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. __X___ 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.

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. ___X__ 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. __X___ 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.

Ohio is temporarily extending PE to individuals in institutions who are eligible under a special income level (SIL), as described in 42 CFR 435.236. Ohio suspends standards listed in section 2 of the state plan (S21) related to the proportion of individuals determined presumptively eligible who submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period. Ohio also suspends standards that relate to the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period. Hospitals are expected to make good-faith efforts to ensure that individuals who are determined presumptively eligible submit regular Medicaid applications and are eligible for Medicaid. Hospital presumptive eligibility periods for the SIL group are limited to no more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

2. ___X__ 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.

Ohio Department of Medicaid (ODM) staff will make presumptive eligibility determinations for the following MAGI covered groups:

Parents and Other Caretaker Relatives: 1902(a)(10)(A)(i)(I); 1931(b) and (d)
Pregnant Women: 1902(a)(10)(A)(i)(III) and (IV); 1902(a)(10)(A)(ii)(I), (IV), and (IX); 1931(b) and (d); 1920
Infants and Children under Age 19: 1902(a)(10)(A)(i)(III), (IV), (VI), and (VII); 1902(a)(10)(A)(ii)(IV) and (IX); 1931(b) and (d)
Adult Group – Individuals below 133% of the FPL: 1902(a)(10)(A)(i)(VIII)
Former Foster Care Children: 1902(a)(10)(A)(i)(IX)

There may be no more than one period of presumptive eligibility per pregnancy. For all other groups, presumptive eligibility periods are limited to no more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

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.

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

The state suspends all cost sharing as described in section 4.18 of the state plan.

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

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical 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. __X___ The agency makes the following adjustments to benefits currently covered in the state plan:

The state will modify the NF benefit and reimburse health care isolation centers (HCICs) to provide COVID-related care for individuals that cannot safely remain at home (including nursing facilities) and/or are discharged from hospitals. Beds in HCICs will be Medicaid certified. A physician's order will be required for admission to an HCIC. The HCICs will be either free-standing or wings of existing facilities (e.g, NFs). The state survey agency (the Ohio Department of Health) will approve HCICs and provide oversight. HCICs will be reimbursed using a tiered system aligning reimbursement with the relative care needs of the individuals receiving services. Rates will be calculated on a per diem basis. See appendix A for additional information.

Ohio suspends limits on private-duty nursing (PDN) post-hospital benefit (currently 56 hours per week and 60 days from date of discharge) as described in Attachment 3.1-A of the state plan, and suspends limits on home health services per day and week as described in Attachment 3.1-A of the state plan, in order to provide alternatives to institutional settings.

Durable Medical Equipment: The state allows physicians and other licensed practitioners, in accordance with State law, to order Medicaid Home Health services as authorized in the COVID-19 Public Health Emergency Medicare interim final rule (CMS-1744-IFC).

3. __X___ 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. __X___ 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. __X__ 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.

Telehealth:

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

Ohio modifies in-person or face-to-face requirements for any state plan service or assessment, as described in Attachment 3.1-A of the state plan, as necessary to prevent virus transmission, and authorizes use of telephonic or other substitutes for in-person or face-to-face requirements.

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.

7. ___X__ 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.

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

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:

Increases to state plan payment methodologies:

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

The maximum payment amounts for laboratory specimen collection and diagnostic testing for COVID-19 are set at 100% of the Ohio Medicare rate for the duration of the emergency.

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

HCICs will be reimbursed using tiered, per diem flat rates intended to match reimbursement with the level of COVID-related need. *Quarantine Level of Need: $250 per patient day* *Isolation Level 1: $300 per patient day* *Isolation Level 2: $448 per patient day* *Isolation Level 3: $820 per patient day*

Isolation Level 3 with ventilator: $984 per patient day

Patient liability will apply to HCIC days in the same manner it applies to other NF days. If the patient comes from a NF to the HCIC, the facility of residence will apply patient liability to the amount due for Medicaid NF services. The HCIC will be responsible for collecting any patient liability not offset by the facility of residence. Patient liability will be collected from an individual admitted to an HCIC from the community in the same manner it is collected from any NF resident newly admitted from the community.

b. Payments are increased through:

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

ii. __X__ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: ___ _____

__X__ Through a modification to published fee schedules –

Effective date (enter date of change): The initial effective dates are:
Lab tests – 3/1/2020
Specimen collection - 3/1/2020

Location (list published location):
https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#1682576-laboratory-services

__X__ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Payment for services delivered via telehealth:

3. __X___ 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. __X___ Differ from current state plan provisions governing reimbursement for telehealth;

Effective 3/9/20, and for the duration of the emergency, Ohio has added a billing code (Q3014) for telehealth originating site fee. That code is found on the Medicine, Surgery, Radiology and Imaging fee schedule at https://www.medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#1682578-medicine-surgery-radiology-and-imaging-and-additional-procedures-non-institutional-services.

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. __X___ Other payment changes:

Ohio temporarily increases limits to the number of bed hold days nursing facility residents and individuals residing in intermediate care facilities for individuals with intellectual disabilities may receive, from 30 days per calendar year as described in Attachment 4.19-C, Supplements 1, 2 and 3 of the state plan, to 60 days per calendar year.

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:

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

1. **Pre-Admission Screening and Annual Resident Review (PASRR).** For HCICs, Ohio designates COVID-19 and quarantine levels of care for individuals with a diagnosis of, or exposure to, COVID-19 and a physician order for quarantine or isolation care as categorical qualification for pre-admission screening. Resident review will be conducted within 30 days of admission. This expands upon the categorical determinations described in Attachment 4.39-A of the state plan.

2. **Nursing Facility Ventilator Weaning Staffing Requirements:** Ohio suspends the requirement described in Attachment 4.19-D, Supplement 1, of the state plan to have an RN with training in basic life support on-site 24 hours per day, seven days per week while ventilator weaning services are provided. The nursing facility may instead have a respiratory care professional or respiratory therapist with training in basic life support available in the facility 24 hours per day, seven days per week.

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.

Appendix A
Health Care Isolation Centers
Overview

HCICs are a temporary nursing facility benefit to the Medicaid program to cover isolation or quarantine services for individuals who cannot safely receive those services where they live.

HCIC Provider Qualifications and Requirements

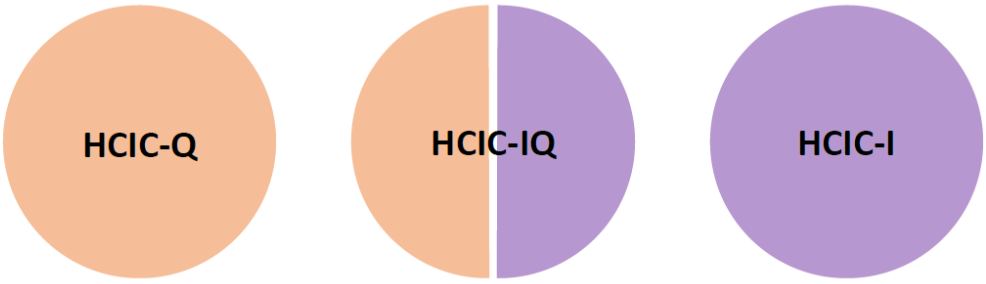
HCICs use Medicaid certified nursing facility beds to create isolation and/or quarantine capacity within communities. The certified beds may be from any of the following:

- Existing certified beds that are temporarily repurposed for HCICs;
- Current licensed capacity that is temporarily certified as surge capacity pursuant to CMS blanket waivers; or
- Certified only capacity that is put in place temporarily as surge capacity pursuant to CMS blanket waivers.

In each case all certification requirements that currently apply to nursing facilities apply to HCICs.

HCICs can be complete buildings or units in existing health care facilities. HCICs will be classified as follows:

- An HCIC-Q will only provide quarantine services
- An HCIC-I will only provide isolation services.
- An HCIC-IQ will provide both quarantine and isolation services.



Each HCIC Unit in an existing building must be in separate and distinct space that is separate from other parts of the building where individuals receive care (e.g., a separate wing or floor). In addition, HCICs must have designated infection control personnel available 24/7 and staff dedicated only to a single HCIC unit.

In addition, HCIC-Is and HCIC-IQs will provide services to individuals with COVID-19 diagnoses and must have the ability to provide complex care to individuals with serious respiratory

conditions. Each isolation unit must have a separate entrance and 24/7 access to a pulmonologist or clinician who can help manage this care including through telehealth. In addition, if the facility is going to provide services to individuals using ventilators, a respiratory therapist must be in the HCIC 24/7.

All HCICs will be strategically located within the existing public health hospital zones designated by the Ohio Department of Health (ODH) in response to the COVID-19 emergency. HCICs will only be designated as an HCIC if the Regional Hospital Zone identifies a need for the capacity. The Regional Hospital Zones are responsible for providing support to the HCIC to ensure the needs of the individuals served are met. In addition, the operator of each HCIC must coordinate hospital transfers and discharges from the HCIC using the processes created in the Regional Zone.

Providers seeking designation as an HCIC will submit an application to ODH. The application must include the following information:

- Identifying Information
- The number of certified beds proposed for service at the HCIC
- An attestation from the individual indicating that the proposed HCIC meets certification requirements, has the financial ability to operate, can appropriately staff the HCIC, and meets all requirements outlined in the Novel Coronavirus-19 (COVID-19) Health Care Isolation Centers Plan
- Acknowledgment that any certified beds added to the facility's capacity are temporary and will cease to exist when the facility no longer operates as an HCIC
- A floor plan of the HCIC
- A letter signed by the facility and the regional hospital zone documenting the need for the isolation and/or quarantine capacity within the Regional Hospital Zone.

ODH will complete any surveys that are required. Special Focus Facilities will not be considered.

ODH will recommend facilities meeting all provider requirements to the Ohio Department of Medicaid (ODM) for consideration as a COVID-19 Community Provider. ODM will assess recommended facilities in light of the need for isolation and/or quarantine capacity for the Medicaid population, existing HCIC capacity in the Regional Hospital Zone and the operator's history of providing quality care. Only those HCICs designated as COVID-19 Community Providers by ODM will be eligible for enhanced Medicaid reimbursement.

Eligibility for the benefit - Individuals Served in HCICs

Individuals served in HCICs must require either isolation or quarantine services, and also health care services. Individuals must meet one of the following levels of care:

- **COVID-19 level of care:** a level of care comparable to that required for admission to a nursing home, a COVID-19 diagnosis (tested or probable1) and a physician order.

- **Quarantine level of care:** a level of care comparable to that required for admission to a nursing home, exposure to COVID-19 which requires quarantine, and a physician order.

Individuals must also be enrolled in the Medicaid program and be eligible for full – not partial - Medicaid benefits under existing MAGI or non-MAGI eligibility criteria.

Reimbursement

HCICs will be reimbursed using a tiered flat per diem rate system. The per diems are intended to match the rate to the individual's level of COVID need as shown in the following table:

Level	COVID Relate Need	Per Diem
Quarantine Level of care	Frequent monitoring	$250
COVID-19 Level 1	Minor COVID related symptoms; frequent monitoring	$300
COVID-19 Level 2	Requires oxygen or other respiratory treatment and careful monitoring for signs of deterioration	$448
COVID-19 Level 3	Requires care beyond the capacity of a traditional NF	$820
COVID-19 Level 3 with ventilator	Requires care beyond the capacity of a traditional NF and ventilator care to support breathing	$984

Patient liability will apply and collection will be the responsibility of the provider.