Dear Ms. Corcoran:

We are pleased to inform you that Ohio’s spending plan and spending narrative submitted on October 19, 2021, in response to the Centers for Medicare & Medicaid Services (CMS) September 28, 2021, request for additional information, meet the requirements set forth in the May 13, 2021, CMS State Medicaid Director Letter (SMDL) #21-003 and are receiving partial approval. Ohio qualifies for a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS) under section 9817 of the American Rescue Plan Act of 2021 (ARP). We have approved the temporary 10 percentage point increase to the state’s FMAP for certain Medicaid HCBS listed in Appendix B of the SMDL. The increased FMAP is available for qualifying expenditures between April 1, 2021, and March 31, 2022. Ohio can begin to implement any activity included in the spending plan if CMS has not identified the activity as not approvable or asked for additional information about the activity, as described beginning on the next page.

Full approval of the state spending plan and spending narrative is conditioned upon resolving the issues described below and upon the state’s continued compliance with program requirements as stated in SMDL #21-003. These requirements are in effect as of April 1, 2021, and continue until March 31, 2024, or until the state has fully expended the funds attributable to the increased FMAP, whichever comes first.

It is important to note that CMS partial approval of the initial spending plan and spending narrative solely addresses the state’s compliance with the applicable requirements set forth under section 9817 and fulfillment of the requirements as stated in SMDL # 21-003. This spending plan approval does not constitute approval for purposes of claiming federal financial participation (FFP). Approval of any activity in your state’s spending plan does not provide approval to claim FFP for any expenditures that are not eligible for FFP. States must continue to comply with all existing federal requirements for allowable claims, including documenting expenditures and draws to ensure a clear audit trail for the use of federal funds reported on the Form CMS-37 Medicaid Program Budget Report and the Form CMS-64, Quarterly Medicaid Statement of Expenditures.

States should follow the applicable rules and processes for section 1915(c) waivers, other Medicaid HCBS authorities, including state plan amendments and section 1115 demonstrations,
and other managed care authorities (as applicable), if they are making changes to an HCBS program and intend to use state funds equivalent to the funds attributable to the increased FMAP to pay the state share of the costs associated with those changes. In particular, your state should be aware:

- An increase to the Medicaid capitation rate for the Program for All-Inclusive Care for the Elderly (PACE) can be implemented as part of the state’s regular annual rate update, or on a temporary basis as an interim rate increase, but must comply with existing submission, review, and approval requirements. States are not permitted to provide supplemental funding to PACE Organizations outside of the PACE Medicaid capitation payment due to regulatory requirements.

CMS is available to provide continued technical assistance to states when implementing changes to HCBS programs under this provision.

**Additional Information Requested**

As your state further plans and develops the activities in its spending plan, CMS will need more information on:

- **Workforce support – HCBS Workforce Development Strategic Fund**
  - Clearly indicate whether each of the initiatives that will be paid for through the fund is focused on providers delivering services listed in Appendix B or that could be listed in Appendix B. If the initiatives are not focused on providers that are delivering services listed in Appendix B or that could be listed in Appendix B, explain how the activities expand, enhance, or strengthen HCBS under Medicaid.
  - Describe how the state will ensure that the scholarships, internships, residency training and fellowship programs, distance learning opportunities, and additional degree programs will increase the number of Medicaid providers that deliver the services that are listed in Appendix B or could be listed in Appendix B.

- **Improvements in IT and Program Infrastructure**
  - Clearly indicate whether specialized recovery services are listed in Appendix B or could be listed in Appendix B. If the services are not listed in Appendix B and could not be listed in Appendix B, explain how the activities that focus on specialized recovery services expand, enhance, or strengthen HCBS under Medicaid.
  - Confirm that the “Strengthen assessment practices for level of care (LOC) and specialized recovery services (SRS) program” activity will not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021. Further, explain how this activity will strengthen assessment practices for LOC and for specialized recovery services program.

- **Using Telehealth and Technology to Support Individuals in the Community**
  - Clearly indicate whether specialized recovery services and school-based health care services are listed in Appendix B or could be listed in Appendix B. If the services are not listed in Appendix B and could not be listed in Appendix B, explain how the activities that focus on specialized recovery services and school-based health care expand, enhance, or strengthen HCBS under Medicaid.
Clearly indicate whether your state plans to pay for ongoing internet connectivity costs as part of any of these activities. Ongoing internet connectivity costs are permissible uses of funds to enhance, expand, or strengthen HCBS under section 9817 of the ARP. However, states must demonstrate how ongoing internet connectivity costs would enhance, expand, or strengthen HCBS. Further, approval of ongoing internet connectivity costs in ARP section 9817 spending plans and narratives does not authorize such activities for FFP.

Clearly indicate if the “Expand use of technology and telehealth with expanded nursing facility (NF)-based HCBS waiver service” is targeted at institutional providers, HCBS providers, or both. If this activity targets institutional providers, please explain how this activity expands, enhances, or strengthens HCBS.

**Address Gaps in Services**
- Clearly indicate how the state intends to “support development of a full behavioral health crisis continuum” including how this activity differs from the “explore potential new or enhanced behavioral health services” activity.

**Supports for Individuals & Informal Caregivers**
- Clearly indicate whether your state plans to pay for capital investment costs as part of the activity to “support strategies to expand current adult day services settings to or develop new capacity.” Capital investment costs are permissible uses of funds to enhance, expand, or strengthen HCBS under section 9817 of the ARP. However, states must demonstrate how capital investments would enhance, expand, or strengthen HCBS and ensure that capital investments will result in settings that are fully compliant with the home and community-based settings criteria. Further, approval of capital investment costs in ARP section 9817 spending plans and narratives does not authorize such activities for FFP.

**Eliminating Disparities and Addressing Social Determinants of Health**
- Clearly indicate if the Ohio Medicaid’s Comprehensive Primary Care (CPC) providers are delivering services listed in Appendix B or that could be listed in Appendix B. If the CPC providers are not delivering services listed in Appendix B or that could be listed in Appendix B, explain how the activities enhance, expand, or strengthen HCBS under Medicaid.
- Confirm that the state will not pay for room and board (which CMS would not find to be a permissible use of funds) as part of the eliminating disparities and addressing social determinants of health activities.
- Confirm that the “Extend use of MyCare waiver screening tool to Ohio Home Care” activity will not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021.

**Multi-System Youth in the DD System**
- Clearly indicate if the additional services will be services that are listed in Appendix B or that could be listed in Appendix B of the SMDL. If the services are not listed in Appendix B and could not be listed in Appendix B, explain how the activities enhance, expand, or strengthen HCBS under Medicaid.

**CMS will need additional information before it can determine whether these activities or uses of funds are approvable under ARP section 9817.** Please update the state’s spending plan and narrative to provide the information requested in this letter.
General Considerations

As part of this partial approval, CMS is noting the following:

- CMS expects your state to notify CMS as soon as possible if your state’s activities to enhance, expand, or strengthen HCBS under ARP section 9817:
  - Are focused on services other than those listed in Appendix B or that could be listed in Appendix B (e.g., behavioral health services that are covered under another benefit but could be covered under the rehabilitative services benefit). If any activities are not directly related to the services listed in Appendix B or services that could be listed in Appendix B, please explain how those activities enhance, expand, or strengthen HCBS under Medicaid;
  - Include room and board (which CMS would not find to be a permissible use of funds); and/or
  - Include activities other than those listed in Appendices C and D.

  **CMS will need additional information before it can determine whether any of those activities or uses of funds are approvable under ARP section 9817.**

- HCBS provider pay increases funded through the 10 percent temporary increased FMAP will require an updated rate methodology. For section 1915(c) waiver programs, states are required to submit a waiver amendment for any rate methodology change. If retrospective approval will be required, the state should make the change in the Appendix K application.

- Consistent with regulations at 42 C.F.R. § 447.252(b), the state plan methodology must specify comprehensively the methods and standards used by the agency to set payment rates. The state plan methodology must be comprehensive enough to determine the required level of payment and the FFP to allow interested parties to understand the rate setting process and the items and services that are paid through these rates. Claims for federal matching funds cannot be based upon estimates or projections. The reimbursement methodology must be based upon actual historical utilization and actual trend factors.

- States providing HCBS through a managed care delivery system must comply with applicable federal requirements, including 42 C.F.R. part 438. States must also ensure that appropriate authority is granted for the services and activities to be covered as well as to deliver such services and activities through a managed care delivery system. Additionally, states will need to assess implications for its managed care plan contracts and actuarially sound capitation rates in order to operationalize any programmatic changes. States that seek to contractually require their managed care plans to increase HCBS provider payments must adhere to federal requirements for state directed payments in accordance with 42 C.F.R. § 438.6(c), including prior approval as required.

- If your state is reducing reliance on a specific type of facility-based or congregate service and increasing beneficiary access to services that are more integrated into the community, your state should be clear with stakeholders in your state’s stakeholder engagement activities, as well as in submissions to CMS of required ARP section 9817 spending plans and narratives and any resulting waiver or state plan amendments, about how these changes enhance the availability of integrated services in the specific waiver or state plan,
and offset any reductions in previously covered services, in compliance with the home
and community-based settings criteria or other efforts to increase community integration.

**Additional Information Related to the Quarterly Spending Plan and Narrative**

Ohio’s next quarterly spending plan and narrative is due 75 days before the quarter beginning
April 1, 2022. Please refer to SMDL #21-003 for information on the quarterly reporting process.

Your state’s quarterly spending plans and spending narratives should:

- Describe how the state intends to sustain the activities it is implementing to enhance,
  expand, or strengthen HCBS under the Medicaid program including how the state intends
  to sustain its planned provider payment increases;
- Provide information on the amount or percentage of any rate increase or additional
  payment per provider and the specific Medicaid authorities under which the state will be
  making those rate changes or payments;
- Provide the additional information described above;
- Clearly indicate if your state has or will be requesting approval for a change to an HCBS
  program and be specific about which HCBS program, which authority it operates under,
  and when you plan to request the change;
- Provide projected and actual spending amounts for each of the state’s planned activities
  to enhance, expand, or strengthen HCBS. In those projections, clearly identify if the state
  intends to draw down additional FFP for any activities, as well as the amount of state and
  federal share for any activities for which the state plans to claim additional FFP and
  whether those activities will be eligible for the HCBS increased FMAP under ARP
  section 9817;
- Clearly indicate whether your state plans to pay for capital investments or ongoing
  internet connectivity costs as part of any activity to enhance, expand, or strengthen
  HCBS. Capital investments and ongoing internet connectivity costs are permissible uses
  of funds to enhance, expand, or strengthen HCBS under section 9817 of the ARP. However, states must demonstrate how capital investments and ongoing internet connectivity costs would enhance, expand, or strengthen HCBS and ensure that capital investments will result in settings that are fully compliant with the home and community-based settings criteria. Further, approval of capital investments and ongoing internet connectivity costs in ARP section 9817 spending plans and narratives does not authorize such activities for FFP;
- Provide updated information (as appropriate) on the status and details of the state’s
  proposed activities to enhance, expand, or strengthen HCBS; and
- Make other revisions needed to: update the amount of funds attributable to the increase in
  FMAP that the state has claimed and/or anticipates claiming between April 1, 2021, and
  March 31, 2022; update anticipated and/or actual expenditures for the state’s activities to
  implement, to enhance, expand, or strengthen HCBS under the state Medicaid program
  between April 1, 2021, and March 31, 2024; update or modify the state’s planned
  activities to enhance, expand, or strengthen HCBS; and report on the state’s progress in
  implementing its planned activities to enhance, expand, or strengthen HCBS.

We extend our congratulations on this partial approval and look forward to working with you
further throughout the implementation of ARP section 9817. Programmatic and financial
questions and state HCBS quarterly spending plan and spending narrative questions for section 9817 of the ARP can be submitted to HCBSincreasedFMAP@cms.hhs.gov.

Sincerely,

Jennifer Bowdoin
Director, Division of Community Systems Transformation

cc: Travis Moore