Ohio | Department of Medicaid

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Medicaid Eligibility Procedure Letter (MEPL) No. 172

Effective Date:	**February 1, 2023**
Issue Date:	**February 28, 2023**
OAC Rules:	**5160:1-1, 5160:1-2, 5160:1-3, 5160:1-4, 5160:1-5, 5160:1-6**
To:	**All Medicaid Eligibility Manual Holders**
From:	**Maureen M. Corcoran, Director**
Subject:	**Resuming Routine Operations Upon Expiration of the Families First Coronavirus Response Act (FFCRA) Continuous Coverage Condition**

Reason for Change:
The Consolidated Appropriations Act, 2023 (CAA, 2023) (Pub. L. 117-328) was enacted on December 29, 2022, and contains various Medicaid provisions that take effect on April 1, 2023, including significant changes to the continuous coverage condition at section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127). Under this section of the FFCRA, states claiming the temporary 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP) have been unable to discontinue Medicaid coverage for most individuals who were enrolled in the program on March 18, 2020, or who became enrolled during the emergency period.

While the newly enacted CAA, 2023 does not address the end date of the COVID-19 Public Health Emergency (PHE), it does address the end of the continuous coverage condition, the temporary FMAP increase, and the unwinding process. Under the CAA, 2023, expiration of the continuous coverage condition and receipt of the temporary FMAP increase are no longer linked to the end of the PHE. The continuous coverage condition will end on March 31, 2023, and the FFCRA's temporary FMAP increase will be gradually reduced and phased down during calendar year 2023. Beginning April 1, 2023, following a renewal, the state will be able to discontinue Medicaid coverage for individuals who are no longer eligible.

Policy:
Applications
The state must resume timely and accurate determinations of eligibility on new applications within the following timelines:

- Eligibility determinations for all pending modified adjusted gross income (MAGI) and other non-disability-related applications (e.g., individuals determined on the basis of being age 65 or older) received while the continuous coverage condition was in effect must be completed within two

months after the end of the month in which the continuous coverage condition ends (i.e., by May 31, 2023).

- Eligibility determinations for all pending disability-related applications received while the continuous coverage condition was in effect must be completed within three months after the end of the month in which the continuous coverage condition ends (i.e., by June 30, 2023).
- Timely processing of all applications must resume within four months after the end of the month in which the continuous coverage condition ends (i.e., by July 31, 2023).

An application is considered to be processed timely when an eligible applicant is enrolled, or an individual who is not able to be determined eligible is denied coverage, within the application timeliness standards described at 42 CFR §435.912(c). The maximum time permitted under this regulation is 90 days for individuals who are applying on the basis of disability and 45 days for all other applicants. Consistent with requirements at 42 CFR §435.912(g), the administrative agency is not permitted to use the application timeliness standards as a waiting period to delay determining eligibility or as a reason for denying eligibility because the state has not determined eligibility within the timeliness standards.

Renewals

Sec. 2, Division FF, Title V, Subtitle D, Sec. 5131 of the CAA, 2023 amends section 6008(b)(3) of the FFCRA, resulting in the end of the continuous coverage condition effective March 31, 2023. With its expiration, beginning April 1, 2023, states claiming the temporary FMAP increase under the FFCRA will be able to discontinue coverage, following a renewal, for ineligible individuals who are enrolled in Medicaid. Consistent with guidance from the Centers for Medicare & Medicaid Services (CMS), the new March 31, 2023, statutory end date of the continuous coverage condition means that states are able to begin their 12-month unwinding period and initiate the first Medicaid renewals that may result in discontinuance as early as February 1, 2023.

Per CMS guidance, the first renewal month that could result in discontinuance of Medicaid coverage is April 2023. At the option of the state, Ohio has elected to begin renewals in the month before the continuous coverage condition ends (i.e., February 2023). The state must *initiate* renewals for all individuals who are enrolled as of the last day of the continuous coverage condition within 12 months (i.e., by January 31, 2024) and must *complete* renewals for all individuals enrolled as of the last day of the continuous coverage condition within 14 months (i.e., by March 31, 2024).

For the month of April 2023, renewals will be initiated in February 2023 and an individual who is determined by the administrative agency to no longer meet all eligibility requirements, or who does not timely return information needed by the administrative agency to complete the renewal, will have coverage discontinued effective May 1, 2023 (with the individual's last date of coverage being April 30, 2023). Renewals for individuals initiated prior to February 2023 that did not result in a determination of eligibility must be initiated again during the state's 12-month unwinding period.

February 2023	• Initiate April 2023 renewals, which may result in discontinuance effective May 1, 2023
March 31, 2023	• Continuous coverage condition expires
January 31, 2024	• Deadline to initiate renewals for all individuals who are enrolled as of March 31, 2023
March 31, 2024	• Deadline to complete renewals for all individuals who are enrolled as of March 31, 2023

Renewals must be conducted in accordance with all applicable federal requirements, including the strategies approved under section 1902(e)(14)(A) of the Social Security Act. In addition, the state must ensure that eligibility renewals occur in an orderly process that:

- Minimizes beneficiary burden and promotes continuity of coverage, including for individuals eligible for other insurance affordability programs;
- Mitigates churn for eligible individuals who lose coverage and later reenroll; and
- Maximizes state effectiveness.

The state is required to initiate renewals of eligibility for its total caseload during the 12-month unwinding period. Until the administrative agency completes a full renewal, the state may not discontinue Medicaid coverage for individuals who were determined ineligible or who did not respond to requests for documentation while the continuous coverage condition was in effect, as individuals' circumstances may have changed since the completion of the renewal conducted while the continuous coverage condition was in effect. Completing a full renewal after the continuous coverage condition expires will ensure that:

1) The state is collecting information from the individual that allows the administrative agency to complete a renewal of eligibility on all bases prior to discontinuing coverage in accordance with 42 CFR §435.916(f)(1);
2) Any adverse action is based on recently available, reliable information and that the state is not discontinuing eligibility or reducing benefits unless it has sought information from the individual in accordance with 42 CFR §435.952(d); and
3) The state fulfills its obligation to complete a renewal of eligibility.

Acting on Changes in Circumstances during the Unwinding Period

During the unwinding period, prior to taking adverse action based on an identified or reported change in circumstances for an individual, the state must complete a full renewal (i.e., next scheduled annual renewal) for any individual unless a **valid** renewal was completed in the 12 months prior to the identified change and the individual was not subsequently determined ineligible as the result of a redetermination upon change in circumstances while the continuous coverage condition was in effect. The only exception to the requirement to complete a renewal prior to taking adverse action is for individuals for whom:

1) A renewal completed within the prior 12 months resulted in a determination that the individual continues to meet eligibility requirements;
2) The individual was not subsequently determined ineligible as the result of a redetermination upon change in circumstances while the continuous coverage condition was in effect; and

3) The administrative agency has received information during the unwinding period that the individual's circumstances changed after the last renewal (and subsequent redetermination upon change in circumstances, if applicable) was completed.

Consistent with the definition at Ohio Administrative Code (OAC) 5160:1-1-01(B)(3), an adverse (i.e., negative) action includes the following:

- Discontinuance of medical assistance,
- Suspension of medical assistance,
- Reduction in an individual's level of benefits or covered services, or
- Increase in the amount of an individual's premium.

Contact Information Updates and Returned Mail

The CAA, 2023 further requires states to meet new, additional conditions related to conducting eligibility renewals, including:

- Using certain specified sources to attempt to ensure that the state has up-to-date contact information for each individual for whom it conducts a renewal; and
- Undertaking a good faith effort to contact, using more than one modality, any individual who is determined ineligible on the basis of returned mail prior to discontinuing coverage for that person.

Receipt of returned mail with an in-state forwarding address or no forwarding address does not indicate that an individual is no longer a state resident or that he/she is ineligible and is not sufficient reason to discontinue an individual's Medicaid coverage. Additional direction regarding contact information updates and returned mail will be addressed in a forthcoming MEPL.

House Bill 110 and Instant Eligibility Verification System (I-E-V-S)

House Bill 110 required the Ohio Department of Medicaid (ODM) to contract with a vendor for use of third-party data sources and systems as part of the renewal process. Public Consulting Group (PCG), the selected vendor, operates the Instant Eligibility Verification System (I-E-V-S), which will compare case information with a variety of electronic data sources and return results of "eligible" or "likely ineligible" for individuals who are mailed a manual renewal packet.

Consistent with 5 USC §552a, information from electronic data sources that results in a positive or neutral outcome (i.e., an I-E-V-S "eligible" result) shall be treated as verified and used to complete an administrative ex parte renewal. Per 42 CFR §435.916, the state must renew eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's case record or other more current information available to the agency, including information accessed through databases. Because I-E-V-S data for individuals who are identified as "eligible" is considered reliable information, the administrative agency is required to use the data and not require additional information from the individual to process his/her renewal.

Conversely, information from electronic data sources that results in a negative outcome (i.e., an I-E-V-S "likely ineligible" result) shall be treated as a lead and the administrative agency must request independent verification from the individual regarding the information before the data can be used in a determination of eligibility.

Self-Attestation

Consistent with case processing standards applicable while the continuous coverage condition is in effect, the state will continue to accept self-attestation of all eligibility criteria, except for citizenship, immigration status, Social Security number (SSN), and qualified income trusts (QITs).

Self-attestation may be accepted for new and pending applications, renewals, and redeterminations and applies to eligibility for MAGI-based, non-MAGI, and long-term services and supports (LTSS) categories of medical assistance. Both 42 CFR §435.945(a) and 42 CFR §435.952(c)(3) authorize the acceptance of self-attestation for eligibility verification.

Action Required:

County Job and Family Services (JFS) offices must:

- Process Medicaid applications according to the standards identified above.
- Process Medicaid renewals, redeterminations, and changes in circumstances according to the criteria identified above. In addition, as described in the table below, only certain actions are permissible during the unwinding period.

When an individual self-attests to information regarding his/her circumstances, the administrative agency is required to attempt to verify the self-attestation via available electronic data sources (e.g., Federal Data Services Hub, E-Verify interfaces, The Work Number, Asset Verification System [AVS], etc.). Results from electronic data sources determine the appropriate actions:

- When information returned from electronic data sources is consistent with the self-attestation, which may include information that is reasonably compatible with the self-attestation, the case must be processed using the self-attestation as verification.
- When information returned from electronic data sources contradicts the self-attestation, additional information must be requested from the individual.
- When information is not returned from available electronic data sources:
    - And the individual has indicated that verifications cannot be accessed and/or submitted, the case must be processed using the self-attestation as verification.
    - And the individual did not indicate that he/she is unable to access and/or submit verifications, additional information must be requested from the individual.

Scenarios listed in the chart below shall be processed according to required actions and/or limitations:

Program Block Status	Trigger	Allowable?	Required Actions and/or Limitations
Last renewal was completed more than 12 months ago	Change identified or reported that results in an *adverse (i.e., negative)* action	No	Individual is not within a 12-month eligibility period and the administrative agency may <u>not</u> act on a change in circumstances which results in a negative action; however, the agency must still update the case record with reported change information, run EDBC without granting a new 12-month

Program Block Status	Trigger	Allowable?	Required Actions and/or Limitations
			eligibility period, and complete an override (when necessary) to maintain coverage until next scheduled annual renewal. The administrative agency must conduct a full renewal (i.e., next scheduled annual renewal) and determine eligibility on all bases before taking an adverse (i.e., negative) action.
Last renewal was completed more than 12 months ago	Change identified or reported that results in a *positive or neutral* action	Yes	Individual is not within a 12-month eligibility period so the administrative agency must update the case record with reported change information and run EDBC without granting a new 12-month eligibility period. An override may be necessary to maintain coverage until next scheduled annual renewal.
Individual previously failed to verify requested information and Medicaid coverage was maintained solely due to the continuous coverage condition	Change identified or reported that results in an *adverse (i.e., negative)* action	No	Individual is not within a 12-month eligibility period and the administrative agency may <u>not</u> act on a change in circumstances which results in a negative action; however, the agency must still update the case record with reported change information, run EDBC without granting a new 12-month eligibility period, and complete an override (when necessary) to maintain coverage until next scheduled annual renewal. The administrative agency must conduct a full renewal (i.e., next scheduled annual renewal) and determine eligibility on all bases before taking an adverse (i.e., negative) action.
Individual previously failed to verify requested information and Medicaid coverage was maintained solely due to the continuous coverage condition	Change identified or reported that results in a *positive or neutral* action	Yes	Individual is not within a 12-month eligibility period so the administrative agency must update the case record with reported change information and run EDBC without granting a new

Program Block Status	Trigger	Allowable?	Required Actions and/or Limitations
			12-month eligibility period. An override may be necessary to maintain coverage until next scheduled annual renewal.
Individual was previously determined ineligible while the continuous coverage condition was in effect	Change identified or reported that results in an *adverse (i.e., negative)* action	No	Individual is not within a 12-month eligibility period and the administrative agency may <u>not</u> act on a change in circumstances which results in a negative action; however, the agency must still update the case record with reported change information, run EDBC without granting a new 12-month eligibility period, and complete an override (when necessary) to maintain coverage until next scheduled annual renewal. The administrative agency must conduct a full renewal (i.e., next scheduled annual renewal) and determine eligibility on all bases before taking an adverse (i.e., negative) action.
Individual was previously determined ineligible while the continuous coverage condition was in effect	Change identified or reported that results in a *positive or neutral* action	Yes	Individual is not within a 12-month eligibility period so the administrative agency must update the case record with reported change information and run EDBC without granting a new 12-month eligibility period. An override may be necessary to maintain coverage until next scheduled annual renewal.
Individual's RE Due Month in Ohio Benefits was set by DBCR (and not due to a renewal having been completed)	Change identified or reported that results in an *adverse (i.e., negative)* action	No	Individual is not within a 12-month eligibility period and the administrative agency may <u>not</u> act on a change in circumstances which results in a negative action; however, the agency must still update the case record with reported change information, run EDBC without granting a new 12-month eligibility period, and complete an override (when necessary) to

Program Block Status	Trigger	Allowable?	Required Actions and/or Limitations
			maintain coverage until next scheduled annual renewal. The administrative agency must conduct a full renewal (i.e., next scheduled annual renewal) and determine eligibility on all bases before taking an adverse (i.e., negative) action.
Individual's RE Due Month in Ohio Benefits was set by DBCR (and not due to a renewal having been completed)	Change identified or reported that results in a *positive or neutral* action	Yes	Individual is not within a 12-month eligibility period so the administrative agency must update the case record with reported change information and run EDBC without granting a new 12-month eligibility period. An override may be necessary to maintain coverage until next scheduled annual renewal.
RE EDBC was run on program block in Ohio Benefits; however, caseworker failed to process information reported on the individual's renewal (failed to update screens and incorporate changes)	Change identified or reported that results in an *adverse (i.e., negative)* action	No	Individual is not within a 12-month eligibility period and the administrative agency may <u>not</u> act on a change in circumstances which results in a negative action; however, the agency must still update the case record with reported change information, run EDBC without granting a new 12-month eligibility period, and complete an override (when necessary) to maintain coverage until next scheduled annual renewal. The administrative agency must conduct a full renewal (i.e., next scheduled annual renewal) and determine eligibility on all bases before taking an adverse (i.e., negative) action.
RE EDBC was run on program block in Ohio Benefits; however, caseworker failed to process information reported on the individual's renewal (failed to update screens and incorporate changes)	Change identified or reported that results in a *positive or neutral* action	Yes	Individual is not within a 12-month eligibility period so the administrative agency must update the case record with reported change information and run EDBC without granting a new 12-month eligibility period. An override may be necessary to

Program Block Status	Trigger	Allowable?	Required Actions and/or Limitations
			maintain coverage until next scheduled annual renewal.
Individual was determined eligible at initial application, annual renewal (including via ex parte/passive renewal), or after successful redetermination upon change and is within a current 12-month eligibility period	Change identified or reported that results in an *adverse (i.e., negative), positive, or neutral* action	Yes	Individual is within a current 12-month eligibility period and the administrative agency may promptly act on a change in circumstances as it ordinarily would in accordance with 42 CFR §435.916(d) and (f)(1).
Individual has Medicaid coverage	Individual voluntarily requests a discontinuance of eligibility, is no longer a resident of the state, or is deceased	Yes	The administrative agency is permitted to discontinue coverage for the three circumstances that were also allowed while the continuous coverage condition was in effect.
Individual is not within a current 12-month eligibility period, Medicaid coverage was maintained due to the continuous coverage condition, and he/she was/is discharged from a medical institution	Individual in an LTC SIL Facility category was discharged from a medical institution while the continuous coverage condition was in effect or is discharged during the unwinding period	No	Individual is not within a 12-month eligibility period and the administrative agency may not act on a change in circumstances which results in a negative action; however, the agency must still update the case record with reported change information, run EDBC without granting a new 12-month eligibility period, and complete an override (when necessary) to maintain coverage until next scheduled annual renewal. The administrative agency must conduct a full renewal (i.e., next scheduled annual renewal) and determine eligibility on all bases before taking an adverse (i.e., negative) action.
Individual was determined eligible at initial application, annual renewal (including via ex parte/passive renewal), or after successful redetermination upon change	Individual in an LTC SIL Facility category is discharged from a medical institution during	Yes	Individual is within a current 12-month eligibility period and the administrative agency may promptly act on a change in circumstances as it ordinarily would in accordance with 42 CFR §435.916(d) and (f)(1).

Program Block Status	Trigger	Allowable?	Required Actions and/or Limitations
and is within current 12-month eligibility period	the unwinding period		
Individual is not within a current 12-month eligibility period, Medicaid coverage was maintained due to the continuous coverage condition, and he/she was/is disenrolled from a home- and community-based services (HCBS) waiver	Individual in an LTC SIL Waiver category was disenrolled from an HCBS waiver while the continuous coverage condition was in effect or is disenrolled during the unwinding period	No	Individual is not within a 12-month eligibility period and the administrative agency may <u>not</u> act on a change in circumstances which results in a negative action; however, the agency must still update the case record with reported change information, run EDBC without granting a new 12-month eligibility period, and complete an override (when necessary) to maintain coverage until next scheduled annual renewal. The administrative agency must conduct a full renewal (i.e., next scheduled annual renewal) and determine eligibility on all bases before taking an adverse (i.e., negative) action.
Individual was determined eligible at initial application, annual renewal (including via ex parte/passive renewal), or after successful redetermination upon change and is within current 12-month eligibility period	Individual in an LTC SIL Waiver category is disenrolled from an HCBS waiver during the unwinding period	Yes	Individual is within a current 12-month eligibility period and the administrative agency <u>may</u> promptly act on a change in circumstances as it ordinarily would in accordance with 42 CFR §435.916(d) and (f)(1).
Individual has long-term care (LTC) Medicaid coverage with patient liability	Change identified or reported that results in an increase to patient liability	Yes	Regardless of when a renewal was last completed for the individual, and without regard to whether the individual is within a current 12-month eligibility period, the administrative agency must recalculate an individual's patient liability in any circumstance in which the agency becomes aware of a change in the individual's income or amount of his/her health care costs.
Individual is not within a current 12-month eligibility	Individual is approved for	Yes	Regardless of when a renewal was last completed for the

Program Block Status	Trigger	Allowable?	Required Actions and/or Limitations
period and Medicaid coverage was maintained due to the continuous coverage condition	Supplemental Security Income (SSI)		individual, and without regard to whether the individual is within a current 12-month eligibility period, the administrative agency must update the case record with reported change information, run RE EDBC, and grant a new 12-month eligibility period. Under the terms of the state's 1634 agreement with the Social Security Administration (SSA), the administrative agency must provide Medicaid eligibility to all individuals eligible for benefits under Title XVI of the Social Security Act.
Individual is not within a current 12-month eligibility period and Medicaid coverage was maintained in a MAGI Adult aid category due to the continuous coverage condition	Change identified or reported that would result in a coverage transition to any other full Medicaid aid category (except an SSI Recipient aid category)	No	Individual is not within a 12-month eligibility period and the administrative agency may <u>not</u> act on a change in circumstances which results in a negative action; however, the agency must still update the case record with reported change information, run EDBC without granting a new 12-month eligibility period, and complete an override (when necessary) to maintain coverage until next scheduled annual renewal. A transition from a MAGI Adult aid category to any other full Medicaid aid category (except an SSI Recipient aid category) is considered a negative action because it results in a reduction in the individual's level of benefits or covered services (from the alternative benefit plan [ABP] to the Medicaid benefit plan). The administrative agency must conduct a full renewal (i.e., next scheduled annual renewal) and determine eligibility on all bases before taking an adverse (i.e., negative) action.

Program Block Status	Trigger	Allowable?	Required Actions and/or Limitations
Individual is not within a current 12-month eligibility period and Medicaid coverage was maintained in a MAGI Parent/Caretaker Relative aid category due to the continuous coverage condition	Increase in earned income identified or reported that would otherwise result in a coverage transition to a Transitional Medical Assistance (TMA) aid category	No	Individual must have been *eligible for* and enrolled in the MAGI Parent/Caretaker Relative aid category for at least three of the six months immediately preceding the loss of eligibility to qualify for TMA. When an individual is not within a current 12-month eligibility period, he/she was enrolled in, but not *eligible for*, a MAGI Parent/Caretaker Relative aid category and is therefore not eligible for TMA. The administrative agency must update the case record with reported change information and run EDBC without granting a new 12-month eligibility period. An override may be necessary to maintain coverage until next scheduled annual renewal.
Individual is not within a current 12-month eligibility period and coverage was maintained in any full Medicaid aid category + MPAP companion due to the continuous coverage condition	Change identified or reported that would result in a coverage reduction to any full Medicaid aid category (with no MPAP companion)	No	Individual is not within a 12-month eligibility period and the administrative agency may <u>not</u> act on a change in circumstances which results in a negative action; however, the agency must still update the case record with reported change information, run EDBC without granting a new 12-month eligibility period, and complete an override (when necessary) to maintain coverage until next scheduled annual renewal. A transition from dual Medicaid-MPAP coverage to a Medicaid-only aid category is considered a negative action because it results in a reduction in the individual's level of benefits or covered services. The administrative agency must conduct a full renewal (i.e., next scheduled annual renewal) and determine

Program Block Status	Trigger	Allowable?	Required Actions and/or Limitations
			eligibility on all bases before taking an adverse (i.e., negative) action.
Individual is not within a current 12-month eligibility period and coverage was maintained in any full Medicaid aid category + MPAP companion due to the continuous coverage condition	Change identified or reported that would result in a coverage reduction to any MPAP-only aid category (with no Medicaid)	No	Individual is not within a 12-month eligibility period and the administrative agency may not act on a change in circumstances which results in a negative action; however, the agency must still update the case record with reported change information, run EDBC without granting a new 12-month eligibility period, and complete an override (when necessary) to maintain coverage until next scheduled annual renewal. A transition from dual Medicaid-MPAP coverage to an MPAP-only aid category is considered a negative action because it results in a reduction in the individual's level of benefits or covered services. The administrative agency must conduct a full renewal (i.e., next scheduled annual renewal) and determine eligibility on all bases before taking an adverse (i.e., negative) action.
Individual is not within a current 12-month eligibility period and coverage was maintained in any full Medicaid aid category due to the continuous coverage condition	Change identified or reported that would result in a coverage transition to any MPAP-only aid category	No	Individual is not within a 12-month eligibility period and the administrative agency may not act on a change in circumstances which results in a negative action; however, the agency must still update the case record with reported change information, run EDBC without granting a new 12-month eligibility period, and complete an override (when necessary) to maintain coverage until next scheduled annual renewal. A transition from a Medicaid aid category to any MPAP-only aid

Program Block Status	Trigger	Allowable?	Required Actions and/or Limitations
			category is considered a negative action because it results in a reduction in the individual's level of benefits or covered services. The administrative agency must conduct a full renewal (i.e., next scheduled annual renewal) and determine eligibility on all bases before taking an adverse (i.e., negative) action.
Individual is not within a current 12-month eligibility period and Medicaid coverage was maintained due to the continuous coverage condition	Individual is incarcerated	Yes	Although the individual is not within a current 12-month eligibility period, the limitation on federal financial participation (FFP) continues to apply when an individual is an inmate of a public institution, consistent with OAC 5160:1-1-03.
Individual was determined eligible at initial application, annual renewal (including via ex parte/passive renewal), or after successful redetermination upon change and is within a current 12-month eligibility period	Individual is incarcerated	Yes	Individual is within a current 12-month eligibility period and the administrative agency may promptly act on a change in circumstances as it ordinarily would in accordance with 42 CFR §435.916(d) and (f)(1). The limitation on federal financial participation (FFP) continues to apply when an individual is an inmate of a public institution, consistent with OAC 5160:1-1-03.

Additional instruction regarding the resumption of routine operations will be provided in forthcoming guidance.

The information is also available on the Ohio Department of Medicaid website and may be accessed at:
Resources for Providers > Policies & Guidelines > Medicaid Eligibility Procedure Letters (MEPLs)
https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/policies-guidelines/medicaid-eligibility-procedure-letters/medicaid-eligibility-procedure-letters