forecasted enrollment to actual values.	ODM Website
Budget Variance Expenditure Report	A monthly report created by ODM comparing forecasted expenditures to actual values.	ODM Website
OBM Monthly Financial Report	A monthly report created by OBM providing information on statewide economic growth, employment, consumer income and consumption, industrial activity, and construction; as well as details on monthly and year-to-date General Revenue Fund (GRF) receipts.	OBM Website
Demographic and Expenditure Dashboard	A dashboard maintained by ODM displaying current enrollment and expenditures for the Medicaid program. Information can be broken down by county, year, program, and demographics.	ODM Website
ODM Quarterly Expenditure Reports to CMS	Two reports submitted by ODM to CMS quarterly. The first identifies anticipated quarterly budgeted costs and the second identifies actual quarterly expenses.	CMS Website

Source: ODM, OBM, CMS

Methodology

After developing an understanding of the state and federal laws governing Medicaid forecasting, we examined the Department's processes for forecasting program enrollment and expenditures, as well as the subsequent monitoring of the forecasts. We compared these processes to best practices from the Government Finance Officers Association (GFOA) to identify opportunities for improvement. We additionally evaluated the historical accuracy of ODM's forecasts, which did not have a statistically significant difference from actual enrollment or expenditures.

Analysis

The Department's financial and enrollment forecasts are created by the Econometrics and Forecasting Unit within the Fiscal Operations Bureau. This team forecasts Medicaid service expenditures by calculating a per member per month (PMPM) cost and multiplying this cost by estimated enrollment. The PMPM calculation varies based on member characteristics that are likely to impact healthcare costs, such as age, gender, medical condition, and eligibility category. These various subgroups are referred to as rate cells. The differentiation of rate cells is important because not all Medicaid recipients require the same amount or intensity of healthcare services. For example, healthcare services for an adult male between the ages of 19 to 64 are likely to be less expensive than an adult male over age 65 who is in a nursing facility. To account for these differences, the Department utilizes rate cells developed by third-party actuaries.

The Econometrics and Forecasting Unit utilizes a third-party forecasting software to generate more than a hundred forecast scenarios. This total includes forecast scenarios for enrollment and expenditures in the various Medicaid service delivery models and other programs, which are then combined into the comprehensive biennial Medicaid forecast. In addition to enrollment and PMPM costs, the financial forecasts also consider underlying economic indicators, such as unemployment, inflation, and labor force participation. The enrollment forecasts consider population trends, such as births, deaths, migration, and future policy changes. Due to the number of factors involved, ODM generates many models based on different methodologies for each forecast. Staff then review each model and determine which is the most appropriate for the particular forecast being developed.

Once the forecast is completed, the Department monitors it throughout the fiscal year and updates it as necessary for internal use. Updates may be created in consideration of more recent actual expenditure observations or as a result of changes to policy or managed care capitation rates. If these updates increase the forecasted expenditure, the State allocates additional funding to the Medicaid program. Additionally, the Department publishes monthly

Budget Variance Reports comparing forecasted enrollment and expenditures to actual values, with some explanation for variances.

The GFOA has guidance on Financial Forecasting in the Budget Preparation Process. This guidance outlines the key steps in the forecasting process, which we compared to ODM's forecasting process as outlined on the previous page. A high-level comparison of the Department's process to GFOA best practices is displayed in the table below. The areas where ODM is partially aligned with best practices will be discussed in more detail.

ODM Forecasting Process Compared to Best Practices

Best Practice	ODM Process
Define Assumptions: Identify the time horizon, objective, political or legal issues, and major revenue and expenditure categories.	
Gather Information: Identify factors impacting revenues and expenditures, factors disrupting the operating environment, prevailing trends, long-term strategic plans.	
Conduct Exploratory Analysis: Examine historical trends and economic conditions, including the business cycle, demographic trends, outliers and historical anomalies, and the relationship between variables.	
Select Methods: Determine the qualitative and quantitative methods to be used, including extrapolation, regression/econometrics, or hybrid forecasting.	
Implement Methods: Make the forecast and include a range of possible forecast outcomes.	
Use Forecast: Inform and assist in decision-making through credible, clear, and relevant presentations.	
Evaluate Forecast: Evaluate the accuracy and effectiveness of the forecast and use the experience to improve forecasting.	



Generally Aligned



Partially Aligned



Not Aligned

Source: GFOA and ODM

Efficient



Effective



Transparent

The GFOA describes three elements that are essential to an informative and effective presentation of a forecast. ODM is generally aligned with two of these three elements, including credibility of the forecaster and the forecast process and linkage of the forecast to decision-making. The element that ODM is only partially aligned with is presenting a clear and reasonable message. The GFOA specifies that this message should be built around the set of assumptions used to create the forecast and address the implications of the forecast. The assumptions should be made clear, with supporting information and an explanation of how they lead to the forecast results. ODM forecasting staff do tailor presentations to their audience to ensure they are presenting an appropriate message and level of detail. However, there is not a list of assumptions accompanying the publicly available forecast report and therefore it is difficult for the public to understand the reasoning behind trends shown in forecast reports.

The last step of GFOA's forecasting process is the evaluation of both the accuracy and effectiveness of a forecast. ODM adequately evaluates the accuracy of its forecasts by retaining forecasts, comparing them to actual results, and identifying the causes of any variance. However, the Department's evaluation of forecast effectiveness is not comprehensive due to a lack of public assumptions. The GFOA recommends that the evaluation of effectiveness includes whether the decision-making system supports the use of forecasting, the forecast is seen as credible, the forecast is relevant to decision-makers' interests, and information is presented so that is accessible. ODM meets the first three of these elements, but publicly available forecasting information does not include a set of core assumptions used that is detailed and complete enough for a reader to understand important factors impacting the forecast. As a result, the forecast information is not accessible, as assumptions are essential to understanding the forecast.

Conclusion

ODM should enhance the transparency of enrollment and financial forecasts by publishing the forecasts and accompanying significant assumptions in a public, central location. Without this information being readily accessible, it is not possible for the public to fully understand the most significant factors impacting the Medicaid program's forecasted enrollment and expenditures. Making this information more accessible will strengthen the public's understanding of Medicaid spending and enable more informed discussions around Medicaid policy and decision-making.

Recommendation 3: Improve Contract Management Practices

Ohio's Medicaid program is facilitated by several third-party vendors that the Department contracts with for various functions, including information systems and managed care plans. These contracts represent a large portion of ODM's total spending. In SFY 2025, the Department spent 41.4 percent (\$253.4M) of its administrative expenditures on contracted services and 66.5 percent (\$27.9B) of its service expenditures on managed care, which is provided by contracted entities. We reviewed six of ODM's contracts that are critical to the "Next Generation" initiative and modularization of OMES. Half of the contracts with cost proposals had significant discrepancies between the planned costs and actual spending on the contracted service, amounting to over \$145 million in unplanned expenses. When comparing ODM's contract procurement and management efforts to best practices, we identified many opportunities for improvement. These opportunities varied from being unique to individual contracts we reviewed to being consistent across all contracts reviewed. The most significant deficiencies we observed were related to strategic planning, vendor references, stakeholder communication and engagement, training of contract managers, and documentation of review processes. ODM should utilize best practices to improve its contract management practices, which may result in fewer unplanned expenses, enhanced service delivery, and more comprehensive stakeholder engagement.

Impact

The most quantifiable impact of improving the Department's contract management practices is decreasing the frequency and quantity of unplanned expenses. Of the six contracts we reviewed, three had a cumulative actual spend that exceeded total planned costs over the time period examined. These excess costs were often associated with contract amendments, which in some cases were related to increased services or scope. Some amount of this is to be expected due to unknown variables associated with implementing a new system or delivery model, but the level of excess costs suggests room for improvement in planning and cost estimation practices. Knowing the full extent of costs for each vendor could potentially have changed the Department's decision during procurement. Additionally, if the Department's key contracts require more resources than planned, this means that there are fewer resources available for the Department's other initiatives. Improving the procurement process will enhance the cost estimations that are used for budgeting, while improving the management process will ensure the Department is adequately evaluating contractor performance and making adjustments accordingly.

Improving contract procurement and management practices will also result in enhanced service delivery and more comprehensive stakeholder engagement. If the Department’s procurement process is more specific and informed, ODM will be able to obtain vendors that best fit the Department’s needs. Additionally, if ODM is identifying and engaging all relevant stakeholders for all contracts, the vendors obtained will be better suited to meet the needs of the stakeholders. This will also contribute to improved stakeholder engagement throughout the Department, which is discussed further in [Recommendation 9](#).

Background

Contracted services constitute a large portion of the Department’s total spending. In SFY 2025, ODM spent 41.4 percent (\$253.4M) of its administrative expenditures on contracted services and 66.5 percent (\$27.9B) of its service expenditures on managed care, which is provided by contracted entities. This resulted in a total of \$28.2 billion spent by the Department on contracted services in this year.

We reviewed six contracts related to ODM’s “Next Generation” initiative and the modularization of the Ohio Medicaid Enterprise System (OMES). The contracts we reviewed, as well as the associated third-party vendors and go-live dates, are displayed in the visual on the following page.

Contracts Reviewed

Contractor	Contract	Description	Go-Live Date
AmeriHealth	Managed Care Organizations (MCOs)	Entities that the Department contracts with to provide healthcare services to Medicaid recipients through a network of healthcare providers. ODM pays the MCOs a monthly premium for each enrollee, called a capitation payment. In return, MCOs pay for all of the healthcare services required by their enrollees.	SFY 2023
Anthem			
Buckeye			
CareSource			
Humana			
Molina			
United HealthCare			
Gainwell Technologies	Single Pharmacy Benefit Manager (SPBM)	A third-party administrator contracted by ODM to manage the entire Medicaid prescription drug program. The SPBM establishes preferred drug lists, processes pharmacy claims, negotiates prescription drug prices, and contracts with pharmacies to obtain prescription drugs.	MC: SFY 2023 FFS: SFY 2024
	Fiscal Intermediary (FI)	A module within OMES that is used to facilitate, track, and process fee-for-service claims, payments, and prior authorizations.	SFY 2023
Deloitte	Electronic Data Interchange (EDI)	A module within OMES that serves as an entry point for the electronic transmission of documents and data to other OMES modules.	SFY 2023
	System Integrator (SI)	A module within OMES that ensures that all the different modules and systems within OMES are interoperable, meaning that they are able to connect, communicate, and work together.	SFY 2023
Maximus	Provider Network Management (PNM)	A module within OMES that serves as a self-service portal for healthcare providers to see claims submitted by their trading partners, submit fee-for-service claims and prior authorizations, and access financial documentation.	SFY 2023*

Source: ODM

*Additional features were added in SFY 2024

Note: The MCO go-live date represents when the most recent iteration of MCO agreements went live, as they are revised and renewed approximately every two years. ODM was directed to contract with an SPBM by the Ohio General Assembly in FY 2019. Prior to this, pharmacy benefits were contracted by each MCO and managed by multiple PBMs. Other systems were preceded by MITS.

Methodology

Based on our understanding of the Department’s “Next Generation” initiative and modularization of OMES, we conducted an initial review of publicly available documents and data regarding ODM’s contracts and contract procurement and management practices. In collaboration with the Department, we identified key contracts and requested the contracts, amendments, and supporting documentation for these contracts. We reviewed these documents, then surveyed contract managers throughout the Department to understand their contract management practices. We compared the survey responses to best practices for contract procurement and management, then held follow-up interviews with contract managers to ensure that our understanding was complete and comparison to best practices was accurate. After this, we obtained and compared ODM’s practices to more in-depth, Medicaid specific contract management best practices. Finally, we held discussions with external stakeholders to hear their perspectives on contracted systems and managed care plans.

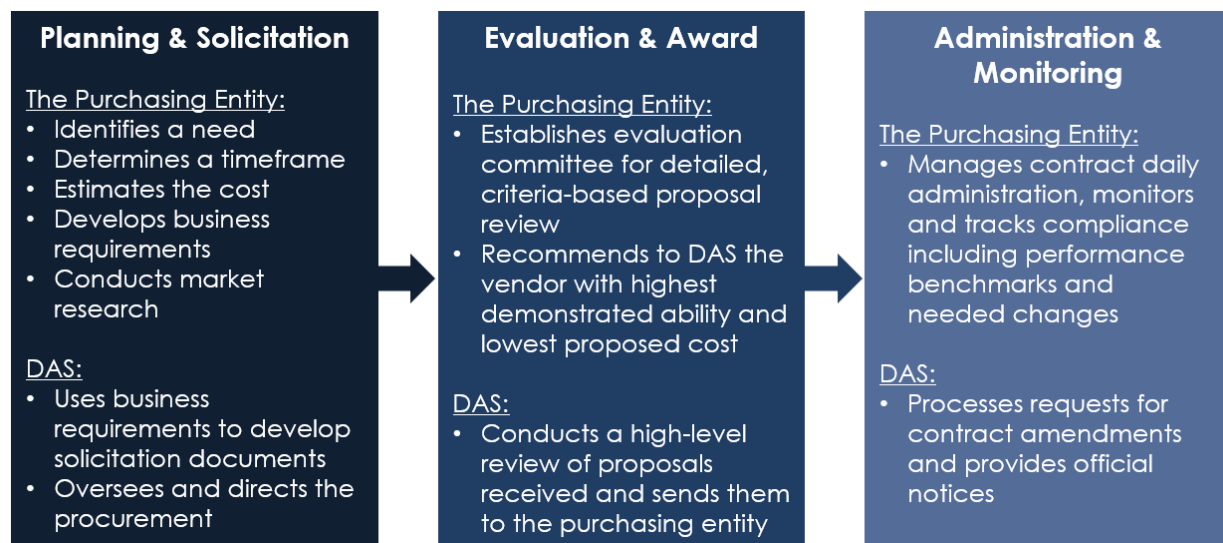
Analysis

ODM has many contracts related to the administration of Ohio’s Medicaid program. The Department has an Office of Contracts and Procurement, which is responsible for preparing all contracts and agreements, as well as establishing contract procurement and management procedures that comply with state and federal laws and regulations. The procurement of contracts is overseen, and in certain cases managed by, the Ohio Department of Administrative Services (DAS). Certain procurements additionally require approval from the State Controlling Board, which is Ohio’s legislative review body with approval authority over state fiscal activities outside of the biennial budget process. When a DAS led procurement is required to acquire contracted services for ODM per Ohio code, both departments work in collaboration throughout all contract phases with DAS having oversight, administrative, and facilitation responsibilities and ODM’s contract managers having responsibilities more targeted towards service requirements and daily administration and monitoring. Once a contract is executed, an ODM contract manager is responsible for monitoring the contract to ensure all provisions are being met, while a DAS contract analyst handles the high-level administration of the contract. These contract managers are located in various divisions of ODM, depending on the item or service being contracted for. ODM’s Office of Contracts and Procurement reviews and approves certain activities conducted by contract managers, including requests for contracted services, competitive selection of vendors, and contract amendments.

Contract Phases

To facilitate our review of ODM's contract management practices, we divided the contract procurement and management process into three broad phases based on the DAS *State of Ohio Procurement Manual* (2023). The first phase is planning and solicitation, the second is proposal evaluation and award, and the third is contract administration and monitoring. The high-level steps for each phase by entity are shown below.

Contract Phases



Source: ODM

Proposed vs Actual Contract Costs

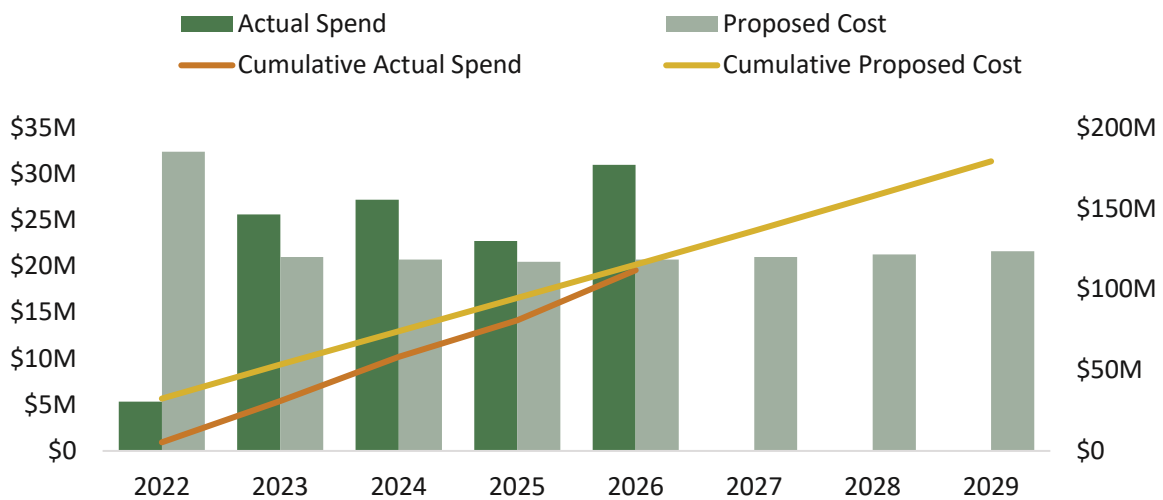
Five out of the six contracts we reviewed had vendor cost proposals submitted during the planning and solicitation phase that were considered during vendor selection.²⁴ We compared these cost proposals to the actual spending on the contracts to identify variation and determine the accuracy of cost estimates. The actual cost of three of the five contracts exceeded the estimated cost outlined in the vendor's cost proposals. Each of these contracts is renewed every two years, as two years is the longest contract term allowable by state law. However, during the procurement process, vendors provided cost proposals for multiple years for

²⁴ The MCO agreement was the only contract without vendor cost proposals. This is because MCOs are paid using capitation rates determined by actuaries, and thus a cost proposal was not applicable.

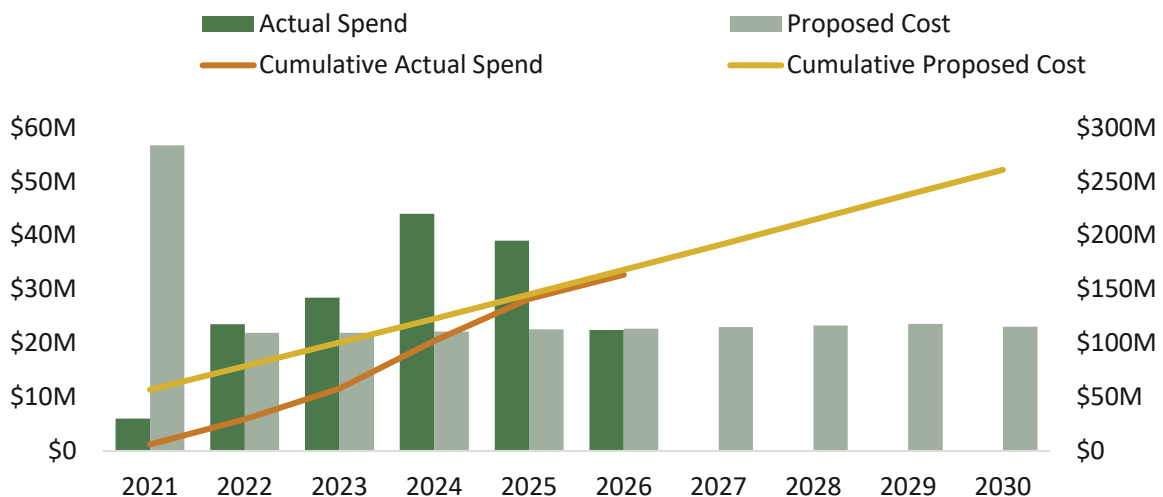
planning purposes. These longitudinal cost proposals, as well as actual spending, for each contract are shown below.

The two contracts with Gainwell Technologies for the SPBM and FI were the only contracts that did not exceed the total proposed cost. Overall, total actual costs fell within five percent below the proposed costs. This overall trend, as well as the annual variation, is displayed in the graphs on the below.

SFY 2022-2029 SPBM Proposed vs Actual Costs



SFY 2021-2030 FI Proposed vs Actual Costs



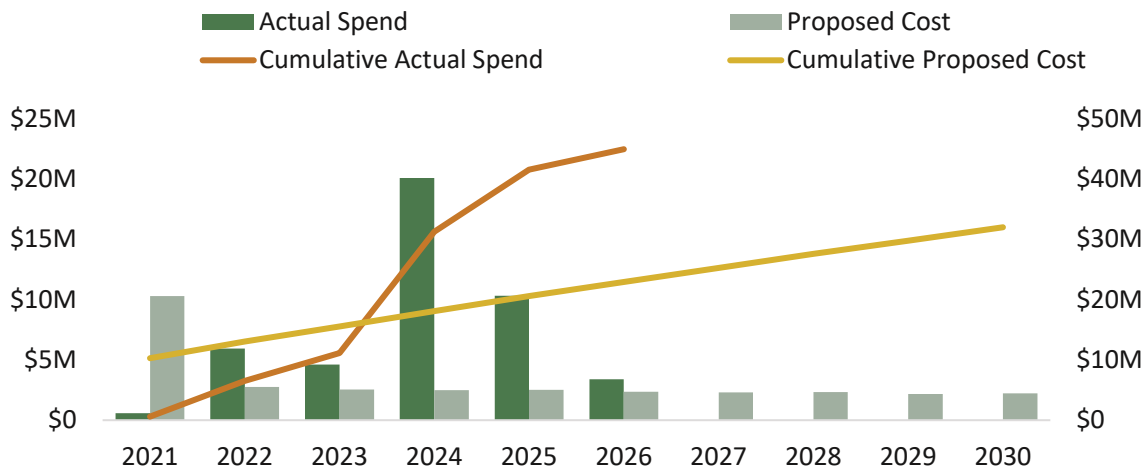
Source: DAS & ODM

Note: In the SPBM and FI cost proposals, years are marked as Year 1, Year 2, etc. SFYs in these graphs are based on these years and the date that the contract was signed.

As shown in the graphs on the previous page, the actual cost of the contracts with Gainwell Technologies fell far below the proposed cost in the first year of each contract. This contributes to the cumulative actual cost of each contract being below the cumulative proposed cost, despite actual costs exceeding proposed costs in subsequent years.

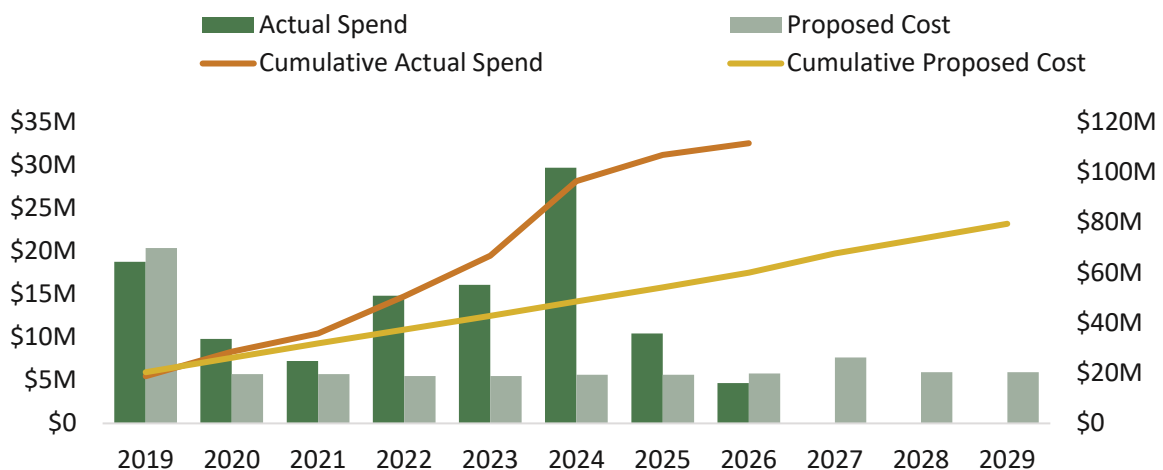
Actual spending for the Deloitte and Maximus contracts exceeded the proposed costs, both in annual and cumulative spending. The actual cost of the Deloitte contracts for the EDI and SI was approximately \$22.0 million and \$51.8 million above proposed costs, respectively. The annual and overall trends for the EDI and SI contracts are displayed in the graphs below.

SFY 2021-2030 EDI Proposed vs Actual Costs



Note: In the EDI cost proposal, years are marked as Year 1, Year 2, etc. SFYs in this graph are based on these years and the date that the contract was signed.

SFY 2019-2029 SI Proposed vs Actual Costs

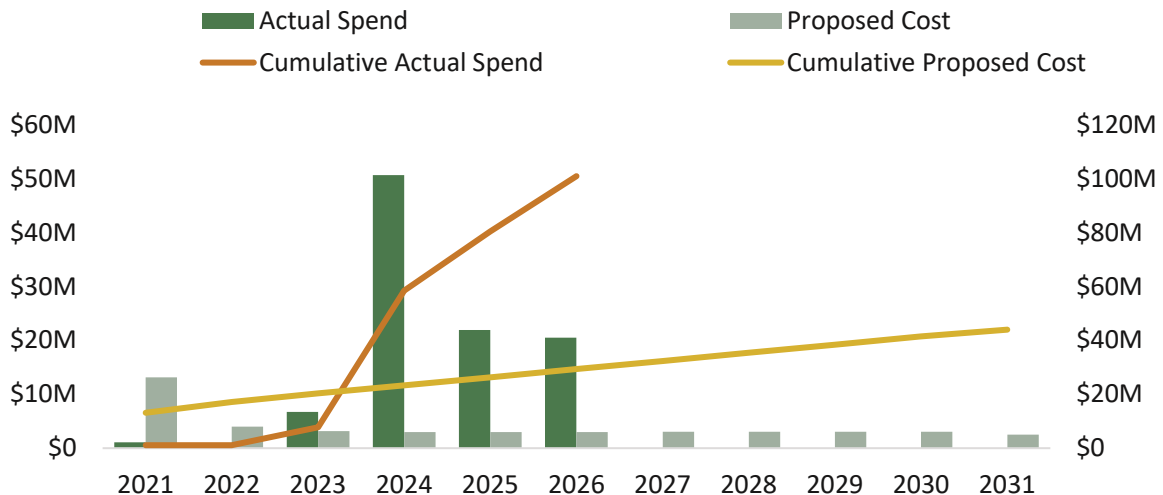


Source: DAS & ODM

As displayed in the graphs on the previous page, actual costs for the EDI exceeded proposed costs in every year except the first year of the contract, while actual costs for the SI exceeded proposed costs in every year except for the first and most recent year of the contract. For both contracts, actual costs were highest in SFY 2024.

The Maximus contract, which is for the PNM, has the most extreme variation between actual and proposed costs. In total, actual spending was nearly three and a half times higher than the proposed costs, a difference of \$71.7 million. Actual spending was below proposed costs for the first two years of the contract, then increased significantly from SFY 2022 to 2024. In SFY 2024, actual spending exceeded the proposed cost by \$47.7 million. The Department did not indicate reasons for this overage. These annual and cumulative trends are displayed in the graph below.

SFY 2021-2031 PNM Proposed vs Actual Costs



Source: DAS & ODM

Notably, the majority of these contracts saw an increase in actual costs following their go-live date. The go-live date is when a system becomes operational and is available for use by its intended audience. All five of these systems went live in SFY 2023, with additional functionalities being added to the SPBM and PNM in SFY 2024.

An important note is the difficulty in using budgeted and actual costs as a performance measure. While CMS previously evaluated whether projects were on budget, recent guidance notes that determining the schedule, budget, and functionality before work started means that there can be limited opportunities to shift priorities or consider user satisfaction once implemented. While these cost fluctuations were approved through contract amendments, the significant level of variation still means that resources must be reallocated to meet increased costs associated with increased scope. Examples of contract amendments related to cost

increases include adding an integrated help desk to the contract scope, increasing the amount of pool hours,²⁵ addressing change requests, and adding maintenance resource hours. To further investigate, we evaluated ODM's contract management practices for each of the six contracts in the three contract phases defined previously.

Planning & Solicitation

There are ten steps within the Government Finance Officers Association's (GFOA) best practices for the planning and solicitation phase, with additional support from the National State Auditors Association (NSAA) for two of the steps. The table on the following page displays each of these steps, as well as each contract's alignment with each step. For more details about the criteria steps, see [Appendix H](#). An important note is that these steps have varying levels of importance, complexity, and difficulty in implementing with effectiveness associated with them.

²⁵ Pool hours enable flexibility by allowing ODM to make small changes and or adjust priorities without having to go through amending the contract via a change order. Pool hours are a separate bucket of time and money that is not guaranteed to the vendor in the same way fixed pricing for acceptable, completed contract deliverables are.

Planning & Solicitation Alignment with Best Practices

	FI	SI	EDI	PNM	SPBM	MCO	Overall Rating
Establish Executive Direction							
Link to Strategic Plan							
Obtain Stakeholder Input							
Consider Requirements Relevant to Service							
Consider Factors Impacting Cost ²⁶							
Develop an RFP/RFA							
Acquire Relevant Knowledge							
Develop Agreement Provisions							
Develop a Transition Plan							
Communicate Selection of Service							



Generally Aligned



Partially Aligned



Not Aligned



Not Applicable

Source: GFOA and ODM

²⁶ While ODM's process for considering factors impacting cost were generally aligned with best practices, we observed significant variation in how actual spending compared to proposed costs by vendor, as discussed in the Proposed vs Actual Costs Section.

All of the Department's contracts that we reviewed were generally aligned with five of the ten applicable steps: executive direction, service requirements, cost considerations, RFP/RFA development, and agreement provisions. The contracts had a variety of alignment with the remaining six applicable steps. Only the SPBM contract was generally aligned with the strategic link step. The other contracts were partially aligned due to the deficiencies outlined in [Recommendation 1](#) or because ODM indicated that the systems contracts were linked to an old document that only describes the Department's goals for OMES, not strategies to achieve or monitor these goals, which is not generally aligned with the criteria. Half of the contracts were only partially aligned with the stakeholder input step, as ODM did not adequately identify and engage relevant stakeholders for these contracts. For more information on the Department's stakeholder engagement efforts, see [Recommendation 9](#). The SPBM contract was only partially aligned with the knowledge acquisition step, as ODM did not perform public outreach during the procurement of the SPBM, citing the legislative mandate to contract with an SPBM as the reason why. One of the contracts did not require the vendor to submit a system retirement and transition plan, while another required this plan but stakeholder feedback regarding the transition indicated that it was not effective. Therefore, these two contracts were only partially aligned with the transition step. Finally, four of the contracts were only partially aligned with the communication step, because ODM sufficiently communicated the outcome of the contract procurement internally in the Department, but did not communicate this information to external stakeholders.

Evaluation & Award

There are seven steps within the NSAA best practices for the evaluation and award phase. All of the contracts we reviewed were generally aligned with all seven steps, except for checking vendor references. The steps, as well as each contract's alignment with each step are displayed in the table on the following page. For more details about the criteria steps, see [Appendix H](#).

Evaluation & Award Alignment with Best Practices

	FI	SI	EDI	PNM	SPBM	MCO	Overall Rating
Have Appropriate Proposal Procedures							
Ensure an Adequate Number of Proposals are Received							
Select an Evaluation Committee							
Use Consistent and Defined Scoring Criteria							
Ensure Bid Integrity							
Check Vendor References							
Document the Award Decision							



Generally Aligned



Partially Aligned



Not Aligned



Not Applicable

Source: NSAA and ODM

Although ODM requires most vendors to provide references and describe previous experiences relevant to the requested services as part of their proposal, the Department indicated that they do not check any of the references provided due to the Department's perception that this process was not valuable in their experience. ODM confirmed that this was not part of the evaluation process or scoring criteria for any of the contracts we reviewed.

Efficient



Effective



Transparent

Administration & Monitoring

There are seven steps within the NSAA best practices for the administration and monitoring phase. All of the contracts we reviewed are generally aligned with four of these seven steps, while the remaining three steps had varying levels of alignment across the contracts. The steps, as well as each contract's alignment with each step, are displayed below. For more details about these criteria steps, see [Appendix H](#).

Administration & Monitoring Alignment with Best Practices

	FI	SI	EDI	PNM	SPBM	MCO	Overall Rating
Assign an Agreement Manager							
Ensure Assigned Personnel are Knowledgeable							
Track Budget							
Track Deliverables							
Withhold Payment Until Deliverables are Received							
Retain Documentation of Service Credits							
Evaluate Contractor Performance							

 Generally Aligned
 Partially Aligned
 Not Aligned
 Not Applicable

Source: GFOA and ODM

Two contracts were only partially aligned with the knowledgeable personnel step. While the contract managers responsible for the contracts we reviewed have varying levels of tenure and experience, the PNM contract manager was unable to answer the majority of our questions regarding the PNM contract. This contract manager had only been assigned to the contract three months prior to our meeting. Additionally, MCO contract managers were unable to

answer most questions during some interviews and provided little detail in requests for information. ODM did not have a formal training structure for contract managers during these procurements, though training is currently in development. This lack of formal training, in combination with moderate turnover amongst contract managers, can lead to a loss of institutional knowledge like we observed with the PNM contract.

The MCO agreement was only partially aligned with the budget tracking step. ODM indicated that this step was not applicable to the management of the MCO agreement because MCOs are paid an actuarially determined capitation rate for each enrollee. However, the MCO agreement and CMS documentation indicate that the Department imposes financial sanctions on MCOs if performance standards are not met. These sanctions impact the total cost outcome of the MCO agreement, and in combination with the substantial cost of the managed care program, indicates a need for budget tracking. As ODM does track the financial sanctions, but does not track other aspects of the MCO budget within agreement management processes, it is partially aligned with this step.

Three contracts were only partially aligned with the performance review step. ODM stated that generally, contract and vendor performance is evaluated and monitored in real time based on the terms of the contract and established service level agreements. The Department uses vendor submitted scorecards listing each service level agreement, the corresponding metric, and performance status reports. Although ODM requires and tracks vendor performance in this way, there is inconsistency in the accuracy and utilization of this information. We identified multiple errors in the FI contractor's report, which was subsequently submitted to CMS, suggesting a lack of data verification on the information submitted by vendors. This is an internal control deficiency, see [Recommendation 4](#) for more information. We also heard about a variety of performance issues with PNM from stakeholders, some of which took years to be resolved or are still an issue currently, suggesting that the Department did not utilize any performance data submitted by the vendor for PNM. Finally, ODM does not have comprehensive information on MCO performance as a result of the lack of budget tracking discussed above and the variation in payment timeliness discussed in [Recommendation 4](#).

Medicaid Managed Care Procurement

In addition to the best practices outlined on the previous few pages, we obtained best practices specific to Medicaid managed care procurement. Princeton University's State Health and Value Strategies has a report on *Medicaid Managed Care Procurements: A Toolkit for State Medicaid Agencies* (2022), which is designed to assist state procurement of Medicaid managed care entities and maximize the benefits of these organizations. Due to the specificity of this criteria, we only utilized it for comparison to the contracts related to managed care, which include the PNM, SPBM, and MCOs. The three contracts related to managed care were generally aligned

with six of the ten steps in this criteria. The remaining four steps had varying levels of alignment between the three contracts. There is an additional optional step of holding a bidders conference to enable the State to directly communicate with bidders. The SPBM and MCO contracts were both aligned with this optional step, while the PNM contract was not. The required criteria steps and contract alignment are displayed in the table below. For more details on the criteria steps, see [Appendix H](#).

Managed Care Procurement Alignment with Best Practices

	PNM	SPBM	MCO	Overall Rating
Select Procurement Team				
Engage Stakeholders				
Publicly Advertise a Specific Procurement				
Develop a Vision Statement				
Ask Bidders to Respond to Questions				
Require Bidders to Follow a Consistent Format				
Evaluate Proposals that Meet Technical Criteria				
Review Bids				
Identify Voting Members				
Document Lessons				

 Generally Aligned
  Partially Aligned
  Not Aligned
  Not Applicable

Source: Princeton University and ODM

One of the three managed care related contracts was only partially aligned with the stakeholder participation step. The Department held a bidder's conference and issued a Request for Information for the SPBM and MCO contracts, but did not seek stakeholder input for the PNM contract. All of the contracts were partially aligned with the vision statement step. While all of the contracts had an overarching vision statement, none adequately linked the vision statement to the measurable scope of work or evaluation criteria. Only one contract was generally aligned with the bidder inquiry questions step, as the solicitations for the SPBM and PNM contracts did not include a list of specific questions for the bidders to answer, nor did ODM request information from industry experts during the procurement of these contracts. Finally, none of the contracts were generally aligned with the document lessons step. The Department was not able to provide documentation of a retrospective review of the contract procurement process and lessons learned for any of the three contracts. ODM indicated that it did this type of review informally for the SPBM and MCOs, but did not do this for the PNM contract.

Conclusion

ODM should improve its contract procurement and management practices where deficiencies were identified in this analysis. The actual costs of the Department's contracted services are frequently exceeding the proposed costs by large margins, resulting in a significant amount of unplanned costs. There is a lot of variation in how contract management is conducted throughout ODM, as well as some issues that are consistent across all of the contracts we reviewed. This is in part due to the distribution of contract managers throughout the Department and a lack of succession planning in the case of departure. These areas where the Department is not aligned with contracting best practices are opportunities for ODM to improve its contract management, which may result in lower unplanned costs, better service delivery, and more comprehensive stakeholder engagement.

While ODM provided a lessons learned document for the PNM after the audit's exit conference and draft review, they failed to provide this documentation when asked about it multiple times during the course of the audit. The audit team was unable to verify when the document was created.

Recommendation 4: Collect and Utilize More Detailed Claim Payment Timeliness Metrics to Improve Transparency and Performance Management

Healthcare providers are paid for services provided to Medicaid recipients through claims submitted to ODM. There are federal and state requirements that set timeframes in which claims must be processed and paid. The federal requirements are set through statute, while the state requirements are set through contracts with MCOs and the contractor for the Fiscal Intermediary, the system that processes fee-for-service claim payments. While our review of claim payment timeliness was limited in scope due to data availability, it indicated that the Department has been largely compliant with federal statutory requirements, while contracted entities have varying levels of compliance with the more stringent state contractual requirements. Additionally, we were unable to identify any systemic changes in the timeliness of claim payments over the past five years for the points in the process where data was available. There may have been changes in timeliness associated with the process steps where data was not available, but we were not able to evaluate this.

The claim payment timeliness metrics currently collected, aggregated, and monitored by ODM are categorized into broad timeframes. These broadly categorized metrics do not allow for in-depth tracking of changes to claim payment timeliness over time or an adequate evaluation of contractor performance because the vast majority of claims are paid within the shortest timeframe measured. The Department should collect more detailed claim payment metrics and utilize it to effectively monitor and manage contractor performance over time, adjust contractual timeliness benchmarks, and improve the public transparency of the claim payment process.

Impact

More detailed claim payment timeliness metrics would assist the Department in effective performance management by offering improved insights into systemic and contractor specific trends in claim payment timeliness. This will enable ODM to not only assess compliance with statutory and contractual requirements, but also effectively evaluate and compare overall contractor performance and determine if the benchmarks could be improved to be more relevant to actual performance. The detailed comparison of contractor performance would be most useful for managed care claims, as there are multiple MCOs with varying levels of compliance with contractual requirements, and therefore varying levels of performance. Claim payment timeliness is relevant for providers because it represents how quickly they are paid for services rendered to Medicaid recipients. Given the substantial impact of Medicaid on Ohio's overall healthcare system, these claim payments represent a significant portion of Ohio's spending on medical services and are therefore important to a provider's financial stability.

Medicaid claims being paid faster means improvements to provider cash flow, which may mean that providers remain willing or are more willing to see Medicaid recipients at their practice. Finally, publicly sharing this detailed timeliness information would improve transparency with the public generally, as well as providers specifically. The Department could utilize this information as evidence if providers are voicing concerns about delayed payments, which has occurred previously.

Background

When a Medicaid recipient receives a service from a healthcare provider, that provider must submit a claim to ODM to receive payment for their services. This claim submission and payment process is facilitated by multiple information systems and contracted entities. It also varies by claim type and service delivery model.

Trading partners are entities that healthcare providers contract with to submit claims on their behalf. Professional, institutional, and dental claims are processed through provider trading partners, the Electronic Data Interchange (EDI), and the Fiscal Intermediary (FI). There is a small portion of providers that submit claims through direct entry to either the Provider Network Management Module or MCO portal, however, the vast majority of providers utilize trading partners. For MCO claims the process is similar, however claims are routed to MCOs through the EDI to complete certain processes. For more information about this process by service delivery model, see [Appendix I](#).

As part of this process, claims can be considered clean or unclean. Clean claims are claims that can be processed without any additional information. Unclean claims require additional information to be processed. Additionally, throughout this recommendation, we use the term “paid” to refer to claims being adjudicated, since that is the terminology used in federal and state requirements. However, it is important to note that adjudication also includes denied claims.

Internal Control Deficiency

In our consideration of data sources for the measurement of claim payment timeliness, we reviewed data within the FI Operational Report Workbook. This workbook is completed by ODM, using data provided by the FI contractor, to comply with CMS reporting requirements.

We found multiple instances of inaccurate counts of paid claims in this workbook. ODM was not able to confirm to us whether the FI contractor had originally sent incorrect values to Department, or whether the Department had entered the information incorrectly into the workbook. ODM does review the information in the workbook to identify any variation outside of set parameters, however, this review did not catch the errors we identified. This represents an internal control deficiency in design of ODM’s operations. Due to this, we used alternative sources of data for our analysis. See [Appendix A](#) and [Methodology](#) for more information.

Methodology

Due to the complexity of the claim payment process and the multiple information systems involved, we explored several data sources in an attempt to measure claim payment timeliness. We were only able to measure the timeliness of specific portions of the claim payment process due to data availability. As a result, our evaluation of claim payment timeliness is limited to the portions of the process we were able to measure, and issues with timeliness occurring outside of these portions is not considered.

For fee-for-service claims, there are two potential sources for claim payment timeliness data: the Fiscal Intermediary Operational Report Workbook (FI ORW) and the Electronic Data Warehouse (EDW). The FI ORW is completed by ODM, using data provided by the FI contractor, to comply with CMS reporting requirements. However, we identified multiple instances of inaccurate counts of paid claims in this workbook, constituting an internal control deficiency. Due to this, we were unable to utilize the FI ORW in our review of claim payment timeliness. The EDW has raw data on claim payment timeliness for two of the three portions of the fee-for-service process, which we were able to use. This availability of data is outlined in the table below.

Aggregate Data Measurement Possibility for Fee-For-Service Claim Payment Process Steps

			FI ORW	EDW
	Trading Partner Submission Date		 FI Log Date	No
	FI Log Date		 Clean Date	No
	Clean Date		 Paid Date	Yes*
			(Internal Control Deficiency)	Yes

Source: ODM

As displayed in the table above, we were able to calculate the time elapsed between the FI log date and clean date, as well as the clean date and the paid date. We were not able to calculate the time elapsed between the trading partner submission date and FI log date due to a lack of available data. If there are delays in this step of the fee-for-service claim payment process, they are not captured in our evaluation of claim payment timeliness.

For managed care claims, there are two potential sources for claim payment timeliness data: MCO prompt pay reports and the EDW. MCO prompt pay reports are submitted quarterly by the seven contracted MCOs. We were able to use these reports in our review of claim payment timeliness. We were not able to utilize data in the EDW, because while this system maintains records of managed care claims paid, it does not include the dates necessary to calculate time elapsed between process steps. This availability of data is outlined in the table below.

Aggregate Data Measurement Possibility for Managed Care Claim Payment Process Steps

				MCO Prompt Pay Reports	EDW
	Trading Partner Submission Date			FI Log Date	No
	FI Log Date			Date Sent to MCO	No
	Date Sent to MCO			Clean Date	No
	Clean Date			Paid Date	Yes* (for Claims Received as Clean)

Source: ODM

As displayed in the table above, we were only able to calculate the time elapsed between the clean date and paid date for claims received as clean. We were not able to calculate the time elapsed between the trading partner submission date and FI log date, FI log date and date sent to MCO, or date sent to MCO and clean date. We were also not able to calculate timeliness for any claims received as unclear. If there are delays in the first three steps of the managed care process, or in the processing of unclear claims, they are not captured in our evaluation of claim payment timeliness.

Finally, we were not able to calculate the timeliness of pharmacy claims. Fee-for-service and managed care pharmacy claims are both handled through the SPBM. According to ODM, the majority of pharmacy claims are processed instantaneously. As a result, there is no log date present for these claims within the EDW. Without the log date, we are unable to calculate timeliness for pharmacy claims.

In summary, for fee-for-service claims, we used the EDW to measure the time between a claim being received by the FI, being marked as clean, and being adjudicated and paid. For managed

care claims, we used MCO Prompt Pay Reports to measure the time between a clean claim being received by an MCO and being adjudicated and paid.

Analysis

Statutory and Contractual Compliance

The federal government sets requirements for claim payment timeliness in the Code of Federal Regulations (CFR). These requirements vary based on service delivery model, as outlined in the graphic below.

Federal Statutory Compliance

Federal FFS Requirements	Federal MCO Requirements
• Pay 90 percent of clean claims within 30 days • Pay 99 percent of clean claims within 90 days • Pay 100 percent of clean claims within 12 months	• Pay 90 percent of clean claims within 30 days • Pay 99 percent of clean claims within 90 days
Generally Compliant	Generally Compliant

Source: CFR and ODM

Using the metrics and data collected by ODM for fee-for-service and managed care claims, we were able to assess the Department's compliance with federal claim payment timeliness requirements. Ohio is generally compliant with federal claim payment timeliness requirements. For more information on compliance with federal requirements, see [Appendix I](#).

ODM has set tighter requirements for claim payment timeliness through its contract for the FI and contracts with MCOs. These requirements are outlined in the graphic on the following page.

State Contractual Compliance

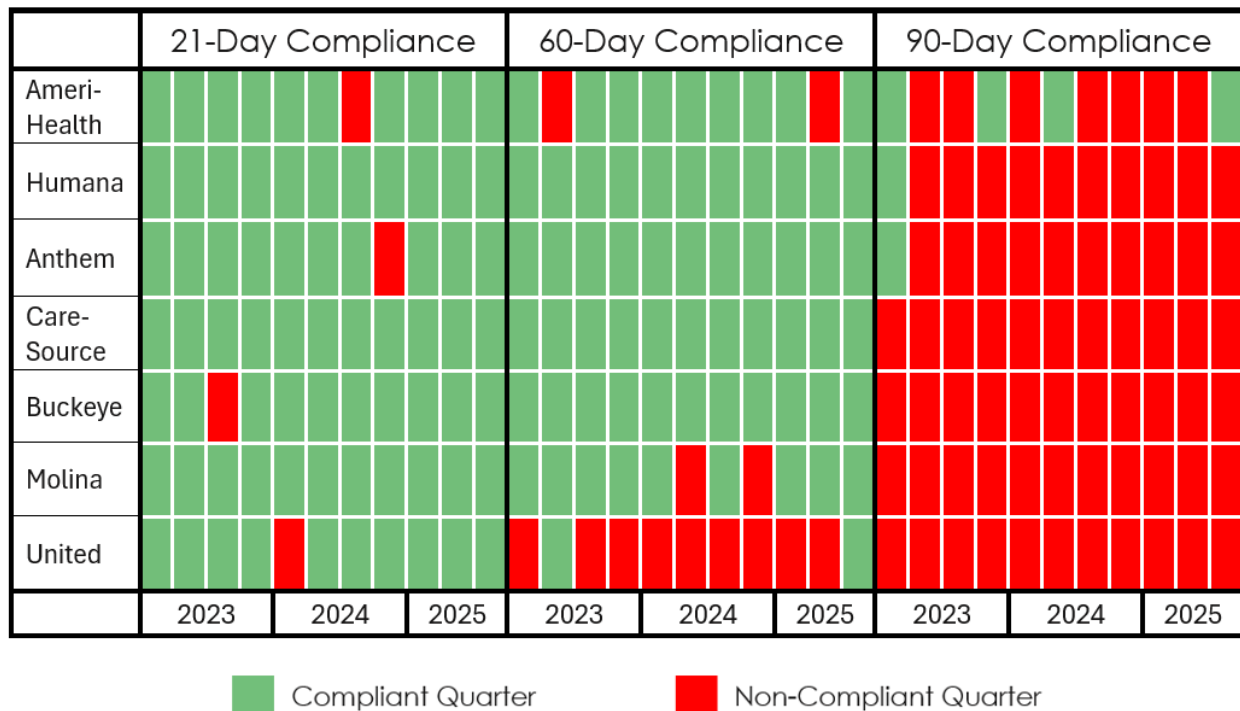
State FFS Requirements	State MCO Requirements
• Pay 100 percent of clean claims within 30 days • Adjudicate unclean claims and pay 100 percent of cleaned claims within 30 days of the correction of the uncleanliness	• Pay 90 percent of clean claims within 21 days • Pay 99 percent of clean claims within 60 days • Pay 100 percent of clean claims within 90 days
Generally Noncompliant	Generally Noncompliant

Source: ODM

The FI contractor is almost entirely not compliant with contractual timeliness requirements set by the state. From February of 2023 to July of 2026, the time period in which the FI system has existed, the FI only paid 100 percent of the claims within 30 days in one of the 42 months measured. However, in the 41 months of non-compliance, the average percentage of timely claims was 99.2 percent, only 0.8 percent from the contractual requirements.

Compliance with contractual timeliness requirements varied significantly between the seven MCOs contracted from January of 2023 to September of 2025. We examined compliance on a quarterly basis because MCOs submit quarterly reports on payment timeliness, as required by the Managed Care Agreement, called Prompt Pay Reports. The graph on the following page displays the portion of quarters that each MCO met and did not meet the three contractual benchmarks over this time period without rounding.

Quarterly Compliance with Contractual Requirements by MCO



Source: MCO Prompt Pay Reports

Note: The managed care agreement requires that MCOs pay 100% of claims within 90 days of receipt. The agreement does not state that the metric used for measuring compliance with this benchmark should be rounded. Therefore, we did not round the metric. This means that if an MCO paid 99.9% of claims within 90 days of receipt, we did not round the figure up to 100%. Instead, we kept the figure at 99.9%, and we marked the MCO as non-compliant with the 90-day compliance requirement.

As shown in the visual above, compliance with contractual requirements varied by MCO. Humana and CareSource were both completely compliant with the 21-day and 60-day requirements. AmeriHealth and Humana were the most compliant overall, with 23 fully compliant quarters. United was the least compliant with only 12 compliant quarters.

In both the FI contract and the MCO contracts, ODM has the authority to levy financial penalties against the contractors if the claim payment timeliness benchmarks are not met. ODM indicated that it only leverages this financial penalty if the timeliness violation is determined to be the fault of the contractor.

Improvement of Metrics Collected

While the claim payment timeliness metrics collected by ODM are sufficient to assess compliance with statutory and contractual requirements, they are not detailed enough to assist with performance management efforts. In *A Performance Management Framework for State and Local Governments* (2010), the National Performance Management Advisory Commission (NPMAC) outlines seven principles of performance management. In one principle, NPMAC recommends that governments measure results with a performance management perspective over a solely compliance focused perspective. While measuring compliance is important to ensure adherence to laws, a focus on performance management is more relevant to achieving substantive and meaningful benefits for the public. Another principle is that decisions and processes are driven by timely, accurate, and meaningful data. Specifically, NPMAC states that decision making informed by performance data allows organizations to understand previous performance results, replicate successful strategies, and improve unsuccessful efforts.

ODM's collection of claim payment timeliness metrics is not aligned with these best practices for performance management. Due to the broad timeframes that claim payments are categorized into, the Department is unable to adequately monitor the performance of the FI contractor and the MCOs outside of statutory and contractual compliance. Over 99 percent of fee-for-service and managed care claims are processed within the narrowest timeframe collected, which is 30 days and 21 days, respectively. ODM has no insight into how quickly these claims were paid within these timeframes because the Department does not collect, aggregate, and monitor more detailed metrics.

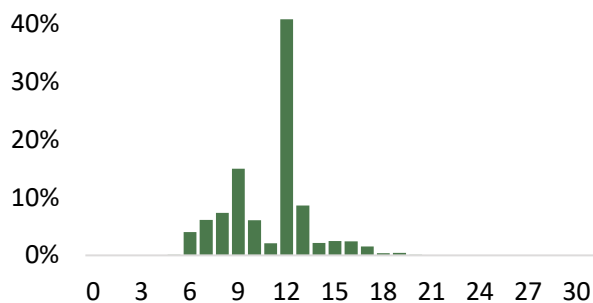
We were able to gain access to the raw data for fee-for-service claims, which allowed us to assess timeliness on a more granular level. However, we could not access similar data for managed care claims, because this comprehensive data is held by the MCOs. The following analyses, while only including fee-for-service claim data, represent the type of metrics that ODM could calculate on a regular basis.

First, we examined the time elapsed between the date a claim is received by the FI and the date that it is marked as clean. We found that over the past six years, the vast majority of claims were marked as clean in two days or less. Approximately 30 to 40 percent of claims each year were marked as clean either instantaneously or the same day as they were received by the FI. This has not changed significantly over the timeframe examined, and is likely not substantially impacting overall claim timeliness. For more detailed information on the time to cleanliness determination, see [Appendix I](#).

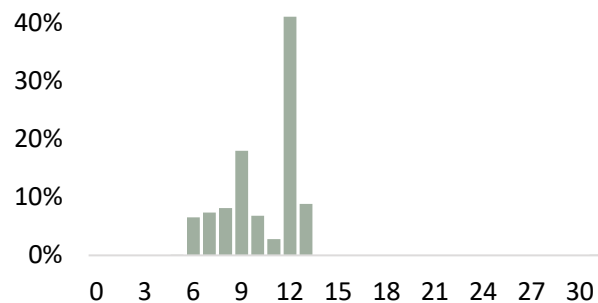
We also reviewed the time elapsed between the date that a claim was marked clean and the date that it was paid. Over the six years examined, the median processing and payment time was 11 days, with a minimum processing and payment time of 4 days and a maximum of over 31 days. The graphs below display the distribution of fee-for-service claims by processing and payment time over the past six years.

Percentage of FFS Claims by Processing and Payment Time

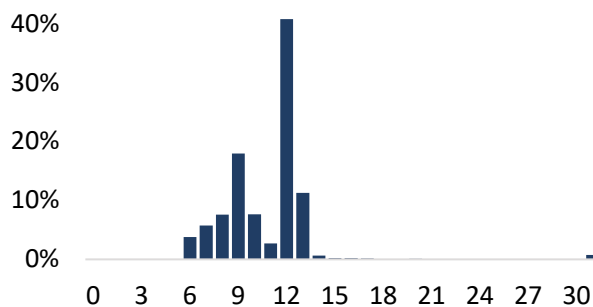
CY 2021



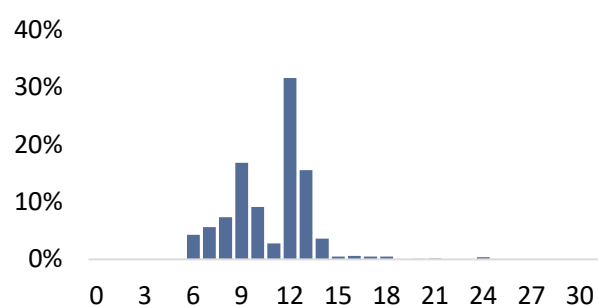
CY 2022



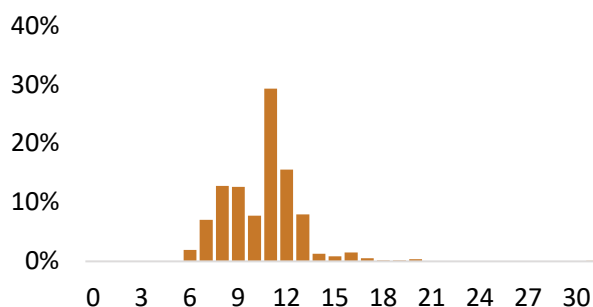
CY 2023



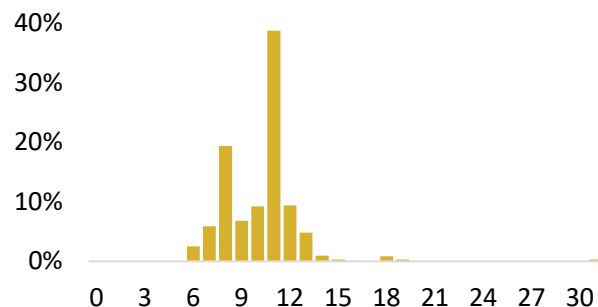
CY 2024



CY 2025



CY 2026



Source: ODM EDW

The overall distribution of claim processing and payment times has been relatively consistent over this time period. The majority of claims in each year are processed and paid within 6 to 15 days, with some slight variation between years. From CY 2021 to 2024, the median processing time was 12 days, which decreased slightly to 11 days in CY 2025 to 2026. According to ODM, the processing and payment times we identified here are in line with their financial cycle, wherein claims marked as clean are held and then processed in batches on a weekly basis, then paid out roughly a week and a few days later. Given that the majority of claims are paid within this small window, this detailed data provides more insight into claim payment timeliness than the large buckets currently aggregated and utilized by ODM.

Collecting, aggregating, and monitoring claim payment timeliness metrics at this level of detail for all claim types will provide the Department with a deeper insight into the processing speed of claim payments, such as the analysis discussed previously. This will improve ODM's ability to manage the performance of the FI contractor and MCOs, as well as enabling the Department to adjust contractual benchmarks to be more meaningful to actual performance.

Public Transparency

In addition to assisting performance and contract management efforts, collecting and sharing more detailed data could improve transparency with the public and healthcare providers. In 2025, multiple healthcare providers voiced concerns about delayed payments, claiming that claim payments were taking longer to process due to system issues. We reviewed claim payment timeliness partially to identify if there were any systemic changes in payment speed over time. From our evaluation, which is limited in scope due to data availability, there were no significant shifts in claim payment timeliness over the past five years.

Currently, the Department publishes limited data on claim payment timeliness. The only data published in the last five years related to claim payment timeliness is limited in timeframe, only showing half a year of claim payments, and in claim type, only showing managed care claims. It is also over a year old and was published for the first time in March of 2026. ODM claimed that more comprehensive information is not published because it is not federally required, there is publicly available testimony on the subject, and it did not want to seem dismissive of provider concerns. Publishing more comprehensive claim payment timeliness data would improve overall transparency and enable ODM to provide evidence of timely payments if providers express concerns about delayed payments again. ODM could do this by publishing more frequent reports, sharing anonymized data, or developing real time dashboards as it has for other datasets on its website. This improvement of transparency would also align the Department with another of NPMAC's performance management principles, which is that information related to performance, decisions, regulations, and processes is transparent, specifically that it is easy to access, use, and understand.

Conclusion

ODM should collect more detailed claim payment timeliness metrics in order to improve performance management, contractor oversight, and public transparency. The categories of timeliness metrics currently collected are appropriate to determine compliance with statutory and contractual requirements, but are too broad to provide insight into systematic trends into claim payment timeliness and variation in payment speed between different contractors. As a result, the Department cannot adequately monitor performance or adjust contractual benchmarks accordingly. More detailed data would allow for more in-depth analysis of claim payment timeliness, such as the analysis discussed in this recommendation. Finally, publishing comprehensive claim payment timeliness data would improve public transparency into the claim payment process and provide evidence for ODM's timely payment of provider claims. This information is relevant to providers, as changes to claim payment timeliness can impact their financial stability and impact their ability to serve Medicaid recipients.

County Oversight

As discussed in the [Background](#), Ohio’s Medicaid program is a “state-supervised, county-administered” structure. This means that county entities, specifically County Departments of Job and Family Services (CDJFS agencies), are responsible for processing Medicaid applications and renewals, conducting eligibility determinations and redeterminations, and enrolling eligible recipients. However, ODM is the single state agency tasked with the oversight of the Medicaid program. This means that while the State has chosen to delegate some of its administrative duties to other governmental entities, ODM is ultimately responsible for the operations and outcomes of these entities as they relate to Medicaid. Due to this, it is critical that the Department has adequate oversight and performance management processes in place to ensure that CDJFS agencies perform their duties efficiently, effectively, and in compliance with federal and state laws.

Ohio provides funding to CDJFS agencies to enable them to complete their responsibilities for the Medicaid program. This funding comes from Medicaid funds, but is passed through the Ohio Department of Job and Family Services (ODJFS) rather than ODM because ODJFS oversees several other public assistance programs that CDJFS agencies administer. In SFY 2025, Ohio provided approximately \$275.7 million to CDJFS agencies.²⁷ This funding is distributed to counties based on the following methodology, in accordance with OAC Rule 5101:9-6-05.

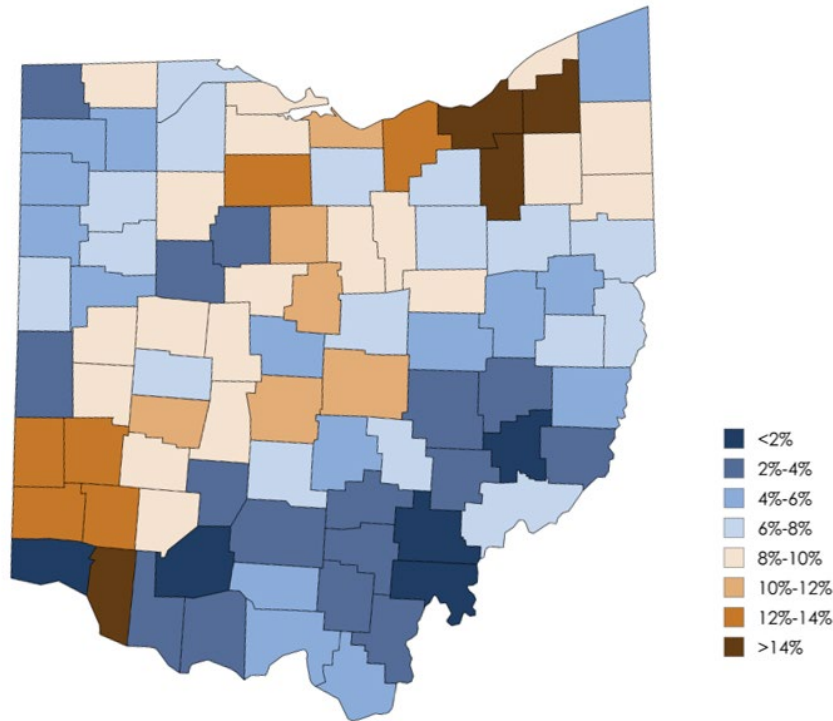
- 30 percent based on county population below the Federal Poverty Level;
- 30 percent based on county population below 200 percent of the Federal Poverty Level;
- 30 percent based on county adjusted public assistance recipients;
- 5 percent based on county unemployment rate; and
- 5 percent based on county poverty rate.

In addition to this state funding, counties are required to contribute a portion of their local funds to CDJFS Medicaid operations, referred to as the Medicaid Mandated Share. In SFY 2025, counties contributed approximately \$17.0 million to CDJFS Medicaid operations through their mandated share. Counties may choose to appropriate additional local funds for this purpose, which is referred to as Ceiling Excess. In SFY 2025, 30 counties contributed Ceiling Excess Funds, resulting in a total of approximately \$5.6 million. Between these two types of local funding, counties contributed a total of approximately \$22.6 million to Medicaid administration in SFY

²⁷ This figure includes the federal share of expenses and funding for Non-Emergency Medical Transportation (NEMT). Transportation costs are covered as an administrative expenditure under the state plan.

2025. The map below displays the percentage that county contributions represented of total Medicaid administrative funding by county in SFY 2025.

SFY 2025 County Share of Medicaid Administrative Funding



Source: OAKS & ODJFS

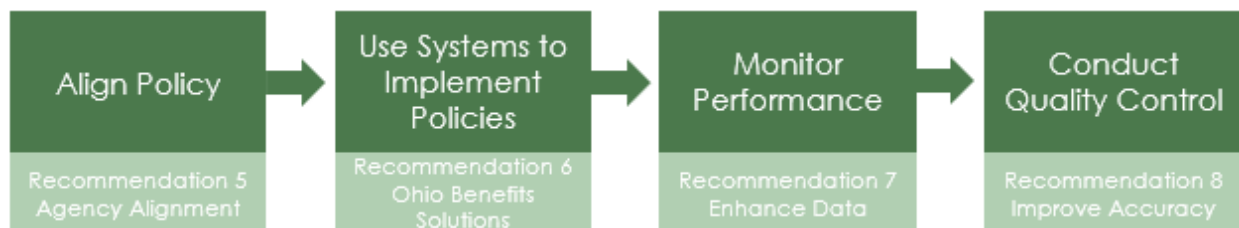
Note: This calculation excludes Non-Emergency Medical Transportation Funding because counties do not contribute a share of funding for this service.

With this funding, CDJFS agencies process Medicaid applications and renewals, determine eligibility, and enroll eligible individuals. This process requires the use of multiple information systems that are operated by the state or federal government, including the Electronic Document Management System, Ohio Benefits, and the Federal Hub. Caseworkers use these systems to receive and process applications and supporting documents, verify applicant information electronically, and determine applicant eligibility based on verified information. If applicant information cannot be verified electronically, caseworkers must reach out to applicants to request manual verification. If an applicant is determined to be eligible and enrolled in Medicaid, that individual's eligibility must be redetermined annually to ensure any changing circumstances do not impact their coverage. For a detailed overview of the eligibility determination and redetermination processes, see [Appendix J](#).

In addition to caseworkers, CDJFS agencies also have management and support staff. This may include supervisors, clerical staff, trainers, and quality assurance staff. Clerical staff typically assist with the early stages of application processing, such as scanning documents and entering information into Ohio Benefits. In-house trainers provide comprehensive training for new caseworkers, as well as refresher training for existing staff members. Quality assurance staff sample and review the accuracy of eligibility determinations made by caseworkers. Not all CDJFS agencies have all of these types of employees, as staffing varies by agency size and structure. In smaller agencies, employees often perform a variety of duties and functions. In larger agencies, it is more likely that employees are dedicated to specific functions. Regardless of staff size and structure, CDJFS agencies are expected to follow the same general processes for eligibility determination and redetermination.

As part of this performance audit, we reviewed Ohio’s Medicaid eligibility determination processes. Since CDJFS agencies are the primary entities responsible for implementing this process, we interviewed a sample of counties selected to represent a wide array of county characteristics. In total, we interviewed 20 CDJFS agencies.²⁸ These agencies represented 22 counties, which is a quarter of the State, and 45.0 percent of Ohio’s Medicaid enrollment as of July 2025. We selected these CDJFS agencies based on a variety of operational characteristics and county features, including staff size, case management model, Medicaid enrollment, county type (rural, suburban, or urban), and ODM engagement region.

Since ODM is responsible for overseeing the CDJFS agencies that are determining eligibility, we utilized the feedback we received from county interviews in conjunction with information from the Department to develop the following recommendations for the enhancement of this oversight process.



To aid in the Department’s implementation of our recommendations, we arranged these recommendations in an order that mirror the Department’s processes. While improvements could be made simultaneously, improvements in earlier recommendations may assist with the implementation of further recommendations impacting later processes.

²⁸ One interview was conducted by email due to ongoing operational challenges at a CDJFS agency.

Recommendation 5: Improve Collaboration with ODJFS and DCY to Align Eligibility Determination Rules, Policies, and Processes Where Possible

In Ohio, public assistance programs are overseen by multiple state agencies, while the day-to-day processes relating to applications and eligibility determinations are the responsibility of County Departments of Job and Family Services (CDJFS agencies). Individuals who receive public assistance often qualify for and receive benefits from multiple programs; however, each state agency that oversees the programs has its own procedures and requirements for the application and renewal process. This can result in the CDJFS requiring multiple documents for the same basic information, such as income verification or residency. ODM should work with ODJFS and DCY to improve collaboration regarding the oversight of public assistance programs in Ohio. This could include aligning policies and procedures where possible and collaborating on training and guidance to reduce duplication of efforts.

Impact

Aligning the eligibility determination rules, policies, and procedures for the various programs overseen by ODM, ODJFS, and DCY where possible would improve the efficiency and effectiveness of application processing and eligibility determination. Ohio is currently not meeting federal or state statutory requirements for application processing timeliness (see [Recommendation 7](#) for more information). Streamlining processes between programs may assist caseworkers in processing applications more quickly, particularly when individuals are applying for multiple programs. This would also improve determination accuracy and simplify training efforts for CDJFS caseworkers, as there would be less variation in policies and processes for caseworkers to understand and implement. Finally, increasing alignment between programs would reduce the burden on applicants and beneficiaries to submit various types of documentation for information verification and alleviate confusion for those who are not well versed in the program requirements.

Background

Ohio County Departments of Job and Family Services (CDJFS agencies) are responsible for processing Medicaid applications and renewals, verifying applicant information, and making eligibility determinations and redeterminations. In addition, CDJFS agencies have similar responsibilities for several other public assistance programs. These programs include Temporary Assistance for Needy Families (TANF),²⁹ Supplemental Nutrition Assistance Program

²⁹ In Ohio, TANF is comprised of Ohio Works First, childcare, and Prevention, Retention, and Contingency.

(SNAP), disability assistance, and adult protective services. Depending on the structure of the county, CDJFS agencies may also be responsible for public children’s services, child support enforcement, and workforce development in addition to public assistance programs.

While these programs are often administered by the same entities on the county level, they are overseen by three separate state agencies. ODM oversees Medicaid, while the Ohio Department of Job and Family Services (ODJFS) oversees SNAP, TANF, adult protective services, disability assistance, and workforce development. Recently, the legislature created the Ohio Department of Children and Youth (DCY) as a separate agency to oversee childcare, child support, and other children’s services. All three of these state agencies create policies and guidelines, set performance standards, and offer trainings to CDJFS agencies for their specific programs. This separation in oversight creates opportunity for conflicting policies, competing priorities, and duplicative activities.

Methodology

As we developed an understanding of county responsibilities in the state-supervised, county-administered structure of Ohio’s Medicaid program, we also identified the responsibilities of CDJFS agencies related to other programs. When we interviewed a selection of CDJFS agencies and other stakeholders, we discussed their experiences reporting to multiple state agencies and the impact of various program responsibilities on operations. Based on this feedback, we obtained supporting documentation and conducted additional research on the funding and responsibilities of each state agency. Additionally, we gathered information regarding processes and allowable resources for eligibility determinations across programs. We obtained a Government Accountability Office report on fragmentation, overlap, and duplication of government resources at the federal level and compared this to the oversight structure of public assistance programs in Ohio.

Analysis

The majority of CDJFS agencies that we interviewed indicated that public assistance employees are not separated by program. Caseworkers in a few counties have a primary program assignment, but almost all counties interviewed expect their caseworkers to make determinations across programs. For example, if a caseworker that is primarily assigned to Medicaid is processing a case that also has a SNAP application, they are expected to process the SNAP application as well, even though it is not their primary program assignment. Most counties do have specialized workers to handle long-term care (LTC), a specific type of care offered through Medicaid that has particularly complex eligibility requirements, and some have additional specialized workers for other complex programs such as childcare or disability assistance. However, these specialized workers may still be expected to make eligibility determinations for programs outside of their specialization. To facilitate this, caseworkers are

trained on all programs that the CDJFS agency handles, either through state training materials or county-developed training programs.

In addition to eligibility determinations for these social support programs being conducted by the same employees, these programs are also often serving the same recipients. According to the U.S. Department of Human Services, approximately 25 percent of Medicaid recipients nationally are on one other social support program, and 45 percent are on two or more other programs. Specifically, about 40 percent of Medicaid recipients nationally are also on SNAP, 25 percent are also on child support, and 4 percent are also on TANF. While we were unable to find similar statistics for Ohio specifically, multiple counties and the Ohio Job and Family Services Directors Association reported that there is a significant overlap in public assistance beneficiaries in Ohio, particularly between Medicaid and SNAP recipients.

Despite this overlap in caseworkers and beneficiaries, at the state level, public assistance programs are managed by three separate entities. These programs were initially overseen by ODJFS, until ODM was created to oversee Medicaid in 2014 and DCY was created to oversee children's services in 2024. Now, each of these state agencies provides CDJFS agencies with training, resources, and guidance to assist them with application processing, eligibility determination, and enrollment. In turn, CDJFS agencies must understand and adhere to the policies and procedures of three state agencies, communicate with multiple contacts at these agencies, and attend multiple webinars and trainings to stay informed of all relevant policy and system changes. Some of this complexity is unavoidable due to the difference in federal program requirements, which increases the need for collaboration between the state agencies overseeing the programs.

Almost all of the counties interviewed identified the lack of communication and misalignment between ODM, ODJFS, and DCY as an issue that impacts their operations and has become more prominent over time. Specific issues identified by multiple counties are listed below.

- Lack of alignment of rules, policies, and processes between programs;
- Inability to use the same documentation or systems for information verification between programs;
- Competing priorities and a lack of understanding of other program responsibilities;
- State agencies not answering questions about other programs;
- Lack of alignment of renewal timelines between programs and inability to shift timelines to align; and,
- Impact of program changes on other programs and quantity of changes across programs.

The lack of alignment of rules, policies, and processes between programs was the most frequently cited issue in our county interviews. Specific examples of this include renewal timelines not matching between programs, causing caseworkers to obtain information from recipients multiple times a year for different program renewals; conflicting alert structures, causing caseworkers to process the same alerts multiple times for each program; and differing application timeliness requirements, which is difficult for the counties to track. The most prominent example of this misalignment is the inability to use the same documentation and electronic verification systems between programs. CDJFS agencies expressed frustration about being required to use certain electronic verification systems for Medicaid, but not being able to use this information for SNAP and still needing to request documentation from the applicant. Alternatively, some documentation that can be used for income verification for SNAP is only considered a “lead” for Medicaid and must be verified by another source. These issues are compounded by a lack of centralized guidance or communication from the state agencies.

While some level of misalignment is to be expected due to varying management priorities and differing federal program requirements, these issues were described as negatively impacting CDJFS operations, specifically making it difficult to train new employees. CDJFS caseworkers must have a comprehensive knowledge of the differing eligibility and documentation requirements for multiple programs in order to accurately process applications and make determinations. This difficulty is compounded by system inaccuracies, which will be discussed in [Recommendation 6](#). A significant amount of training is required to get new workers up to speed, with some counties indicating it can take months for a caseworker to be independently processing cases. Although the state agencies do provide training materials, interviewees reported that a large portion of new worker training falls on the CDJFS employees, many of whom are providing training in addition to other job responsibilities. While the training and knowledge base required for CDJFS caseworkers must be comprehensive and complex due to differing federal program requirements, aligning state policies and procedures where possible would help to alleviate some of this burden.

Previous Collaboration Efforts

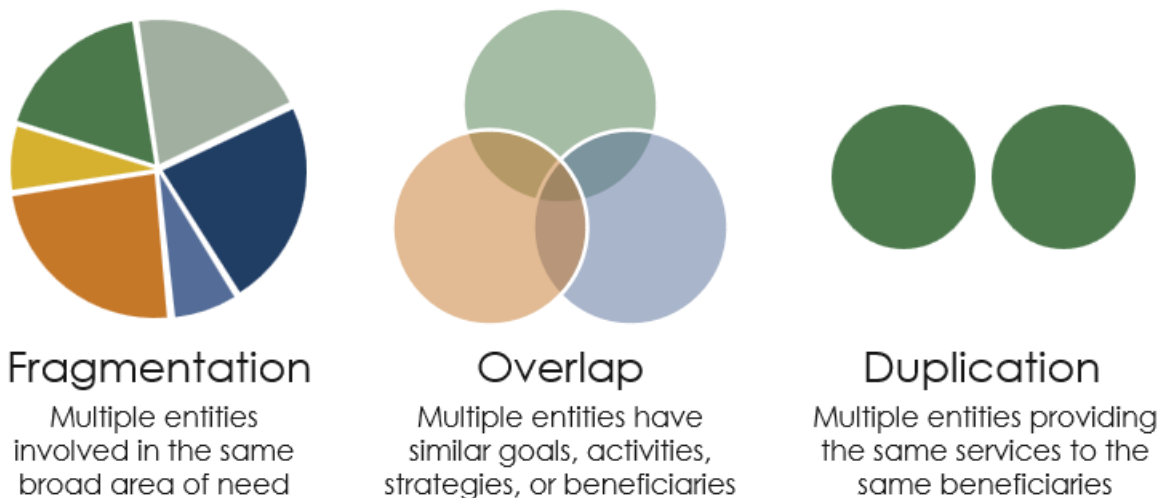
Collaboration between ODM, ODJFS, and DCY has declined recently. ODM indicated that previously, the three agencies collaborated on a virtual, interactive new worker training program designed for new CDJFS employees that covered all of the CDJFS administered programs overseen by the agencies. This training was offered semiannually and was received well by the counties we spoke to. Multiple CDJFS agencies indicated that they liked this training option, specifically appreciating the multi-agency collaboration and live, interactive nature. However, counties reported that this training program had been discontinued without explanation. The Department confirmed that the joint new worker training is no longer offered, however, ODM is still offering this type of training for the Medicaid program.

Another collaborative effort that has been discontinued is joint monthly webinars from ODM and ODJFS. Counties indicated that these webinars were helpful because the two agencies could jointly answer questions. With the joint webinars discontinued, counties must now attend multiple webinars a month for the various state agencies. About half of the CDJFS agencies interviewed identified this as a difficulty, as their staff lack time to attend webinars and other training opportunities. ODM indicated that the joint monthly webinars were discontinued because there were no longer regular operational changes that the Department felt needed to be discussed with the other agencies. However, ODM also mentioned that the agencies do discuss whether changes should be communicated jointly and would bring back joint conferences if the state agencies felt it was necessary.

Improvement Opportunities

In the GAO's annual Report to Congressional Committees on Opportunities to Reduce Fragmentation, Overlap, and Duplication, the GAO identified opportunities for potential financial benefits and efficiency improvements in federal programs and agencies that have duplicative goals and activities. As a part of this report, the GAO defines fragmentation, overlap, and duplication, all three of which can be found in the multi-agency oversight of public assistance programs in Ohio. These definitions are displayed visually below.

GAO Definitions of Fragmentation, Overlap, and Duplication



Source: GAO

ODM, ODJFS, and DCY all facilitate social service programs that are meant to provide assistance to low-income individuals and other vulnerable populations, causing fragmentation in the broad area of public assistance. While the specific services provided by these programs vary,

they all share common goals, methods for administration, and beneficiary populations. This fragmentation has resulted in conflicting policies and procedures regarding eligibility determination for the various programs overseen by these agencies. Specifically, there is significant variation in the documentation and electronic verification sources that CDJFS caseworkers can use to verify applicant information during the application and renewal process, which makes the process more confusing and difficult for both CDJFS caseworkers and applicants.

Due to this fragmentation in public assistance, these three agencies have overlap in their goals, activities, strategies, and beneficiaries. ODM, ODJFS, and DCY all have similar goals for the programs they oversee: to provide support to individuals that need it, but cannot afford it. In order to achieve this goal, all three entities utilize CDJFS agencies to process applications and make eligibility determinations for their respective programs, providing the CDJFS agencies with resources, guidance, and technical assistance to accomplish this. Finally, recipients of the programs overseen by ODM, ODJFS, and DCY are often on multiple programs, creating an overlap in the beneficiaries targeted by these three agencies.

This overlap also causes duplication of efforts between the three agencies. ODM, ODJFS, and DCY all have programs that operate within Ohio Benefits, and therefore create processes that CDJFS agencies must follow to process applications in the system. To enable CDJFS workers to follow these processes, all three state agencies provide separate trainings and sets of policies for counties to inform them how each program works within the system. This is a duplication of efforts, as multiple agencies are providing training on the same topic and the procedures and trainings for programs within Ohio Benefits could be conducted as a joint effort. As discussed earlier, the state agencies did previously hold joint trainings on a variety of topics, including Ohio Benefits, but this no longer occurs.

Additionally, a Milliman report on *Performance Management in Medicaid Managed Care Programs* (2026) discusses common challenges with Medicaid performance management and strategies for success. One challenge identified is fragmentation, as state Medicaid agencies are operating within a broader network of agencies that contribute to the health and wellbeing of citizens. Therefore, coordination with other state agencies is essential, especially to meet the increasingly complex needs of Medicaid recipients. Specifically, the report recommends shared governance structures, interagency work groups, joint initiatives, and cross-agency data sharing to facilitate a unified approach to improve the health and social outcomes of beneficiaries. In Ohio, the separation of ODM, ODJFS, and DCY makes this collaboration even more important. ODM does participate in a few interagency work groups with ODJFS and DCY, however, only one of these groups is related to the alignment of policy changes. This work group is organized by the Ohio Job and Family Services Directors' Association rather than the state agencies

themselves. Additionally, CDJFS feedback suggests that any interagency collaboration that is occurring is not effectively aligning program rules or streamlining processes.

Conclusion

ODM should improve collaboration with ODJFS and DCY to align eligibility determination rules, policies, and processes for their respective county-administered programs where possible. This collaboration could include forming an interagency workgroup, engaging in a joint initiative, or adopting other shared governance structures. Doing so would improve the efficiency and accuracy of eligibility determinations for these programs by streamlining the training and work of county caseworkers and reducing the administrative burden on program recipients. This collaborative effort would also decrease the fragmentation, overlap, and duplication currently present in the state oversight of social support programs, resulting in a more efficient and effective use of state resources.

Recommendation 6: Work with ODJFS and CDJFS Agencies to Identify Issues with Ohio Benefits and Develop Solutions

Ohio Benefits is Ohio’s eligibility and enrollment system for Medicaid and other public benefit programs. CDJFS caseworkers utilize this system to process applications and renewals, verify information, and make eligibility determinations and redeterminations. All of the counties we interviewed reported experiencing issues with Ohio Benefits. Over 20 common issues were pervasive among the respondents related to general functionality, determination accuracy, alerts, automation, and the self-service portal. ODM should work with ODJFS, which is responsible for managing Ohio Benefits, and CDJFS agencies, who are the primary users of the system, to identify and develop solutions for issues with Ohio Benefits. Doing so will improve application timeliness, determination accuracy, and the experiences of caseworkers and beneficiaries.

Impact

Many of the issues with Ohio Benefits that were identified by CDJFS agencies negatively impact application timeliness and determination accuracy, as well as serving as a source of frustration for CDJFS caseworkers. The structure of Ohio Benefits and necessity of overrides and workarounds to ensure the system is correctly determining eligibility places the burden of accuracy on caseworkers and requires them to have an in-depth knowledge of eligibility policy, which increases the opportunity for error. The quantity of alerts that caseworkers must process takes time away from their primary responsibility of processing applications and renewals. Ineffective automation can cause both inaccurate eligibility determinations and additional work for caseworkers, which again takes time away from application processing. The self-service portal also creates issues for both applicants and caseworkers. County feedback, along with surveys conducted by nonprofit entities, indicate that Medicaid applicants and beneficiaries find the portal difficult to navigate and not user-friendly. As a result, user errors often create additional work for caseworkers, as submitted applications are incomplete or incorrectly filled out. Developing solutions for these system issues will assist the State in meeting statutory application timeliness requirements, ensuring that recipients are eligible for Medicaid benefits, and improving the experience of CDJFS caseworkers and Medicaid recipients.

Background

Ohio Benefits went live in October 2013 to begin the process of replacing Ohio’s legacy system, the Client Registry Information System – Enhanced (CRIS-E). Initially, Ohio Benefits was used solely for the determination and enrollment of MAGI Medicaid, with ABD Medicaid eligibility added later. While full implementation of all public benefits programs was targeted for the end

of 2015, difficulties with the system implementation led to several delays. From go-live to 2018, Ohio Benefits was utilized for Medicaid eligibility determination and enrollment, while other public assistance programs still utilized CRIS-E. In 2018, other public assistance programs, including SNAP, were migrated to Ohio Benefits and CRIS-E began the process for being phased out. HB 96 of the 136th General Assembly required the transfer of the administration of Ohio Benefits from the Department of Administrative Services (DAS) to the Ohio Department of Job and Family Services (ODJFS) by July 1, 2026, and the transfer of the program's administration to the ODJFS Director by July 1, 2027.

Methodology

During our interviews with CDJFS agencies, we asked about their experiences with state information systems. Ohio Benefits was one of the primary systems discussed in response to this question. Based on the quantity and range of feedback provided on Ohio Benefits, we conducted additional research on the system, its issues, and similar systems across the country. Additionally, we shadowed county caseworkers who made determinations in Ohio Benefits. We used this information to compare Ohio Benefits to other state eligibility systems and identify opportunities for improvement.

Analysis

State Medicaid agencies process applications and renewals through Eligibility and Enrollment Systems. Ohio, along with 34 other states, operates an Integrated Eligibility and Enrollment System (IEES), which allows people to apply for multiple public assistance programs through one system. Ohio's IEES allows individuals to apply for MAGI Medicaid, non-MAGI Medicaid,³⁰ Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and publicly funded childcare services. There are 14 other states that include all of these programs in their IEES.

Ohio Benefits is Ohio's IEES, which is used by CDJFS agencies to process applications and determine eligibility across public assistance programs. This system is developed and supported by a third-party vendor. Notably, this contract is not managed by ODM. It was previously managed by the DAS but was recently transferred to the ODJFS. ODJFS staff indicated that the management of the system will remain consistent throughout this transition and that there are no planned updates to the functionality of the system.

³⁰ The methodology used to calculate income varies based on applicant type. A Modified Adjusted Gross Income (MAGI) is used for most applicants, while an alternative methodology based on the income calculation for Supplemental Security Income is used for applicants over the age of 65 and individuals applying on the basis of disability or blindness. This alternative methodology is referred to as non-MAGI.

All of the CDJFS agencies we interviewed indicated that they regularly experience issues with Ohio Benefits. We were able to identify over 20 common issues related to general functionality, determination accuracy, alerts, automation, and the self-service portal. These issues are summarized in the visual below.

Commonly Identified CDJFS Issues with Ohio Benefits

General Functionality	Determination Accuracy	Alerts	Automation	Self-Service Portal
• Inconsistent functioning • System updates • Conflicts between programs • Opportunity for error • Lack of information about errors	• Quantity and frequency of overrides and workarounds required for the system to produce function correctly • Online ticket portal submission	• Quantity of alerts that caseworkers must process • Must sort through many alerts to find those that are relevant to eligibility	• Passive renewal issues • Bots not functioning correctly or creating more work for caseworkers	• Not user-friendly • Difficult to navigate • Applications come in incomplete or multiple times • New indicators

Source: CDJFS Feedback

General Functionality

General functionality issues include inconsistent functioning, system updates or fixes breaking other parts of the system, conflicts between programs, increased opportunity for error due to the structure of the system, and a lack of information about errors. Multiple CDJFS agencies indicated that while Ohio Benefits works well when an individual is only applying for one program, the combination of eligibility determinations or redeterminations for multiple programs causes issues such as overwriting of information. These issues are compounded by the variation in eligibility policy and processes between programs discussed in [Recommendation 5](#). Ohio's previous Eligibility and Enrollment System, CRIS-E, had a different structure than Ohio Benefits. CRIS-E had a "driver" built into the system, which directed a caseworker through the eligibility determination process and required the entry of necessary information to continue in the process. Ohio Benefits does not have this structure, so caseworkers must navigate through the system and decide which information should be entered. While CDJFS staff were split on their preference for the "driver" in CRIS-E, many counties indicated that the structure of Ohio Benefits increases the opportunity for error in the determination process as caseworkers need to have strong knowledge of the program to ensure information is entered and processed correctly. Additionally, when Ohio Benefits is not able to process a determination due to lacking or incorrect information entry, it does not indicate what or where the error is, so the caseworker must search for the error manually. These general functionality issues make it difficult for CDJFS caseworkers to complete their work accurately and in a timely manner.

Determination Accuracy

Almost all CDJFS agencies indicated that they must utilize overrides and workarounds to ensure that eligibility determinations made by Ohio Benefits are accurate. Overrides are a method for caseworkers to take manual control of Ohio Benefits to correct improper system actions, while workarounds are an indirect method to bypass improper system actions without altering the automation. Overrides require a secondary authorization, typically from a supervisor or manager. Most counties felt that there are too many overrides and workarounds required, with a few counties mentioning that they have a list of hundreds of known overrides and workarounds to refer to when Ohio Benefits returns an incorrect result. Since the system often returns incorrect results, this means that caseworkers cannot rely on the system's built-in functionalities. As a result, multiple counties indicated that CDJFS caseworkers must have an in-depth knowledge of eligibility policy across all programs in order to identify when Ohio Benefits is operating incorrectly and understand what the correct action or result should be. This reliance on caseworker knowledge and experience to ensure the system is functioning accurately increases the opportunity for error within the eligibility determination and redetermination process.

Additionally, the Department has an online ticket portal for CDJFS agencies to submit questions and notify ODM of issues, including those related to systems. The CDJFS agencies we spoke to indicated that the Department asks them to submit a ticket to this portal every time they encounter an issue in Ohio Benefits that requires an override or workaround. ODM will then use the quantity of tickets submitted to prioritize issues to be fixed in system updates. However, counties said that they do not have time to do this and no longer submit tickets for issues that they already know the solution to because they know what response ODM will provide.

Alerts

Another issue identified by almost all of the CDJFS agencies we interviewed was the quantity of alerts. Counties receive alerts through Ohio Benefits regarding changes in circumstances that may impact eligibility for public benefit recipients in their county. These changes include new employment, pregnancy, residency, and death. CDJFS caseworkers are supposed to process these alerts continuously to ensure that recipients are maintaining their Medicaid eligibility. However, many counties indicated that the alerts are unnecessary, irrelevant, or redundant. They often receive and work the same alert quarterly or for multiple programs. Not all alerts impact eligibility, so CDJFS staff must sort through massive amounts of alerts to locate and work those that are relevant to recipient eligibility. Multiple counties indicated that the volume of alerts received increases the likelihood of missing important alerts. Proposed solutions included removing alerts that do not impact eligibility, indicating the priority level of alerts, and having a

threshold for financial change alerts. ODM indicated that the Department has made a significant effort to reduce redundant and unnecessary alerts, and some counties did mention that the issues with alerts have improved over time. However, these issues are still present and impacting CDJFS operations.

Automation

Over half of the counties mentioned issues with automation in Ohio Benefits. These issues are primarily related to passive ex parte renewal, which is discussed in [Issue for Further Study 1](#), and bots. State agencies create automated bots in Ohio Benefits intended to process changes that caseworkers would otherwise be responsible for processing. ODM indicated that its bots were developed because these changes were not being processed by counties, so automation was the solution to ensure that the work was being completed. Examples of bots include the “death bot,” which removes deceased individuals from Medicaid coverage, the “baby bot,” which creates a new case for babies born in families on Medicaid, and the “address bot,” which updates recipient addresses when they move. While counties indicated that these bots can be helpful, they often do not work correctly and therefore create additional work for caseworkers. The “death bot” does not work between programs, so it may remove a deceased individual from Medicaid benefits but not SNAP, causing the deceased individual to continue receiving SNAP benefits until a caseworker catches it. The “baby bot” does not include the newborn’s name or link the baby to the mother, making it difficult for a caseworker to identify the family that the newborn belongs to. Additionally, hospitals often also create a new case for the newborn, resulting in duplicative cases. The “address bot” generates a fallout list of addresses that could not be confirmed by the bot, which caseworkers must then go through and confirm manually. Multiple counties expressed a desire to be able to opt out of bots and passive ex parte renewal, preferring to process applications, renewals, and changes manually because they are more confident in the accuracy of manual processing than automation. While the Department disagreed with our characterization of the baby bot during review of the report, ODM’s characterization conflicts with testimonial evidence from CDJFS agencies and the Department failed to provide any supporting documentation for their claims.

Self-Service Portal

Finally, many CDJFS agencies have experienced issues with the Ohio Benefits Self-Service Portal. This portal can be used by applicants or recipients to submit applications for public assistance programs, report changes impacting eligibility, and upload documentation for information verification. While some counties appreciated the ease of access for applicants and recipients, many indicated that the Self-Service Portal is not user-friendly. Applicants and beneficiaries often struggle to navigate the portal, enter information in the incorrect location, create duplicate documents, and accidentally apply multiple times. This frustrating applicant and

beneficiary experience with the portal was also identified in a survey of Ohio Benefits Self-Service Portal users conducted by a coalition of nonprofit entities. These issues are also frustrating for CDJFS caseworkers. Information entered by users create new indicator alerts, which CDJFS caseworkers must approve or deny. Caseworkers must also sort through the duplicate documents or applications submitted to ensure they are not being processed multiple times. While the Self-Service Portal provides convenience for applicants and recipients, its complexities create issues for users and caseworkers.

These issues with Ohio Benefits have been reported on by multiple entities since 2019, including the Ohio Auditor of State, the Ohio Inspector General, the previous ODM Director, and nonprofit organizations. Each of these entities, with the exception of the previous ODM Director, issued recommendations to ODM to improve the system issues. These reports and recommendations show that ODM has been aware of the issues with Ohio Benefits for years, but any efforts to address them have not been sufficient based on current county feedback.

Recommendations from Other Entities

The Ohio Auditor of State, through its Medicaid Contract Audit Division, recommended that ODM evaluate and re-design the alert system, create a joint new user training and regional long-term care training, reduce and monitor the backlog of applications and renewals, address the lag in receiving applications from the Federally Facilitated Marketplace and Social Security Administration, create an improved reporting system to aid counties, and increase staffing at ODM and funding to counties to address backlog. Notably, these recommendations are based on the steps identified by ODM in its 2020 Corrective Action Plan. For more information on this audit and these recommendations, see [MCA Audit Report](#). As discussed in this recommendation, the alert system still causes issues and creates additional work for CDJFS agencies. As discussed in [Recommendation 5](#), ODM, ODJFS, and DCY did create a joint new user training, but it was recently discontinued. As discussed in [Recommendation 7](#), ODM does monitor the backlog of applications and renewals, but is still not meeting statutory requirements, has not addressed the lag in receiving applications from the Federally Facilitated Marketplace and Social Security Administration, and the State has not increased the funding to CDJFS agencies outside of incentive payments. Finally, ODM did create an online ticket system to assist counties, however, over half of the CDJFS agencies indicated having issues with this ticket system, including slow and unhelpful responses from ODM.

In 2020, the Ohio Inspector General recommended that ODM “ensure that its eligibility determination system has the functionality to verify eligibility requirements and perform eligibility determinations in accordance with Federal and State requirements.” Per county feedback, Ohio Benefits still does not consistently and accurately make eligibility determinations. This includes the passive ex parte renewal process, which is discussed in [Issue](#)

[for Further Study 1](#), as well as general eligibility determination in Ohio Benefits, which CDJFS caseworkers often have to override or workaround to achieve an accurate determination.

Also in 2020, three nonprofit organizations conducted a survey of Ohio Benefits Self-Service Portal users. This survey found that the portal does not meet the needs of users, specifically mentioning that it is not mobile friendly, it is difficult to navigate, and it has a multitude of system errors. As a result, the organizations recommended that the State improve the Ohio Benefits Self-Service Portal using human-centered design principles. While the State is not obligated to follow recommendations from nonprofit organizations, this survey and recommendation support the feedback from CDJFS agencies regarding issues with the Ohio Benefits Self Service Portal.

Finally, Georgetown University's Beeck Center for Social Impact and Innovation recently published a series of reports on its research initiative *Implementing Benefits Eligibility and Enrollment Systems*. In one of these reports, *Insights on State Approaches and Processes* (2026), the Center identifies key characteristics and necessary features of IEES, as well as associated challenges and recommendations for states utilizing this type of system. Specifically, the report states that the combination of policies and users across programs makes these systems particularly complex, but valuable to the experience of beneficiaries and caseworkers.

One challenge identified in this report is that many states' IEES have grown incrementally over time as states have added programs and addressed technical problems. As a result, many systems have accumulated complex coding and a significant amount of technical debt, which occurs when technical problems are solved with quick fixes rather than more intensive, but sustainable, system upgrades. Based on CDJFS feedback, Ohio Benefits has become less functional over time as more public benefit programs were added to it. Additionally, the previous ODM Director indicated that from 2015 to 2019, known defects in Ohio Benefits increased from about 300 to nearly 1,110 as new components and functionalities were added to the system. According to counties, there is still a large number of known issues in the system that caseworkers must override or work around, so these defects remain unaddressed. To address these concerns, the Center recommends that states split systems into modular components to allow for independent control and implementation of features and invest in development environments to test data and automations prior to the deployment of system changes.

Another challenge identified by the Center is that federal agencies tend to develop policies and guidance for public benefit programs in siloes, which makes system integration difficult. In Ohio, this also applies to state agencies, as the oversight of the programs in Ohio Benefits is split between three state agencies. CDJFS caseworkers identified misalignment between the policies and processes for the various programs they are responsible for, as discussed in [Recommendation 5](#). They also indicated that issues with Ohio Benefits occur more frequently

for applicants or recipients that are on multiple programs. To address this challenge, the Center recommends that benefit programs are considered collectively, rather than in isolation, when developing policy and legislation, and that states adopt a governance model that enables collaboration and transparency between partner agencies.

It is critical for ODM to consider stakeholder feedback when making policy, process, or system changes, which is further discussed in [Recommendation 9](#). For Ohio Benefits, this means that CDJFS agencies must be consulted as ODM attempts to address and improve the system issues identified in this recommendation. As the primary users of Ohio Benefits, CDJFS caseworkers have the most knowledge and firsthand experience of the system and its issues, and will therefore be able to assist in developing effective, realistic solutions.

Conclusion

ODM should work with ODJFS and CDJFS agencies to identify and develop solutions for the multitude of issues in Ohio Benefits that impact Medicaid eligibility determinations and renewals. This should include, at a minimum, improving the functionality and accuracy of Ohio Benefits, reducing the number of overrides and workarounds required, reducing the quantity of alerts, improving automation, and making the Ohio Benefits Self-Service Portal more user friendly. Developing solutions to these issues will improve application timeliness and determination accuracy, as well as the experience of CDJFS caseworkers and Medicaid applicants and beneficiaries.

Recommendation 7: Enhance Data Collection to Identify Issues Impacting Application Processing Timeliness

Medicaid applications are required by law to be processed within a certain number of days. Ohio has historically failed to meet this requirement and falls below the national average for processing timelines. While this information shows an opportunity and need for improvement, ODM does not currently utilize appropriate county-level data that would allow it to comprehensively evaluate the performance of CDJFS agencies or identify the root causes of timeliness issues. ODM should enhance the collection of application processing timeliness data and use this information to identify issues delaying application processing and develop process improvements or other solutions accordingly. This should be done in conjunction with CDJFS agencies to ensure that solutions are appropriate and feasible.

Impact

The collection and utilization of relevant and meaningful data is an essential component to effective performance management. Collecting data related to the speed of application processing at the county level will provide the Department with a more accurate view of county performance and enable it to identify practices that are yielding better results and adjust practices that are yielding worse results. This effort will also foster dialogue with the CDJFS agencies, who are key stakeholders in the implementation of any process improvements. Enhancing data collection and collaborating with CDJFS agencies will enable ODM to develop effective solutions and align Ohio with federal and state timeliness requirements.

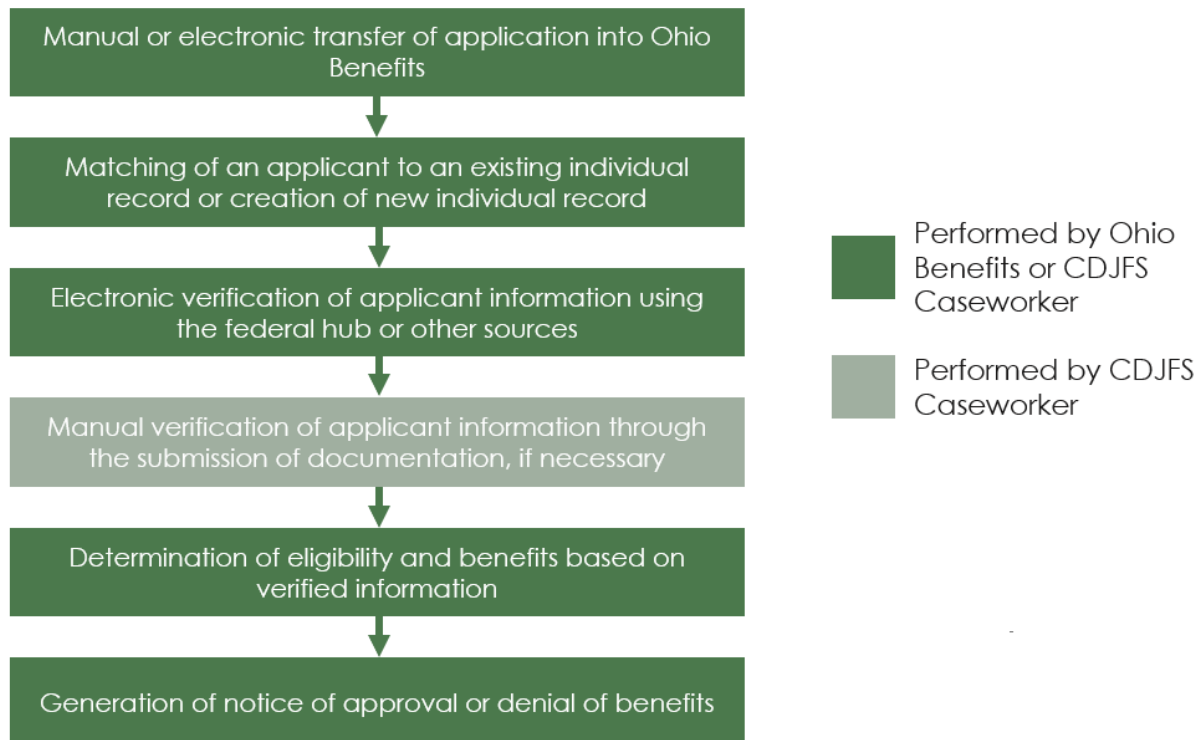
Background

There are multiple methods available for Ohioans to apply for Medicaid coverage. These methods include traditional paper applications, online application portals, and phone applications. Traditional paper applications can be submitted to CDJFS agencies in person, by mail, or by fax. Online application portals that individuals can apply through include the Ohio Benefits Self-Service Portal, the Federally Facilitated Marketplace, or the Social Security Administration. Finally, individuals can apply via phone by calling their CDJFS agency or the Ohio Medicaid Consumer Hotline, a state-run customer service line for Medicaid applicants and recipients. While having multiple avenues to submit applications can introduce more challenges, it also provides more opportunities for vulnerable populations to access the system.

Applications submitted through the online portals are processed electronically by Ohio Benefits when possible, falling out of this automatic process if there is an information mismatch or other issue. When this fallout occurs, the application is processed manually by a CDJFS caseworker for

the remainder of the process. Applications submitted in-person, by mail or fax, or through the phone are processed manually by CDJFS caseworkers for the entirety of the process. Caseworkers utilize Ohio Benefits, Electronic Data Management System, and electronic verification systems for this manual processing. At a high level, the eligibility determination process is displayed below. For a more detailed overview of this process, see [Appendix J](#).

High-Level Overview of Initial Application Process



Source: ODM

If an applicant is within the Aged, Blind, and Disabled (ABD) eligibility category, applying for long-term care (LTC), or being considered for presumptive eligibility or a reasonable opportunity period,³¹ the eligibility determination process has additional steps that are not shown here. The process map in [Appendix J](#) provides more detail on these areas.

³¹ Presumptive eligibility provides applicants with the opportunity to receive immediate healthcare services through Medicaid coverage if they are presumed to be eligible based on self-attested income information. A reasonable opportunity period provides non-citizen applicants who declare a qualified non-citizen status and are otherwise eligible for Medicaid coverage with a period of time to verify this status, within which they are able to receive immediate healthcare services.

Methodology

As a part of our effort to evaluate the performance variation between CDJFS agencies, we attempted to obtain application processing time data by county from ODM. However, ODM did not track application timeliness data and could only provide data showing the number of pending applications in various timeframes. This data depicts a point in time look at pending applications, rather than continuous data depicting the length of time it takes CDJFS agencies to process applications. We were able to use this pending application data to determine compliance with statutory requirements for application processing timeliness, and requested that ODM begin collecting application timeliness data at the county level. Next, we developed a process map showing the eligibility determination and redetermination processes. We shared this process map with the CDJFS agencies we interviewed, and asked them to identify any inaccuracies, points of variation, or pain points within our process map. We used this information to revise the process map and identify issues that may be impacting application processing timeliness throughout the state.

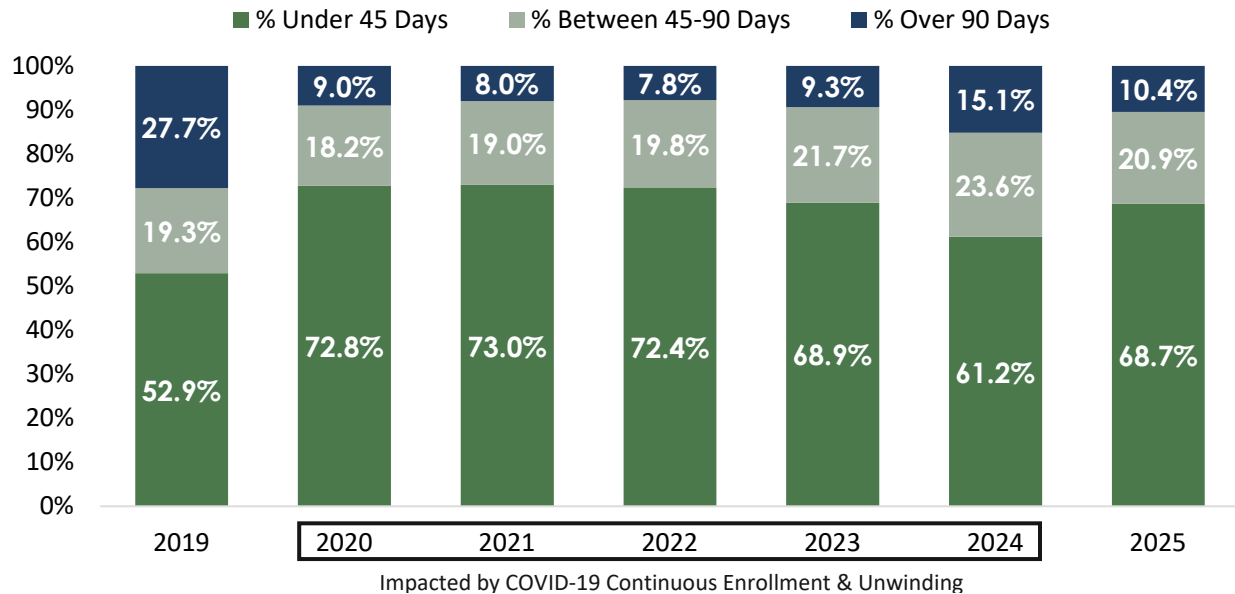
Analysis

Statutory Compliance

The federal government, as part of its oversight of state administration of the Medicaid program, sets requirements for the length of time that Medicaid applications must be processed within. Per CFR Part 435, all eligibility determinations must be made within 90 days for individuals applying for Medicaid on the basis of disability, and within 45 days for all other applicants. These same requirements are established by the state in the Ohio Administrative Code.

In order to monitor compliance with these statutory requirements, ODM collects data on the number of pending Medicaid applications by timeframe and county. This data is collected weekly and sent to CDJFS agencies to ensure that pending applications over 45 or 90 days are prioritized for completion. Many CDJFS agencies indicated that this report on pending applications, which also contains information on pending renewals, is critical to their internal processes for application tracking. Using this data, we conducted a comparison of pending applications to the statutory requirements outlined above. The graph on the following page displays the results of this comparison.

CY 2019-2025 Monthly Average Percentage of Pending Applications



Source: ODM Pending Application Data

Note: Due to rounding, not all numbers will equal 100 percent.

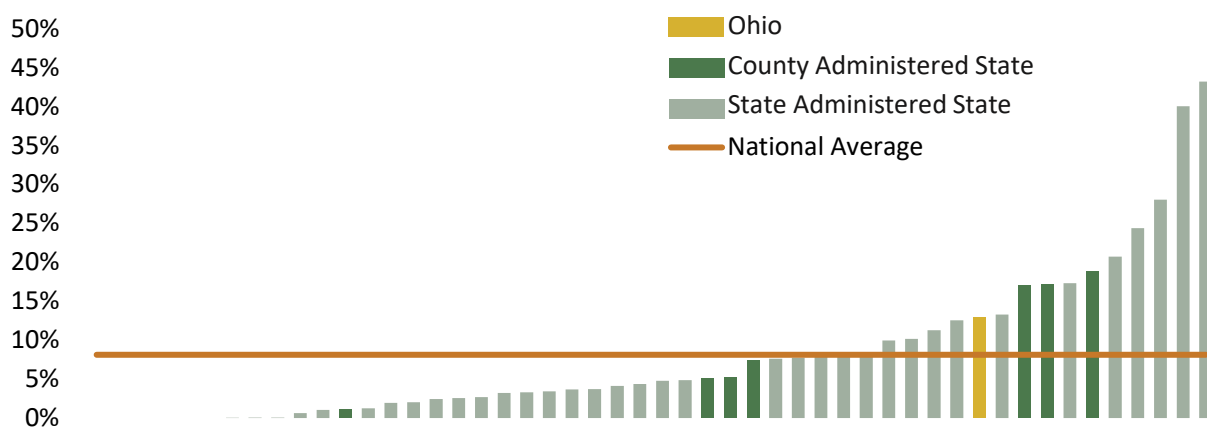
In this graph, the blue portion of the bar represents the monthly average percentage of pending applications that were pending for over 90 days, which are out of compliance with statutory requirements. We found that a monthly average of approximately 10.4 percent of applications were out of compliance with statutory requirements in CY 2025. Overall, this percentage has decreased from CY 2019 to CY 2025, although it increased from CY 2020 to CY 2024. However, it is important to note that the COVID-19 Continuous Enrollment provision was in effect from March of 2020 to March of 2023, during which Medicaid recipients could not be disenrolled. As a result of this, CDJFS agencies did not have to conduct annual renewals, which reduced the overall caseload and allowed caseworkers to focus on applications, thus improving timeliness. After this provision ended, eligibility for all recipients had to be redetermined, a process referred to as unwinding. This process increased CDJFS caseloads, thus lowering timeliness in CY 2024.

The light green portion of the bar represents the monthly average percentage of pending applications that were pending for over 45 days, but under 90 days. Depending on the type of applicant, these applications may be out of compliance with statutory requirements, but may be acceptable if they are on the basis of disability. The data is not granular enough to break these applications down by applicant type, so we cannot determine what portion of these applications are out of compliance with statutory requirements.

Nationwide Comparison

While ODM tracks pending application data by county to ensure compliance with statutory requirements, the Department does not track application processing timeliness data at the county level. This data would show the total number of applications processed within various timeframes over a period of time, rather than the number of applications pending within the timeframes at the point in time when the report was run. Despite not previously collecting this data on the county level, the Department does collect the statewide totals, as it is required to report this information to CMS. This information allowed us to compare Ohio's performance to other states. The graph below shows the percentage of MAGI applications processed in 45 days or more for each state, as well as a national average. As this comparison only includes MAGI applications, those processed in over 45 days are out of compliance with statutory requirements.

CY 2023 Monthly Average Percentage of MAGI Applications Processed in Over 45 Days



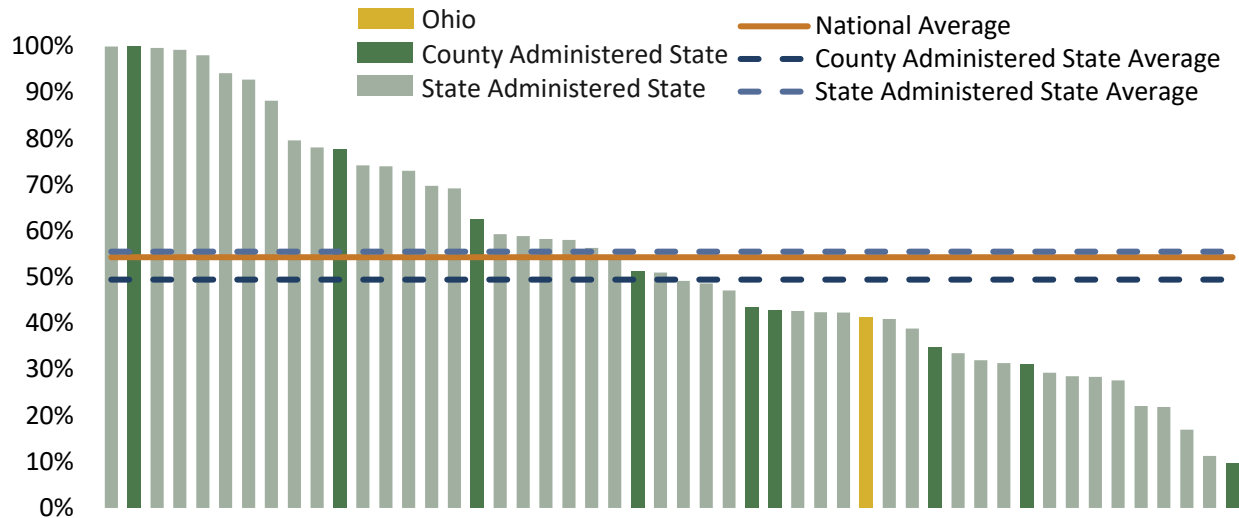
Source: CMS Medicaid & CHIP Scorecard

Note: This graph does not display the county administered state average or state administered state average because they are within 0.5 percentage points of the national average.

We found that 12.9 percent of Ohio's MAGI applications were processed in more than 45 days in CY 2023, which were out of compliance with statutory requirements. This percentage is the 11th highest in the country, ranking Ohio 39th out of the 50 states. It is also worse than the national average, county-administered state average, and state-administered state average.

In addition to having a higher level of noncompliance with federal requirements, Ohio's application processing speed is also lower than other states. The graph on the following page shows the percentage of MAGI applications processed in seven days or less for each state, as well as a national, county-administered, and state-administered average.

CY 2023 Monthly Average Percentage of MAGI Applications Processed in 7 Days or Less



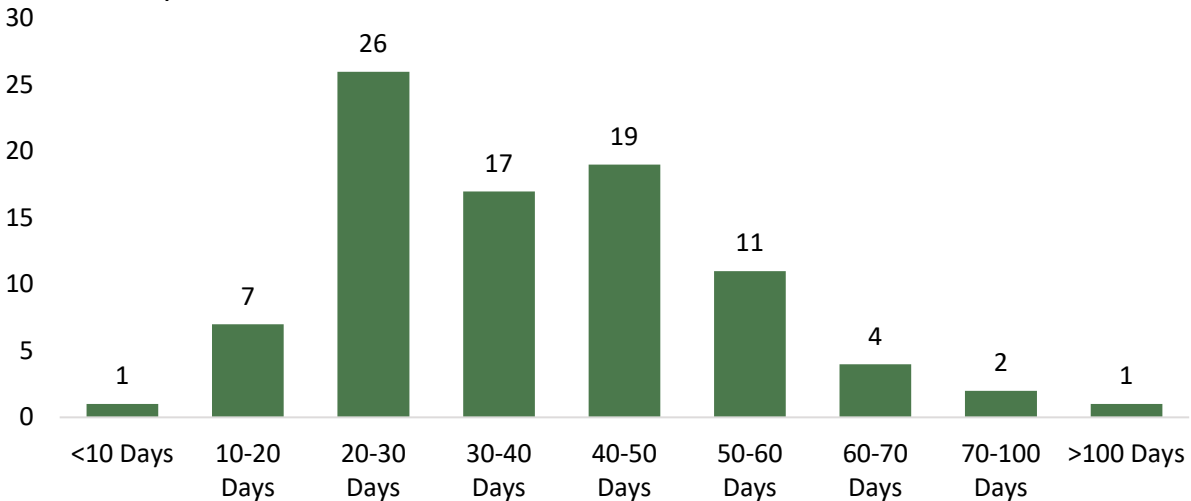
Source: CMS Medicaid & CHIP Scorecard

Ohio's monthly average percentage of MAGI applications processed in 7 days or less ranks 34th out of all of the states and falls below the national average and county-administered state average. Notably, the county-administered state average is lower than both the national average and the state-administered state average. However, there is negligible correlation between county-administered status and the percentage of applications processed in 7 days or less.

These national comparisons show that, in addition to not meeting statutory timeliness requirements, Ohio is not able to process applications as quickly as most other states are. This suggests that there is potential for Ohio to improve its application processing speed through process improvements or other best practices. However, ODM does not currently have the data necessary to identify issues impacting timeliness or examine county performance. As a state where eligibility determinations are administered by local entities, the collection and analysis of county level performance data is critical to identify practices that are yielding better results and adjust practices that are yielding worse results.

During the course of this audit, we requested that the Department begin running the application timeliness report at the county level monthly, which it was able to, showing that ODM does have the technical capability to collect this information. Using this data, we were able to create examples of the types of metrics ODM could utilize to improve timeliness. The graph on the following page displays the distribution of CDJFS agencies by their average application processing speed from May to June of 2026.

CDJFS Distribution by Average Application Processing Time from May 2026 to June 2026



Source: ODM

The Department could use this type of metric to evaluate county performance and identify effective and ineffective county practices. ODM could meet with high-performing counties, or those that are processing applications more quickly, to identify any processes or strategies they utilize to improve timeliness that could be applied to other counties. On the other hand, the Department could meet with low-performing counties, or those that are processing applications slowly, to understand the obstacles they face in meeting timeliness standards and assist them in alleviating these obstacles or otherwise improving processes. See [Appendix K](#) for more examples of how application timeliness data could be utilized by the Department.

Factors Impacting Timeliness

When we process mapped the eligibility determination and redetermination processes with counties, CDJFS staff identified a number of issues that hinder application processing. For a comprehensive overview of the feedback identified through this process mapping, see [Appendix J](#). The issues that were described as delaying application processing and increasing processing times are largely related to the applications themselves, based on which method an individual is applying through. E-applications, or applications submitted through online portals, were identified as an issue for multiple reasons. Applications from the Federally Facilitated Marketplace and Social Security Administration were reported to drop down to CDJFS agencies much later than they were submitted, which then counts against a county's timeliness metric. For example, a Social Security Administration application that was transmitted to the CDJFS agency one week ago, but had been submitted by the applicant four weeks ago, is counted as the full four weeks in the county's application processing time.

Counties also mentioned that Federally Facilitated Marketplace and Social Security Administration applications frequently do not have all of the necessary information filled out or are submitted on behalf of individuals who did not know they were applying. These federal e-applications, as well as older versions of paper applications, do not include permission for the CDJFS agency to utilize electronic verification systems to verify applicant information, which is required for the eligibility determination process. This creates an additional step in the process, as the CDJFS caseworker must reach out to the applicant to obtain this permission. Counties also reported that applications submitted through the Ohio Medicaid Consumer Hotline are typically given to CDJFS agencies without all necessary information, and sometimes without notification. Finally, counties indicated that all applications, as well as renewal packets, do not request resource information, which is required for processing ABD and LTC applications. All of these application issues create a need for additional outreach to the applicant, which delays the application processing and eligibility determination.

In addition to these specific issues with application types, counties also expressed overarching staffing and funding concerns. Most of the counties we interviewed felt that their office was understaffed or that their staff had unmanageable caseloads, specifically mentioning difficulties with retaining and hiring employees. Some of the factors that were identified as contributing to these difficulties include not being able to pay competitive wages, long training timelines, difficult and heavy workloads, and inflexible work hours. Due to the decentralized structure of Ohio's Medicaid administration and the combined duties of county caseworkers, it is difficult to accurately quantify the number of Medicaid caseworkers in the State. As a result, we could not analyze the overall sufficiency of county caseworker staffing levels.

Specifically related to wages, multiple counties mentioned that their stagnant funding from the state and resulting tight budgets make it difficult for them to adequately compensate their employees. Over the past 12 years, Ohio's standard state funding allocated to CDJFS agencies for Medicaid appropriations has only increased 1.9 percent. In the last few years, ODM has provided additional funding to encourage improvements in application processing timeliness, referred to as incentive funding. When this incentive funding is included, state Medicaid funding for CDJFS agencies has increased by 15.0 percent. However, counties indicated that they are not able to rely on this funding, as it depends on their quarterly performance, and therefore cannot use it to hire additional staff members or increase wages. In comparison, Ohio's state appropriations for Medicaid administration at the state level have increased by

35.3 percent.³² For information on what state Medicaid administrative expenditures consist of, see [Financial Background](#) and [Appendix E](#).

As discussed in the [County Oversight Background](#), counties are required to contribute a mandated share of administrative expenses and some counties utilize local funds to cover administrative spending above state allocations and required mandated share. This decision is made at the local level, typically by county commissioners. These contributions, as well as federal funding allocated to CDJFS agencies, are not included in the statistics on the previous page.

While state funding for CDJFS agencies has remained stagnant over time, county caseloads have increased. From CY 2017 to 2025, the number of Medicaid applications received increased by approximately 20.8 percent. In addition to this, the CDJFS agencies we interviewed noted that policies, processes, and systems have become more complicated over time while expenses have risen. This has resulted in what the majority of counties described as unmanageable caseloads.

Additional factors that impact timeliness may be county specific, as there is a significant range in the percentage of pending applications that are out of compliance with statutory requirements between counties. It is also likely impacted by the Medicaid open enrollment period, which occurs in November and creates an influx of applications.

Best Practices

The National Performance Management Advisory Commission (NPMAC) has *A Performance Management Framework for State and Local Government*, which outlines seven principles of performance management. These principles can be applied to ODM's oversight of CDJFS agencies and can serve as best practices that may assist the Department in collecting and utilizing data to facilitate performance improvements.

One of the NPMAC's principles of performance management is that goals, activities, and measures are relevant to the priorities and well-being of the government entity and the community it serves. The NPMAC describes relevancy as being meaningful to intended audiences, specifically stating that performance goals and measures can be related to compliance with laws and requirements, but should also include those that are meaningful to the recipients of services. ODM's oversight activities are aligned with the first part of this

³² Medicaid administrative expenditures at the state level includes expenses for statewide systems used by counties during the eligibility determination process, as well as the employees that provide trainings and technical assistance to counties.

principle, as it collects and monitors data with the goal of meeting statutory requirements for application processing timeliness. However, ODM does not have additional performance targets or metrics related to the speed of application processing, which directly impacts the experience of both applicants and CDJFS caseworkers. The quicker an application is processed, the sooner an eligible applicant can access the medical services covered by Medicaid. Delays in application processing that could potentially be avoided or streamlined are a source of frustration for CDJFS caseworkers and contribute to an increased workload as the CDJFS agency continues to receive applications. Additionally, improving application processing speed will result in a more efficient use of public resources.

Another principle is to ensure that information related to performance is easy to access, use, and understand. The NPMAC indicates that this transparency can encourage dialogue about how to improve performance and keep stakeholders informed of the reasoning behind decisions made. The Department makes an effort to provide counties with information related to pending applications and renewals. This includes a weekly report that ODM sends to each county detailing their pending applications and renewals, as well as a dashboard that displays this information for all counties in the state. This allows CDJFS agencies to monitor their own compliance with statutory requirements and ensure their pending applications are addressed, as well as to compare their performance to other counties. However, this data transparency is again limited to information about pending applications. If counties would like information about their application processing times, they must collect this data themselves.

The next NPMAC principle is that goals, activities, and resources are aligned with an organization's priorities and desired outcomes. A lack of alignment between these elements can result in competition for resources, rather than collaboration and improvement. ODM provides incentive funding to counties based on their ability to meet statutory timeliness requirements. While this is a good motivator for counties, this practice means that these sources of funding are not predictable, which makes it difficult for CDJFS agency to make lasting improvements to their timeliness, such as hiring additional staff when needed.

Finally, the NPMAC recommends that decisions and processes be driven by timely, accurate, and meaningful data. Collecting and utilizing adequate performance data is essential for effective performance management and decision making. While ODM collects pending application data to monitor compliance with statutory requirements, it does not collect and utilize application processing timeliness data at the county level. Without this data, the Department cannot adequately monitor county performance or use this information to identify the root cause of timeliness issues and make adjustments to operations accordingly.

Conclusion

As Ohio is not compliant with federal and state statutory requirements regarding timeliness, ODM needs to identify opportunities for process improvements to ensure Medicaid applications are processed within acceptable timeframes. Collecting and utilizing application processing timeliness data at the county level would provide ODM with a more comprehensive view of county performance related to application processing timeliness. It would also serve as another tool for the Department to identify issues impacting timeliness and develop process improvements or other solutions to address these issues. This should be done in conjunction with the CDJFS agencies that are responsible for implementing the processes to ensure that solutions are achievable and effective.

Recommendation 8: Expand, Standardize, and Communicate Quality Control Efforts to Improve the Accuracy of Eligibility Determinations

As the state agency overseeing Medicaid in Ohio, ODM is responsible for ensuring the accuracy of Medicaid eligibility determinations and redeterminations, which are primarily made by CDJFS agencies. Once every three years, the Department conducts 800 case reviews over a 12-month period in compliance with federal minimum standards for the Medicaid Eligibility Quality Control (MEQC) program. This represents less than one percent of the total number of applications and renewals processed in Ohio. In MEQC off-years, ODM conducts additional, less standardized case reviews. The limited and inconsistent data obtained through current quality control efforts cannot be used to confirm the accuracy or effectiveness of CDJFS operations across the state. Further, this information cannot be reliably used for year-over-year comparisons or performance management efforts. In addition, ODM does not effectively communicate the results of comprehensive quality control case reviews to the counties, which limits the ability of CDJFS agencies to use this information to improve internal operations or performance management. ODM should expand, standardize, and communicate quality control efforts to improve the accuracy of eligibility determinations and redeterminations throughout the state.

Impact

Quality control reviews are an important piece of Medicaid program integrity efforts. These reviews serve as an internal control to ensure eligibility determinations are happening accurately and prevent ineligible individuals from being incorrectly enrolled into the program. The continuous improvement of quality control processes is necessary to adequately monitor eligibility determinations amidst policy and system changes in the Medicaid program. The improvement of ODM's quality control reviews, including reviewing a more representative sample of cases, collecting more consistent data, and increasing collaboration with CDJFS agencies, will assist the Department's efforts to reduce potential opportunities for fraud, waste, and abuse within Ohio's Medicaid program.

Background

CMS performs and requires state Medicaid agencies to perform quality control reviews to ensure the integrity of the Medicaid program. The required quality control efforts are broken down into two programs, which occur on offset cycles: the Payment Error Rate Measurement (PERM) program and the Medicaid Eligibility Quality Control (MEQC) program. The first PERM report was issued in 2008 and the current iteration of the MEQC program began in 2017. This cycle is displayed in the graphic on the following page.

MEQC and PERM Cycle



Source: CMS & ODM

The PERM program, in which CMS reviews a sample of each state’s Medicaid and CHIP claim payments from a 12-month period and produces an improper payment rate, occurs once every three years. In the off-years of the PERM program, states are required to complete a 12-month MEQC review, which is intended to ensure states are making accurate eligibility determinations so that Medicaid services are appropriately provided to eligible individuals. The 12-month MEQC review, referred to as a “pilot year,” requires state Medicaid agencies to evaluate a sample of active and negative eligibility determinations. Active cases are those where the applicant was determined to be eligible, while negative cases are those where the applicant was determined to be ineligible and denied coverage. Through this process, the agency must identify and correct any errors, which are improper determinations resulting in financial consequences; or deficiencies, which are improper applications of eligibility rules that do not have financial consequences.

As the state Medicaid agency, ODM conducts the MEQC reviews for Ohio’s Medicaid program. These reviews are conducted by the Department’s Bureau of Program Integrity (BPI), housed within the Legal office. This section of ODM is responsible for detecting and preventing fraud, waste, and abuse, as well as coordinating audits performed on the agency. BPI conducts quality control reviews in accordance with MEQC requirements during pilot years and conducts additional, less standardized reviews during non-pilot years to ensure that quality control and performance management efforts are ongoing. The case reviews are done on the county level by ODM, and any errors or deficiencies identified are communicated to and corrected by the CDJFS agency that made the determination. However, ODM does not directly communicate the total number of cases sampled or the cases found to be correct to the counties.

Methodology

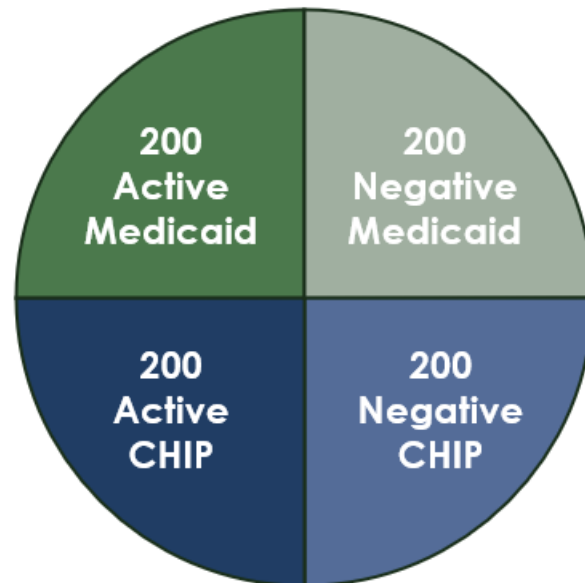
We met with the sections within ODM responsible for county oversight to develop an understanding of the performance metrics tracked and utilized to evaluate county performance. One of the performance metrics identified was quality control reviews. We obtained data on the number and results of quality control reviews performed and used this information to calculate accuracy and error rates by county. We then discussed these results and the structure of quality control efforts with ODM and conducted research on federal quality control requirements. Finally, we talked to CDJFS agencies about their internal quality control efforts and experience with ODM's quality control program as well as other stakeholders. All of this information was compared to best practices for fraud risk assessment and data analytics.

Analysis

Sample Size

The Department conducts quality control reviews both to comply with federal requirements and as a county oversight method. During pilot years, ODM reviews a sample of 800 case determinations, the composition of which is displayed in the visual to the right. This sample size and composition is based on the minimum requirements set by CMS and does not include adjustments for population, although CMS does give states the discretion to review larger sample sizes if desired. The sample reviewed by ODM includes case determinations and redeterminations made by county caseworkers, as well as those made entirely by the Ohio Benefits system through the passive ex parte process.³³ For comparison, ODM and CDJFS agencies received a total of approximately 850,000 applications and processed approximately 3.5 million redeterminations in CY 2025, the most recent pilot year. The sample of cases reviewed during this pilot year represented less than one percent of the determinations and redeterminations made.

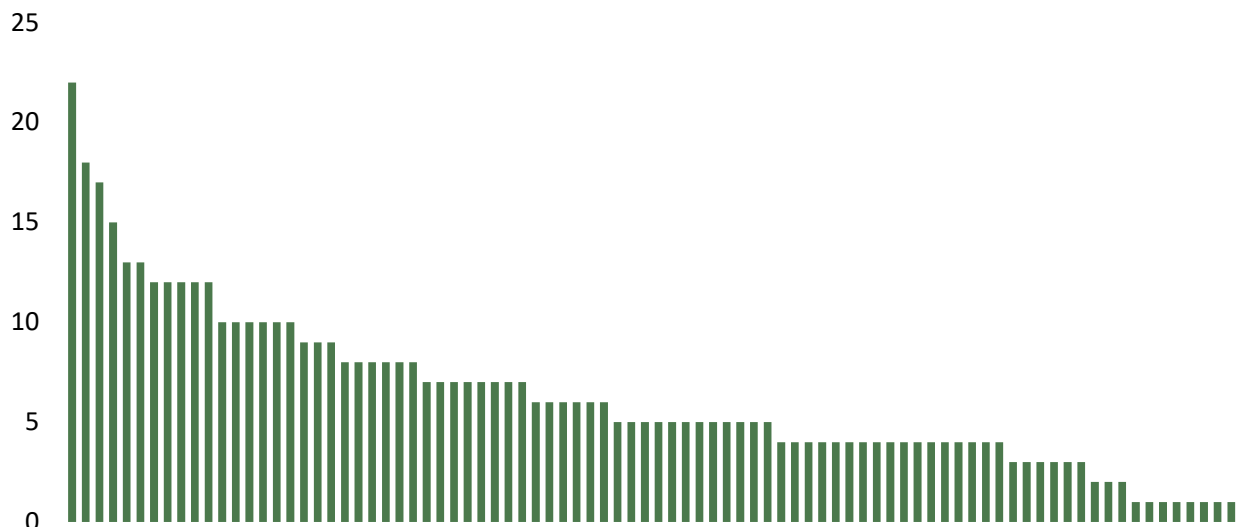
Distribution of MEQC Cases



³³ Passive ex parte refers to eligibility determinations or redeterminations made entirely by the system without contacting the Medicaid applicant or recipient.

When looking at county-level MEQC data, between 1 and 22 cases were reviewed per county in CY 2025. CMS requirements state that the sampling of cases for MEQC review must be done randomly, therefore there is not a set number of cases that must be reviewed by county or based on county population. ODM's sampling methodology is stratified to ensure that case reviews are spread amongst larger and smaller counties. The graph below displays the distribution of cases reviewed by county in CY 2025.

CY 2025 Cases Reviewed for MEQC by County



Review Methodology

During non-pilot years, ODM is not required to follow the same MEQC standards it must adhere to during pilot years. The Department's quality control efforts during non-pilot years are focused primarily on case determinations and redeterminations made by county caseworkers, rather than those made by the system through the passive ex parte renewal process. ODM indicated that it conducts special quality control projects in these off-years. As a result of the Department's specific focuses, the cases reviewed in non-pilot years are not all randomized samples. Additionally, ODM does not review the same sample size in non-pilot years, reviewing approximately 1,200 cases in CY 2023 and 770 in CY 2024. Due to this variation in sample size and type of cases sampled, quality control results cannot be accurately compared between pilot and non-pilot years.

Quality control in the MEQC format began in 2019 and was moved to an electronic system in 2022. Prior to 2022, quality control was completed on manual worksheets.³⁴ Upon request, the Department was able to provide its 2019 pilot year report that was submitted to CMS, which contained a high-level summary of the year's MEQC results as was required by CMS at the time. ODM had to request this report from CMS, as it was not retained internally, and the report was not as comprehensive as the other years of data, specifically lacking a breakdown of results by county. While entities can have varying document retention policies, this illustrates that historical quality control results were not kept for the purpose of comparing performance over time. In discussions with the Department, they informed us that the only appropriate way to look at quality control results over time was to compare pilot years. Since ODM only had comprehensive data available for two pilot years, that means they would only have the capability to compare two results.

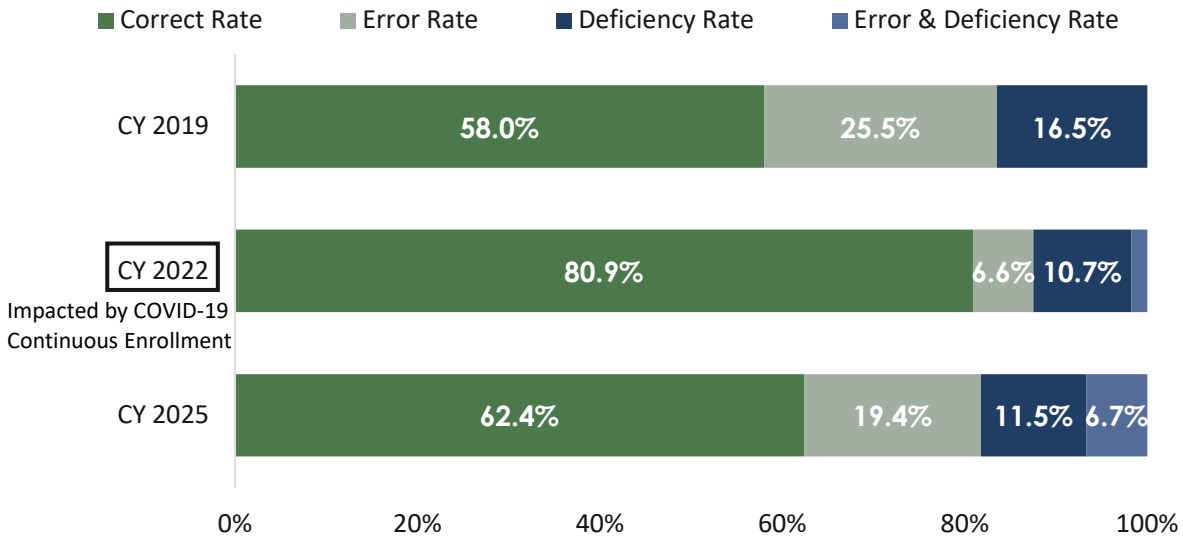
The lack of consistent, historical quality control data limited our ability to conduct an analysis of eligibility determination and redetermination accuracy over time. We were able to compare three pilot years at the state level, two of which we could also compare at the county level.³⁵ The graph on the following page displays the statewide percentage of case determinations

³⁴ In ODM's review of the report draft, it indicated that the electronic quality control system was created and used intermittently beginning in 2020. It was updated and used consistently beginning in 2022. Manual worksheets were physical paper prior to 2019 and fillable PDFs from 2019 to 2022.

³⁵ The county-level comparison of MEQC results was determined to be unreliable due to a difference in the naming convention used for passive/ex parte cases between the two pilot years. In CY 2022, these cases were labeled as their county of origin, although county caseworkers did not touch these cases. In CY 2025, these cases were labeled as "ODM," seemingly based on feedback from CDJFS agencies that they were held accountable for cases that were out of their control.

reviewed during MEQC pilot years that were found to be accurate, have errors, have deficiencies, and have errors and deficiencies.³⁶

Statewide MEQC Pilot Year Results



Source: ODM MEQC Data

Note: CY 2019 does not have a percentage for errors and deficiencies because this category was not included in the high-level summary provided. CY 2022 falls within the COVID-19 continuous enrollment period, when Medicaid recipients could not be disenrolled from the program.

As shown in the graph above, correct determination rates have increased slightly from CY 2019 to CY 2025, while error rates and deficiency rates have decreased slightly. CY 2022 was an outlier in these three years because it was impacted by the COVID-19 continuous enrollment provision. This provision required states to maintain the enrollment of nearly all Medicaid recipients during the public health emergency. Approximately 43 percent of the cases reviewed in CY 2022 were redeterminations, the vast majority of which resulted in a renewal of eligibility due to this provision.

County Communication

In addition to ODM's quality control efforts described previously, many CDJFS agencies perform quality control internally. Almost all of the counties we interviewed have employees conduct quality control reviews, with about half having staff members dedicated to quality control.

³⁶ Errors are improper determinations resulting in financial consequences. Deficiencies are improper applications of eligibility rules that do not have financial consequences.

However, multiple counties indicated that they are currently prioritizing SNAP quality control efforts over Medicaid, and only review Medicaid cases if they accompany a SNAP case undergoing review. Some counties attributed this prioritization to the current financial implications around SNAP accuracy, while others stated that they have always focused quality control efforts on SNAP. As a result, counties are largely reliant on ODM for quality control functions.

When asked about ODM's quality control efforts, counties indicated that they only hear about MEQC errors and deficiencies from ODM, and generally indicated that few MEQC results are received. Counties seemed generally unaware of how MEQC worked and were under the impression that they were doing well because they do not hear from ODM regarding MEQC often and therefore do not have context on their results. Many counties mentioned that they would like more comprehensive information on their MEQC results, such as the total number of cases reviewed or the number that were found to be correct. ODM does maintain a dashboard displaying MEQC results, however, only one county interviewed was aware of this dashboard. This lack of effective communication makes it difficult for counties to understand their performance and limits their ability to utilize the information to improve operations and performance management.

Best Practices

The GAO's *Framework for Managing Fraud Risks in Federal Programs* (2015) outlines best practices for combatting fraud risks in government agencies and programs. This framework describes fraud risk management as strategic and continuous efforts to ensure program integrity by reducing the likelihood and impact of improper activities that can lead to fraud. As quality control is a method to ensure that improper activities, including both errors and fraud, are not occurring within eligibility determinations, the best practices outlined in framework can be applied to Medicaid quality control efforts. However, it should be noted that quality control is only one aspect of the Department's fraud mitigation efforts and there are other entities that sample cases to determine whether eligibility determinations were appropriate.

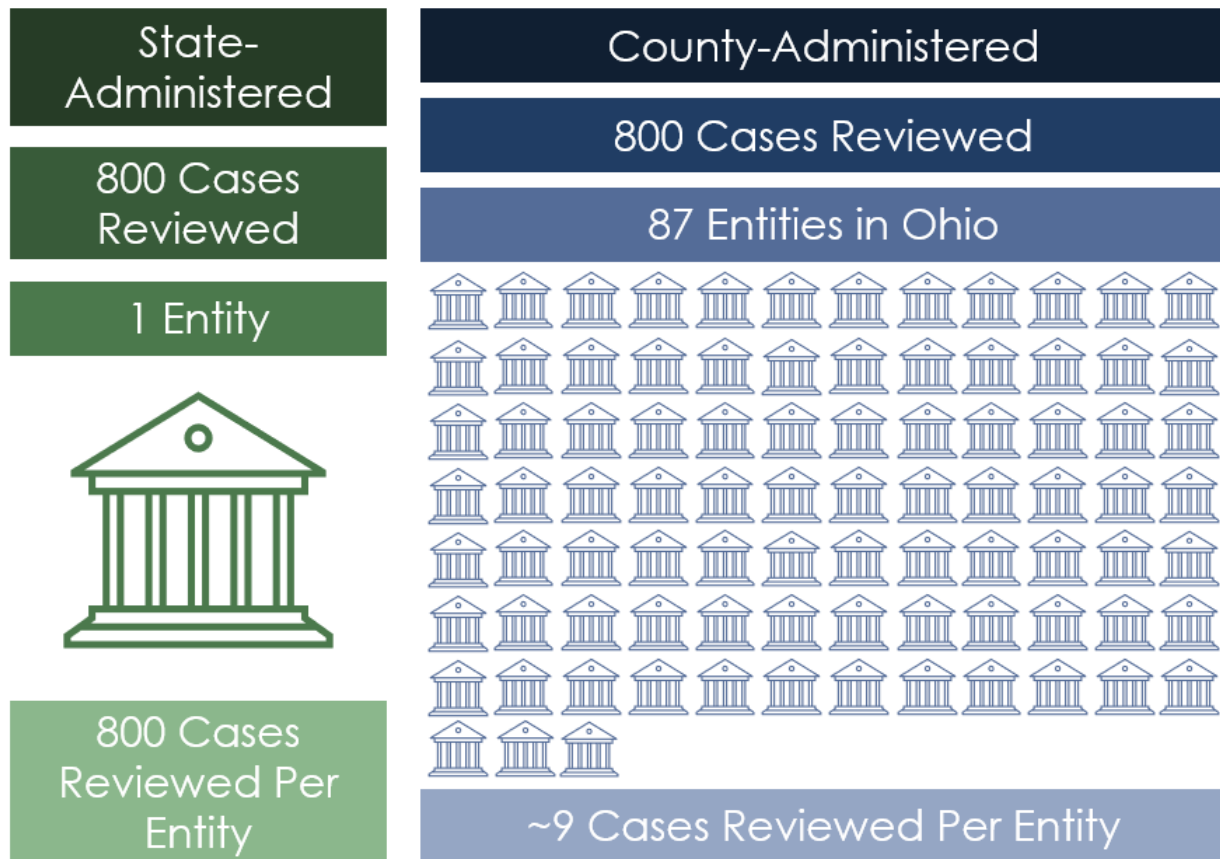
In this framework, the GAO recommends that government entities consider certain factors when planning the scope and frequency of fraud risk management activities. These factors include size, resources, maturity of the agency or program, and recent structural changes. Medicaid is a large program, with a multitude of public entities and employees involved in its administration. ODM oversees the majority of these employees, including direct oversight of individuals employed by the Department and indirect oversight of individuals employed by the 88 CDJFS agencies. Additionally, approximately a quarter of Ohio's population is enrolled in Medicaid, making the impact of ODM's operations widespread. The Department is also responsible for a significant amount of state and federal resources, with an appropriation of

almost \$45 billion in SFY 2025. As ODM was established in 2014, it is a relatively young state agency, although Medicaid administration was handled by other state agencies prior to the creation of ODM. Finally, the Department has been undergoing recent structural changes with the “Next Generation” initiative and modularization of information systems. All of these characteristics point to a greater need for frequent, comprehensive fraud risk management activities.

In addition to the consideration of these factors, the GAO also indicates that the frequency of fraud risk management activities is “a function of need and not just a matter of demonstrating compliance with standards.” This is particularly relevant to Ohio’s Medicaid program. While ODM is meeting the quality control requirements set by the federal government, these requirements are inherently less impactful for a county-administered eligibility determination system than a state-administered one. In a state-administered system, all 800 case determinations reviewed through the MEQC process are made by the same entity, while they are split between numerous entities in a county-administered system. In Ohio specifically, the case determinations reviewed are split between 87 entities: the 86 CDJFS agencies³⁷ and ODM. This difference is displayed visually on the following page.

³⁷ Hocking, Ross, and Vinton counties are combined into one CDJFS agency.

CMS Minimum QC Requirements by Eligibility Determination Structure



Source: CMS

Note: An average of 9 cases is reviewed per entity. The actual number of cases reviewed per entity ranged from 1 to 22 in 2025.

Additionally, the minimum requirement set by CMS is not adjusted for state population or caseload. This means that, although ODM is following federal requirements, the MEQC program is less impactful for Ohio than it is for a smaller state with a state-administered eligibility determination system.

The GAO fraud framework further recommends the use of qualitative and quantitative analyses to identify and understand the likelihood and impact of fraud risks. The use of quantitative analyses for this purpose is also supported by CMS guidance on *Data Analytic Capabilities Assessment for Medicaid Program Integrity* (2014), which outlines how data analytics and predictive modeling can be used as a tool in the detection of fraud, waste, and abuse in Medicaid programs. Specifically, CMS states that data analytics using historical data can enable program integrity units to identify patterns of suspicious behavior and use them to prevent future fraud, waste, and abuse. CMS additionally identifies benefits of effective data analytics, including a positive return on investment and strengthened program integrity safeguards. Due

to the inconsistency in ODM's current quality control methodologies for pilot and non-pilot years, the lack of retainment of historical quality control data, and the small sample sizes of quality control reviews at the county level, ODM does not have the quality of data necessary to perform effective data analysis to improve program integrity.

Finally, the GAO fraud framework emphasizes the importance of communication and collaboration with both internal and external stakeholders to share information on fraud risks. As a key stakeholder in the eligibility determination process, CDJFS agencies must be sufficiently informed and included in quality control efforts. However, based on our interviews with CDJFS agencies, counties are not aware of their comprehensive quality control results as ODM only communicates errors and deficiencies to them. Improving the communication of MEQC methodology and results would allow CDJFS agencies to use this as a performance measure to inform their internal management, training, and quality control efforts.

Collecting more robust and frequent quality control data could give ODM insight into how their training, policies, and procedures are translated into results and where there may be room for improvement. Where improvements are made, more regular and comparable quality control results can more quickly evaluate the effectiveness of those improvements.

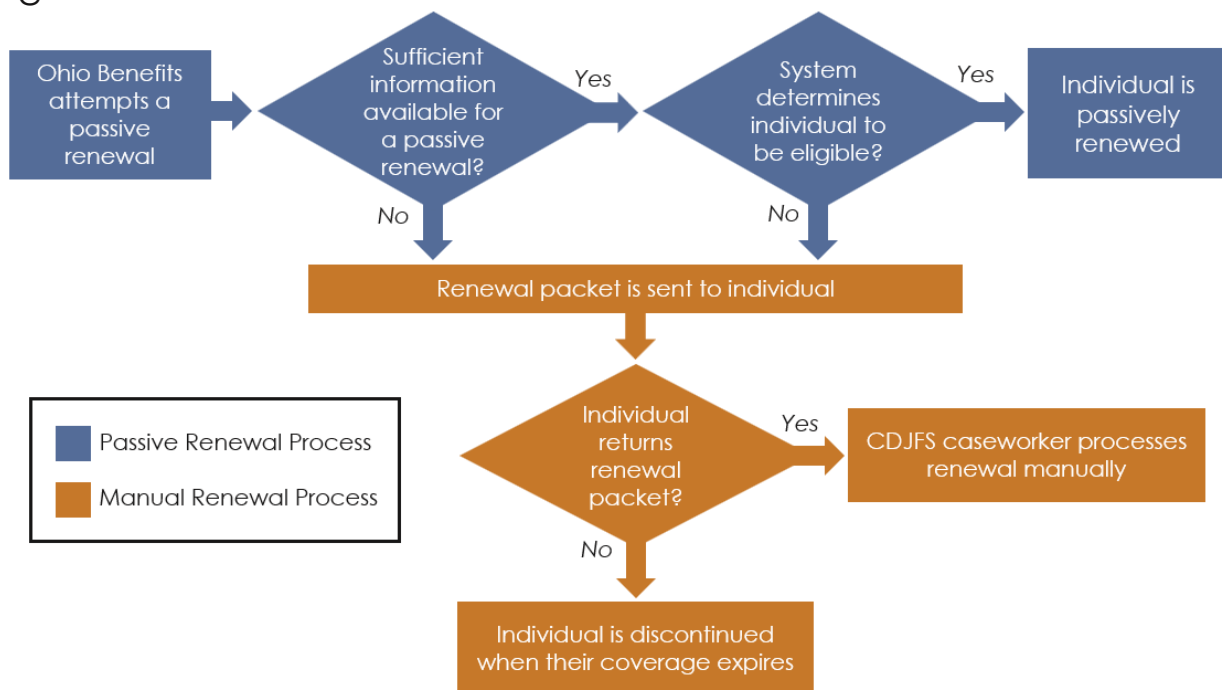
Conclusion

The Department should expand, standardize, and communicate its quality control efforts for eligibility determinations and redeterminations. A shift from focusing solely on compliance with federal standards to utilizing quality control efforts for performance management will allow for continuous improvement and better policies, procedures, and training provided to CDJFS agencies. Expanding these quality control efforts would result in a more comprehensive review of the accuracy of eligibility determinations across the state, therefore reducing potential opportunities for fraud, waste, and abuse. Standardizing the methodology utilized across years would create more consistent data that can be used for effective data analysis and pattern identification. Finally, improving the communication of quality control results to counties will assist counties in internal efforts to improve the accuracy of their operations.

Issue for Further Study 1: The Passive Ex Parte Renewal Process

The State is required to conduct eligibility redeterminations for all Medicaid recipients each year and renew coverage for recipients who are still eligible. These renewals can be completed manually, in which recipients fill out a renewal form and CDJFS caseworkers process the renewal, or passively, in which the Ohio Benefits system processes the renewal automatically using electronic data sources. This is referred to as passive ex parte renewal. Passive means that the renewal is completed by the eligibility system, while ex parte means the renewal is completed without requiring action from the recipient. Passive ex parte renewal is an important tool to assist with timely eligibility redeterminations and reduce the likelihood of procedural disenrollment. Procedural disenrollment occurs when a Medicaid recipient is disenrolled from the program during their annual redetermination not because they were found to be ineligible, but because they did not complete the paperwork or submit the documentation necessary to maintain their eligibility. By renewing eligible recipients without requiring additional information from them, passive ex parte renewal decreases the likelihood of procedural disenrollment. If functioning correctly, passive ex parte renewal also reduces caseworker workloads. The flow chart below displays a high-level overview of the renewal process. For a more detailed view of the renewal process, see [Appendix J](#).

High-Level Renewal Process



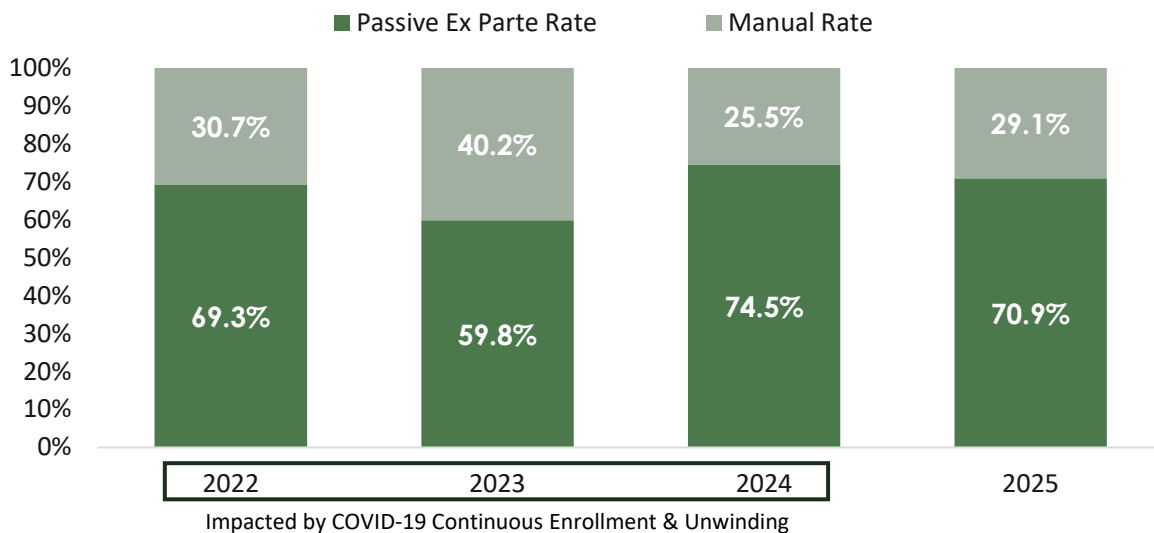
Source: ODM

Efficient • Effective • Transparent

The renewal process begins automatically a few months before the renewal is due. Almost all renewals are passively attempted by Ohio Benefits. If the system has sufficient information available to redetermine eligibility, the individual is passively renewed. If the system does not have sufficient information available or finds the individual to be potentially ineligible, the individual is sent a renewal packet and a CDJFS caseworker manually processes the redetermination upon receipt of the packet. If the individual does not return the renewal packet, they are discontinued when their Medicaid coverage expires. They then have a 90-day reinstatement period, during which they can submit their renewal packet and restart the redetermination process. An individual also has a 90-day reinstatement period if they do not provide documentation requested by the CDJFS agency to manually verify their information within 20 days.

In CY 2025, approximately 70.9 percent of redeterminations were completed through the passive ex parte process, resulting in almost 1.5 million individuals that were passively renewed. The remaining renewals, approximately 600,000, were processed manually by CDJFS caseworkers. The graph below displays the percentage of renewals processed passively and manually over the past four CYs. Notably, CY 2022 was during the COVID-19 Continuous Enrollment provision and CY 2023 was when the unwinding process began.

CY 2022-2025 Manual vs Passive Ex Parte Renewals



Source: ODM Renewal Data

Note: CY 2022 only includes half a year of data.

As displayed in the graph on the previous page, the passive ex parte renewal rate has increased slightly from CY 2022 to CY 2025, including a significant dip in CY 2023 and subsequent increase in CY 2024. However, counties indicated that the passive ex parte renewal rates in recent years are lower than they have been historically, which has contributed to increased workloads and made it more difficult for counties to hit timeliness requirements for incentive funding. Reductions in passive ex parte renewals or the passive ex parte renewal rate require CDJFS agencies to process more manual renewals.

Almost half of the CDJFS agencies we interviewed indicated that passive ex parte renewal does not always function accurately, specifically mentioning that individuals go through the passive ex parte renewal process for years, do not fall out of the passive ex parte renewal process when they should, and are far over income when they do fall out. Additionally, multiple counties stated that CDJFS agencies are unable to stop passive ex parte renewal for individuals or discontinue passively renewed individuals that caseworkers believe may no longer be eligible. A frequently cited example of this is individuals that the county receives returned mail for, meaning that they have moved and have not updated their address. These individuals may have moved within the state and may still be eligible for Ohio Medicaid, but the inability to stop passive ex parte renewal for these individuals makes it impossible for counties to reassess their eligibility, identify if they have moved out of state, and discontinue them if necessary. If these individuals went through the manual renewal process, the county would be able to discontinue them for non-response. ODM indicated that caseworkers should be able to process this non-response as a change to an individual's eligibility, but counties did not seem to be aware of this. Finally, a few counties indicated that passively renewed cases are counted against the county in quality control reviews, even though the county does not touch these cases and has no information on the determinations made. Giving caseworkers a way to flag cases to fall out of the passive ex parte renewal process or enhancing training around passive ex parte renewal processes could improve the passive ex parte renewal process, or the CDJFS agency perception of these cases.

The passive ex parte renewal of individuals who are potentially ineligible is problematic for several reasons, including the capitation payments that the State continues to pay to MCOs on their behalf. The majority of Ohio's Medicaid recipients are enrolled in a managed care plan. As described in the [Background](#), the State pays MCOs a monthly premium for each enrollee called a capitation payment. In turn, the MCOs pay for all of the covered healthcare services required by their enrollees. If passive ex parte renewal is occurring inaccurately, the State is continuing to pay for capitation payments on the behalf of individuals who may not be eligible for Ohio Medicaid coverage and may not be using Medicaid services at all. However, actuaries do consider service utilization when determining managed care capitation rates. Individuals enrolled in the FFS model may also be passively renewed incorrectly. These recipients are able to receive services, which the State is obligated to pay for, despite the fact that they may not

actually be eligible for Medicaid. Finally, the passive ex parte renewal of potentially ineligible individuals also increases the Medicaid caseload, which contributes to increased administrative expenses at both the state and county level. All of these issues represent a waste of taxpayer dollars.

As discussed earlier, having a passive ex parte renewal process is important for reducing application processing times, reducing CDJFS workloads in some cases, and reducing rates of procedural disenrollment. However, improper passive ex parte renewals also come at a cost to taxpayers. From our discussions with CDJFS agencies and review of the Ohio Benefits system, it is not clear if passive ex parte renewal inaccuracies are due to policy issues, system errors, or a mistranslation of policy into the system. ODM should consider reviewing the passive ex parte renewal process to identify the extent of these issues, the root cause of the issues, and make improvements accordingly to reduce potential opportunities for fraud, waste, and abuse.

Stakeholder Engagement

Throughout the course of our audit, we observed instances of insufficient stakeholder engagement across the Department. Stakeholder engagement is the intentional and organized process of seeking out the input of interested and affected parties and allowing this input to have some level of influence over the decision-making process. This process enables the government to incorporate the concerns, needs, and values of the public and other stakeholders into programs, policies, and decisions.

Stakeholder engagement is important for a governmental entity to ensure it is meeting the needs of the population it exists to serve. This is particularly relevant to public benefit programs, which exist solely to provide assistance to vulnerable populations. Any decisions or changes made to these programs must consider the needs and priorities of the populations receiving the services. Additionally, effective stakeholder engagement can strengthen agency decision-making and program development by utilizing different perspectives to identify and address issues and concerns early in the planning process, rather than during implementation. This dialogue can also help build public support for the government's decisions or programs, which promotes shared implementation and increased compliance.

Given the size and impact of the Medicaid program in Ohio, there are a multitude of stakeholders that ODM must consider when making decisions, creating policy, developing new programs, or evaluating the efficacy of existing programs. These stakeholders include, but are not limited to, the following.

- Medicaid recipients;
- Caretakers and families of Medicaid recipients;
- Healthcare providers and pharmacies;
- Managed care entities;
- Centers for Medicare & Medicaid Services (CMS);
- State agencies involved in Medicaid administration;
- County Departments of Job and Family Services;
- Area Agencies on Aging;
- Local Health Departments;
- County Boards of Developmental Disabilities;
- County Alcohol, Drug, and Mental Health Boards;
- School Districts;
- Third-party vendors;
- The Ohio General Assembly and,
- Ohio taxpayers.

The following recommendation describes instances in which we observed insufficient stakeholder engagement with these groups and suggestions for improvement.

Recommendation 9: Develop and Utilize a Stakeholder Engagement Plan

During our audit, we observed a significant variation in the use and efficacy of stakeholder engagement efforts across the Department. This includes not engaging with key stakeholders during procurement processes, failing to successfully engage with partner agencies conducting eligibility application processing, and not publishing critical data and narratives that would inform public understanding of the program. Additionally, ODM does not have public guidance for engaging in the rulemaking process posted in the Register of Ohio, which is in violation of ORC § 119.0311. ODM also lacked proper stakeholder identification. This resulted in limited public engagement for the one rule change we reviewed. This lack of standardized stakeholder engagement across Department can be attributed to the absence of any overarching operational plans and stakeholder-focused leadership. ODM should develop and utilize a stakeholder engagement plan to standardize and improve stakeholder engagement efforts throughout the Department.

Impact

Ohio's Medicaid program provides health insurance coverage to over 3 million Ohioans and utilizes over \$40 billion of state and federal resources each year. To facilitate this, a multitude of governmental and private entities are involved in the administration of the program and delivery of healthcare services. Given the size of the vulnerable population relying on Medicaid for their healthcare, the significant financial impact of the program, and the number of entities involved with the delivery of the Medicaid program, effective stakeholder engagement is critical.

When done effectively, stakeholder engagement allows a government organization to understand and utilize stakeholder perspectives to identify issues and concerns early and develop solutions that reflect public interests. Engaging with the entities involved in the delivery of the Medicaid program and the individuals receiving Medicaid services will enable ODM to identify the interests and needs of providers, administrators, and beneficiaries and improve program administration and service delivery accordingly. Identifying these stakeholder concerns and developing solutions early in the planning process, rather than after a policy or program has been implemented, can save the Department time and money. Finally, working with a variety of stakeholders when making significant financial decisions, and then providing enhanced information about the program's expenditures to the public will allow for improved utilization of Ohio's resources and greater transparency and public trust in this \$40 billion program.

Methodology

While stakeholder engagement was not included in our initial audit objectives, we observed a significant variation in stakeholder engagement efforts across the Department as we conducted our audit analyses. As a result of these observations, we obtained best practices for stakeholder engagement in state and local governments and compared ODM's practices to them. Additionally, we conducted additional research to learn more about ODM's practices for encouraging public participation in the rule making process.

Analysis

On the Department's website, ODM indicates that it achieves its healthcare mission with the support and collaboration of stakeholder partners. Specifically, ODM names state health and human services agencies, associations, advocacy groups, and individuals as its stakeholders, and states that these stakeholders provide feedback for the Department's continuous improvement. However, ODM does not have a publicly available stakeholder engagement plan and did not provide one when asked for any overarching operational plans that the Department has in place. As a result, stakeholder engagement efforts vary throughout ODM, similarly to the strategic planning and program evaluation efforts discussed in [Recommendation 1](#).

The National Performance Management Advisory Commission's (NPMAC) *A Performance Management Framework for State and Local Government* (2010) describes the importance of considering stakeholder needs and expectations when setting performance objectives and targets, which are then translated into programs, services, and activities through an operational plan. The following are instances of insufficient stakeholder engagement that we observed during our audit.

Enrollment & Financial Forecasting

As discussed in [Recommendation 2](#), the Department's forecasting process for Medicaid enrollment and expenditures is robust and largely aligned with best practices, particularly in engaging stakeholders in its development, but it is not completely transparent. While the forecast itself is publicly available, it is not accompanied by the underlying assumptions or forecast narrative, making it difficult for the public to comprehensively and effectively understand the causes and implications of the forecasted values. According to NPMAC, the principle of transparency means that information is not only easy to access, but also that it is complete, well organized, easy to use, and easy to understand. The lack of forecast assumptions and narrative makes the publicly available forecasting information incomplete, difficult to use, and difficult to understand. This limits the public's ability to engage in the forecasting process and understand Medicaid spending overall. NPMAC further indicates that making performance information transparent can encourage dialogue on how to improve

performance, resource management, policy making, and public participation in government. Improving the transparency of the Department's forecasting information can therefore improve the engagement of stakeholders, specifically the public, in understanding the Medicaid program. As a result, key stakeholders may have more trust in the program and related expenditures.

Contract Management

As discussed in [Recommendation 3](#), the Department's contract procurement processes had varying levels of stakeholder input. For the procurement of the Provider Network Management module contract, ODM did not seek input from healthcare providers or managed care plans. As a self-service portal for providers and a centralized provider credentialing system for managed care plans, these two groups would be the primary users of the system. Without seeking input from these stakeholders during the procurement process, the Department did not have a comprehensive understanding of what providers and managed care plans needed from the future system or what they valued in the existing system. As a result, we heard many complaints about the system from providers, as well as from County Departments of Job and Family Services (CDJFS agencies), who interact with providers and use the system themselves.

NPMAC describes communication as a critical component of any change effort, specifically indicating that a good communication process does not solely consist of providing information, but also inviting feedback and questions. While ODM provided updates on the procurement of the Provider Network Management module to the Medicaid Advisory Committee and stakeholders, this communication was not conducted early in the procurement process and did not request feedback from an appropriate amount of stakeholders.

Some of the Department's contract procurement practices did adequately engage stakeholders and incorporate their feedback. In the procurement process for the Managed Care agreements and the Single Pharmacy Benefit Manager contract, ODM identified relevant stakeholders and utilized listening sessions, focus groups, and requests for information to gather stakeholder feedback. This variation in stakeholder engagement efforts between various procurement processes points to a need for an overarching stakeholder engagement framework at the Department.

Provider Claim Payments

As discussed in [Recommendation 4](#), ODM does not publish current, comprehensive data on claim payment timeliness. Without having this data publicly available, the Department was not able to provide evidence to disprove provider concerns regarding delayed claim payments. NPMAC outlines the importance of the effective communication of performance data,

specifically indicating that stakeholders must have access to and understand the performance data to ensure that they are informed and engaged in their government. Further, stakeholder understanding of performance data can spark discussion and debate on how to improve outcomes.

County Oversight

As discussed in the [County Oversight](#) section, CDJFS agencies are responsible for processing Medicaid applications and renewals, determining eligibility, and enrolling eligible individuals. Due to this significant responsibility, CDJFS agencies are key stakeholders in many aspects of Medicaid administration. During our interviews with CDJFS agencies, multiple counties indicated that they do not feel that ODM consults them or listens to their concerns. Further, over half of the counties we spoke to expressed that there is a lack of communication from ODM ahead of policy or system changes, which can make it difficult to implement these changes in a timely manner. This county feedback suggests that ODM is lacking in both communication and engagement, as differentiated by the National Association of Medicaid Directors (NAMD). NAMD emphasizing the difference between communication and engagement. Communication is a one-way provision of information, while engagement is a two-way conversation where stakeholders can provide feedback and engage in joint problem solving.

As a part of its county oversight efforts, ODM has a County Engagement Unit that is responsible for providing guidance and technical assistance to CDJFS agencies. As a part of this responsibility, the County Engagement Unit has five county engagement liaisons, each of which serves as the primary point of contact for a geographic region of 16 to 19 CDJFS agencies. These liaisons are required to meet with each of their counties at least once a quarter, but report typically speaking to their counties weekly or daily.

The majority of the CDJFS agencies we interviewed have a positive and productive relationship with their county engagement liaison. Positive feedback provided by these counties includes that their liaisons are quick to respond, very helpful and knowledgeable, and able to track down answers to county questions and provide beneficial resources. However, a few counties felt neutral to negative about their county engagement liaison, indicating that their liaison was slow to respond or not communicating with them as frequently as they would like.

Due to the variation in county feedback regarding experiences with county liaisons, we requested any data that ODM collects regarding county engagement liaison activities or communications with counties. The Department provided two quarterly summaries created by the county liaisons, which outlined the common pain points, application processing issues, and other insights that counties have communicated to them over the quarter. However, these

reports did not include all counties or county engagement regions and did not contain information on the frequency of communications. NPMAC indicates that the collection and utilization of adequate performance data is essential to effective performance management. The information collected in the quarterly summaries is incomplete, and therefore inadequate to assist ODM in effectively managing the performance of its county engagement liaisons. If these liaisons are providing satisfactory services to the counties, they could also be used to improve the Department's stakeholder engagement with counties. Additionally, without collecting comprehensive data from liaison communications to identify systemic issues across counties, the Department's ability to develop future training efforts or process and system improvements to address the issues is limited.

Rule Making Process

State agencies have the authority to adopt administrative rules regarding an agency's general policy, operating procedures, assignment of responsibilities, and code of ethics. When an agency proposes a rule, it is required to publish a public notice of its intention and hold a public hearing on the proposed rule. ORC § 119.0311 requires state agencies to publish guidelines for public engagement with their rule-making process in the Register of Ohio.

ODM does not have rule-making guidelines posted in the Register of Ohio. To understand the Department's processes for public engagement during the rule-making process without these guidelines, we reviewed the public engagement process for one of ODM's rules that is being amended.

Ohio's Common Sense Initiative (CSI) reviews state agency rules to identify those that may pose obstacles to Ohio businesses. As part of this process, there are public filings of rule changes that could impact businesses.

One of the recent CSI filings during the audit period was regarding changes to Rule 5160-1-17.12: Qualified entity requirements and responsibilities for determining presumptive eligibility. In Ohio, there are Qualified Entities that can make presumptive eligibility determinations for Medicaid. After presumptive eligibility expires, recipients must submit an application for Medicaid to continue receiving benefits, which Qualified Entities are required to remind individuals of and assist them with if requested. During our conversations with CDJFS agencies, several noted difficulties with Qualified Entities, including a lack of applications for continuing eligibility for individuals that Qualified Entities determined to be presumptively eligible, duplicative applications created by Qualified Entities, and inaccurate presumptive eligibility determinations made by Qualified Entities. In this rule change, ODM will require all Qualified Entities to coordinate that all presumptively eligible recipients submit a full application, among other changes. Since the CDJFS agencies must process the applications for

Medicaid after presumptive eligibility expires, this will result in an increased workload. Despite this, ODM only identified CDJFS agencies as a stakeholder because they are Qualified Entities and noted no other impacts to the agencies. Finally, ODM’s public engagement attempt was posting the rule change on its website for seven days, which resulted in one comment.

Required Advisory Groups

CFR Title 42 § 431.12, effective July 2024, requires states to establish a public Medicaid Advisory Committee (MAC) with a dedicated Beneficiary Advisory Council (BAC) by July 2025. The purpose of these groups is to give former Medicaid beneficiaries, their family members, and caregivers an opportunity to advise the state Medicaid agency on policy development and other matters related to Medicaid administration. ODM published its first annual MAC report in August 2026. This report included summaries of activities over the past year. While this report is required to include recommendations from the BAC and the state’s response to recommendations, Ohio’s report noted that no formal recommendations were made since the committee was just formed. As these groups mature in their operation, ODM could further utilize them as part of their stakeholder engagement processes.

Conclusion

ODM should develop and implement a stakeholder engagement framework to standardize and improve stakeholder engagement efforts throughout the Department. Currently, stakeholder engagement practices vary significantly across different divisions within ODM, with some adequately engaging stakeholders and reaping the benefits, while others either do not engage stakeholders at all or do not do so effectively. Adopting a Department-wide stakeholder engagement framework would require all divisions to follow the same standards, and therefore gain the benefits of effective stakeholder engagement in decision-making and program development.

Client Response Letter

Audit standards and AOS policy allow clients to provide a written response to an audit. The letter on the following pages is the Department's official statement in regards to this performance audit. Throughout the audit process, staff met with Department officials to ensure substantial agreement on the factual information presented in the report. When the Department disagreed with information contained in the report, and provided supporting documentation, revisions were made to the audit report.



September 24, 2026

Keith Faber, Auditor of State of Ohio
Attn: Virginia Frazier, Performance Audit Manager
Medicaid/Contract Audit Section
65 East State Street, 14th Floor
Columbus, Ohio 43215

Dear Auditor Faber:

Thank you for the opportunity to respond to the Draft Report issued by the Auditor of State (AOS or Auditor) regarding the Ohio Department of Medicaid (ODM) Next Generation and Medicaid Enterprise System (MES) Performance Audit.

Over the last several years, ODM has been building and improving its Next Generation and MES to improve the overall performance of the agency and the services provided to Ohio Medicaid enrollees and to meet new federal mandates. ODM has worked to enhance and upgrade the Ohio Medicaid processes and systems to ensure that the system is focused on providing the best care and services to the individual. ODM provides the following responses to the AOS recommendations and comments for additional context on these topics.

Strategic Planning and Management

Recommendation 1: ODM does not have organization-wide strategic, operational, or staffing plans in place to articulate the Department's goals and identify the activities and programs in place to achieve these goals. Strategic planning and program evaluation efforts for ODM's major programs are fragmented across multiple offices, with significant variation in the efficacy and intentionality of practices utilized by these offices. As a result, the divisions and offices within ODM are not operationally aligned, have institutional knowledge gaps, functional silos, and information retention issues. This makes it difficult for ODM to properly evaluate the effectiveness of programs and ensure that the program is effective and efficient. ODM should align strategic plans and program evaluation efforts throughout the Department with operational strategies. This will improve the overall operation of the Department as well as the delivery and efficiency of Medicaid programs.

ODM Response: ODM acknowledges and agrees with the importance of developing a formal strategic plan to identify, measure, and report the furtherance of its goals and

activities. Since the initial announcement of the Next Generation Medicaid program, ODM has prioritized the development and implementation of various components that now underpin our major programs. This was accomplished through a series of competitive procurements to support ODM's traditional managed care program, the single pharmacy benefit manager, the OhioRISE plan for children with complex needs, the Next Gen MyCare plans to focus on members' particular needs, and several systems vendors to support initiatives including the electronic data interchange, the fiscal intermediary and centralized credentialing to improve provider efficiencies.

These components were strategically designed to support ODM's mission—to establish a program “focused on the individual” to improve wellness and health outcomes, emphasize personalized care for Medicaid enrollees, improve care for children and adults with complex needs, support providers in better patient care, and improve programmatic transparency and accountability. In sum, despite the absence of a formal strategic planning document, over more than six years, ODM has successfully established the necessary programmatic improvements and operational and systems supports with the collaborative partnership of no less than 15 managed care entities and information technology vendors.

With that foundational structure firmly in place, implementing a formalized strategic plan and operational and staffing plans are a natural next step in ensuring the continued success of ODM's Next Generation program. This would allow ODM the ability to pull together its resources and best practices across the Department, while also identifying potential opportunities for measurement, refinement and improvement.

Recommendation 2: ODM creates a biennial Medicaid Caseload and Expenditure Forecast Report in collaboration with the Office of Budget and Management that projects two years of Medicaid enrollment and expenditures. This forecast is used in the development of Ohio's biennial budget to ensure that an appropriate amount of funding is allocated for the provision of healthcare services to Medicaid recipients. The Department considers a variety of factors in its forecast, including recipient characteristics, economic indicators, and population trends. ODM's forecasting process is largely aligned with best practices identified by the GFOA, except for ensuring the public transparency of forecast materials. While the Medicaid Caseload and Expenditure Forecast Report is publicly available on the Office of Budget and Management's website, ODM does not publish this report, instead producing monthly Budget Variance Reports comparing forecasted values to actual enrollment and expenditures. Additionally, none of these reports are accompanied by detailed forecast assumptions. The Department should enhance the transparency of its enrollment and financial forecasting process by publishing the forecast report and an accompanying public narrative in a central location.

ODM Response: As noted in the report, ODM develops and publicly shares numerous forecast-related documents that explain and report on both the development of the forecast and its overall performance. Historically, the Department has provided a Services Forecast Report alongside the Executive submission. Due to the inclusion of the Caseload and Expenditure report in law, also to be provided alongside the Executive budget, ODM merged concepts and only produced the newly required Caseload and Expenditure Report in law. This new report maintained much of the same forecasting information including Spending Summary, Caseload, PMPM, Policy Proposals, etc. This report is included as part of the Executive Budget submission package outlined on OBM's website, however, ODM consistently seeks ways to increase transparency and will evaluate additional changes to forecast documentation and associated location.

Recommendation 3: Ohio's Medicaid program is facilitated by several third-party vendors that the Department contracts with for various functions, including information systems and managed care plans. These contracts represent a large portion of ODM's total spending. In SFY 2025, the Department spent 41.4 percent (\$253.4M) of its administrative expenditures on contracted services and 66.5 percent (\$27.9B) of its service expenditures on managed care, which is provided by contracted entities. We reviewed six of ODM's contracts that are critical to the "Next Generation" initiative and modularization of OMES. Half of these contracts had significant discrepancies between the planned costs and actual spending on the contracted service, amounting to over 145 million dollars in unplanned expenses. When comparing ODM's contract procurement and management efforts to best practices, we identified many opportunities for improvement. These opportunities varied from being unique to individual contracts we reviewed to being consistent across all contracts reviewed. The most significant deficiencies we observed were related to strategic planning, vendor references, stakeholder communication and engagement, training of contract managers, and documentation of review processes. ODM should utilize best practices to improve its contract management practices, which may result in fewer unplanned expenses, enhanced service delivery, and more comprehensive stakeholder engagement.

ODM Response: In 2016, the Centers for Medicare and Medicaid Services (CMS) required states to modernize their Medicaid systems from single, monolithic structures to modular Medicaid Enterprise Systems (MES). Each module had to be procured separately. For Ohio's Single Pharmacy Benefit Manager (SPBM) module, the Ohio Legislature required the Ohio Department of Medicaid (ODM) to use a third-party vendor.

ODM followed all state and federal procurement rules, including Ohio Revised Code Chapter 125, DAS policies, and federal requirements under 2 CFR 200 Subpart D. ODM

worked with internal program stakeholders and sought public input through a Request for Information. Feedback from end users continues to inform future procurements. Cost increases occurred because modularization was new for states, and many needs could not be anticipated before development. Ohio was an early adopter, limiting available lessons from other states. As modules were implemented in phases, Ohio-specific system needs emerged only after work began.

Some added costs improved Medicaid program management and overall fiscal health for the Department. For example, ODM expanded provider credentialing, a process to verify that providers meet required qualifications, within the PNM module to centralize work previously done by managed care plans. While this was a slight increase in state cost to operate a centralized PNM model, approximately \$130M was removed from the managed care rates, demonstrating a significant savings to the state. Costs also increased due to the creation of the Integrated Help Desk (IHD), which provides necessary coordination support across multiple modules. Additionally, to ensure that each module vendor complies with contract requirements, contracts include Service Level Agreements with potential financial penalties for poor performance.

ODM and CMS established “pool hour” amendments for several contracts to cover unforeseen work outside normal maintenance and operation. These hours are tightly controlled, and costs are only incurred with ODM approval.

Finally, all module contracts and amendments require CMS approval before costs can be added. Each module has met federal statutory and regulatory requirements to receive CMS certification.

Recommendation 4: Healthcare providers are paid for services provided to Medicaid recipients through claims submitted to ODM. There are federal and state requirements that set timeframes in which claims must be processed and paid. The federal requirements are set through statute, while the state requirements are set through contracts with MCOs and the contractor for the Fiscal Intermediary, the system that processes fee-for-service claim payments. While our review of claim payment timeliness was limited in scope due to data availability, it indicated that the Department has been largely compliant with federal statutory requirements, while contracted entities have varying levels of compliance with the more stringent state contractual requirements. Additionally, we were unable to identify any systemic changes in the timeliness of claim payments over the past five years.

The claim payment timeliness metrics currently collected, aggregated, and monitored by ODM are categorized into broad timeframes. These broadly categorized metrics do not allow for in-depth tracking of changes to claim payment timeliness over time or an adequate evaluation of contractor performance because the vast majority of claims are paid within the shortest timeframe measured. The Department should collect more detailed claim payment metrics and utilize it to effectively monitor and manage

contractor performance over time, adjust contractual timeliness benchmarks, and improve the public transparency of the claim payment process.

ODM Response:

ODM agrees on the importance of detailed claims payment metrics and its relation to efficient and accurate payments for services. ODM has and will continue work to improve the accuracy and efficiency of claims payments.

County Oversight

Recommendation 5: In Ohio, public assistance programs are overseen by multiple state agencies, while the day-to-day processes relating to applications and eligibility determinations are the responsibility of County Departments of Job and Family Services (CDJFS agencies). Individuals who receive public assistance often qualify for and receive benefits from multiple programs; however, each state agency that oversees the programs has its own procedures and requirements for the application and renewal process. This can result in the CDJFS requiring multiple documents for the same basic information, such as income verification or residency. ODM should work with ODJFS and DCY to improve collaboration regarding the oversight of public assistance programs in Ohio. This could include aligning policies and procedures where possible and collaborating on training and guidance to reduce duplication of efforts.

ODM Response: ODM concurs regarding the importance of alignment and coordination across different public assistance programs. Policy leaders have actively explored the alignment and streamlining of eligibility across public assistance programs for decades, gaining major momentum following the 1996 welfare reform and continuing after that. More recent experience in alignment occurred during unwinding where ODM utilized a waiver to enable counties to renew Medicaid eligibility for Medicaid members who were also SNAP participants with gross income at or below the Medicaid MAGI income level. However, that waiver was time limited to unwinding and has since lapsed. ODM requested CMS to make SNAP a standalone Medicaid eligibility category. CMS stated that MAGI income eligibility could not be waived.

Medicaid, TANF, and SNAP have separate distinct eligibility criteria, income thresholds, exemptions, and verification requirements. While Ohio has streamlined certain verification processes that can be applied across multiple programs, federal regulations ultimately determine which verification sources and document types are permissible for each program. Income verification, such as current pay stubs, can be used across all programs within the Ohio Benefits Eligibility System. Additionally, almost all current reliable verification can be used across all programs.

ODM, JFS, and DCY are already closely involved in efforts to align where possible, including the enhancement of the EDMS in 2022 to allow cross-program visibility of documents such as income records and birth certificates. ODM, ODJFS and DCY began bi-monthly collaboration meetings in September 2026. These meetings are intended to work toward aligning operational work, training efforts, and system changes.

Recommendation 6: Ohio Benefits is Ohio's eligibility and enrollment system for Medicaid and other public benefit programs. CDJFS caseworkers utilize this system to process applications and renewals, verify information, and make eligibility determinations and redeterminations. All of the counties we interviewed reported experiencing issues with Ohio Benefits. Over 20 common issues were pervasive among the respondents related to general functionality, determination accuracy, alerts, automation, and the self-service portal. ODM should work with ODJFS, which is responsible for managing Ohio Benefits, and CDJFS agencies, who are the primary users of the system, to identify and develop solutions for issues with Ohio Benefits. Doing so will improve application timeliness, determination accuracy, and the experiences of caseworkers and beneficiaries.

ODM Response: The income eligibility verification system (IEVS) is required by federal statute in the Social Security Act for both ODM and ODJFS public assistance programs. The number of alerts generated is directly correlated to the number of people receiving Medicaid/SNAP/TANF and other public assistance benefits in Ohio. The Ohio Benefits system is configured to generate alerts to push important eligibility details to county caseworkers for review and action. Anytime a new program is added to the Ohio Benefits system, or changes are made to a program or process, new alerts are generated. ODM and our partners continue to search for ways to improve the number and nature of alerts generated. ODM meets with ODJFS every other month to review IEVS-specific topics and because of the joint agency collaboration, nine enhancements were completed in 2025 to reduce alert generation.

The agencies collectively are evaluating the full scope of potential IEVS alert reduction efforts for the next year. The following updates which have the potential for additional reduction of IEVS alerts:

- Release 5.5 Automation of Verified Upon Receipt Interfaces – alerts will be suppressed when the system automatically completes reconciliation of SDX information received. Completed 6/12/26
- Release 5.6 IRS Unearned Income Updates – increases the income threshold for alert generation. Completed 8/22/26

The state agencies have a process in place for CDJFS agencies to submit system enhancement requests (for all systems) and to report system issues. The vendor works

with the CDJFS to resolve tickets directly and county feedback is provided at our all-agency meetings where system issues are discussed. As they are the end users, we provide frequent reminders of the opportunities to provide input.

Recommendation 7: Medicaid applications are required by law to be processed within a certain number of days. Ohio has historically failed to meet this requirement and falls below the national average for processing timelines. While this information shows an opportunity and need for improvement, ODM does not currently utilize appropriate county-level data that would allow it to comprehensively evaluate the performance of CDJFS agencies or identify the root causes of timeliness issues. ODM should enhance the collection of application processing timeliness data and use this information to identify issues delaying application processing and develop process improvements or other solutions accordingly. This should be done in conjunction with CDJFS agencies to ensure that solutions are appropriate and feasible.

ODM Response: ODM monitors timeliness metrics at the statewide level. The Department provided the auditors with the timeliness metrics that we monitor for counties, which are based on the number of applications and redeterminations that are currently backlogged. The metrics utilized on the ODM public county activities dashboard measures the proportion of open applications/redeterminations that are specifically past due. ODM incentivizes counties to actively work on addressing these aged applications rather than allowing them to be ignored in favor of solely processing new or easy applications.

Recommendation 8: As the state agency overseeing Medicaid in Ohio, ODM is responsible for ensuring the accuracy of Medicaid eligibility determinations and redeterminations, which are primarily made by CDJFS agencies. Once every three years, the Department conducts 800 case reviews over a 12-month period in compliance with the minimum federal standards for the Medicaid Eligibility Quality Control (MEQC) program. This represents less than one percent of the total number of applications and renewals processed in Ohio. In MEQC off-years, ODM conducts additional, less standardized case reviews. The limited and inconsistent data obtained through current quality control efforts cannot be used to confirm the accuracy or effectiveness of CDJFS operations across the state. Further, this information cannot be reliably used for year-over-year comparisons or performance management efforts. In addition, ODM does not effectively communicate the results of comprehensive quality control case reviews to the counties, which limits the ability of CDJFS agencies to use this information to improve internal operations or performance management. ODM should expand, standardize, and communicate quality control efforts to improve the accuracy of eligibility determinations and redeterminations throughout the state.

ODM Response: ODM acknowledges and agrees with the importance of ensuring that Medicaid recipients meet eligibility requirements and appreciates the recommendation to expand and standardize the eligibility review process. ODM will review options for increased standardized case reviews. MEQC plans to begin sending monthly statistics to impacted counties, in addition to posting results on the dashboard. MEQC will continue to issue certificates to counties and individual case workers with correct case reviews. Additionally, MEQC will continue to maintain and foster collaboration with the CDJFS agencies, ODM Eligibility Operations, Eligibility Policy, and Systems to ensure that all issues are addressed and corrected timely.

Issue for Further Study 1: The State is required to conduct eligibility redeterminations for all Medicaid recipients each year and renew coverage for recipients who are still eligible. These renewals can be completed manually, in which recipients fill out a renewal form and CDJFS caseworkers process the renewal, or passively, in which the Ohio Benefits system processes the renewal automatically using electronic data sources. Having a passive renewal process is important for reducing application processing times, reducing CDJFS workloads in some cases, and reducing rates of procedural disenrollment. However, improper passive renewals also come at a cost to taxpayers. Several CDJFS agencies we spoke to expressed concerns that individuals they know are not eligible for Medicaid have been passively renewed without any way for the CDJFS to discontinue their enrollment. In some cases, CDJFS agencies discussed how the recipients themselves were not aware they were still enrolled in Medicaid. Given Ohio's use of managed care, this means Ohio may be paying capitation rates for individuals who are not eligible for Medicaid.

ODM Response: ODM has long recognized the importance of ex parte reviews and Medicaid eligibility accuracy. 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 Public Health Emergency 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. In the year prior to commencement of unwinding, ODM MEQC conducted a review every month of cases approved through ex parte to evaluate for accuracy. The result of those examinations showed a very high degree of accuracy.

CDJFS workers are always able to process a change in circumstance to discontinue either ongoing or prior months of eligibility. If a county worker believes that there has been a change in circumstances in a Medicaid case – e.g. a change of address - the county worker is required to reevaluate the case without regard to when ex parte is scheduled to run or has run. *OAC 5160:1-2-01.*

Stakeholder Engagement

Recommendation 9: During our audit, we observed a significant variation in the use and efficacy of stakeholder engagement efforts across the Department. This includes not engaging with key stakeholders during procurement processes, failing to successfully engage with partner agencies conducting eligibility application processing, and not publishing critical data and narratives that would inform public understanding of the program. Additionally, ODM does not have public guidance for engaging in the rulemaking process posted in the Register of Ohio, which is in violation of ORC § 119.0311. This, and a lack of successfully identifying proper stakeholders, resulted in limited public engagement for the one rule change we reviewed. This lack of standardized stakeholder engagement across the Department can be attributed to the absence of any overarching operational plans and stakeholder-focused leadership. ODM should develop and utilize a stakeholder engagement plan to standardize and improve stakeholder engagement efforts throughout the Department.

ODM Response: As provided in the AOS Questionnaire responses submitted in April 2026, ODM subject matter experts who regularly work with stakeholders in each program area were involved in the procurement process in order to write RFP requirements to address not only the needs of the newly required modular system, but also the end users and stakeholders. Specifically, for the Next Generation Managed Care procurement, ODM solicited feedback and gathered information through 17 listening sessions co-sponsored by community-based organizations in locations around the State. Participants included Medicaid members, community partners, providers, and advocates and interviews were conducted with potential applicants (MCOs) and support vendors (e.g., IT vendors), provider associations, and other stakeholder groups. ODM also released two Requests for Information (RFI) to gather more information. The first RFI gathered information from Medicaid members and providers. The second RFI gathered feedback from potential applicants and support vendors. ODM procurement leads also publicly presented on the progress of the design and procurement process to the Medical Care Advisory Committee in February 2020.

Additionally, for the Single Pharmacy Benefit Manager procurement, ODM issued an RFI to gather information to establish the eligibility criteria and requirements needed to have a third-party administrator serve as Ohio's pharmacy benefit manager (PBM). For example, ODM requested feedback on fourteen PBM functions, information on current challenges in the pharmacy space, and information on how pharmacy payments are handled. ODM received information from vendors that provide pharmacy benefit services and solutions and Medicaid pricing information; pharmacies; managed care plans; and other interested parties (including the Ohio Pharmacists Association and The Ohio State University's College of Pharmacy) through

the RFI. ODM used this information to draft the RFP required by the legislature. ODM then invited the vendors that had submitted responses to the RFI to be interviewed by ODM staff to provide additional information on the following specific topics:

- State and market pharmacy trends;
- PBM structural concepts;
- PBM-industry information relevant to the procurement of a single pharmacy benefit manager; and
- Clarification of and elaboration on information provided in responses to Requests for Information that would assist ODM in structuring and preparing for its procurement of a single pharmacy benefit manager.

ODM staff provided briefings and updates to the Medicaid Advisory Committee (MAC), including a presentation to MAC on the SPBM at a public standing committee meeting.

Additionally, ODM acknowledges that we have not met the requirements of ORC § 119.0311 and appreciates the Auditors for bringing this to the Department's attention. ODM will take immediate steps to remediate this oversight. However, ODM has other supports in place to encourage and facilitate stakeholder engagement with the Department. ODM maintains a robust and well-established engagement process for rulemaking, which includes posting draft rules on our website for public comment, occasional targeted distributions of preclearance draft rule packages for development feedback and utilizing various listservs to broaden external stakeholder participation during the clearance and post-clearance process. Further, ODM does maintain information on our website dedicated to keeping stakeholders informed of the rulemaking process and rules moving through it. This resource encourages active involvement and allows interested parties to sign up for rule notifications, so they are alerted when draft rules are posted for public comment. ODM continues to provide multiple avenues for soliciting feedback and encouraging stakeholder involvement in the rulemaking process.

ODM appreciates the Auditor of State's review and recommendations. Thank you for the opportunity to provide comments and feedback on your Exit Conference Draft Report. Please let me know if you have any questions or need additional information.

Sincerely,

A handwritten signature in blue ink that reads "Scott Partika". The signature is fluid and cursive, with the first name "Scott" and last name "Partika" clearly distinguishable.

Scott Partika, Director

Date: September 24, 2026

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Appendix A: Purpose, Methodology, Scope, and Objectives of the Audit

Performance Audit Purpose and Overview

Performance audits provide objective analysis to assist management and those charged with governance and oversight to improve program performance and operations, reduce costs, facilitate decision making by parties with responsibility to oversee or initiate corrective action, and contribute to public accountability.

Generally accepted government auditing standards (GAGAS) require that a performance audit be planned and performed so as to obtain sufficient, appropriate evidence to provide a reasonable basis for findings and conclusions based on audit objectives. Objectives are what the audit is intended to accomplish and can be thought of as questions about the program that the auditors seek to answer based on evidence obtained and assessed against criteria.

We conducted this performance audit in accordance with GAGAS. 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.

Audit Scope and Objectives

In order to provide the Department with appropriate, data driven, recommendations, the following questions were assessed within each of the agreed upon scope areas:

Summary of Objectives and Conclusions

Objective	Recommendation
Strategic Planning and Performance Evaluation	
What opportunities exist to improve the efficiency and effectiveness of the Ohio Department of Medicaid's strategic planning and performance evaluation practices?	Recommendation 1 and Recommendation 9
Program and Financial Forecasting	

What opportunities exist to improve the efficiency and effectiveness of the Ohio Department of Medicaid's program and financial forecasting practices?	Recommendation 2
County Oversight	
What opportunities exist to improve Ohio's eligibility determinations and performance outcomes?	Recommendation 5 , Recommendation 6 , Recommendation 7 , Recommendation 8 , and Issue for Further Study 1
State Contract Management	
What opportunities exist to improve the Ohio Department of Medicaid's contract monitoring processes?	Recommendation 3
Provider Claim Processing and Interactions	
What opportunities exist to improve the efficiency and effectiveness of Ohio Department of Medicaid's provider claim processing?	Recommendation 4

Although assessment of internal controls was not specifically an objective of this performance audit, internal controls were considered and evaluated when applicable to scope areas and objectives. The following internal control components and underlying principles were relevant to our audit objectives³⁸:

- Control environment
 - We assessed the Department's exercise of oversight responsibilities in regard to ensuring accurate enrollment and financial data.
 - We assessed the Department's exercise of oversight responsibilities in regard to managed care entity program goals and agreement provisions.
 - We assessed the Department's exercise of oversight responsibilities in regard to key enterprise system agreement provisions.
 - We assessed the Department's exercise of oversight responsibilities in regard to County Department of Job and Family Services eligibility determinations and renewals.
 - We assessed the Department's exercise of oversight responsibilities in regard to detecting improper data entry in system operational reports.

³⁸ We relied upon standards for internal controls obtained from *Standards for Internal Control in the Federal Government* (2014), the U.S. Government Accountability Office, report GAO-14-704G

- Risk Assessment
 - We considered the Department’s activities to assess fraud risks.
- Information and Communication
 - We considered the Department’s use of quality information in relation to its forecasting, enrollment, quality control, agreement expenditure, and claim payment timeliness data.
- Control Activities
 - We considered the Department’s compliance with applicable laws and contracts.

The internal control deficiency that were identified during the course of the audit are discussed in the corresponding recommendation.

Audit Methodology

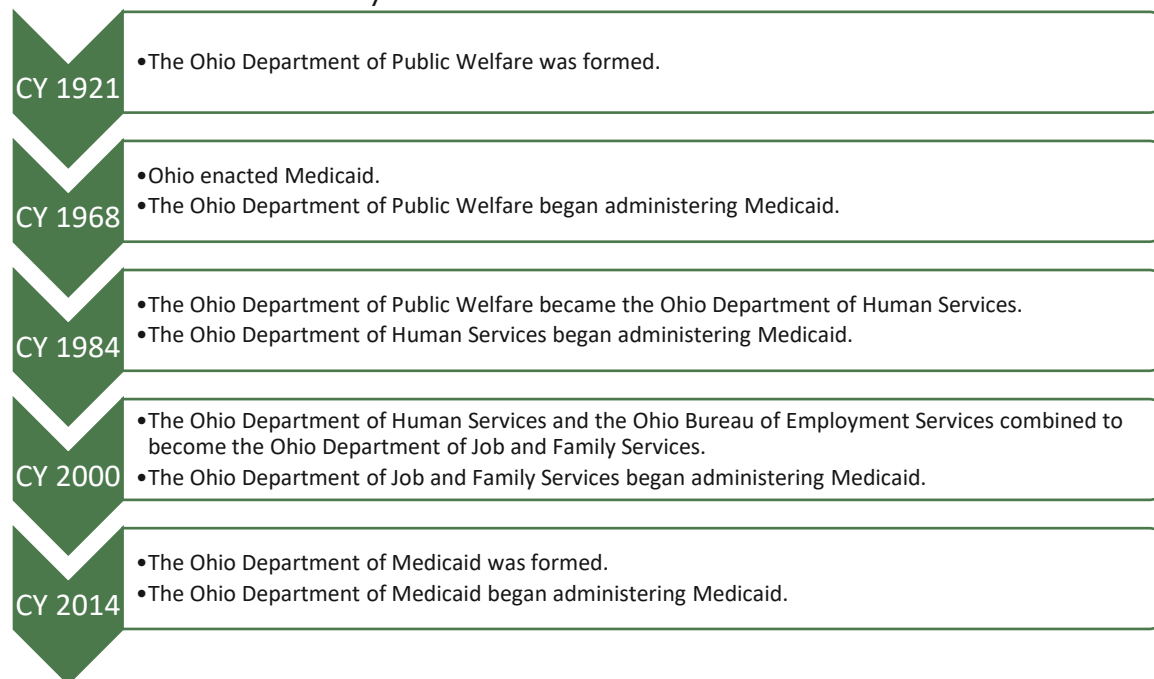
To complete this performance audit, auditors gathered data, conducted interviews with numerous individuals associated with the areas of the Department’s operations included in the audit scope, and reviewed and assessed available information. Assessments were performed using criteria from a number of sources, including:

- Industry Standards;
- Leading Practices;
- Statutes; and
- Policies and Procedures.

Appendix B: Brief History of Medicaid Administration in Ohio

In CY 1965, Title XIX of the Social Security Act was signed into law, creating Medicaid as a federal and state entitlement program to provide medical assistance for individuals and families with low incomes and resources. This first iteration of the Medicaid program was not solely based on income level. To be eligible, an individual also had to be a child, a parent or adult caretaker of a child, an older adult, or disabled. There was also a separate eligibility threshold for an individual's financial assets. Ohio enacted Medicaid in CY 1968, under the administration of the Ohio Department of Public Welfare. While the program is currently administered by the Ohio Department of Medicaid, the program has had a long history of administrative changes within the state. A brief overview of this history is shown below.

Administrative History of Medicaid in Ohio



Sources: Ohio History Connection, Health Policy Institute of Ohio, Ohio Secretary of State

In addition to administrative changes, there have also been changes to Medicaid eligibility over the program's history that impact the program's administration. The Children's Health Insurance Program (CHIP) was added to the Social Security Act in 1997, which allocated additional funding for Medicaid to provide healthcare coverage for more low-income families.

CHIP has a higher income threshold than Medicaid, thus increasing the population of children able to access healthcare through the program. States have the discretion to provide this coverage as an expansion to their existing Medicaid programs or as a separate program. Ohio chose the first option, adding CHIP benefits as an expansion to the State's Medicaid plan.

Passed in CY 2010, the Affordable Care Act expanded Medicaid eligibility to include all adults under the age of 65 that meet low-income requirements, called Group VIII. The federal reimbursement rate is higher for this group, at 90 percent for all states. However, a CY 2012 Supreme Court ruling gave states discretion in adopting this expanded eligibility. Ohio, along with 25 other states, decided to adopt the expanded eligibility in CY 2014. Since then, an additional 14 states have done the same, leaving only 10 states still operating under the original Medicaid eligibility requirements. Some of the states that have adopted expanded eligibility have implemented trigger laws that require some action at the state level dependent on change at the federal level. Ohio is one of ten states that require termination of expansion if the share of federal funding drops. State expansion status, implementation date, and trigger law status are included in the table below.

State Expansion Status

State	Medicaid Expansion Status	Implementation Date	Trigger Law In Place
Alabama	Not Adopted	N/A	N/A
Alaska	Adopted	9/1/2015	No
Arizona	Adopted	1/1/2014	Yes
Arkansas	Adopted	1/1/2014	Yes
California	Adopted	1/1/2014	No
Colorado	Adopted	1/1/2014	No
Connecticut	Adopted	1/1/2014	No
Delaware	Adopted	1/1/2014	No
Florida	Not Adopted	N/A	N/A
Georgia	Not Adopted	N/A	N/A
Hawaii	Adopted	1/1/2014	No
Idaho	Adopted	1/1/2020	Yes
Illinois	Adopted	1/1/2014	Yes
Indiana	Adopted	2/1/2015	Yes
Iowa	Adopted	1/1/2014	Yes
Kansas	Not Adopted	N/A	N/A
Kentucky	Adopted	1/1/2014	No
Louisiana	Adopted	7/1/2016	No
Maine	Adopted	1/10/2019	No
Maryland	Adopted	1/1/2014	No
Massachusetts	Adopted	1/1/2014	No
Michigan	Adopted	4/1/2014	No
Minnesota	Adopted	1/1/2014	No

Mississippi	Not Adopted	N/A	N/A
Missouri	Adopted	10/1/2021	No
Montana	Adopted	1/1/2016	Yes
Nebraska	Adopted	10/1/2020	No
Nevada	Adopted	1/1/2014	No
New Hampshire	Adopted	8/15/2014	Yes
New Jersey	Adopted	1/1/2014	No
New Mexico	Adopted	1/1/2014	Yes
New York	Adopted	1/1/2014	No
North Carolina	Adopted	12/1/2023	Yes
North Dakota	Adopted	1/1/2014	No
Ohio	Adopted	1/1/2014	Yes
Oklahoma	Adopted	7/1/2021	No
Oregon	Adopted	1/1/2014	No
Pennsylvania	Adopted	1/1/2015	No
Rhode Island	Adopted	1/1/2014	No
South Carolina	Not Adopted	N/A	N/A
South Dakota	Adopted	7/1/2023	No
Tennessee	Not Adopted	N/A	N/A
Texas	Not Adopted	N/A	N/A
Utah	Adopted	1/1/2020	Yes
Vermont	Adopted	1/1/2014	No
Virginia	Adopted	1/1/2019	Yes
Washington	Adopted	1/1/2014	No
West Virginia	Adopted	1/1/2014	No
Wisconsin	Not Adopted	N/A	N/A
Wyoming	Not Adopted	N/A	N/A

Source: KFF Status of State Action on the Medicaid Expansion Decision

Ohio's expansion status impacts the administration of the Medicaid program as well as overall spending on healthcare services for beneficiaries. Due to this, we considered expansion status in the additional nationwide financial comparisons discussed in [Appendix F](#).

Appendix C: Performance Audit Legislation

In HB 96 of the 136th General Assembly, the Ohio legislature mandated that the Ohio Auditor of State complete a performance and financial audit of the Ohio Department of Medicaid. The specific language in the bill regarding this mandate is below.

“SECTION 751.70. Not later than December 31, 2027, the Auditor of State shall conduct a performance and fiscal audit of the Department of Medicaid's next generation system. The Auditor of State shall submit a copy of the audit report to the the [sic] standing committees of the House of Representatives and the Senate that primarily consider legislation governing the Medicaid program and the Legislative Service Commission.

In conducting the audit under this section, the Auditor of State may examine any of the following components of the system:

- (A) The Provider Network Management;
- (B) The Ohio Medicaid Enterprise System;
- (C) The Ohio Resilience Through Integrated Systems and Excellence (OhioRISE) Program;
- (D) The Electronic Data Interchange;
- (E) The Medicaid state pharmacy benefit manager that was selected in accordance with section 5167.24 of the Revised Code;
- (F) Centralized Provider Credentialing;
- (G) Prior authorization requirements;
- (H) Issues with late payments to Medicaid providers;
- (I) Any other aspects of the system that the Auditor of State considers relevant.”

Appendix D: ODM Structure

As discussed in the Background, ODM employed 732.3 FTE in SFY 2025.³⁹ These employees are organized into 13 offices identified by the Department. The SFY 2025 FTE within each office, alongside an overview of office roles is given below. The office descriptions were provided by ODM and edited slightly for length and clarity.

Chief of Staff

The Chief of Staff's office employed 26.2 FTE in SFY 2025. The Chief of Staff manages the Department's Human Resources (HR) office, the External Business Relations office, and the ODM Business Services office. The sum of FTE within these offices in SFY 2025 was 19.4 FTE. The HR and Business Services teams focus primarily on ODM staff, assisting with hiring, payroll, planning, employee relations, and building security. Additionally, they work with external stakeholders as well to ensure compliance with state and federal requirements. The External Business Relations team focuses on relations with constituents.

Communications

The Communications office employed 4.7 FTE in SFY 2025. Housed under the Chief of Staff, the office manages both internal and external communications to ensure clarity, consistency, and impact. The team leads the development and distribution of press releases and public statements, employee and stakeholder newsletters, presentations and agency reports, and promotional materials. Communications staff collaborate across departments to review and refine content, ensuring it is accessible, well-structured, and aligned with agency messaging and state branding.

³⁹ FTE counts are calculated by taking the average of three points in time within SFY 2025. Individual departments' FTEs are rounded and therefore do not sum to the total FTE.

Data and Integrated Systems

The Data and Integrated Systems office employed 62.5 FTE in SFY 2025. The office performs strategic and performance analytics for the Medicaid program using dashboards to publish details about the Medicaid program. The maintenance and operation of the Ohio Medicaid Enterprise System (OMES) is managed within this office. Additionally, the office has other responsibilities related to data management including but not limited to the maintenance of the Medicaid Enterprise Data Warehouse, the Electronic Data Interchange, and MCO encounter data.

Fiscal Operations

The Fiscal Operations office employed 56.8 FTE in SFY 2025. The office is responsible for the management of financial activity for ODM. In general, the broad functions in this area include the following:

- Accounting: Oversees fiscal control and accountability for both revenue and payment management.
- Advanced Planning Documents: Manages the creation, submission and updates related to the APDs for enhanced funding related to IT projects to CMS.
- Budget: Develops and manages the ODM budget. The econometrics & forecasting area projects service costs of the program.
- Fiscal Management Planning and Rate Setting: Manages cost reports and settlements specific to sister state agencies, hospitals, Federally Qualified Health Centers/Rural Health Centers, Medicaid School Program and long-term care facilities. Additionally, manages the Nursing Facility franchise fee program.
- Managed Care Rate Setting: Develops capitation rates for Managed Care, MyCare, and OhioRise.
- Reporting: Prepares quarterly CMS financial reports and the Medicaid cost allocation plan. Additionally, reconciles fund and grant balances and reports federal grant status.

Health Innovation and Quality

The Health Innovation and Quality office employed 62.6 FTE in SFY 2025. The office is led by a Medical Director who manages a team of clinicians and health care experts to oversee the Medicaid pharmacy and dental programs as well as utilization management. This office establishes clinical policy and manages the clinical aspects of operations, with a focus on the safety of vulnerable populations. Additionally, the Health Innovation and Quality team focuses on more closely linking improved quality of care and health outcomes with payment through collective impact models as well as alternative payment mechanisms. The Health Research and Quality team within this office works with stakeholders, such as Managed Care Entities (MCEs) and health systems to implement quality improvement-informed interventions to improve health care outcomes for Medicaid recipients.

Information and Technology Services

The Information and Technology Services office employed 29.6 FTE in SFY 2025. The office manages all ODM IT systems, hardware, software, telephone, audio-visual equipment, business intelligence, applications development, IT Risk Management, IT Security, enterprise architecture and development/deployment of Artificial Intelligence (AI) solutions. This office's goal is to enable Medicaid's mission through information, technology, customer service and support, infrastructure operations, database administration and provides technical support to ODM staff and vendors.

Legal Counsel

The Legal Counsel office employed 92.0 FTE in SFY 2025. In general, the functions of the office include the following:

- **Contracts and Procurements:** Prepares and processes contracts and agreements between the Department and other entities and is responsible for following state-mandated procurement procedures.
- **General Counsel:** Provides legal counsel to the Department regarding Medicaid policy and any other matter requiring legal guidance; administers the department's rule filing and public record processes; and coordinates litigation affecting the department.
- **Privacy:** Works to ensure the Department meets all applicable privacy standards.
- **Program Integrity:** Works to detect and prevent fraud, waste, and abuse. Additionally, coordinates all audits that are performed on the agency, along with any corresponding responses to such audits.

Legislation

The Legislation office employed 2.1 FTE in SFY 2025. The office works with lawmakers, the Governor's office, and internal and external stakeholders on legislative and policy items affecting Ohio's Medicaid program.

Managed Care

The Managed Care office employed 44.6 FTE in SFY 2025. The office is responsible for policy and operations for the traditional Managed Care Organizations (MCOs) and MyCare Ohio Plans (MCOPs) in collaboration with the Legal Counsel and Policy offices. Its duties include oversight of MCO/MCOP provider networks, general contract (or provider agreement) compliance, maintaining and updating managed care Ohio Administrative Code (OAC) rules, maintaining the MCO/MCOP provider agreements, and providing member services to ensure individuals are enrolled correctly in their MCO/MCOP.

Operations

The Operations office employed 169.2 FTE in SFY 2025. In general, the functions of the office include the following:

- **Business Operational Support:** Supports County Departments of Job and Family Services through county engagement and technical assistance, eligibility compliance, and central processing of Medicaid applications. An eligibility and special projects team assists CDJFS agencies in making eligibility determinations.
- **Ohio Benefits:** Works with DAS, Accenture and ODM business areas to design, plan, and execute federal rules within the system. Additionally, it monitors and manages the release management processes for system compliance and development. Works with all ODM offices on a variety of projects related to Medicaid eligibility. This team also supports systems used by County Department of Job and Family Services such as Electronic Document Management System, Customer Service Standardization, and Interactive Voice Response.
- **Claims Operations:** Runs the third-party liability program and the Medicaid Buy-In program. This includes maintaining a vendor contract for identifying third party liability and ensuring Medicaid is the payer of last resort when applicable.
- **Network Management:** Manages all provider relations including oversight, engagement and compliance. Develops, designs, monitors and implements the Provider Network Management (PNM) system collaboration and works with Maximus in managing the day-to-day system operations.

Policy

The Policy office employed 107.0 FTE in SFY 2025. This office is responsible for all ODM policies that are not specifically intended for a Managed Care Entity (MCE). The team oversees the Medicaid State Plan, various waivers, and most OAC rules implementing the Medicaid program in Ohio. The team is made up of a Long-Term Services and Supports Bureau, the Health Plan Policy Bureau, and the Behavioral Health team.

Project Management Office

The Project Management Office employed 23.8 FTE in SFY 2025. The office works throughout the Department to develop standardized methodologies, streamline processes, and generate data insights with the goal of supporting the Department's overall mission.

Strategic Initiatives

The Strategic Initiatives office employed 26.8 FTE in SFY 2025. The office focuses on implementing change for families and children in Ohio. The team is responsible for the OhioRISE program including policy, operations, contracting, and the multisystem youth program. Additionally, the offices oversees several programs that offer funding targeted at prevention and wellness, including the Medicaid School Program, the Maternal and Infant Support Program, the Comprehensive Maternal Care Program, and the Comprehensive Primary Care Program through its Maternal, Child, and Family Wellness section.

SFY 2025 Table of Organization Subunit Breakdown

Medicaid Director	Health Innovation and Quality	Pharmacy/Dental		
		Clinical Operations	Prior Authorization	
			Clinical Review	Compliance and Safety Check
		Health Research and Quality	Special Populations	
			Quality Improvement	Performance Improvement
				Population Health Management
			Cross-System Collaboration	
			Health Innovation Research	
	Policy	CMS Liaison SPA and Waiver Management		
		Long-Term Services and Supports	Interagency Policy	
			Long-Term Care Rate Setting	
			Integrated Care Policy	
			Care Coordination and Review	Managed Care Care Coordination
				Home and Community Based Services Care Coordination
				Care Coordination Systems and Incidents
			Home and Community-Based Services Policy	Aged and Disabled Program Policy
			Nursing Facility Policy	Front Door Policy
				Long Term Services and Supports Compliance
			Money Follows the Person Grant	
		Health Plan Policy	Policy Management and Development	
			Hospital Services	
			Non-Institutional	
			Eligibility Policy	
		Behavioral Health Policy		
	Data and Integrated Systems	Strategic and Performance Analytics	Data Governance	Contracts and DSA
				Data Integrity

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			Performance Analytics	Population and Health Equity Analytics
				Clinical Data Analytics
				Research and Program Evaluation
			Strategic Analytics	Reporting and Analysis
				Analytic Management and Strategic Research
		Infrastructure and Operations	OMES/MITS System	
			OMES (MITS) System	
			Claims Resolution Outreach	
		Electronic Data Interchange and Encounters		
		Analytic Support - Electronic Data Warehouse		
		Vendor Relationship Services		
	Fiscal Operations	Financial Management	Accounting	Revenue Management
				Payment Management
			APD Management and Financial Management, Planning and Rate Setting	Financial Management, Planning and Rate Setting
				APD Management
			Reporting	Cost Allocation
				Cash and Grants Management
		Budget and Rate Setting	Budget	Econometrics and Forecasting
				Budget Management
			Managed Care Rate Setting	
	Managed Care	Network Management and Operations	Member/Marketing Material	
		Contract Management and Compliance		
		Policy and Program Development		
		Member Services	Managed Care Reconciliation	

Efficient • Effective • Transparent

			Systems Management	
	Project Management Office	Quality Assurance and Performance		
		Continuous Improvement		
		Project Delivery (4 Teams)		
	Strategic Initiatives	OhioRISE	OhioRISE Program Operations and Policy	Policy and Program Development
				OhioRISE Operations
			MSY Program	
		Maternal, Child, and Family Wellness		
Assistant Director	Legal Counsel	Privacy/HIPAA		
		Program Integrity	Program Integrity Compliance	EVV Compliance and Training
				Compliance Coordination
			Surveillance/Utilization Rev	Data Support
				Provider Audit and Review
				Clinical Audit and Review
			Managed Care and Provider Audits (2 Regions)	
			Provider Compliance	Provider Audits and Compliance Review
				Behavioral Health Audits and Compliance Review
			Long-Term Care and State Agency Audits	State Agency/Subs Columbus
				Long Term Care Audit and PPR Columbus/Cincinnati
		Provider and Program Compliance		
		Managed Care and Eligibility		
		Contract and Procurement		
	Information and Technology Services	Application Development (2 Teams)		

		Telephone/Operations Support		
		Operations and Business Intelligence	End User Support	
			Analytics Tool Support	
	Legislation			
	Operations	Business Operational Support	Provider Relations	Managed Care Oversight and Non-Institutional Engagement
				Managed Care Oversight and Institutional Engagement
			Eligibility and Special Projects (3 Teams)	
			Eligibility Operations	Disability Determination
				Direct Enrollment
				Eligibility Compliance & Projects
				Central Processing
			County Engagement	County Technical Assistance
		Claims Operations	Claims Control	
			Cost Avoidance/Buy-In	
		Network Management	Network Compliance	
			Credentialing and Long-Term Care Provider Management	
			Provider Enrollment	
		Ohio Benefit Systems		
Chief of Staff	Human Resources	Recruitment Payroll/Benefits	Payroll/Benefits	
			Recruitment	
			External Recruitment	
		ELPD		
		Employee Relations		
	Communications*			
	Business Services			
	External Business Relations			

Source: ODM Table of Organization

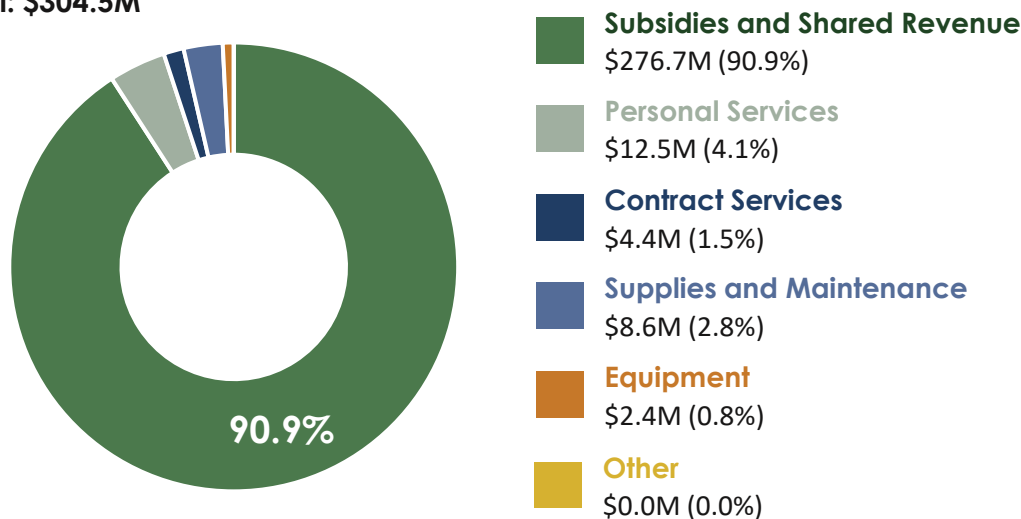
Note: There is a sixth level of subunits that is not captured here due to space limitations.

Appendix E: Medicaid Administrative Spending by State Agency

In SFY 2025, Ohio's state agencies spent \$1.2 billion in federal and state funds for the purposes of administering Medicaid, which includes some non-recurring federal funding from the American Rescue Plan Act. The distribution of these administrative expenditures by state agency, excluding ODM because it is depicted in the [Financial Background](#), are shown in the graphs in the following pages.

SFY 2025 ODJFS Medicaid Administrative Expenditures

Total: \$304.5M



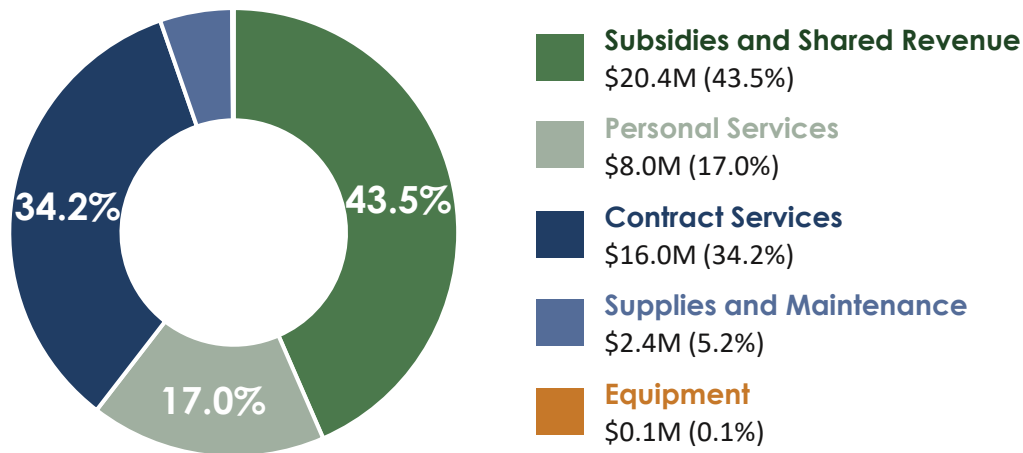
Source: OAKS GL-0028

Note: Other includes Judgements, Settlements, and Bonds and Transfers and non-expense items.

The majority of ODJFS's administrative expenditures are Subsidies and Shared Revenues that are passed through to County Departments of Job and Family Services for the determination of Medicaid eligibility, as well as Non-Emergency Medical Transportation, which provides Medicaid beneficiaries with transportation to and from medical appointments. See [County Oversight](#) section for more information. Personal Services, Contract Services, Supplies and Maintenance, Equipment, and Other expenses made up less than 10 percent of ODJFS's administrative Medicaid spending in SFY 2025.

SFY 2025 ODA Medicaid Administrative Expenditures

Total: \$46.8M

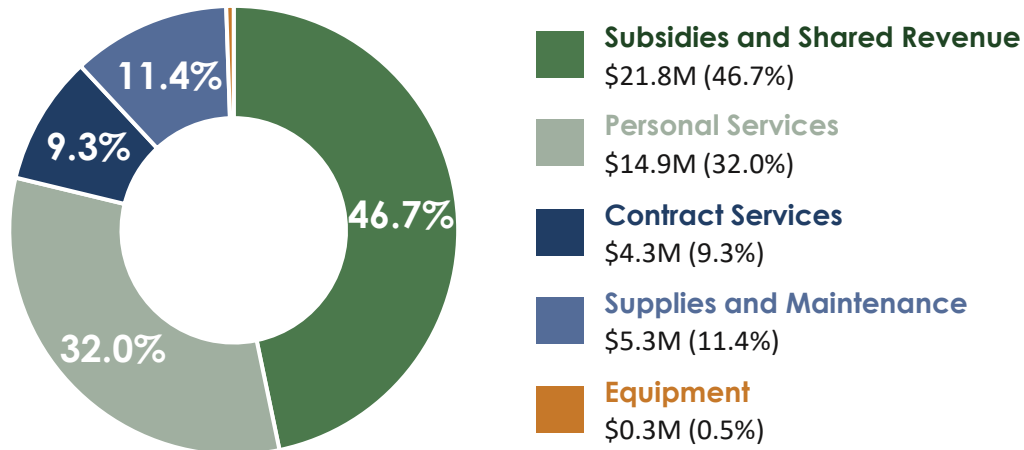


Source: OAKS GL-0028

The Ohio Department of Aging (ODA) administers Medicaid programs for older Ohioans, including PASSPORT, Assisted Living, and PACE. While ODA oversees Areas Agencies on Aging (AAAs), which are responsible for conducting eligibility screenings and assessments for long-term care and providing care coordination for some waiver recipients, ODA distributes Medicaid funding to the AAAs. ODA's Medicaid administrative expenditures depicted in the chart above consist of payments to medical centers and administrative and information technology contractors, salaries and benefits for agency employees, and supplies related to the administration of these programs.

SFY 2025 ODH Medicaid Administrative Expenditures

Total: \$46.6M

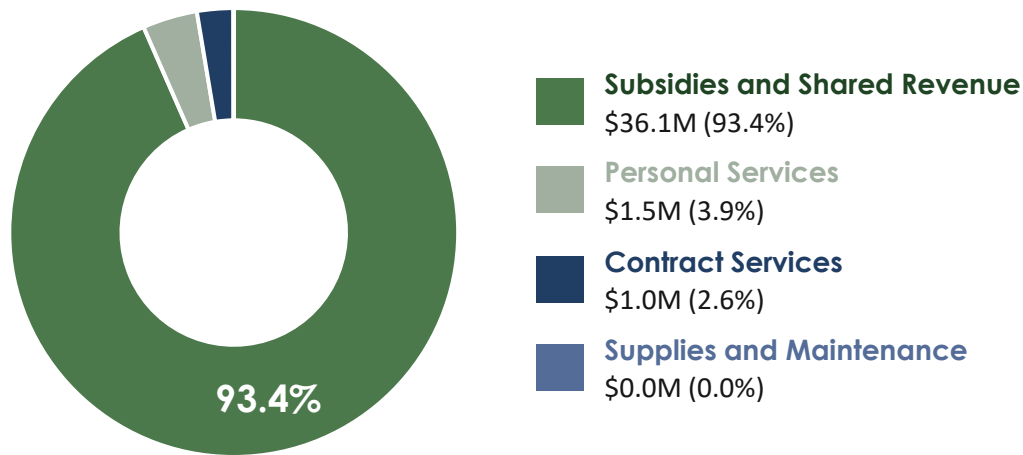


Source: OAKS GL-0028

The Ohio Department of Health employs individuals to survey and certify healthcare facilities participating in the Medicaid program to ensure compliance with state and federal regulations. The largest category of expenditure is Subsidies and Shared Revenue, which includes funds distributed to local health departments to remove barriers to accessing Medicaid services and to reduce gaps in Medicaid services through Medicaid Administrative Claiming.

SFY 2025 DBH Medicaid Administrative Expenditures

Total: \$38.6M



Source: OAKS GL-0028

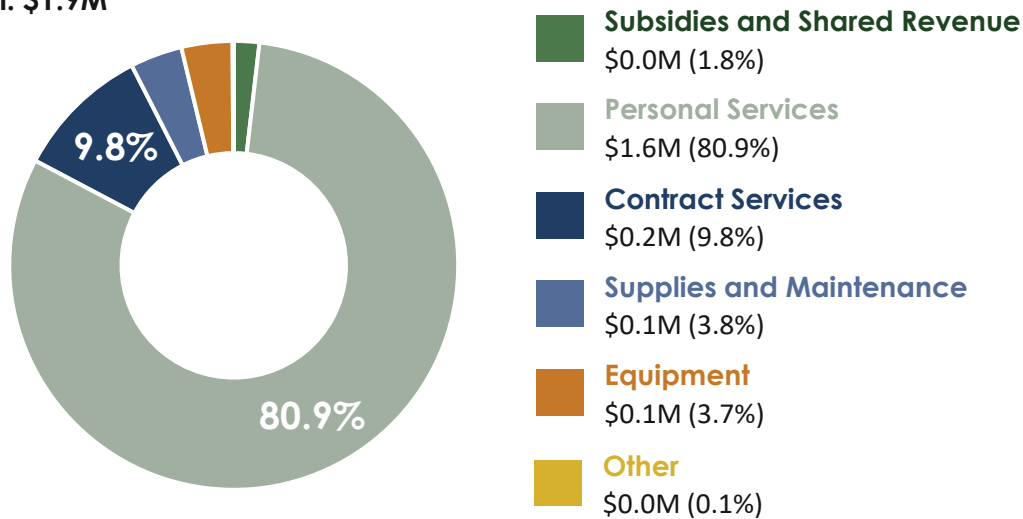
The Ohio Department of Behavioral Health (DBH) works with local behavioral health service boards to ensure the provision of mental health services and conducts Pre-Admission Screening and Resident Reviews (PASRR) for individuals seeking institutional placements. The majority of DBH's administrative expenditures in SFY 2025 were distributed for the development and delivery of PASRR assessments.

SFY 2025 ODHE Medicaid Administrative Expenditures

The Ohio Department of Higher Education (ODHE) had \$32.3M in Medicaid expenditures in SFY 2025, solely within the Subsidies and Shared Revenue category for the administration of Home and Community Based Services provider relief payments to public and private higher education institutions throughout the state. These payments were made using one-time federal funding, therefore, ODHE will not be involved in Medicaid administration moving forward.

SFY 2025 DCY Medicaid Administrative Expenditures

Total: \$1.9M



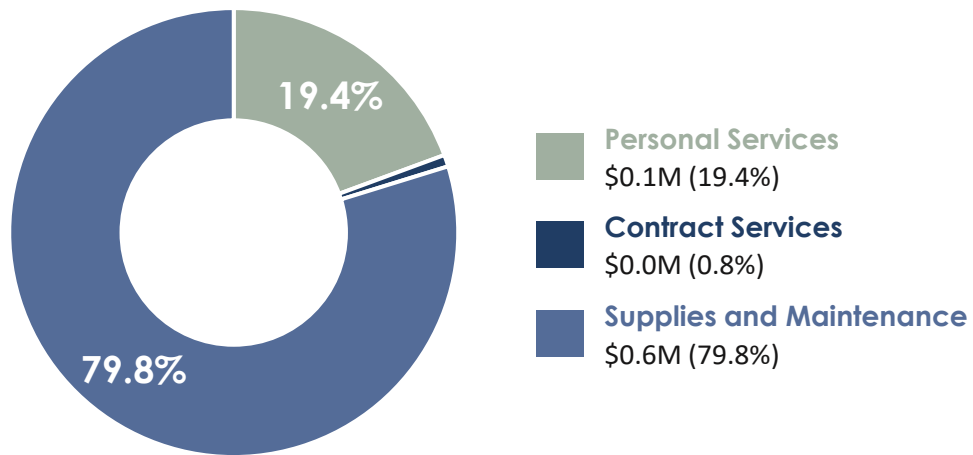
Source: OAKS GL-0028

Note: Other includes Judgements, Settlements, and Bonds and Transfers and non-expense items.

The Ohio Department of Children and Youth provides support to Medicaid eligible adoptive children through adoption subsidies. Unlike other state agencies, DCY's largest Medicaid administrative expenditure category in SFY 2025 was Personal Services at \$1.6M or 80.9 percent.

SFY 2025 PB Medicaid Administrative Expenditures

Total: \$0.8M

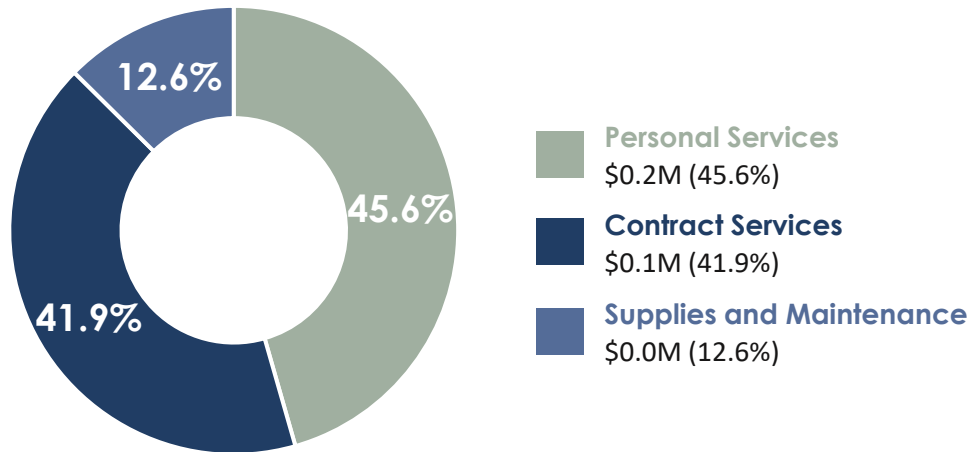


Source: OAKS GL-0028

The Pharmacy Board's \$756.5K in Medicaid expenditures were for the Ohio Automated Rx Reporting System, which tracks the controlled and select non-controlled prescription drugs provided to patients across the state. This system is utilized to help providers manage medications for both Medicaid recipients and other patients and reduce drug-related adverse events.

SFY 2025 ODEW Medicaid Administrative Expenditures

Total: \$0.4M



Source: OAKS GL-0028

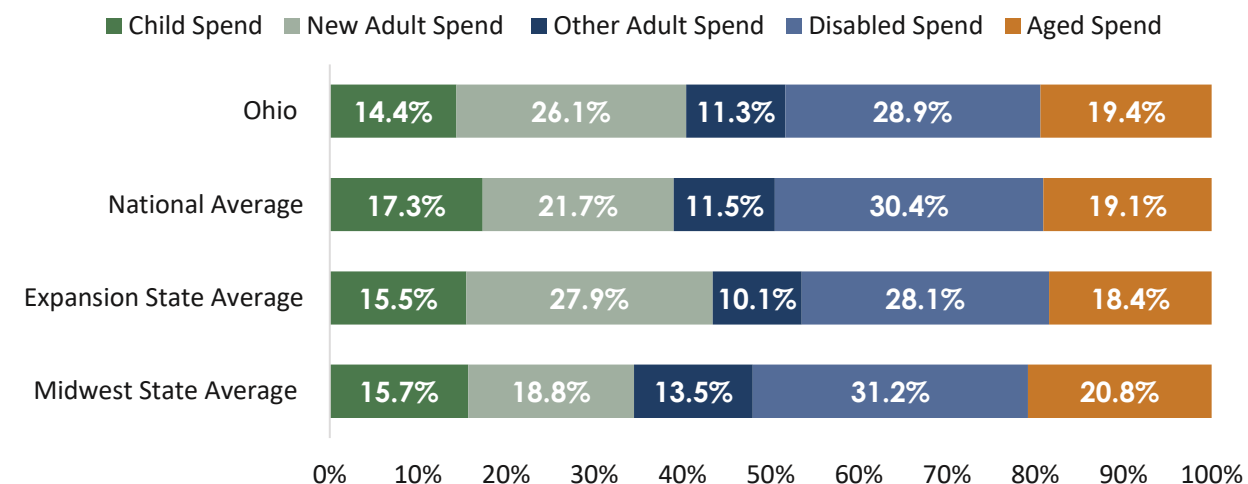
The entirety of the Ohio Department of Education and Workforce's SFY 2025 \$353.9K Medicaid expenditures were for the administration of the Medicaid Schools Program, which provides school districts with funding for services provided to Medicaid-eligible students. This program was transferred to ODM in SFY 2026.

Appendix F: Additional Nationwide Financial Comparisons

As discussed in the [Financial Background](#), Ohio's Medicaid spending on services per enrollee is in line with the national average and spending on administration per enrollee is below the national average. The following graphs show a more detailed comparison of Ohio's Medicaid spending to other states and national averages using data from the Medicaid and CHIP Payment and Access Commission (MACPAC). MACPAC compiles and summarizes the financial and enrollment data that state governments submit to CMS to create user-friendly reports and statistics regarding state Medicaid programs.

There are many factors that impact a state's Medicaid spending, such as the FMAP rate, expansion status and other policy decisions, demographics, and health care infrastructure. Additionally, benefit spending varies significantly between the various populations that are eligible for Medicaid. The graph below displays the percentage of spending on Medicaid benefits that can be attributed to each eligibility group for FFY 2023. FFY 2023 is the most recent year available for this data at a national level. Notably, these eligibility groups are not the same as those discussed in the Eligibility Section. This is because states organize their eligibility groups differently, so a less specific level of categorization is used at the national level. Child and most other adult spend would fall into Ohio's CFC group while aged and disabled spend would both fall into Ohio's ABD group. New adult spend represents Group VIII.

FFY 2023 Benefit Spending Distribution by Eligibility Group

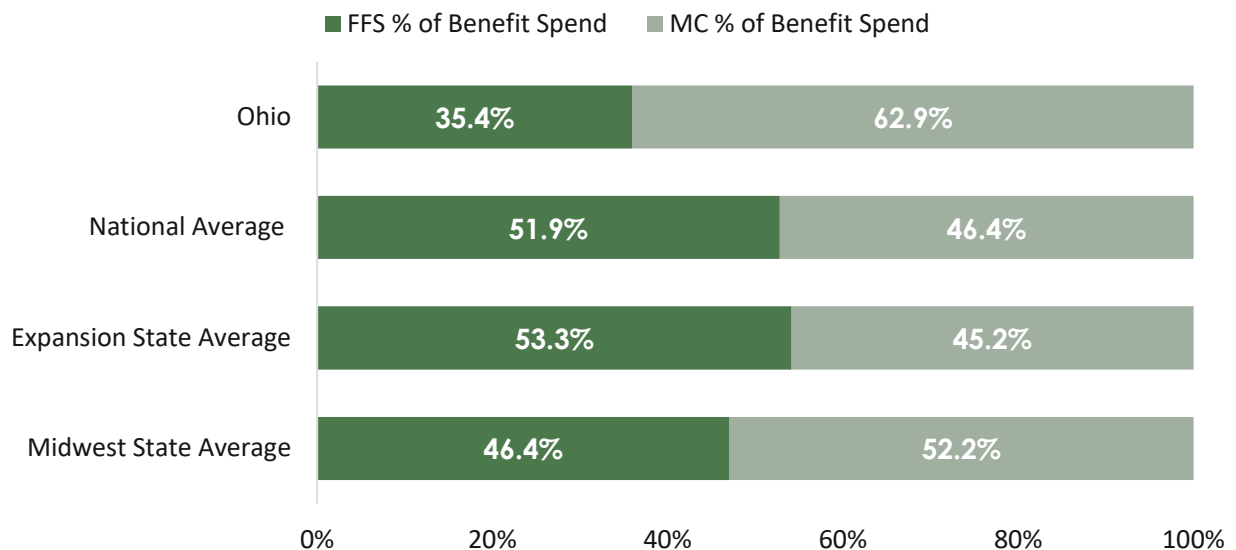


Source: MACPAC Exhibit 21

Ohio's benefit spending on aged individuals and other adults is in line with the national average, while spending on children and disabled individuals makes up a smaller portion of total service expenditures than the national average. Additionally, Ohio spends a larger portion of its Medicaid service expenditure on new adults, or Group VIII, than the national average. This is impacted by state expansion status, as ten states have not adopted expansion and therefore do not have any spending for this eligibility group, as discussed in [Appendix B](#). In comparison to expansion states exclusively, Ohio spends a slightly lower portion of service expenditures on this group. Finally, in comparison to Midwest states exclusively, Ohio spends less on all eligibility groups except for new adults.

Another factor that impacts state spending on Medicaid services is the utilization of different service delivery methods. The graph below shows the percentage distribution of benefit spending between managed care and FFS delivery models in FFY 2024.

FFY 2024 Managed Care vs Fee-For-Service Benefit Spend Distribution



Source: MACPAC Exhibit 17

Ohio's Managed Care expenditure percentage is higher than the national average, expansion state average, and Midwest state average, with approximately 35.4 percent of benefit expenditures being spent through the FFS model and 62.9 percent spent through the managed care model. Ohio has been moving to increase managed care for years, including with the Next Generation initiative.

Appendix G: Strategic Planning & Program Evaluation Criteria

Strategic Planning Criteria Comparison

Managed Care and MyCare are only partially aligned with the third step of the GFOA criteria: defining the problem(s). In this step, the GFOA indicates that an organization should use its analysis of its environment to identify the most critical issues for the organization and the community. The Managed Care and MyCare offices require MCOs to identify risks for their members based on characteristics and health needs. However, the offices did not have any documentation of risk identification for their internal operations. For example, we asked each of these offices how ODM ensures that capitation payments are made for eligible members, are not duplicative, and are not made for individuals that are ineligible or deceased. Staff were able to speak to the automatic and manual processes in place to ensure capitation payments are made properly, including routine reviews of eligibility data and monitoring of members with a date of death, but were not able to provide us with any documentation of the internal risk identification or resulting risk mitigation efforts. This is despite these issues being identified as findings in previous Auditor of State audits of Ohio's Medicaid program, see the Ohio Auditor of State's [Medicaid Audits](#) for information on these findings. Additionally, based on feedback we received during our interviews with CDJFS agencies, many indicated that there are issues with continuing enrollment of potentially ineligible individuals due to inaccuracies in the passive ex parte renewal process. See [Issue for Further Study 1](#) for more information on this process.

The Managed Care Office was also only partially aligned with the seventh step of GFOA's strategic planning process: execute and monitor tactics. The GFOA indicates that governmental entities can allocate funding to implement the tactics identified in a strategic plan and monitor their effectiveness to determine if future funding should be allocated or if tactics should be altered. The Managed Care Office sets minimum performance standards in its agreements with MCOs which are evaluated in the annual External Quality Reviews. However, the Managed Care Office was not able to provide documentation of evaluations of cost effectiveness or participation in the budget process while other program offices were able to. This is despite the Department sending \$10.9 billion in capitation payments to these MCOs in CY 2025, and these payments being a significant portion of the Department's biennial Medicaid Caseload and Expenditure Forecast Report, which is used as part of the state budget process. While these caseloads and expenditures are monitored as part of the forecasting process, program managers should be aware as these are important figures for performance management.

Program Evaluation Criteria Comparison

Health Innovation and Quality, SPBM, and OhioRISE are generally aligned with all of the PQM logic model guiding principles. MyCare is generally aligned with three and Managed Care is only generally aligned with one. This partial alignment with many of the guiding principles is largely due to a lack of documentation to support the practices that staff described in interviews. Given conflicting testimonial evidence provided by different areas of the Department, as well as testimonial evidence from stakeholders we interviewed, we required documentary evidence to show that the Department was generally aligned with best practices. This requirement was explained to the Department in several meetings and written requests.

All offices except for Managed Care are generally aligned with the principle of using evidence-based information. PQM recommends that quality improvement strategies should be based on the best available information, including scientific research, clinical guidelines, and data from previous similar initiatives. During the development of new agreements with MCOs, the Managed Care Office indicated that it used the experience and feedback of staff members that were involved in the previous MCO agreements to make improvements. However, the office was not able to provide any documentation of this process, while the other offices were able to provide detailed information on the evidence used in decision-making processes.

Managed Care was only partially aligned with the principle of revisiting the completed logic model frequently. PQM recommends that the logic model is reviewed and revised continuously based on new evidence, practices, or insights. MCOs are contractually obligated to submit performance measures to ODM. The Managed Care Office indicated that this information is used to adjust performance standards and amend contract requirements, in collaboration with senior ODM staff and MCOs. However, the only documentation of this process that the Managed Care Office provided was from the design and implementation of the “Next Generation of Managed Care” Initiative, which occurred in 2019. This documentation did not show a continuous process of review and revision in the current MCO structure.

Managed Care and MyCare were only partially aligned with the final three principles: evaluation of selected indicators in context, balancing comprehensiveness with parsimony, and incorporation of feedback mechanisms. PQM recommends that all indicators within a logic model are evaluated regularly to understand how they impact various assumptions, activities, and outcomes. MCOs undergo annual External Quality Reviews, as required by the federal government. ODM indicated that the results of these reviews are used to hold MCOs accountable to program requirements, evaluate the effectiveness of ODM’s Population Health and Quality Strategy, support program integrity efforts, and inform policy and program

changes. However, neither the Managed Care Office nor the MyCare Office were able to provide documentation to support this statement.

PQM also recommends that logic models strike a balance between the comprehensive inclusion of all relevant factors and the more focused inclusion of only the most impactful factors. ODM contracts with a third party to perform the annual External Quality Review of MCOs. However, the Managed Care and MyCare Offices were not able to identify which measures within these reviews are the most impactful to program performance, indicating that relative value of the measures reviewed in the External Quality Review is not considered for program management. Personnel from other program areas were able to identify impactful measures and the value these measures provide to their respective programs. In a follow-up request for documentation, ODM provided the same list of focus areas for both Managed Care and MyCare. While these programs both utilize MCOs to connect enrollees with healthcare services, the populations served by each program are very different with differing characteristics and needs. Therefore, the focus areas of each program should reflect this.

Finally, PQM recommends that organizations design mechanisms for ongoing feedback and data collection, allowing for the continuous monitoring of performance and outcomes. While ongoing data collection does occur as a result of the External Quality Reviews of MCOs, Managed Care and MyCare staff were unable to explain how this data impacts other areas of program management. Additionally, neither office was able to provide documentation of feedback mechanisms for their programs.

Appendix H: Contract Management Criteria

As noted in [Recommendation 3](#), there are three general phases of the contract management process used in this report: Planning and Solicitation, Evaluation and Award, and Administration and Monitoring. To aid in our analysis, we aligned our criteria with these phases. More detail about the steps from these criteria are included in the sections below.

Planning and Solicitation

There are 11 steps within the Government Finance Officers Association (GFOA) best practices for the planning and solicitation phase, with additional support from the National State Auditors Association (NSAA) for two of the steps, which are indicated with asterisks. These steps are outlined below.

1. Executive Direction: Establish an executive direction consisting of clear expectations and standards for analyzing service delivery options in collaboration with the entity's policy team.
2. Strategic Link: Link the contracted service to the entity's strategic plan and consider how the service is affected by demographics, geography, citizen concerns, the economy, and the local political environment.
3. Stakeholder Input: Obtain the input of relevant stakeholders.
4. Service Requirement: Understand and consider the requirements relevant to the contracted service, including employment laws, existing labor agreements, human resource impacts, and financial risks mitigation.
5. Service Alternatives: Evaluate service alternatives, including not providing the service, providing it in-house, providing it jointly with another entity, or privatizing it.⁴⁰
6. Cost Considerations: Consider all of the factors impacting cost, including avoidable costs, verification of cost accuracy, specialized costs, and value of costs.
7. RFP/RFA Development*: Develop a Request for Proposal (RFP) or Request for Agreement (RFA).
8. Knowledge Acquisition: Acquire relevant knowledge, including peer government comparisons, public opinion, specialized knowledge, and management capacity.

⁴⁰ The service alternatives step was not applicable to any of the contracts reviewed because the contracted services are either required by the state or federal government or require a level of technical capabilities and capital that ODM is not equipped to perform in house.

9. Agreement Provisions*: Consider the flexibility, reversibility, and financial risks of agreement provisions.
10. Transition: Develop a transition plan to ensure a smooth transition to the contracted service.
11. Communication: Communicate the selection of the contracted service to stakeholders.

Evaluation and Award

There are seven steps within the National State Auditors Association (NSAA) best practices for the evaluation and award phase. These steps are outlined below.

1. Proposal Procedures: Have appropriate procedures in place to handle late or incomplete proposals.
2. Proposal Adequacy: Ensure that an adequate number of proposals were received.
3. Evaluation Committee: Use an evaluation committee to score and evaluate proposals. This committee should be comprised of individuals who are unbiased and knowledgeable.
4. Scoring Criteria: Use fixed, clearly defined, and consistent scoring criteria to measure the proposal against the RFP requirements.
5. Bid Integrity: Control bids upon receipt to ensure that bids are not opened prematurely or accepted after the due date.
6. Vendor References: Carefully check vendor references.
7. Documented Decision: Document the award decision and keep supporting materials

Administration and Monitoring

There are seven steps within the NSAA best practices for the administration and monitoring phase. These steps are outlined below.

1. Agreement Manager: Assign a contract manager with the authority, resources, and time to monitor the contract.
2. Knowledgeable Personnel: Ensure that the contract manager possesses adequate skills and has the necessary training to properly manage the contract.
3. Budget Tracking: Track budgets and compare invoices and charges to contract provisions.
4. Deliverable Tracking: Ensure that deliverables are received on time and document the acceptance or rejections of deliverables.
5. Conditional Payment: Withhold payments to vendors until deliverables are received.
6. Service Credit Documentation: Retain documentation supporting charges against the contract.

7. Performance Review: After contract completion, evaluate the contractor's performance on this contract against a set of pre-established, standard criteria and retain this record of performance for future use.

Medicaid Managed Care Procurement

In addition to criteria by contract management step, we also have guidance from Princeton University's State Health and Value Strategies in *Medicaid Managed Care Procurements: A Toolkit for State Medicaid Agencies* (2022). The descriptions of relevant components of the criteria are included below.

1. Procurement Team: Select a procurement team that is as small and inclusive as possible.
2. Stakeholder Participation: Engage stakeholders, including current enrollees, healthcare providers, community-based organizations, potential bidders, and legislators.
3. Public & Specific: Publicly advertise the procurement and ensure it includes a specification-driven assessment of bids based on pre-determined questions and criteria.
4. Vision Statement: Ensure the procurement has a measurable scope of work requirements and evaluation criteria that reflects the state's vision and priorities.
5. Bidder Inquiry Questions: Ask bidders to respond to 10 to 15 carefully identified and worded questions that reflect the state's goals, objectives, and values and require data driven responses where possible to assess bidder qualification.
6. Bid Organization: Require bidders to follow a consistent format and limit the number of attachments for an efficient review process.
7. Evaluation Process: Only review cost proposals from bidders that meet certain minimum technical evaluation criteria.
8. Bid Review: Allow the evaluation committee sufficient time to thoroughly review bids independently prior to reviewing as a group to ensure a fair and comprehensive review.
9. Voting Members: Identify an odd number of qualified voting members to participate in the bid review.
10. Document Lessons: Document procurement lessons learned in a systematic way so they can be utilized in future procurements.

In addition to these steps, the criteria indicates that states can optionally hold a bidder's conference after the solicitation is publicly released. This would typically occur seven to ten days after the solicitation is released and would allow the state to directly communicate the request and hear questions from potential bidders.

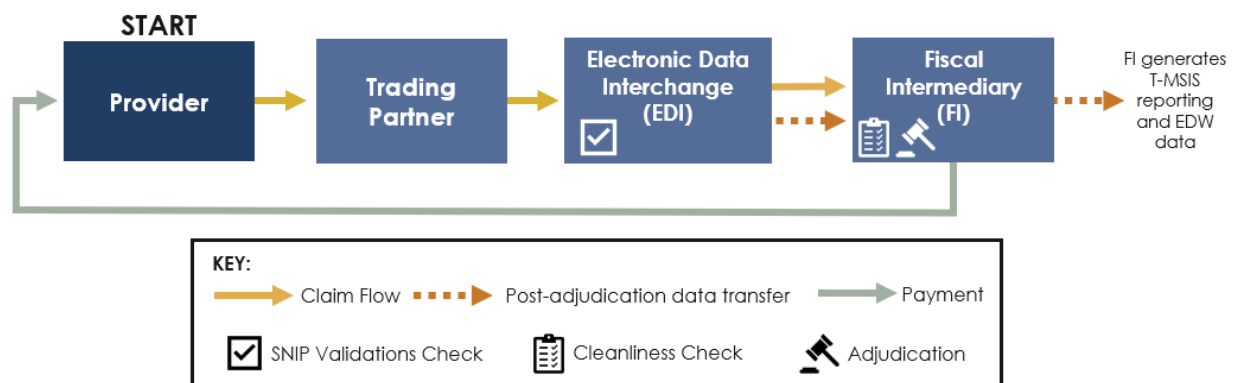
Appendix I: Claim Payment Timeliness

Claim Payment Process

When a Medicaid recipient receives a service from a healthcare provider, that provider must submit a claim to ODM to receive payment for their services. This claim submission and payment process is facilitated by multiple information systems and contracted entities. It also varies by claim type and service delivery model.

Professional, institutional, and dental claims are processed through provider trading partners, the Electronic Data Interchange (EDI), and the Fiscal Intermediary (FI). Trading partners are entities that healthcare providers contract with to submit claims on their behalf. There is a small portion of providers that submit claims through direct entry to either the Provider Network Management Module or MCO portal, however, the vast majority of providers utilize trading partners. The process for fee-for-service professional, institutional, and dental claims is outlined in the flow chart below.

Fee-For-Service Professional, Institutional, and Dental Claim Payment Process



Source: ODM

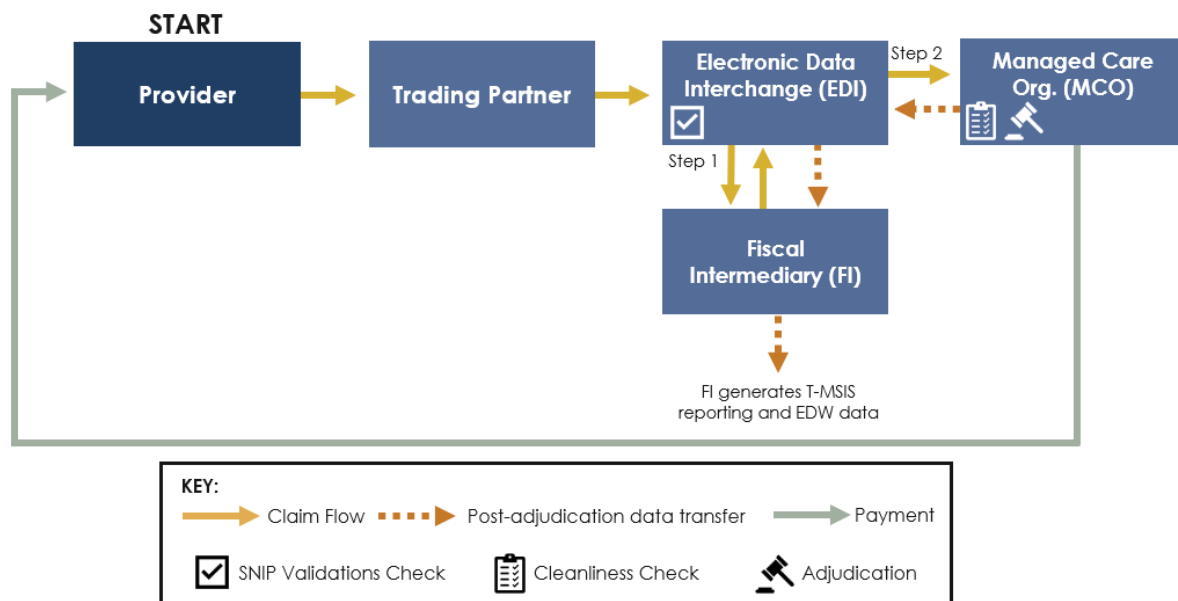
For fee-for-service claims, in which the provider is paid directly by the Department, a provider sends a claim to their trading partner, who then submits the claim to the EDI. The EDI performs a series of Strategic National Implementation Process (SNIP) validation checks, which verify that the provider, sender, and recipient IDs are valid and recognized by the system and that the recipient is actively eligible for Medicaid benefits. If the claim does not pass these checks, it is rejected. If it does pass these checks, the claim progresses to the FI. The FI performs cleanliness checks, which verify that the provider is certified to perform the service and the member is eligible to receive the service, as well as ensure that prior authorization was received if needed.

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and the provider is not under prepayment review.⁴¹ If a claim is determined to be clean through these checks, the FI adjudicates and pays the claim. Claims are paid through electronic money transfers. If a claim is determined to be unclean, the claim is marked as pending until the cause of uncleanness is resolved. Finally, the FI communicates the results of the adjudication to the trading partner.

The process for managed care professional, institutional, and dental claims is slightly more complicated due to the inclusion of MCOs. This process is outlined in the flow chart below.

Managed Care Professional, Institutional, and Dental Claim Payment Process



Source: ODM

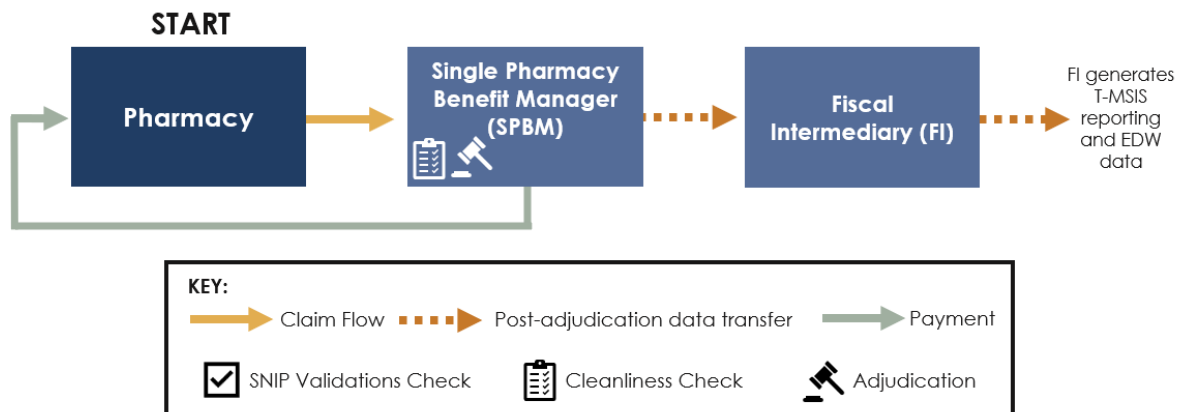
The beginning of the claim payment process for managed care claims follows the fee-for-service process. Claims are sent to trading partners by providers, trading partners then submit the claims to the EDI, and the EDI performs SNIP validation checks. However, once the claim is transmitted to the FI and assigned a tracking number, it is sent to the MCO through the EDI. The MCO then completes cleanliness checks, rather than the FI. If the MCO determines the claim to be clean, it is adjudicated and paid through electronic money transfer. If the claim is determined to be unclean, the claim is marked as pending until the cause of uncleanness is

⁴¹ Healthcare services requiring prior authorization need approval from an insurer before a member can receive care. Providers under prepayment review have all of their claims reviewed before the claims are paid, often because the provider has a history of errors in their billing.

resolved. After a claim is adjudicated and paid, the MCO sends a record of the claim to the FI through the EDI. The FI then communicates the results of the adjudication to the trading partner.

The claim payment process for pharmacy claims is simpler and consistent between fee-for-service and managed care. Pharmacies submit all claims to the Single Pharmacy Benefit Manager (SPBM), which conducts cleanliness checks and adjudicates and pays clean claims. Unclean claims are marked as pending until the cause of uncleanliness is resolved. After payment, the SPBM sends a record of the claim to the FI. This process is outlined in the flow chart below.

Pharmacy Claim Payment Process



Source: ODM

The FI holds or receives records of all claims adjudicated through these processes. Some of this data is imported into the Transformed Medicaid and CHIP Statistical Information System (T-MSIS) and replicated to ODM's Enterprise Data Warehouse (EDW). T-MSIS is the system through which state Medicaid agencies submit data to CMS, including the federally required claim data submission. The EDW is the Department's system to house and perform advanced analytics on a variety of datasets.

Requirements & Metrics Collected

The federal government sets requirements for claim payment timeliness in the Code of Federal Regulations (CFR). These requirements vary based on service delivery model. State Medicaid agencies are required to pay 90 percent of clean fee-for-service claims within 30 days of the date received, 99 percent within 90 days, and 100 percent within 12 months. Managed care organizations are required to pay 90 percent of clean claims within 30 days of the date

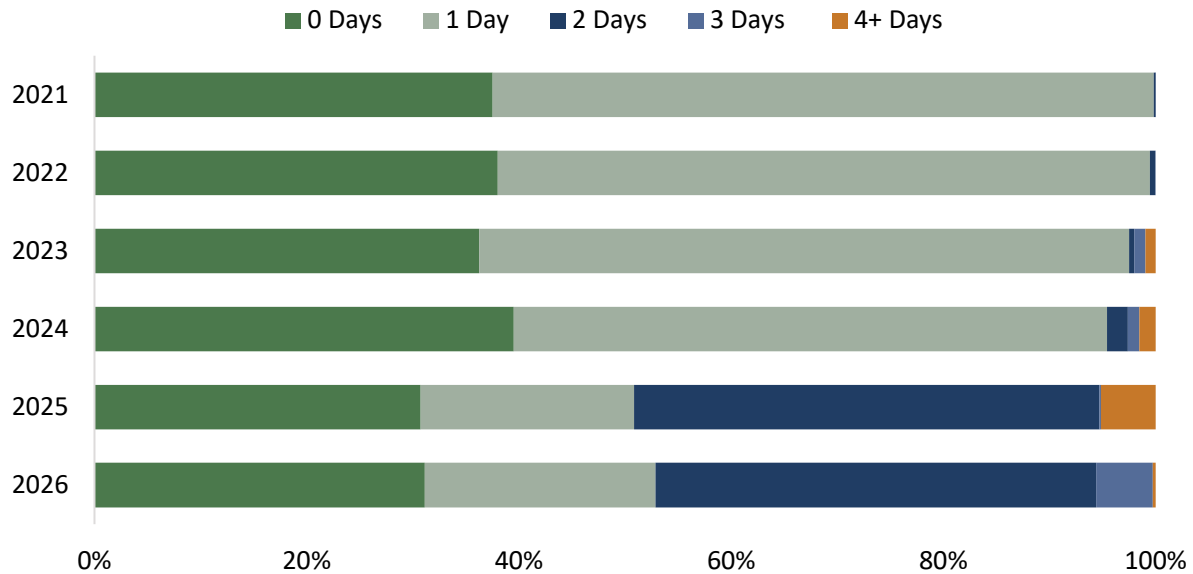
received, and 99 percent within 90 days. There is not a statutory requirement for 100 percent of managed care claims to be paid within a certain timeframe.

ODM has set tighter requirements for claim payment timeliness through its contract for the FI and contracts with MCOs. The FI contractor is required to pay all clean claims within 30 days of receipt. Unclean claims must be adjudicated and paid within 30 days of the correction of the cause of uncleanness. To determine compliance with federal statutory requirements and contractual requirements, ODM tracks the percentage of fee-for-service claims that are paid within 30 days, within 90 days, and within 12 months by claim type. This metric measures the time elapsed between the date that a claim is marked clean and the date that a claim is paid, therefore, this metric can be used to determine compliance with the contractual requirements for both clean and unclean claims.

In the current MCO contracts, which have been in place since the beginning of CY 2023, MCOs are required to pay 90 percent of all clean claims within 21 days of receipt, 99 percent within 60 days, and 100 percent within 90 days. In order to demonstrate compliance with these contractual requirements, MCOs submit quarterly Prompt Pay Reports to ODM detailing their claim payment timeliness. These Prompt Pay Reports are based on a template provided by ODM, so they are standardized across MCOs. The reports include the following metrics by claim type: counts of clean claims paid between 0 and 21 days, between 22 and 60 days, between 61 to 90 days, and over 91 days; counts of unclean claims; counts of pending claims; and counts of claims wherein alternative payment schedules were used. These measures are then summarized in the reports to simply show the percent of clean claims paid within 21, 60, and 90 days by claim type, which ODM uses to assess MCO claim payment timeliness. However, these summarized metrics only include claims received by the MCO as clean.

Fee-For-Service Cleanliness Time Using fee-for-service claim data in the EDW, we examined the time elapsed between the date a claim is received by the FI and the date that it is marked as clean. Of the 51.3 million fee-for-service claims that were processed by the FI in SFY 2025, 30.7 percent were marked as clean either instantaneously or the same day as they were received by the FI and 20.1 percent were marked as clean in one day. This is a decrease from previous years, as displayed in the graph on the following page.

CY 2021-2026 Percentage of FFS Claims by Days to Cleanliness Determination



Source: ODM EDW

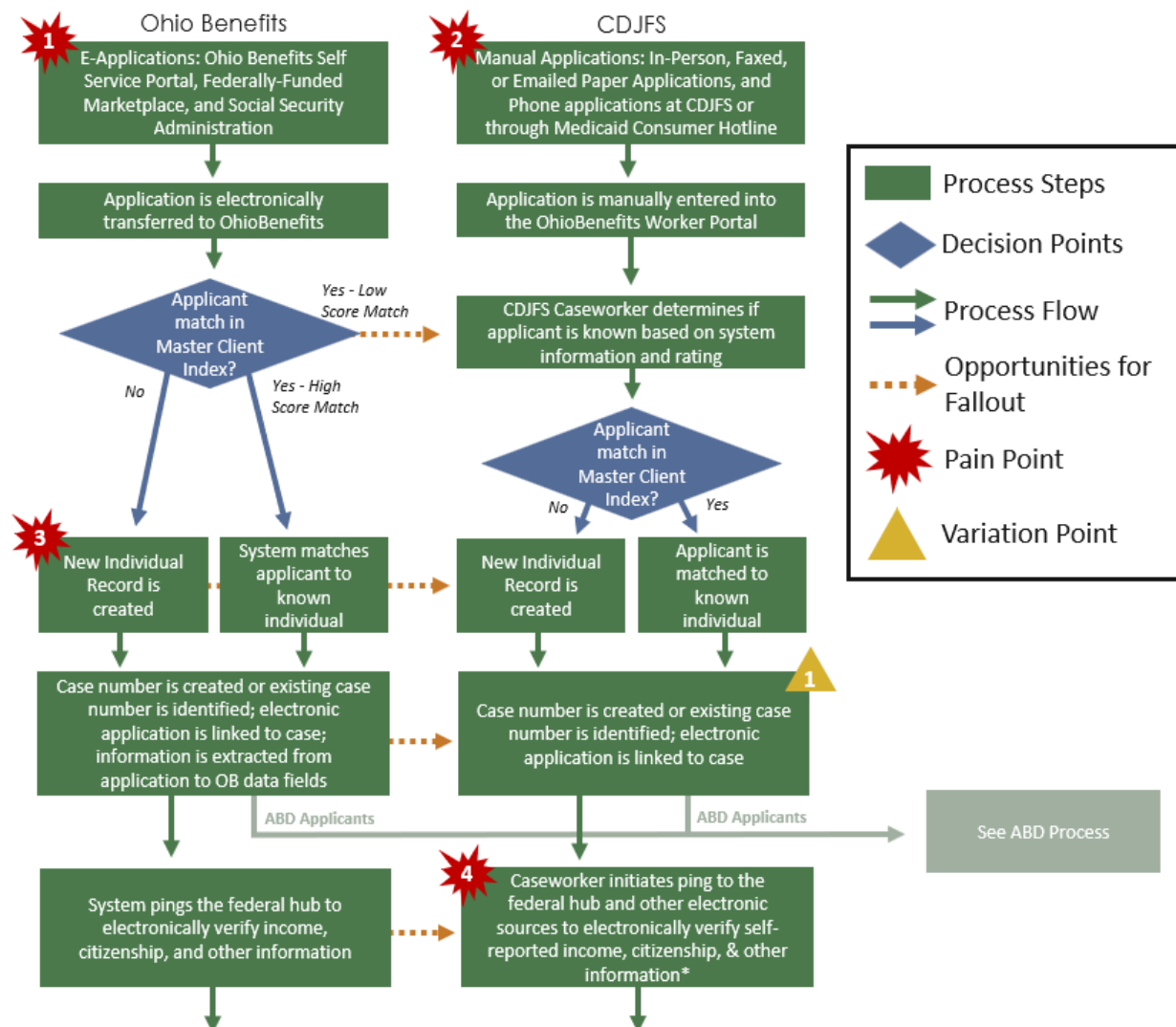
In CY 2021 and CY 2022, nearly all fee-for-service claims were marked as clean within one day.⁴² This percentage has decreased over the past four years, and in CY 2026 only 52.8 percent were marked as clean in one day. The percentage taking two or three days to be marked clean has increased over this time period, while the percentage of claims taking over four days to be marked clean hit a high in CY 2025. Within this category, there is a very small percentage of claims taking over 31 days to be marked clean.

⁴² According to ODM, the clean date for FFS claims from CY 2021 and CY 2022 are not the exact clean dates, but are estimates. ODM assigned these estimated clean dates in the process of converting FFS claims from MITS into the FI.

Appendix J: Eligibility Process Maps

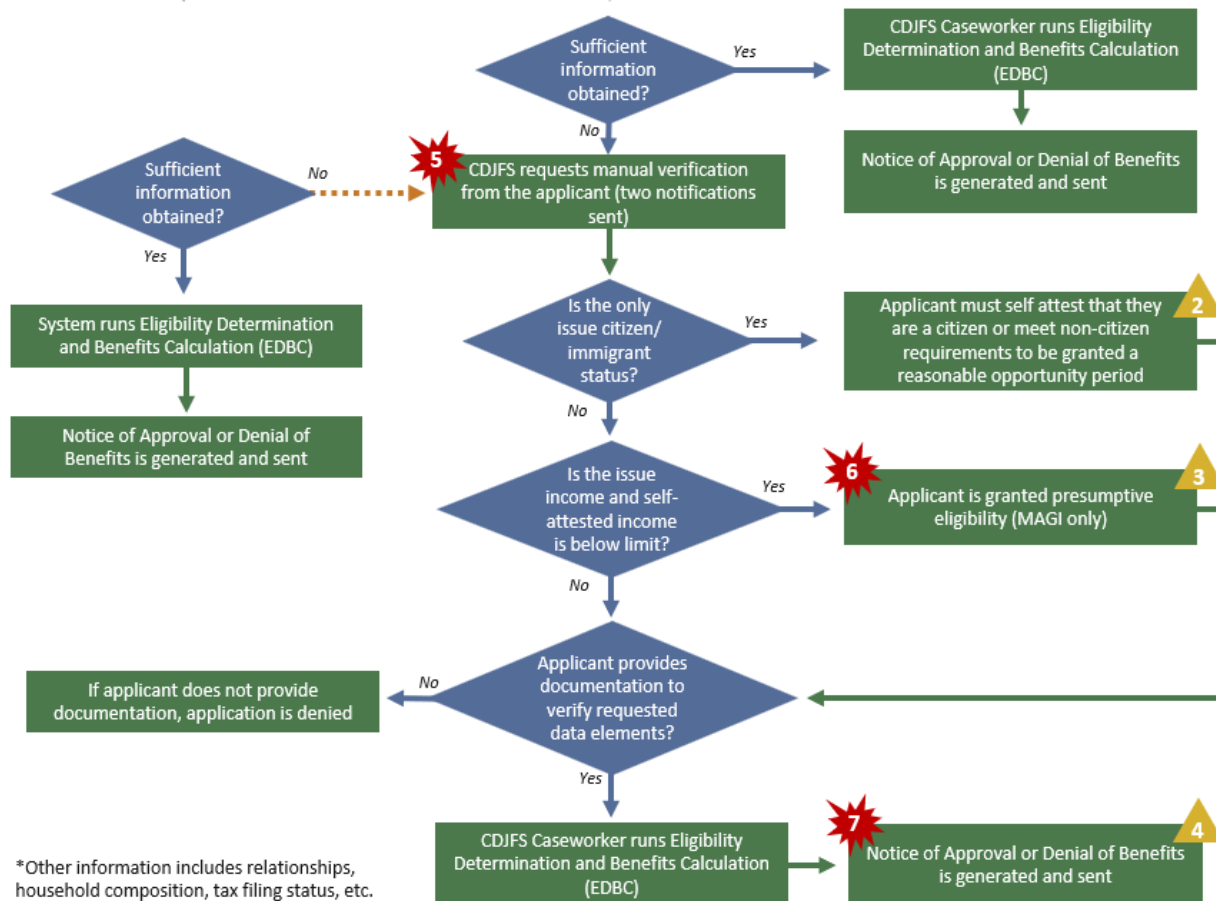
During our interviews with CDJFS agencies, we created process maps of the eligibility determination and redetermination processes and identified any pain points and variation points within these processes. Pain points are areas that pose difficulties for counties, while variation points are areas where we identified differing processes between the counties. The resulting process maps are shown below. In each process map, the green rectangles represent process steps, while the blue diamonds represent decision points, where the process may take alternative routes depending on the outcome. Fallout occurs when a process becomes manual.

Initial Eligibility Determination Process Map



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Initial Eligibility Determination Process Map Continued



Source: ODM & CDJFS Feedback

Note: Only variation points discussed by more than one CDJFS are shown.

The process map shown above and on the previous page displays the steps within the initial determination process, from application to notice of approval or denial of benefits. In this process, counties identified seven pain points and four variation points. These seven pain points are listed below, with numbers corresponding to the process map above and on the previous page.

1. Issues with e-applications, including the following.
 - a. Applications from the Social Security Administration are sent to CDJFS agencies late, not fully filled out, and for individuals who did not know they were applying. This last issue occurs when the federal system sends a Medicaid application to a CDJFS agency without adequately notifying or explaining this to the applicant. Counties also struggle to contact the Social Security Administration for assistance.

- b. Applications from the Federally Facilitated Marketplace are sent to CDJFS agencies late, not fully filled out, and for individuals who did not know they were applying. This last issue occurs when the federal system sends a Medicaid application to a CDJFS agency without adequately notifying or explaining this to the applicant.
 - c. Federal e-applications do not grant permission for the CDJFS agency to use electronic information verification systems.
 - d. The Ohio Benefits Self-Service Portal is not user friendly, causing users to make errors, enter information in the incorrect place, and submit duplicate applications or documents. User changes generate new indicators, which overwrite existing information and CDJFS caseworkers must approve or deny. Ohio Benefits Self-Service Portal applications can also be difficult to read.
 - e. E-applications must be manually entered into the Electronic Document Management System.
2. Applications from the Medicaid Consumer Hotline are sent to CDJFS agencies without necessary information and/or notification. Applications and notices of approval or denial of benefits are very long and could be streamlined to improve applicant and recipient understanding.
 3. Ohio Benefits creates new individual records when it should not, causing duplicate individuals in the system.
 4. Federal data hub does not work consistently and does not contain necessary information. ODM indicated that this is a federal system that states are required to use and have no input on.
 5. Cannot use the same documentation for the manual verification of information between programs. Ohio Benefits automatically sends a second manual verification request even if the documents have been received, but have not yet been processed.
 6. Presumptive eligibility is supposed to be determined within 24 hours and can only be approved on the date that the CDJFS caseworker first opens it. Counties lack time to run presumptive eligibility.
 7. The notice of approval or denial of benefits generated by Ohio Benefits is not always correct.

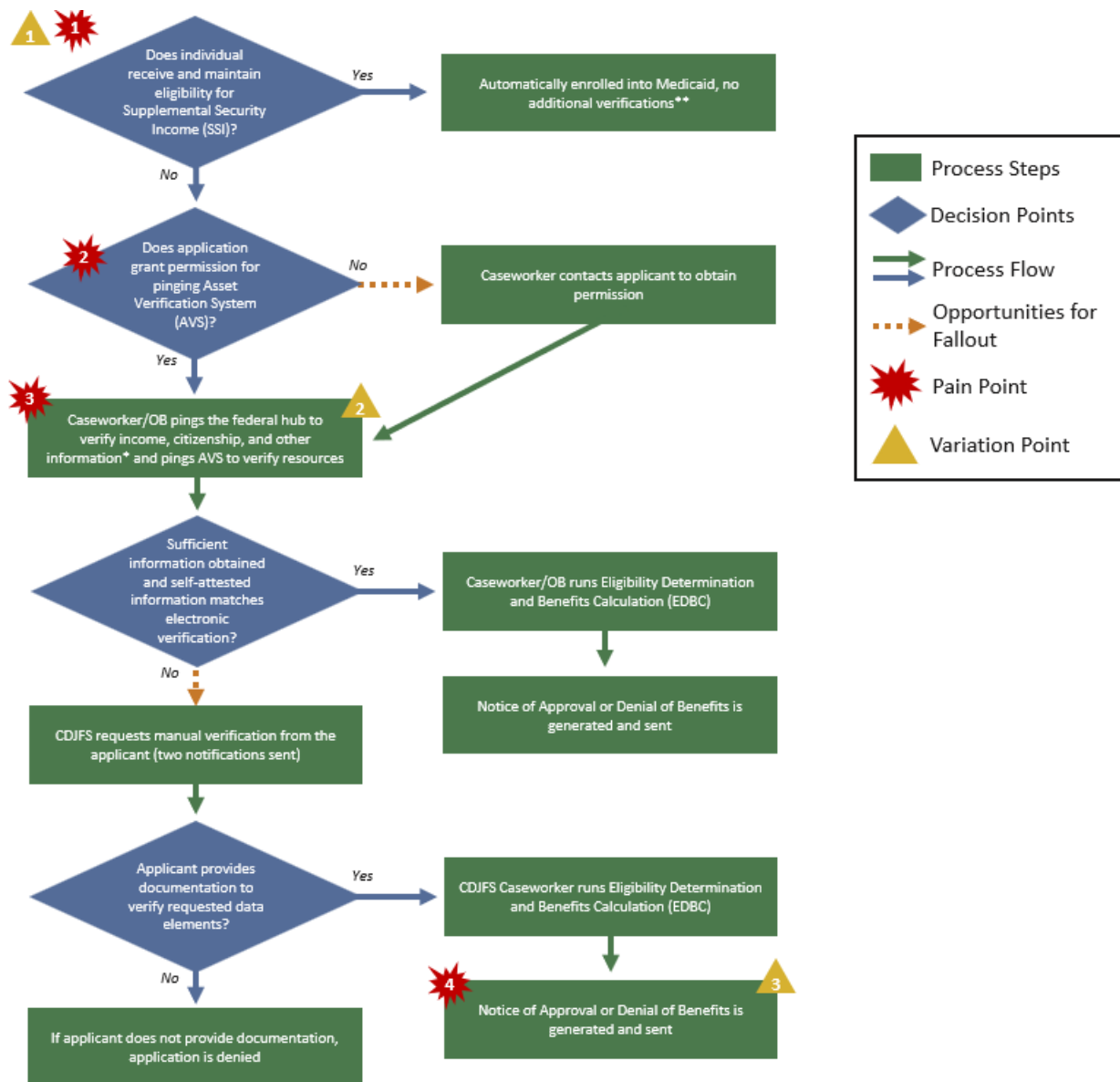
The four variation points are listed below, with numbers corresponding to the process map on the previous two pages.

1. Some counties have a screening, shelling, or indexing process for applications, in which the first few steps of the process are completed by clerical staff or supervisors before reaching caseworkers.
2. Some counties utilize citizen self-attestation to grant reasonable opportunity periods frequently, while others rarely need to do so.

3. Some counties determine presumptive eligibility before sending manual verification requests, while others struggle to determine it within 24 hours or do not determine it at all.
4. Some counties have their caseworkers review and approve the notice of approval or denial of benefits before it is sent.

The initial eligibility determination process varies slightly for ABD applicants, who must meet additional eligibility requirements regarding financial assets. The ABD specific eligibility determination steps are displayed in the process map on the following page.

ABD Initial Eligibility Determination Process



*Other information includes relationships, household composition, tax filing status, etc.

**This has changed for some non-citizens as of 10/6/2026

Source: ODM & CDJFS Feedback

Note: Only variation points discussed by more than one CDJFS are shown.

While the process map on the previous page displays the additional steps taken for ABD applicants, it does not show how much time or effort is required for each step, as CDJFS agencies indicated that there is often a substantial amount of back and forth between the county and the applicant to obtain the correct information. Additionally, if an applicant is applying for long-term care, there are additional steps in the application process not captured here. Within the ABD process, there are four pain points, listed below, with numbers corresponding to the process map visual on the previous page.

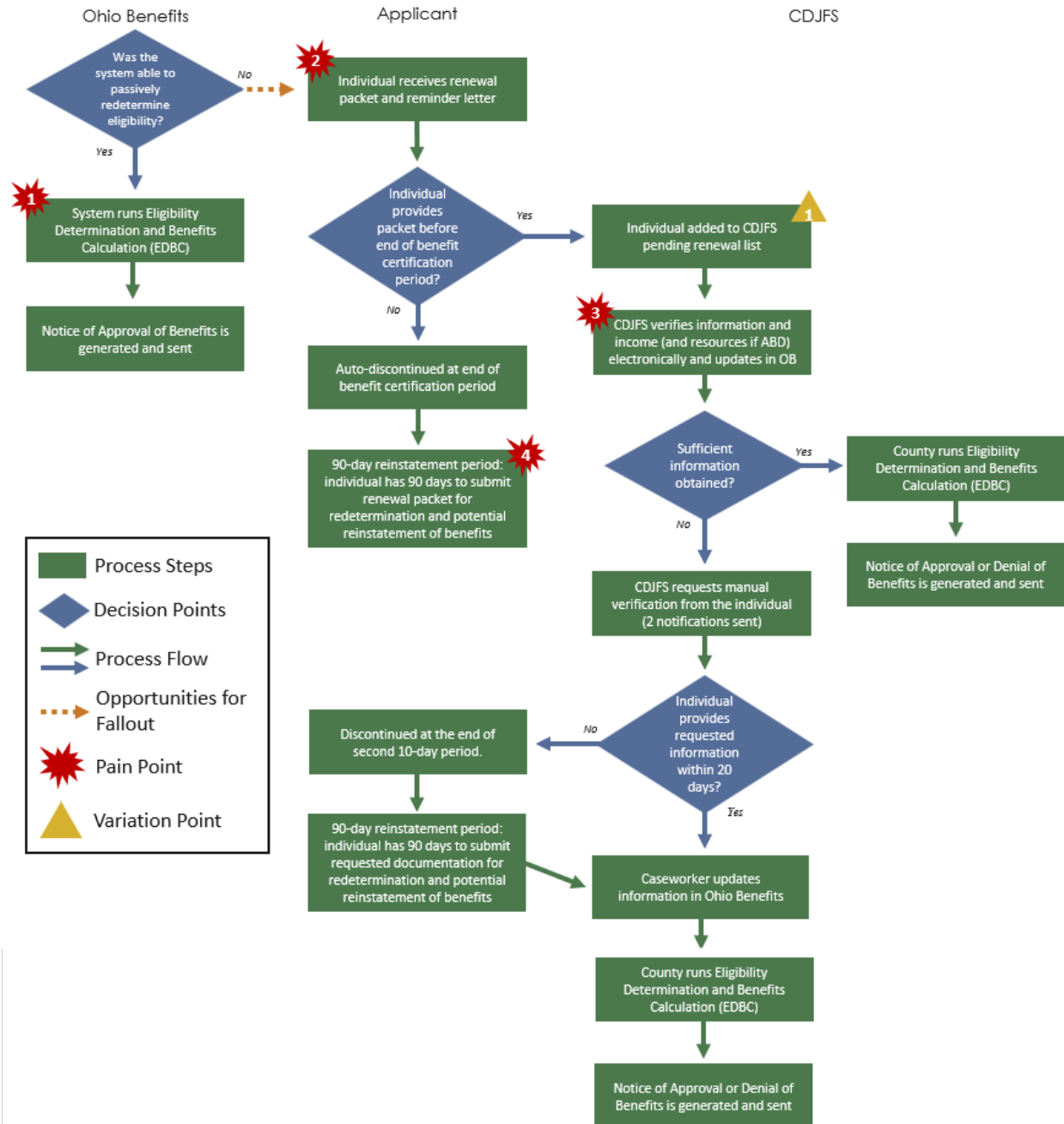
1. Applications do not request resource information, which guarantees that CDJFS caseworkers will have to contact ABD applicants to obtain this information.
2. Not all types of applications grant permission for the CDJFS agency to utilize the Asset Verification System (AVS) to verify applicant information. Counties are required to use this system, so the caseworkers must reach out to the applicant to obtain this permission if it is not granted in the application. This is particularly an issue with federal e-applications and older paper applications.
3. Information verification through AVS is not instant, CDJFS agencies receive results from AVS via alerts over multiple weeks. CDJFS agencies do not have time to wait for the AVS verification to run because they are trying to meet statutory timeliness requirements and do not know when the verification will be completed. Additionally, AVS does not capture local banks or all types of assets.
4. The notice of approval or denial of benefits generated by Ohio Benefits is not always correct.

There are three variation points within the ABD process, which are listed below, with numbers corresponding to the process map visual on the previous page.

1. CDJFS agencies identified various entities that are able to determine blindness and disability in addition to the Social Security Administration, including ODM, the Department of Developmental Disabilities, Veterans Affairs, and the State.
2. Some counties do not wait for the AVS verification to be complete to send out a manual verification request.
3. Some counties have their caseworkers review and approve the notice of approval or denial of benefits before it is sent.

Finally, CDJFS agencies must redetermine eligibility for all Medicaid recipients on an annual basis. This redetermination process is done for some recipients by the Ohio Benefits system, which is referred to as a passive ex parte renewal. CDJFS caseworkers conduct the redeterminations for the remaining Medicaid recipients. This process is displayed in the process map on the following page.

Eligibility Redetermination Process



Source: ODM & County Feedback

Note: Only variation points discussed by more than one CDJFS are shown.

Within the eligibility redetermination process, counties identified four pain points. These are listed below, with numbers corresponding to the process map visual on the previous page.

1. System renewal determination is not accurate and the county is not able to stop passive ex parte renewal for individuals they believe are no longer eligible. Only certain individuals within a block are passively renewed (i.e. a parent is renewed but their child is not). Lacking information on passively renewed cases.
2. Renewal packet is very long and could be streamlined. Renewal packets do not request resource information, which means that counties must reach out to individuals to obtain this information or use known information, which may be outdated.
3. Combination of renewals with other programs is problematic due to different renewal timelines, different documentation required, and different reinstatement periods.
4. Tracking during the reinstatement period is difficult because recipients can return packets or documents anytime within the 90-day reinstatement period, and CDJFS agencies may not be notified of this.

Additionally, there was one variation between counties in the redetermination process, which is listed below.

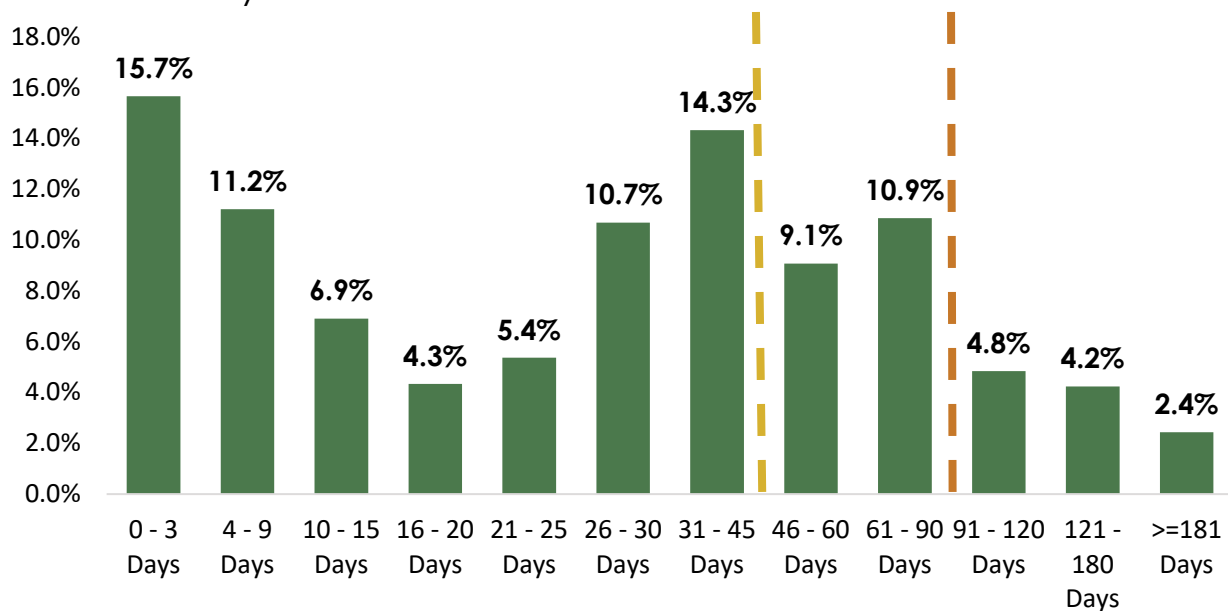
1. Counties indicated various locations that the pending renewal list is pulled from, including Ohio Benefits, Electronic Document Management System, BI Portal, as well as being provided by ODM.

Appendix K: Application Timeliness

As discussed in [Recommendation 7](#), ODM has not historically collected application processing timeliness data on the county level. During the course of our audit, we requested that the Department begin collecting this data and provide it to us. This showed that ODM does have the technical capability to collect the data and enabled us to review three months of application processing timeliness data on the county level. We used this information to create examples of the types of analysis the Department could conduct with the data.

First, we created a statewide summary of the data. The graph below displays the three-month average percentage of applications processed in each timeframe. In this graph, the orange dotted line represents the statutory requirement for applications on the basis of disability, while the yellow dotted line represents the statutory requirement for all other applications.

Statewide 3-Month Average Percentage of Applications Processed by Timeframe



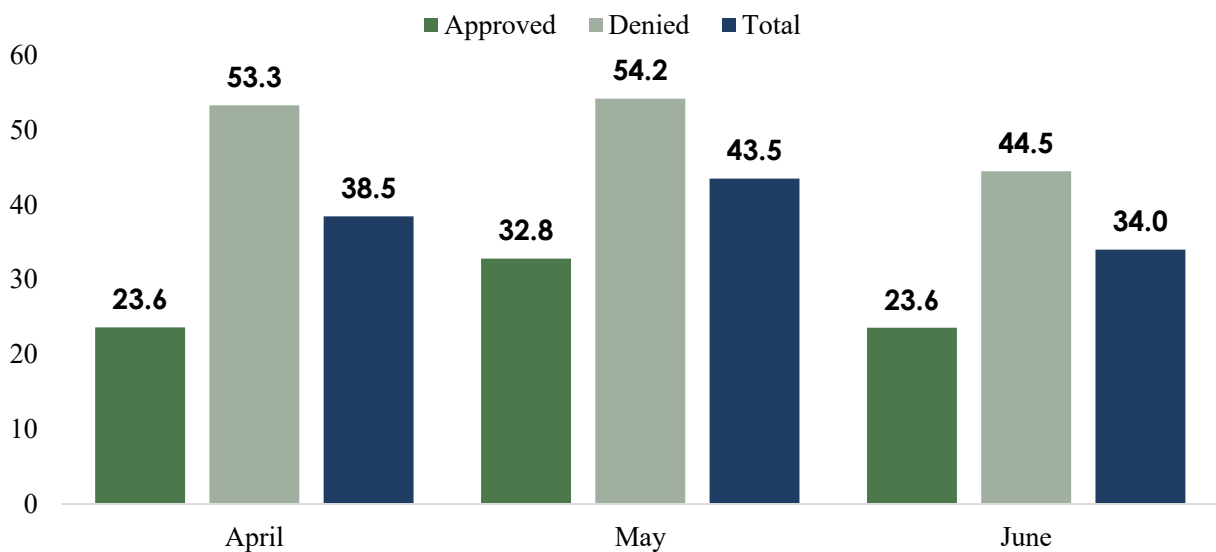
Source: ODM

As shown in this graph above, the State processed approximately 33.8 percent of applications in 15 or fewer days from April 2026 to June 2026. It also shows that approximately 11.5 percent of applications were processed in more than 90 days, which are out of compliance with statutory requirements. While this look is similar to the information provided by the pending application data examined in [Recommendation 7](#), it provides a more comprehensive summary of the State's performance during the whole time period, rather than just the point in time that the

report was pulled. Additionally, while not depicted here, ODM has the ability to filter the data by county to further investigate root causes of noncompliance.

This data includes a distinction between applications that were approved and denied. The graph below shows the average processing time, in days, for approved and denied applications by month.

Statewide Average Time to Eligibility Determination

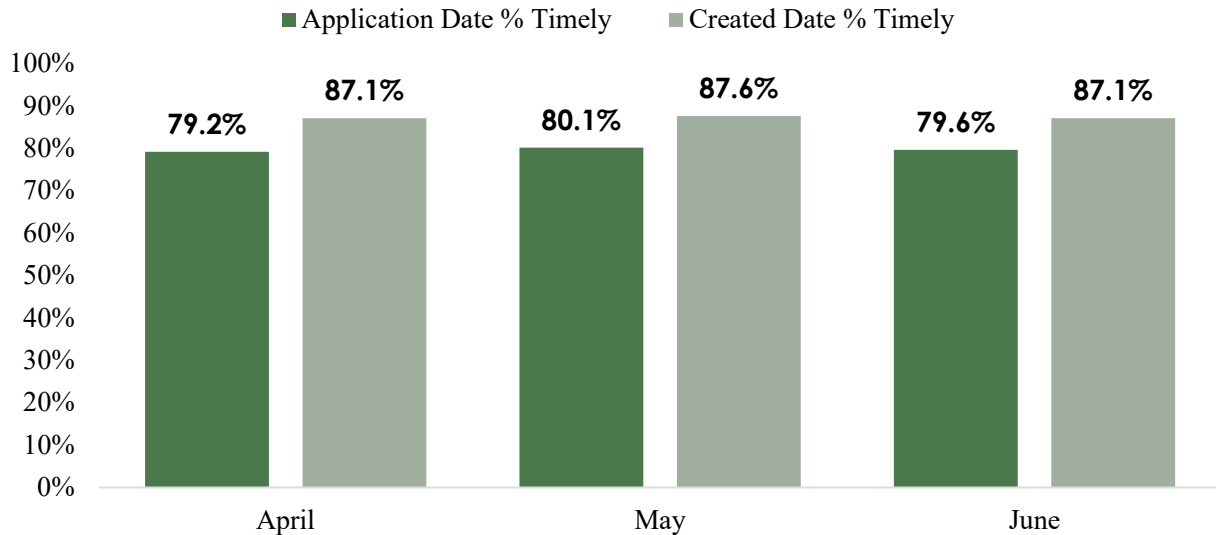


Source: ODM

As displayed in graph above, denied applications took longer to process than approved applications on average. With a difference of between 20 to 30 days, this longer timeline for denied applications may be impacting overall application timeliness performance. The longer timelines are likely partially due to CDJFS agencies having to send two requests for manual information verification and wait for 10 days after each request before denying an applicant.

The data also has a timeliness assessment using two different start dates: the application date and the created date. The application date is the date that an individual submits their Medicaid application, while the created date is the date that the application enters the system. The percentage of applications timely using each of these start dates is shown in the graph on the following page.

Statewide Average Percentage of Applications Timely

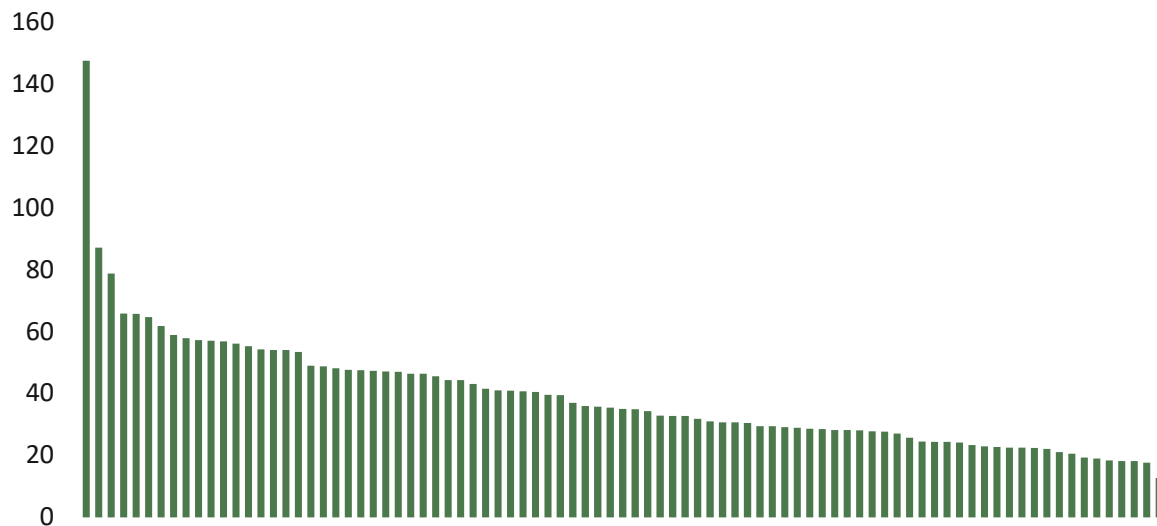


Source: ODM

As shown in this graph, applications are consistently more timely when timeliness is measured using the created date, rather than the application date. This may be related to CDJFS feedback that counties receive federal e-applications much later than they are submitted by an applicant. Therefore, created date may be a more accurate representation of timeliness within the control of counties.

This data is collected on the county level, meaning that the above information can be broken down by CDJFS agency. This would be a beneficial tool to assist ODM in evaluating and improving the performance of individual CDJFS agencies. For example, the graph on the following page shows the average application processing time, in days, by county over the three months of data.

Average Application Processing Time by County



Source: ODM

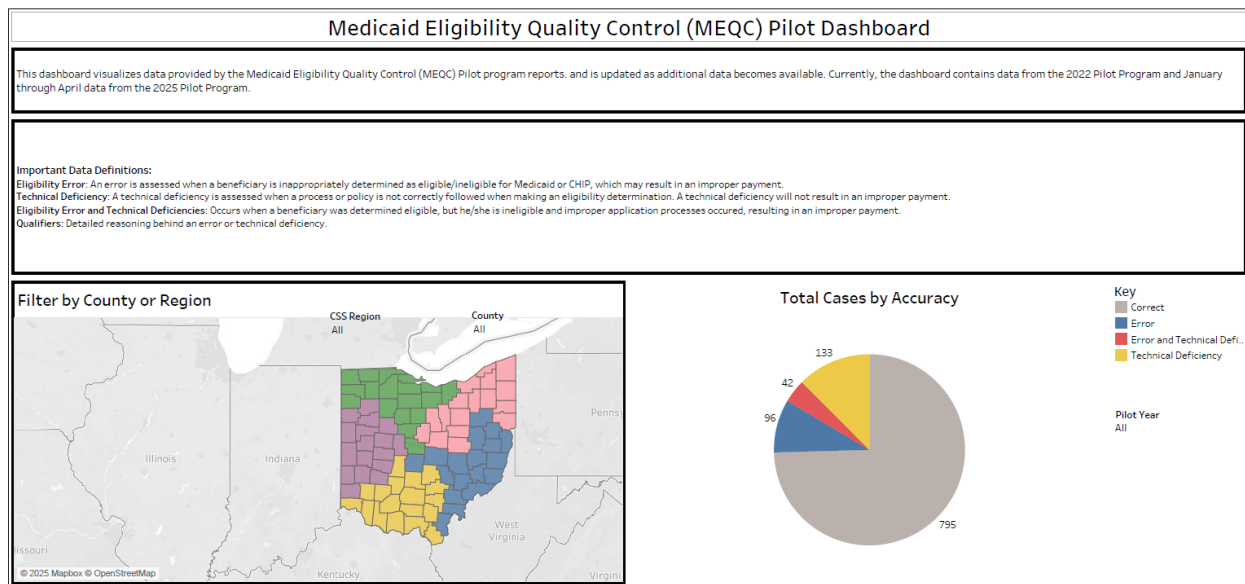
As shown above, there is a wide range of average processing times between the counties, with a maximum of 147 days and a minimum of 0 days. This type of information can assist ODM in identifying how different CDJFS agencies are performing in more detail, which can inform the Department's efforts to improve the eligibility determination process overall.

The application processing data at the county level that we received from ODM is limited to three months. With a broader time period of data, the Department would be able to observe and analyze timeliness trends over time, which could further inform process improvements. This is particularly important given the seasonal nature of timeliness due to the open enrollment period that we discussed with CDJFS agencies during our interviews. Finally, collecting even more granular data would allow ODM to pinpoint specific issues causing timeliness delays, such as particular types of applications.

Appendix L: Quality Control Dashboards

As discussed in [Recommendation 8](#), ODM publishes data on quality control efforts in a dashboard shared with CDJFS agencies. The first component of the dashboard includes information on the Medicaid Eligibility Quality Control Pilot results, shown below.

MEQC Pilot Dashboard Example

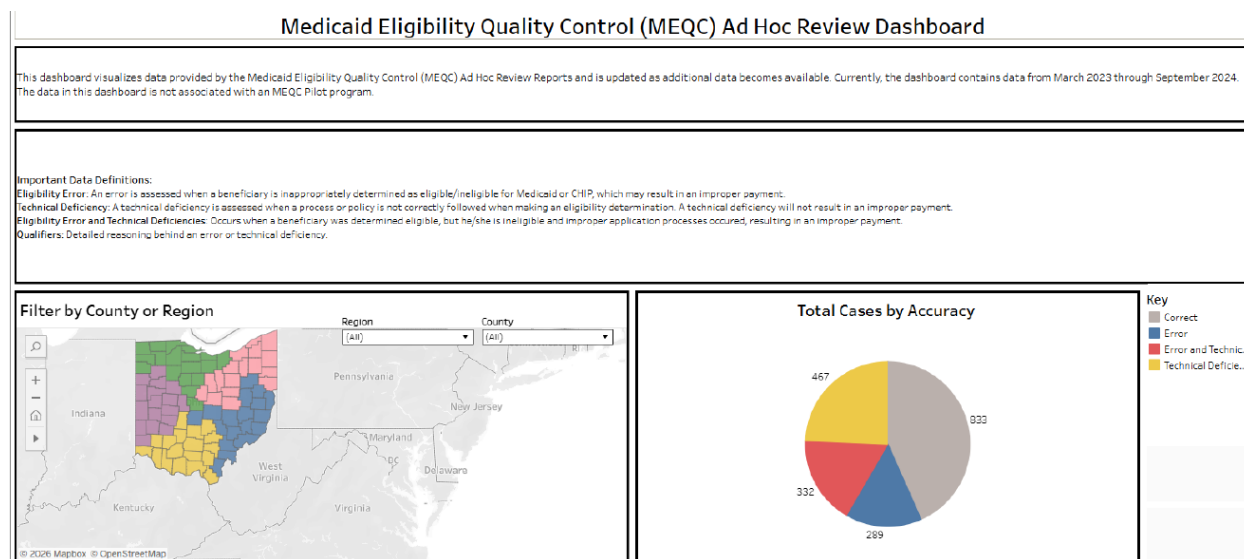


Source: ODM

As included in the dashboard description, this component of the dashboard includes two years of pilot program data, 2022 and 2025.

The second component of this dashboard includes data for ODM’s MEQC ad hoc review for March 2023 through September 2024. As discussed in [Recommendation 8](#), these reviews use a different methodology than pilot years.

MEQC Ad Hoc Dashboard Example



Source: ODM

While these dashboards can be utilized by counties to review their results and the results of other counties, only one county we interviewed was aware of this dashboard. Visit the [Analytics Ohio website](#) to view the dashboard.

OHIO AUDITOR OF STATE KEITH FABER



OHIO DEPARTMENT OF MEDICAID

FRANKLIN COUNTY

AUDITOR OF STATE OF OHIO CERTIFICATION

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



Certified for Release 10/15/2026

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