Due to the ending of the Public Health Emergency as of 5/11/23, the policies presented here are no longer in effect.

Section 7 – General Provisions

7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

___X__ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. _____ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. ___X__ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. _____ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Please describe the modifications to the timeline.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

   a. _____ The agency uses a simplified paper application.

   b. _____ The agency uses a simplified online application.

   c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

   a. _____ All beneficiaries

   b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums, and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. _____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

   a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

   b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

State/Territory: Ohio

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Rate Increases and Supplemental Payments to Enhance, Expand, and/or Strengthen Home and Community-Based Services (HCBS), Implemented in Accordance with the State's HCBS Spending Implementation Plan Pursuant to Section 9817 of the American Rescue Plan Act.

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

   a. ____ Published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

b. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. __X__ The agency increases payment rates for the following services:

(1) Community Behavioral Health Services (2) Non-Institutional DMEPOS Providers (3) Home Health

a. __X__ Payment increases are targeted based on the following criteria:

(1) Community Behavioral Health Services: Payments will be made for mental health and substance use disorder services rendered by mental health agencies and substance use disorder treatment providers that are active Medicaid providers. **(2) Non-Institutional DMEPOS Providers:** Supplemental one-time payments for workforce relief payment will be made to Non-Institutional (Community) Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) providers. **(3) Home Health:** Supplemental one-time payments for workforce relief payment will be made to State Plan Home Health providers of State Plan Home Health Physical Therapy, State Plan Home Health Occupational Therapy, State Plan Home Health Aide, State Plan Home Health Nursing, Private Duty Nursing and RN Assessment services.

b. Payments are increased through:

i. __X__ A supplemental payment or add-on within applicable upper payment limits:

(1) Community Behavioral Health Services Ohio will make a one-time payment for behavioral health (BH) (mental health and substance use disorder) services rendered by community mental health (MH) agencies and community substance use disorder (SUD) treatment providers. Services include physician and non-physician licensed BH

practitioner services, mental health rehabilitative services, and substance use disorder treatment services rendered by practitioners operating within community MH agencies and community SUD treatment providers. Active community MH agencies and community SUD treatment providers during an established timeframe will be included for this one-time payment. BH services rendered by hospitals, professional groups, or independent BH practitioners not operating within a community MH or SUD treatment provider are excluded.

The one-time payment amount is based on a percentage of the provider's payment for services for an established timeframe as a proportion of all provider payments during the period. Specifically, as of the established payment date, Ohio will calculate the total value of claims paid to each provider for dates of service from 7/1/2020 through 6/30/2021; multiply that value by 10%)to determine the amount to be paid to each provider; and then will issue a one-time payment for the calculated amount to each provider. If a provider's calculated amount is less than $100, the minimum payment will be $100.

The payment will be made after Ohio's 1135 SPA approval is received from CMS. While providers have up to a year to submit claims; only claims paid on or before the established payment date will be used in determining a provider's payment. The State considers this a one-time payment and no additional reconciliation will occur if additional claims are paid after the established date.

(2) Non-Institutional DMEPOS Providers: Ohio will make a one-time workforce relief payment to Non-Institutional (Community) Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) providers.

The one-time payment amount is based on a percentage of the provider's payment for services for an established timeframe. Specifically, as of the established payment date, Ohio will calculate the total value of claims paid to each provider for dates of service from 7/1/2020 through 6/30/2021; multiply that value by 10% to determine the amount to be paid to each provider; and then will issue a one-time payment for the calculated amount to each provider. If a provider's calculated amount is less than $100, the minimum payment will be $100.

The payment will be made after Ohio's 1135 SPA approval is received from CMS. All available claims from the period between July 2020 and June 2021 will be used to determine the payment a provider may receive, up to an additional 10%. While providers have up to a year to submit claims; only claims paid on or before the established payment date will be used in determining a provider's payment. The State considers this a one-time payment and no additional reconciliation will occur if additional claims are paid after the established date.

(3) Home Health: Supplemental payments to be made to eligible State Plan Home Health providers of State Plan Home Health Physical Therapy (G0151),

State Plan Home Health Occupational Therapy (G0152), State Plan Home Health Aide (G0156), State Plan Home Health Nursing (G029 and G0300), Private Duty Nursing (T1000) and RN Assessment (T1001) services.

Total supplemental Home Health payments will equal 10% of the total amount spent on these services with dates of service from 7/1/20-6/30/21, resulting in a projected total payment of approximately $46.1 million.

The one-time payment amount is based on a percentage of the provider's payment for services for the established timeframe. Specifically, as of the established payment date, Ohio will calculate the total value of claims paid to each provider for dates of service from 7/1/20-6/30/21; multiply that value by the established percentage 10% to determine the amount to be paid to each provider; and then will issue a one-time payment for the calculated amount to each provider. If a provider's calculated amount is less than $100, the minimum payment will be $100.

The payment will be made after Ohio's 1135 SPA approval is received from CMS. All available claims from the period between July 2020 and June 2021 will be used to determine the payment a provider may receive a minimum of $100, up to an additional 10%. While providers have up to a year to submit claims; only claims paid on or before the established payment date will be used in determining a provider's payment. The State considers this a one-time payment, and no additional reconciliation will occur if additional claims are paid after the established date.

ii. ____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

   a. ____ Are not otherwise paid under the Medicaid state plan;

   b. ____ Differ from payments for the same services when provided face to face;

   c. ____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

   d. ____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

      i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

      ii. ____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _____ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

   a. ____ The individual's total income

   b. ____ 300 percent of the SSI federal benefit rate

   c. ____ Other reasonable amount: _____

2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

   The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.