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VORYS

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Ohio Auditor of State Medicaid Compliance Examinations

What to Expect, How to Prepare and
Recent Trends

The Ohio Auditor of State (the Auditor) conducts Medicaid compliance examinations (commonly referred to as audits), to identify improper payments and to ensure compliance with Medicaid reimbursement requirements. These audits are unique from other provider post-payment reviews — they follow a particular process, their findings are ultimately public and, therefore, can have significant financial and reputational effects on the provider. Providers who navigate alone do so at their peril.

This white paper focuses particularly on behavioral health providers, but the process is universally applicable to all Ohio Medicaid provider types.

Compliance Examination Timeline

PHASE	DAY*	EVENT
I	0	Notification of selection for Medicaid compliance examination
	7	Entrance conference; Request for records
	37	Records due; Auditor fieldwork begins
II	100	Auditor issues Draft Findings
	105	Provider’s final opportunity to provide additional information
III	135	Auditor issues Draft Report
	140	Exit Conference
	145	Provider’s Response to the Draft Report
	160	Report Finalized and Published

**Time frames are approximate. For example, fieldwork usually takes between one and three months but can take longer depending on the scope of the audit and the Auditor’s workload. The deadlines given to the provider are generally the same (e.g., 30 days for the initial records production and five business days to provide additional information after receipt of Draft Findings).*

PHASE I: PRODUCTION OF RECORDS

The audit begins with a notification to the provider, which often arrives as formal correspondence delivered via email, as well as a phone call or separate email from the Auditor. Next is an entrance conference during which the Auditor explains the audit process and provides their request for records. Providers typically have 30 days to submit records. The scope of the request is often quite broad, typically encompassing hundreds of services over a multi-year period. An organized, thorough and prompt response is essential, positioning the provider well for a successful audit.

Once it has received the records (typically via its secure file transfer portal), the Auditor reviews the documentation for compliance with Medicaid billing requirements. The Auditor also verifies that all practitioners who appear in the clinical records are appropriately licensed, enrolled in Medicaid and not subject to an exclusion. This phase also includes an EHR walkthrough during which the Auditor meets with a team of provider representatives to learn about the provider’s documentation and billing systems. The Auditor’s fieldwork generally lasts one to three months.

PHASE II: DRAFT FINDINGS AND PROVIDER RESPONSE

Upon completion of its fieldwork, the Auditor issues Draft Findings, in which they identify allegedly deficient claims and the reasons for its findings. The Auditor also notifies the provider of any issues with its practitioner qualifications. Providers have only five business days to respond to the Draft Findings by providing additional relevant information (such as supplemental clinical notes, treatment plans or records of prior authorization). This is the final opportunity for the provider to supplement its record production to the Auditor.

Although not required, we strongly recommend providers address disputed findings in a formal correspondence analyzing the applicable Medicaid billing requirements. It is imperative to eliminate any findings as soon as possible, as sample test findings can be extrapolated into much larger findings if the error rate is high enough.

A note on extrapolation: The Auditor may extrapolate their findings when the number of allegedly deficient services passes a certain threshold in a sample test. Although this specific threshold is somewhat unclear (and currently not in applicable law or guidance), the fewer allegedly deficient claims in a sample, the less likely the Auditor is to extrapolate their findings.

PHASE III: REPORTING AND FINAL STEPS

After considering the provider's response and any supplemental documentation, the Auditor produces a Draft Report. The Draft Report summarizes the types of services it reviewed, which Medicaid reimbursement requirements were analyzed, the number of findings and the amount of overpayment finding (if any). Providers will likely have to request from the Auditor the current line-item list of allegedly deficient claims.

Providers have the choice to take part in an exit conference and are asked to sign a representation letter. We recommend providers take advantage of the exit conference to raise any issues with the Draft Report and ask the Auditor to explain their reasoning for any claims remaining in dispute. Following the exit conference, providers have the opportunity to provide a final response within five business days. We strongly recommend submitting a comprehensive response, which will be included as part of the audit file.

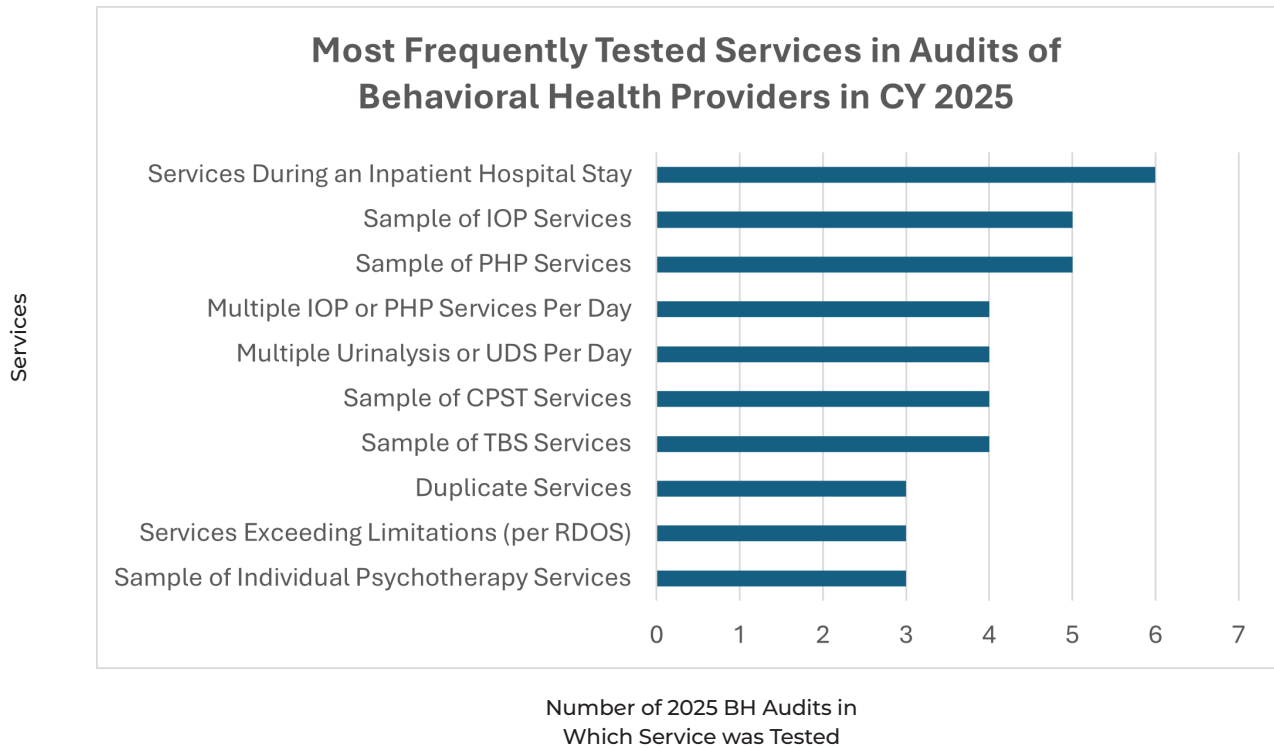
The Final Report and provider response are then sent to the Ohio Department of Medicaid (ODM) and published on the Auditor's website. Sometimes, the Auditor will issue a press release, depending on the nature and amount of the findings. Although the Auditor may make findings, they do not always result in a Medicaid overpayment. In order for ODM or a managed care entity (MCE) to recover an overpayment, each must do so within the applicable statute of limitations.

RECENT TRENDS

2025 saw a continued focus on Medicaid providers, with the Auditor conducting 47 Medicaid provider compliance examinations, 14 of which involved behavioral health providers. The Auditor made overpayment findings in 93% of their behavioral health provider compliance examinations. Overpayment findings ranged from zero to more than \$1.75 million, with findings for nine of the 14 compliance examinations under \$10,000. The average finding exceeded \$250,000, not including interest.

We understand that the Auditor conducts intensive data mining to identify their subjects — providers of expensive services, high-volume providers or providers flagged for specific, perceived billing irregularities. We believe that AI tools have allowed for enhanced data analytics, and have permitted the Auditor to conduct more audits than in the past.

Services most frequently tested during 2025 include outpatient services provided during inpatient hospital stays, intensive outpatient and partial hospitalization group counseling, CPST / TBS and individual psychotherapy.



STRATEGIC CONSIDERATIONS

Providers should approach the audit process with a heightened level of care. Timely, organized document production and proactive engagement with the Auditor are vital. Specific recommendations are as follows:

- *Engage legal counsel who have experience guiding Medicaid behavioral health providers through these audits as soon as possible.* We have seen that delay negatively affects the outcome of the audit.
- *Set the right tone at the entrance conference.* Be cordial and be willing to explain clinical, documentation and billing practices.
- *Take advantage of the lull during the Auditor’s fieldwork.* Self-assess documentation and anticipate arguments the Auditor will likely make. Remember, providers have only five business days from receiving the Draft Findings to first set forth arguments disputing alleged deficiencies.

- *Be careful to distinguish between Medicaid billing requirements and certification or other requirements.* Not all documentation errors result in noncompliance with Medicaid billing requirements.
- *Pay close attention to the Representation Letter.* Do not hesitate to revise, as appropriate to your particular circumstances.
- *Perhaps most importantly, treat the final response like a persuasive legal brief.* The provider's goal should be to convince ODM or the MCE that the Auditor's findings will likely not withstand a challenge.

CONCLUSION

Ohio Auditor of State Medicaid compliance examinations are a very specific type of post-payment review fraught with challenges for the unfamiliar and inexperienced. A misstep could result in significant findings, or lead to additional audits down the road. And unlike traditional payor post-payment reviews, the Auditor's Final Report will be a public record and findings could be the subject of an Auditor press release.

Vorys health care attorneys have significant experience helping providers navigate these unique audits. We have found that smaller providers are often not equipped to handle on their own, while larger providers may be too busy to devote the necessary resources. Working alongside provider clinical and billing teams, we have achieved numerous successful results for providers across the state. Our health care attorneys stand ready to work with your team to craft a strategic audit response to minimize findings and limit exposure.

If you would like further information on how our health care attorneys can assist with an Ohio Auditor of State Medicaid compliance examination, please contact Liam Gruzs or your regular Vorys attorney.

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