

# OHIO AUDITOR OF STATE KEITH FABER



**U.S. House Committee on Oversight and Government Reform  
Task Force on Defending Constitutional Rights and Exposing Institutional Abuses  
Hearing on Fraud in Medicaid Personal Services Waiver Programs  
Keith Faber, Ohio Auditor of State  
June 3, 2026**

Chairman Gill, Ranking Member Simon, and members of the Task Force:

Thank you for the opportunity to testify today regarding fraud risks and oversight concerns within Medicaid.

As Ohio's Auditor of State, my office is responsible for ensuring taxpayer dollars are spent legally, transparently, and efficiently. American taxpayers do not care whether dollars originate from the federal government or the state, they simply know that it is their money, and they do not want it stolen, wasted, or abused.

Since taking office, my administration has worked aggressively to identify fraud, waste, abuse, and control failures. To date, we have identified more than **\$9 billion** in unsupported or fraudulent public expenditures, with Medicaid and unemployment programs representing the two largest areas of concern.

As Auditor, my office has secured the conviction of more than **164 public officials**, while also expanding fraud reporting initiatives, fraud awareness campaigns, and cybersecurity training efforts.

Most recently, my office has been engaged with federal partners on public benefits fraud, including participation in the Vice President's fraud task force here in Washington. Earlier this year, when significant Medicaid concerns surfaced in Ohio, we quickly shared our findings with federal partners to help inform broader oversight and enforcement efforts. But our work has not stopped at the federal level. Over the last several months, I have testified multiple times before the Ohio General Assembly, repeatedly raising these concerns, outlining the weaknesses our audits and reviews have identified, and urging lawmakers to strengthen oversight, accountability, and fraud prevention across the Medicaid program.

There is one point that I want to make clear: our role as auditors is not to administer Medicaid programs or adjudicate eligibility decisions. While we audit government and look for control weaknesses, it is the benefit agency's responsibility to detect and identify individual beneficiary waste, fraud, and abuse. Our role is to identify weaknesses in controls, detect anomalies, investigate credible tips, and report findings so corrective action can occur.

This year's State Single Audit – which is a rigorous, comprehensive financial and compliance audit - identified potentially up to **\$4.4 billion** in fraud-related risk exposure connected to ineligible recipients in Ohio Medicaid programs. Our testing found an ineligible rate of 15.6%. This year's findings again highlighted the need for substantially stronger oversight and internal controls.

Today, I want to focus on two areas where our office identified significant concerns: Electronic Visit Verification, or the GPS that ensures providers are where they say they are, and individuals who are enrolled in Medicaid in multiple states at the same time.

Congress required EVV systems to help ensure accountability in Medicaid-funded home care services. The purpose is straightforward: verify that services occurred, that the right caregiver provided the service, and that the service occurred at the authorized time and location.

Our audit found that approximately 56 percent of home care services were not processed through the EVV system, representing an estimated **\$1.1 billion of nearly \$2 billion** in paid claims that were not matched to an EVV visit.

That is a significant control weakness.

Our audit work identified problems involving incomplete or inaccurate visit data, inconsistent provider compliance, and insufficient oversight mechanisms.

One important lesson from this work is that collecting large amounts of data does not automatically create accountability. Technology alone does not prevent fraud. Oversight agencies must have the staffing, analytical tools, and authority necessary to identify suspicious patterns and act quickly when concerns emerge, and most importantly, they need to be motivated to enforce controls.

Our office recommended stronger transparency measures, enhanced provider monitoring, and better use of predictive analytics to identify abnormal billing activity before improper payments occur to the Department of Medicaid.

In March 2024, our office released a report on Concurrent Enrollment, finding that more than **124,000 individuals** were enrolled in Ohio Medicaid and at least one other state for three consecutive months. Ohio paid managed-care organizations more than **\$1 billion** associated with those enrollees.

These findings highlight broader systemic challenges facing Medicaid oversight nationally, including fragmented data systems, outdated technology, delayed reporting, limited real-time monitoring capabilities, and insufficient interstate data sharing.

Too often, Medicaid oversight still operates under a “pay-and-chase” model where taxpayer dollars go out first and recovery efforts happen later, sometimes years later. Prevention is substantially more effective than post-payment recovery.

Our office recently provided recommendations to the Centers for Medicare and Medicaid Services focused on strengthening Medicaid program integrity. Those recommendations included expanding predictive analytics, improving interstate data sharing, strengthening provider screening processes, enhancing transparency tools, and improving pre-payment review systems.

Effective oversight requires coordination among state auditors, Medicaid agencies, attorneys general, federal oversight entities, managed care organizations, and law enforcement partners. Fraud schemes evolve quickly, and oversight systems must evolve just as quickly.

Medicaid was created to protect society’s most vulnerable. Unfortunately, bad actors are abusing the system to enrich themselves. Across the country, those administering this program have failed to protect taxpayers. Core safeguards have been compromised, removed, or simply ignored.

As a result, everyday Americans, who are finding it harder to afford their own lives, are subsidizing the abuse of the system. This is an affront to fiscal responsibility and the rule of law. We must stop this waste, fraud, and abuse to ensure there are resources to serve those who truly need these services and to avoid passing even more debt to our children and grandchildren.

Thank you again for the opportunity to testify today. I look forward to answering your questions.

OHIO AUDITOR OF STATE  
**KEITH FABER**



Appendix

- I. Electronic Visit Verification (full report available at [ohioauditor.gov](http://ohioauditor.gov))
- II. The Cost of Concurrent Enrollment (full report available at [ohioauditor.gov](http://ohioauditor.gov))
- III. 3/18/2026 Auditor of State letter to NASACT
- IV. 3/30/2026 NASACT letter to CMS

OHIO AUDITOR OF STATE  
KEITH FABER



Ohio Department of Medicaid

# **ELECTRONIC VISIT VERIFICATION**

Auditor of State Report

November 2024

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# OHIO AUDITOR OF STATE KEITH FABER



## Letter from the Auditor

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

Congress passed the 21<sup>st</sup> Century Cures Act (the Act) in 2016, and amended it in 2018 to extend compliance deadlines, to address vulnerabilities for fraud, waste and abuse in home health services. Section 12006(a) of the Act required states to implement an Electronic Visit Verification (EVV) system to verify Personal Care Services (PCS) by January 1, 2020, and Home Health Care Services (HHCS), by January 1, 2023. The Ohio Department of Medicaid (the Department) began a three-phase implementation of EVV in 2018 and completed the process in 2021.

Pursuant to Ohio Rev. Code §117.11, we conducted this audit in the public interest to assess the Department's compliance with implementation of the Act's EVV requirements by analyzing EVV data for the period January 1, 2022, through December 31, 2022, to determine whether payments for services were supported by EVV data and to identify barriers to the use of EVV for data pre-payment or post-payment.

The audit found that EVV was utilized for 44 percent of provider paid PCS and HHCS claims in 2022. Stakeholders indicate low compliance rates will continue until there is more of an incentive such as EVV data being required to be submitted as a condition of payment. Ohio spent approximately \$2 billion for personal care and home health care services in 2022. Ohio is one of 34 states that did not require an EVV data match for claims paid prior to the December 31, 2022. Also, the Department spent approximately \$146 million to design, implement, test, and support the EVV system. This audit report contains recommendations, supported by a detailed analysis and feedback from stakeholders. This report has been provided to the Department and its contents have been discussed with the appropriate staff and leadership within the Department. It is the Auditor's hope that the Department will use the results of this audit as a resource for future changes to its EVV system.

This audit report can be accessed by visiting the Auditor of State's website at [OhioAuditor.gov](https://OhioAuditor.gov) and choosing the "Search" option.

Sincerely,

A handwritten signature in black ink that reads "Keith Faber".

Keith Faber  
Auditor of State  
Columbus, Ohio

November 1, 2024

## EXECUTIVE SUMMARY

Home health care services reimbursed through the Medicaid program have been identified as high risk for fraud, waste, and abuse. Nationwide investigations completed by the HHS-OIG for the period 2011 to 2015 over home health services resulted in \$975 million in Medicare recovered funds<sup>1</sup>. These earlier reports (dating back to 2006) raised concerns about fraud, waste, and abuse in Medicaid-funded Personal Care Services (PCS) and culminated in a 2016 HHS OIG investigative advisory recommending the Centers for Medicare and Medicaid (CMS) issue regulations to “more fully and effectively use its authorities to improve oversight and monitoring of PCS programs across all states.”<sup>2</sup>

Section 12006(a) of the 21st Century Cures Act (the Act) mandates that states implement Electronic Visit Verification (EVV) for all Medicaid PCS and Home Health Care Services (HHCS) that require an in-home visit by a provider. This applies to PCS provided under sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), and Section 1115; and HHCS provided under 1905(a)(7) of the Social Security Act or under a waiver. Otherwise, the state is subject to incremental Federal Medicaid Assistance Percentage (FMAP) reductions up to 1% unless the state has both made a “good faith effort” to comply and has encountered “unavoidable delays.”

Pursuant to Ohio Rev. Code §117.11, we conducted this audit in the public interest to assess the Ohio Department of Medicaid’s (the Department) compliance with the implementation of the Act’s EVV requirements. As part of this audit, we analyzed EVV data for the period January 1, 2022, through December 31, 2022, the most recent full year data available, to determine whether payments for services were supported by EVV data and to identify barriers to the use of EVV data pre-payment or post-payment. During the audit period, approximately \$2 billion in paid claims were processed which should have been matched to an EVV visit. The audit found that EVV was utilized for 44 percent of provider paid PCS and HHCS claims in 2022. Ohio is one of 34 states that did not require EVV data as a condition of payment prior to December 31, 2022. The following factors may have attributed to the low compliance:

- Lack of an incentive by providers to enter EVV data as it was not required as a condition of payment;
- the administrative burden related to the matching process between EVV, claims data, and manual adjustments; and
- reluctance by beneficiaries to participate in EVV due to privacy concerns or a general misunderstanding of EVV.

In addition, the Department spent approximately \$146 million to design, implement, test, and support the EVV system. We selected a sample of 100 providers including home health care agencies, non-agency nurses and non-agency personal care aides. For each provider selected, we compared the number of paid services by procedure code to the number of EVV processed<sup>3</sup> visits in calendar year 2022 to determine the percent of services paid but not processed in EVV.

We found that approximately 56 percent of all services paid were not processed in the EVV system indicating the paid services were not matched to a verified EVV entry. The non-agency personal care aides had the highest percent of paid services without a matching processed visit at 62 percent.

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<sup>1</sup> The HHS-OIG report entitled, *Nationwide Analysis of Common Characteristics in OIG Home Health Fraud Cases*, by Thomas Komaniecki, Regional Inspector General for Evaluation and Inspections, June 2016 (OEI-05-16-00031) is available at [Nationwide Analysis of Common Characteristics in OIG Home Health Fraud Cases](#).

<sup>2</sup>University of California San Francisco Health Workforce Research Center on Long-Term Care report entitled, *Impact of Electronic Visit Verification (EVV) on Personal Care Services Workers and Consumers in the United States*, by Jacqueline Miller, Mary Lou Breslin, and Susan Chapman, RN, PhD, July 2021 is available at [UCSF Health Workforce study](#).

<sup>3</sup> A processed visit is when an EVV visit has been matched to a claim.

We found that 37 of the 100 providers in our sample did not submit any EVV data at all. We also found that approximately 34 percent of all EVV entries were manually adjusted.



**Based on our sample results, more than 56% of PCS and HHCS services were paid without a matching EVV entry during our audit period.**

Based on our analysis and feedback from stakeholders, we recommend that the Department:

- Communicate with beneficiaries to address common misconceptions about EVV and consider if reconvening the Stakeholder Advisory Group or similar committees to ensure beneficiaries and providers have an opportunity to provide input and feedback;
- Create a statewide scorecard to be shared among all EVV stakeholders to improve reporting on the effectiveness of the EVV system;
- Evaluate its implementation plan and timeline for requiring EVV as a condition of payment for all required services and take into account feedback from the various stakeholders. The Department should consider establishing a standard for percentage of auto-verified EVV data matches that providers must achieve. The Department should also proactively reach out to non-compliant providers to offer technical assistance and additional training.

## RECOMMENDATIONS

This report includes the following recommendations to the Department to improve the EVV process. These recommendations are limited to the results of procedures performed during this audit and may not reflect all deficiencies or weaknesses.

### Recommendation 1: Communication

In our interviews we learned that some beneficiaries are reluctant to allow the provider to use an EVV device in their home for fear of privacy breaches and a general misunderstanding of its need. We recommend the Department continue to develop informational public service announcements that providers can share with beneficiaries to address common misconceptions. We also recommend the Department consider if reconvening the Stakeholder Advisory Group or similar committee is appropriate to ensure beneficiaries and providers have an opportunity to provide input and feedback. This could also include being available for more one-on-one discussions and conducting targeted training/technical assistance to ensure providers maintain compliance with laws and regulations.

### Recommendation 2: Statewide EVV Scorecard

We recommend the Department consider creating a statewide scorecard to be shared among all EVV stakeholders to improve reporting on the effectiveness of the EVV system. As one trade association suggested, a statewide scorecard could be shared to show EVV utilization and the accuracy of matching as a way stakeholders and the public are informed of compliance with EVV and where EVV utilization is not meeting expectations. The process of creating a statewide scorecard could be tied into the Department's EVV monitoring processes and could be an effective tool to educate and advocate to providers on the importance of EVV utilization as the Department moves forward in implementing EVV data matches as a condition of payment. We also recommend the Department evaluate and identify how often a statewide EVV scorecard should be updated and made available to all stakeholders.

### Recommendation 3: EVV Match as a Condition of Payment

As outlined under the Recent Rule and Program Changes section, feedback received from stakeholders indicates provider utilization of EVV is low because claim payments are not tied to verified EVV entry. The Department is continuing to evaluate when the first phase of the claims adjudication process with home health service claims billed through the State Plan for FFS will commence. We recommend the Department continue to evaluate the implementation plan and timeline for requiring EVV as a condition of payment for all required services. This plan should include feedback/input from the various stakeholders over the amount of time before and during the initial claims denial effective date to allow technical assistance and a smooth transition.

In addition, the Department should consider establishing a standard for percentage of auto-verified EVV data matches that providers must achieve. The Department should proactively reach out to non-compliant providers to offer technical assistance and additional training.

OHIO AUDITOR OF STATE  
KEITH FABER



Ohio Department of Medicaid

# **THE COST OF CONCURRENT ENROLLMENT**

Auditor of State Report

MARCH 2024

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# OHIO AUDITOR OF STATE KEITH FABER



## Letter from the Auditor

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

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

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

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

This audit report can be accessed by visiting the Auditor of State's website at [OhioAuditor.gov](https://OhioAuditor.gov) and choosing the "Search" option.

A handwritten signature in black ink that reads "Keith Faber".

Keith Faber  
Auditor of State  
Columbus, Ohio

March 13, 2024



## EXECUTIVE SUMMARY

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



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

For this audit, we collaborated with the Office of Audit Services in the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) to obtain capitation payment data (a fixed per-member per-month payment). We used this data to identify instances in which the Ohio Department of Medicaid (the Department) made capitation payments for enrollees who concurrently had capitation payments made on their behalf by another state or territory.

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

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

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



## RECOMMENDATIONS

### RECOMMENDATION 1: Increase the Use of Technology in Application Process

The Department should work with other state Medicaid agencies and CMS to maximize the use of information technology for identifying individuals already enrolled in the Medicaid program at the time of the initial application. Currently, the enrollment process includes the electronic verification of eligibility factors using various sources. Examples of eligibility factors include the verification of income and of non-financial factors such as citizenship and social security numbers. With state residency being a key requirement, the Department should advocate for a system that also returns information regarding an individual's enrollment in another state's Medicaid program.

Along with this added functionality, the Department should work with other Medicaid state agencies and CMS to develop a consistent and streamlined approach for communication between states, such as each state implementing a single email address that can be used to identify and address concurrent enrollment issues. Feedback from the CDJFS staff interviewed highlighted the difficulties in communicating with other states to resolve residency issues and the Department's staff echoed this concern.

The Department indicated that currently verification from another state would not be sufficient in verifying residency; therefore, the Department should advocate with CMS to change the requirements to allow for that type of verification to be sufficient. Sharing that an applicant has attested to residency in a different state should be sufficient for the prior state to initiate the disenrollment process of the enrollee.

With an additional interface that allows states to identify an applicant who is already enrolled in another state's Medicaid program during the application process and an improved communication and coordination system between Medicaid state agencies, the Department would be able to identify and resolve potential concurrent enrollment in a proactive manner and save public dollars from being misspent.



**RECOMMENDATION 2: Earlier Identification of Concurrent Enrollment**

Ohio’s current Medicaid application only includes prompts for the applicant to provide a home and a mailing address. The Department should expand the application to include questions to ascertain if the individual recently moved to Ohio and if the individual was enrolled in the Medicaid program in the prior state. This information would provide an additional avenue to proactively identify concurrent enrollment and avoid the overpayments currently being made.

The Department should advocate with other state Medicaid agencies and CMS to have a requirement that each state implement a similar process of inquiry to identify potential concurrent enrollment. This addition to the application process along with the consistent and streamlined communication between states (noted in recommendation 1) would allow states to reduce the incidence of concurrent enrollment. While Ohio Admin. Code § 5160:1-2-10(B)(2) indicates that processing delays in terminating medical assistance in the prior state of residence is not grounds for denying Medicaid benefits in Ohio, improvements in proactively identifying concurrent enrollment so that the prior state of residence can end its enrollment would be beneficial and reduce public funds being misspent.

In reviewing the information for the sampled enrollees, we noted that a significant number of individuals were enrolled in states for multiple years but never received any services through that state’s Medicaid program. After the current unwinding process is complete, the Department should perform an administrative review of enrollees that have not received any services through the program in a set period, such as two years. The set period may be different for different age groups. In these instances, the Department should review the cases of these enrollees for issues such as outstanding PARIS alerts, returned mail with no forwarding address and/or returned mail with an out of state forwarding address, journal entries regarding address/residency and changes in other benefit programs.

Implementing these proactive steps to identify individuals that may no longer be residents of Ohio, along with the other recommendations included in this report will ensure Ohio has a robust system to reduce unnecessary capitation payments. Proactive identification of individuals that no longer reside in Ohio would also aid other benefit programs such as SNAP.

**RECOMMENDATION 3: Improvements in Clearing of PARIS Alerts**

The Department’s data shows that there were over 64,000 pending PARIS alerts at the end of December 2022. The number of pending alerts ranged from three in one small county to over 15,000 in one of the larger metro counties. With the end of the PHE and completion of the unwinding process, there have been many changes that impacted CDJFS staff.



In previous audits, the Department has outlined efforts to improve its processing of PARIS alerts. These efforts included analyzing and improving the functionality of the eligibility system, deploying County Engagement managers to work closely with the CDJFS offices, and reducing the alerts generated by the eligibility system<sup>11</sup>. The Department should continue in its efforts to work with CDJFS offices to address PARIS alerts.

In addition, the Department should work with other states and CMS to develop a simplified method to communicate issues involving an enrollee's residency status to assist all states in reducing the costs of concurrent enrollment. The Department should advocate for an enhancement to the PARIS alert data, specifically to have contact information for each state incorporated with the alerts. Currently the contact varies by state, with some states using a single email address and others with relying on individual contact information. Including contact information in the alert would help ensure that there is a clear communication pathway which would benefit the entire program.

The Department should also evaluate benefits from increased collaboration between CDJFS offices. In 2014, Ohio launched County Shared Services, an initiative to expedite and standardize eligibility and enrollment processes across county lines for Medicaid and other programs. CDJFS staff suggested there may be a benefit in increased collaboration between CDJFS offices, building on the benefits currently gained in the shared services groups. For instance, CDJFS offices that do not have backlogs of uncleared alerts could assist CDJFS offices that have backlogs. The Department should continue to engage in dialogue with the CDJFS offices to explore this option and others that maybe identified to assist CDJFS offices in clearing backlogs with PARIS alerts along with other casework activities.

#### **RECOMMENDATION 4: Reducing Financial Impact of Concurrent Enrollment**

Today more than 90 percent of Ohioans enrolled in Medicaid are assigned to a managed care entity to receive their services.<sup>12</sup> Because of this significant use of managed care, the Department should request that CMS provide matches based on T-MSIS data, similar to the data used for this audit, that show concurrent enrollment. This data combined with the PARIS alerts can be used to identify concurrent enrollment that has not yet been resolved, and enrollees that frequently move between states or that spend a regular portion of the year in another state and enroll in that state's Medicaid program during that time.

The Department should evaluate the cost and benefit of moving select enrollees that have been identified as a risk for concurrent enrollment from managed care to the fee-for-service model. This may include, but is not limited to, enrollees that receive SSI and are identified in the data as being enrolled in another state. As noted above, the Department is not able to terminate the benefits for an enrollee receiving SSI that has moved out of

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<sup>11</sup> See audit report on PARIS Alerts issued by Auditor of State, Keith Faber, on December 15, 2022 which is available on the AOS website: [Public Assistance Reporting Information System Alerts](#).

<sup>12</sup> Statistic reported on Ohio Department of Medicaid's website as of January, 5, 2024.



Ohio and instead continues to make capitation payments for this individual until the Social Security Administration updates its file.

The Department indicated it does not currently have a process to move an enrollee from managed care to fee-for-service and that it would involve a manual process to suppress auto-enrollment which would be difficult and time consuming. And, if it was then determined that the enrollee was an Ohio resident, the Department would have to manually update information to re-enroll the enrollee in a managed care plan.

Despite the reported difficulties, changing the status to fee-for-service allows for the enrollee to access Medicaid services while efforts are made to verify residency. If the enrollee has moved out of state and is not using Ohio Medicaid benefits, then Ohio will not incur any costs for this individual as opposed to continuing to make unnecessary capitation payments.

### **RECOMMENDATION 5: Review Subsequent Concurrent Enrollment Data**

While PARIS alerts are an important tool in identifying concurrent enrollment, these alerts are insufficient to identify all instances of concurrent eligibility. In our review of Ohio's eligibility system, we did not identify PARIS alerts for 27 percent of the individuals that were enrolled in another state. The Department should request CMS provide the data matches using the T-MSIS data for 2023, similar to what was used for this audit, to identify concurrent enrollment in another state.

The Department should determine if the concurrently enrolled individuals identified in the T-MSIS data are currently enrolled in Ohio's Medicaid program. For those currently enrolled individuals, Ohio should conduct a case review and contact the other state's Medicaid program to resolve the concurrent enrollment. In its review, the Department should prioritize those individuals that are concurrently enrolled in more than two states. For any indication of fraudulent enrollment, the Department should contact the appropriate law enforcement agency. For those individuals that are found to have established residency in another state, the Department should ensure that enrollment in Ohio's program is terminated in a timely manner.

### **MATTER FOR FURTHER STUDY**

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

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<sup>13</sup> Georgia, Massachusetts, Tennessee, and Wisconsin are not a part of the compact.

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

**FROM:** Ohio Auditor of State

**DATE:** March 18, 2026

**RE:** Important RFI Concerning Medicaid Program Fraud - Input Requested

**1) What statutory or regulatory changes are needed to strengthen states' ability to effectively reduce fraud, waste, and abuse in Medicaid and CHIP? And what regulatory or administrative changes could CMS make to empower states to:**

**(a) pursue bad actors; and (b) better coordinate program integrity efforts with the federal government, law enforcement, and other states?**

- State Verification Plans – Reasonable Compatibility Tests (Recommendation – Enhance the requirements for verification plans).
  - Specific Regulations include:
    - 42 CFR 435.945(j) requires all states to develop their own verification plan describing the verification policies and procedures adopted by the State to implement the provisions set forth in the federal regs.
    - 42 CFR 435.952(b) states if information provided by or on behalf of an individual is reasonably compatible with information obtained by the agency, the agency must determine or renew eligibility based on such information.
    - 42 CFR 435.952(c) states an individual must not be required to provide additional information or documentation unless information needed by the agency cannot be obtained electronically or information obtained electronically is not reasonably compatible, as provided in the verification plan described in 42 CFR 435.945(j).
  - The idea of “reasonable compatibility” is a very vague term that does not ensure States are adopting effective policies and procedures regarding their verification plans.
    - We have identified instances where reasonable compatibility for earned income verification was utilized and verified earned income amounts from a previous (inactive) employment source was compared to attested income amounts from a new (active) income source. Per Ohio laws (adopted based on the above federal regulations), the Department was actually required not to attempt to obtain more information since reasonable compatibility had been determined. It was also explained that discrepancies in source of income would not be a consideration when verifying income amounts for eligibility.
    - While the State technically had the authority to take this approach, we do not believe that this type of approach was in accordance with the intent of the federal regulations. The way it is currently being utilized increases the risk of Medicaid eligible income being determined inaccurately and results in an increased risk of fraud and abuse.

- Income Eligibility Verification System (IEVS) Alerts – Consider implementing or enhancing federal regulations that provide more specific guidelines on clearing IEVS alerts. This could include:
  - Adding a medium priority that would include IEVS alerts which could be considered error prone but that have a less immediate impact on eligibility. This medium priority level could have a longer review period (i.e., 90 days instead of 45) and could lessen the immediate workload of the caseworkers clearing higher priority level alerts.
  - While there are CFRs requiring States to review and compare information received from IEVS data matches, this does not seem to be what is always happening during the passive (automatic) renewal process. IEVS alerts are often not worked during the passive renewal process and there are times that a caseworker does not touch a case for years.
- If not currently in place, consider a formal process for how to handle unresponsive or uncooperative providers through payment suspension and including termination.
- Consider adding onto the existing CMS Preclusion List as a way for other states to obtain this information regarding providers who may close in one state and open in another state to help pursue bad actors.
- Consider best practices for how eligibility determinations are completed, including how to best incorporate manual and automatic application procedures.
- Consider tightening rules around requiring income verification, such as increasing the length of income history needed in order to renew eligibility.
- Consider restricting presumptive eligibility (outside of emergency care). Application processes should include ID and eligibility verifications being fully processed before approval.
- Consider/encourage the use of scorecards or publicly available dashboards to maintain transparency over various processes; for example, during the [Electronic Visit Verification public interest audit](#), the Ohio Auditor of State recommended Ohio consider using a scorecard to show the progress being made by providers using the Electronic Visit Verification system.
- Consider increased oversight and monitoring if it is determined improper payments are made. This could be done through enhanced desk reviews and/or corrective action plans.

## 2) What data or tools would enhance state program integrity activities?

- If there aren't already, potentially consider enhancing federal regulations to ensure Medicaid related system transitions are approached appropriately including data retention schedule requirements, plans requiring approvals, etc.
  - State specific – The Department of Medicaid recently switched their Fiscal system from Medicaid Information Technology System (MITS) to a new Fiscal Intermediary (FI) system and Provider Network Management (PNM) as part of the Ohio Medicaid Enterprise System (OMES) modernization. While the transition aims to have beneficial results, the transition was not smooth, and it resulted in various errors due to improper retention of documents and a full lack of transition for certain required processes.
- Consider stronger outreach efforts and mandatory compliance training to help ensure key laws and regulations are being followed, especially over new or upcoming changes.
- Less ambiguity in factors used to determine eligibility so there is a more clearly defined process requiring less subjective consideration and evaluation of unique factors.
- Use the Transformed Medicaid Statistical Information System (T-MSIS) data to perform predictive data analytics and identify key areas of concern on which audits or reviews should be focusing. Flag patterns of potential fraud on a national basis. Share this data and information with states/auditors to allow for consistent methods to root out fraud, waste, and abuse.
- Consider providing access for both state program integrity staff and also their policy counterparts to technical assistance sessions and materials produced by the Medicaid Integrity Institute.
- Consider simplifying the process for law enforcement/oversight agencies to receive access to data.
- Consider a tool that provides an alert anytime abnormal surges or decreases in codes is identified.
  - Minnesota, Indiana and Ohio have all seen spikes in usage of certain codes that remained undetected. It appears Ohio only found the problem because children's hospitals raised a concern.

**3) Would expanded use of federal databases, such as Do Not Pay (DNP), or non-federal databases provide states with more comprehensive information to move away from a “pay-and-chase” model and toward pre-payment review?**

Yes. Expanded use of federal databases, including Do Not Pay (DNP), would significantly enhance states’ ability to shift from a reactive “pay-and-chase” model to a proactive pre-payment review framework. Access to centralized, real-time data sources allows states to verify eligibility, identify deceased individuals, detect duplicate enrollments, confirm provider exclusions, and flag high-risk entities before payments are issued.

Integrating DNP and other federal and non-federal data sources into eligibility and claims processing systems strengthens front-end controls and reduces improper payments, administrative burden, and recovery costs. Pre-payment controls are considerably more cost-effective than post-payment recovery efforts, which often require lengthy investigations and may result in limited recoupment.

To maximize effectiveness, states would benefit from:

- Real-time or near-real-time system integration capabilities
- Clear federal guidance on permissible data matching and privacy safeguards
- Technical support and funding to modernize legacy systems

Roadblocks to this are the costs associated with integrating an automated proactive pre-payment review into the current Medicaid system, and having the review performed in a timely fashion so benefits are not delayed for those who are truly eligible.

- State Wage Information Collection Agency (SWICA) alerts could be considered a non-federal database and while they do provide states with more comprehensive information, they increase the volume of IEVS alerts and a lot of the time they aren’t worked or aren’t worked properly. If used correctly, they could help states move away from a “pay-and-chase” model.

Expanded and streamlined access to comprehensive databases would support stronger program integrity while preserving timely access to services for eligible beneficiaries.

**4) What successful strategies have certain states implemented that could serve as best practices for others?**

- SWICA Alerts – When used correctly, these alerts are a great way to identify new potential income and/or incomes for recipients or households. IEVS alerts are required across all states; however, SWICA are only used by some. While there’s a lot of room for improvement (i.e., they are often not worked timely), they are a great starting point to potentially identifying fraud or abuse.
- A new division in addition to or as an extended branch of the current Medicaid Eligibility Quality Control (MEQC) group within the Department.
  - State Medicaid has a MEQC group, which is responsible for ensuring eligibility decisions are made properly for the Medicaid Cluster and CHIP programs. MEQC performs reviews for the following: 1) CMS mandated pilot that occurs on a three-year cycle, 2) negative case renewal discontinuances/terminations and active case reviews for approval, and 3) automated health system vendor calls to ensure accuracy (i.e., listen to calls conducted by the vendor agents and take notes on any issues found while the vendor completed their renewal interview with the recipient). While the State currently does not have an additional division, it could be beneficial to designate a division within the Department that would review 100% of certain types of redeterminations or eligibility determinations at certain times. For example, passive renewals that are completed by bots are often where ineligible recipients are identified during audits. These passive renewals may need to be audited more often internally to ensure eligibility accuracy. Another example could be self-reported income since this type of income is usually taken at the recipient’s word at first. These determinations may need to be reviewed more often to ensure self-reported income is being followed up on.

**5) What is the most effective way for states to learn about up-to-date technology and data analytics tools available to combat fraud, waste, and abuse in Medicaid and CHIP?**

- A multi-tiered approach combining awareness, practical training, and implementation support would be most effective. Introductory webinars and virtual briefings are valuable for raising awareness of emerging technologies, data analytics tools, artificial intelligence applications, and best practices. These sessions reduce travel and cost barriers, allowing broader participation across states. However, hands-on training opportunities are essential to ensure stakeholders gain a practical and operational understanding of how to deploy and use these tools effectively. Interactive workshops, simulation-based learning, and peer-to-peer collaboration sessions allow staff to translate theory into implementation strategies.
  - To drive meaningful adoption:
    - Training opportunities should be affordable and supported by federal funding where possible.
    - Sessions should be tailored to varying levels of technical expertise (executive leadership, program managers, IT professionals, auditors, and investigators).
    - States should be provided with implementation toolkits, model procurement language, and case studies demonstrating measurable return on investment.
    - Ongoing technical assistance should be available after training to help states implement what they learn.

Providing access not only to information but also to deployable tools and technical guidance will help ensure that states can implement improvements quickly and effectively.

**6) What incentives could encourage states to proactively strengthen program integrity efforts, and what new penalties, if any, may be necessary to address state noncompliance?**

States are often constrained by limited financial and staffing resources, which can delay or restrict proactive investments in program integrity. Cost and time are significant barriers to implementing system upgrades, advanced analytics, and expanded oversight activities.

Incentives that may encourage stronger proactive efforts include:

- Enhanced federal matching rates for investments in technology modernization and advanced analytics
- Grant funding dedicated to fraud prevention system upgrades
- Performance-based financial incentives tied to measurable reductions in improper payments
  - Incentive if a certain % of fraud is identified within the state. Potentially could increase the FMAP or match rate.
  - Flexibility in reinvesting recovered funds into further program integrity initiatives

Positive incentives may be more effective than punitive measures in driving sustainable improvements. However, clear accountability standards remain important. Rather than imposing new penalties, strengthening existing oversight mechanisms, establishing clear performance benchmarks, and requiring corrective action plans for repeated noncompliance may achieve better long-term results.

**7) What data or information should be made publicly available that would allow for transparency in Medicaid by states, health plans, and providers?**

Information from Managed Care plans on their quality measures and performance metrics to help ensure provider transparency. The ability to view Managed Care quality reports and network adequacy data would be valuable for transparency.



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March 30, 2026

Centers for Medicare & Medicaid Services  
Department of Health and Human Services

Via: Electronic Mail

Re: CMS–6098–NC, RIN 0938–AV97, Request for Information (RFI) Related to  
Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH)

To Whom It May Concern:

On behalf of the National State Auditors Association (NSAA), representing state audit officials nationwide, we appreciate the opportunity to provide input on the above-referenced Request for Information. We commend the Centers for Medicare & Medicaid Services (CMS) for its continued commitment to strengthening program integrity and for seeking stakeholder feedback on strategies to combat fraud, waste, and abuse across Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and the Marketplace.

The National State Auditors Association (NSAA) is an affiliate of the National Association of State Auditors, Comptrollers and Treasurers (NASACT) dedicated to uniting state auditors by encouraging and providing opportunities for the free exchange of information and ideas between auditors at the state, federal, and local levels.

The following comments reflect our observations and recommendations based on the experience of our member offices across multiple states. We look forward to engaging with your office in more detail as CMS explores efforts to reduce fraud, waste, and abuse.

**Program Integrity Enhancements**

CMS has an opportunity to strengthen program integrity through improved coordination, oversight, and enforcement mechanisms.

Enhanced coordination across federal and state entities is critical. States would benefit from improved information sharing, including access to additional federal databases and tools that allow for cross-state comparisons of provider and beneficiary data.

Strengthening national-level visibility, such as expanding databases of known fraud patterns or sanctioned individuals, would further support these efforts. An example of this is our members’ work with HHS-OIG. Some of our members are using data from three sources: their state, neighboring states, and federal data to identify situations where individuals are concurrently enrolled in multiple state Medicaid plans. Working together to



reduce concurrent enrollments is critical to protecting both state and federal funds from waste.

Outside of the concurrent enrollment example, states maintain separate connections to multiple federal data sources to verify eligibility and other program requirements. Because most eligibility factors, aside from state residency, rely on federally maintained data, a centralized system would reduce administrative complexity and improve consistency while supporting states in identifying bad actors.

One state also suggested requiring the use of Office of Motor Vehicles (OMV)-equivalent driver's license data to identify beneficiaries who move out of a state. Most states' OMV-equivalent agencies participate in an interstate compact to share data when residents move between states. While the usability of the data differs from state to state, it is an example of leveraging existing information to improve program integrity.

### **Eligibility and Provider Oversight**

In discussions among our members, Eligibility has consistently been the primary area of concern with the Medicaid program. Eligibility determination processes represent a significant area of risk and would benefit from additional federal clarity and strengthened controls. State audits have identified concerns related to insufficient verification procedures, overreliance on automated processes, and inconsistent handling of eligibility alerts.

CMS guidance would benefit from increased specificity. For example, vague regulatory concepts - such as "reasonable compatibility" in eligibility determinations - have led to inconsistent application across states and increased risk of improper payments. This highlights the need for clearer federal expectations to ensure consistent and accurate implementation.

CMS should pursue regulatory changes that strengthen oversight of eligibility functions performed by state-based exchanges. The Compliance Supplement for the Medicaid program does not currently direct state auditors to test verifications performed by these exchanges, despite their significant role. For example, in one state, the exchange determined eligibility for approximately 75% of Medicaid beneficiaries during fiscal year 2025 and is also responsible for CHIP eligibility determinations. This represents a substantial volume of determinations without assurance that verifications were performed correctly.

CMS should address the contradiction between two federal requirements. Title 2 CFR Part 200.515 requires auditors to report questioned costs for statewide single audit findings. However, under Section 1903(u) of the Social Security Act and Title 42 CFR Part 431, Subpart Q, states are required to return recoveries based on eligibility errors only when identified through the Payment Error Rate Measurement (PERM) program. This lessened



emphasis on questioned costs could lead state Medicaid agencies to not take aggressive action to remedy issues that caused questioned costs identified in Single Audits.

Enhancing requirements for verification plans, clarifying expectations for resolving eligibility alerts, and strengthening controls around passive renewals and presumptive eligibility should also be prioritized. Increased emphasis on staffing adequacy and specialization for eligibility determinations could further improve accuracy and reduce risk.

CMS could also strengthen oversight of contractors and program integrity partners by increasing incentives for participation and ensuring more consistent engagement. For example, states have raised concerns regarding limited participation and capacity among Unified Program Integrity Contractors (UPICs) and Recovery Audit Contractors (RACs), which can hinder timely investigation and recovery efforts. CMS should consider adding minimum use standards to Title 42 CFR Part 455, Subpart F to prevent underutilization of RACs.

Provider oversight could be strengthened through more frequent enrollment validation, clearer ownership disclosure requirements, and enhanced mechanisms to track providers across state lines. Expanding tools such as preclusion lists or establishing national tracking mechanisms would help prevent providers from re-entering the system in different states after sanctions.

CMS should also consider implementing regulatory changes to strengthen oversight of providers with confirmed improper claims or significant overpayments. For example, requiring periodic provider audits and shortening re-enrollment periods would enhance monitoring and reduce future improper claims. A standard five-year re-enrollment cycle may be too long for providers with a history of improper payments.

### **Leveraging Data**

The use of data and technology is central to advancing program integrity efforts. CMS should consider establishing minimum data analytics standards and expanding the use of predictive analytics at the national level. Leveraging systems such as the Transformed Medicaid Statistical Information System (T-MSIS) could identify patterns of fraud across states that could significantly improve detection and prevention.

States would benefit from access to real-time or near-real-time data, improved system integration, and tools that generate alerts for abnormal billing patterns or eligibility anomalies. CMS could also support states by providing technical assistance, implementation guidance, and funding to modernize legacy systems and adopt advanced analytics tools.

CMS may also wish to consider the benefits of common data analytics software across states or creating a centralized technology clearinghouse of approved analytics tools,



including descriptions of capabilities and use cases. A shared analytics environment would allow states to securely upload data and run standardized fraud detection models. Additionally, model algorithms and analytic templates could be developed to identify high-risk providers, unusual billing patterns, and eligibility anomalies.

Expanding access to federal databases, including Do Not Pay (DNP), could help shift states from a “pay-and-chase” model to a more proactive pre-payment review approach. Enhanced data integration would allow states to verify eligibility, identify duplicate enrollments, and detect high-risk providers before payments are issued. Currently, utilizing Do Not Pay requires states to each enter into agreements separately with the Department of Treasury. Our members have discussed the possibility of a single agreement between the Federal government and all states which would encourage broader use of DNP by states.

However, access alone is insufficient. CMS should consider requiring the use of certain data sources and providing guidance on how to effectively integrate and act on results. States have noted that data tools are most effective when paired with clear expectations, adequate staffing, and timely follow-up processes.

### **Money Follows the Person**

CMS should include Money Follows the Person (MFP) Demonstration Program (Assistance Listing 93.791) in Part 4 of the Compliance Supplement. Established by the Deficit Reduction Act of 2005 and implemented beginning in 2007, the MFP program is administered by approximately forty states and often qualifies as a Type A program. This is especially important given the significant federal investment over the last two decades.

### **Guidance, Training, and Best Practices**

CMS can further support states by providing clearer guidance, expanded training opportunities, and mechanisms for sharing best practices. A multi-tiered approach including webinars, hands-on training, technical assistance, and implementation toolkits would help states adopt modern technologies and strengthen program integrity efforts.

CMS should issue management decision letters that provide actionable guidance, rather than brief responses that do not support resolution.

Training is a key mechanism to ensure stakeholders remain current on strategies to combat fraud, waste, and abuse. A strong example is the NASACT Medicaid Training Summit, a partnership between NASACT and the U.S. Department of Health and Human Services (HHS). This training includes sessions from both state and federal Medicaid auditors and is designed for auditors at all experience levels. Between 200 and 300 attendees representing state and territorial auditors, CPA firms, state Medicaid staff, and the federal government attend this virtual training held around the beginning of April each



year. This training has been essential to spreading the word on the success of states working together and with HHS-OIG to identify instances of concurrent enrollment.

CMS should also consider publishing summaries of common fraud schemes, emerging risks, and effective mitigation strategies. This would demonstrate CMS's commitment to program integrity and enhance partnerships with other entities that provide Medicaid oversight.

CMS may wish to require states to report and publish information related to fraud recoveries, program performance, and managed care outcomes to improve transparency and strengthen program integrity. Increased transparency can enhance accountability and support oversight efforts. Additionally, CMS should consider sharing the results of its reviews of state-based exchanges with state auditors to assist with their risk assessments.

### **Incentives and Accountability**

States face resource constraints that can limit proactive investments in program integrity. CMS should consider providing financial incentives - such as enhanced federal matching rates, grant funding for additional audits, or performance-based rewards tied to reductions in improper payments.

Allowing states to retain a portion of recovered funds could further incentivize investment in fraud prevention. At the same time, clear accountability standards and strengthened oversight remain essential to ensure consistent compliance.

### **Conclusion**

We appreciate the opportunity to provide these comments. We believe that clearer guidance, stronger oversight, improved data sharing, and expanded use of analytics will significantly enhance efforts to prevent and detect fraud, waste, and abuse.

NSAA looks forward to a continued collaboration with CMS to support these important objectives.

Sincerely,

A handwritten signature in blue ink that reads "Pat McCarthy". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

Pat McCarthy  
President, NSAA  
State Auditor, Washington