

# Medicaid State Plan – Attachment 7

## *General Provisions*

---

### **Contents**

**[Attachment 7.2-A Plan for Title VI](#)**

**[Attachment 7.4 Medicaid Disaster Relief for the COVID-19 National Emergency](#)**

**[Attachment 7.4-A Rescissions to the State’s Disaster Relief Policies for the COVID-19 National Emergency](#)**

## State Plan Under TITLE XIX of the Social Security Act

State WASHINGTON

## Plan for Title VI

## I. Introduction:

The Department of Social and Health Services has established and implemented an affirmative action program in the area of employment in accordance with Title VII of the Civil Rights Act of 1964, Executive Orders, and Regulations hereunder. The program, in general, has been successful. Since the program was initiated, the department, while lacking in some areas of the program, has made tremendous strides in other areas. Admittedly, there is still a distance to go in order to completely eliminate discrimination on the basis of race, color, religion, creed, sex, national origin, handicap, or age in employment and personnel matters. Such discrimination, however, cannot be overcome in a short period of time. The department is making and will continue to make progress in that area and will continue to vigorously take positive steps to remove discriminatory employment and personnel practices, and to accomplish the goal of providing equal employment opportunities.

While striving for equal employment opportunities is necessary and beneficial to the department, it does not touch on all forms of discrimination. The department, fully aware of the negative consequences of discrimination on individuals, institutions, and society, has a legal, social, and moral obligation to eliminate all forms of discrimination within the agency,

The Department of Social and Health Services has, therefore, formulated in the following pages a nondiscrimination plan consistent with Title VI of the 1964 Civil Rights Act. The general, long-range goal of this plan is to promote the full realization of nondiscrimination with regard to departmental programs and activities based on race, color, or national origin. The first part of the plan establishes the departmental policy and commitment; the latter portion establishes the methods of administration or procedures by which the agency will ensure nondiscrimination. This plan, like the affirmative action plan, will be revised and updated on a continuing basis to ensure that departmental practices comply with the goal of the policy.

This plan, along with the affirmative action program, augments the departmental Minority Community Service, Indian Affairs, and Asian Affairs Policies. As in the case of these policies and others, it is how they are implemented or put into operation that is of major importance and, pursuant to this; the department shall place the greatest effort into the implementation of the plan rather than into the plan itself as a statement or a programming concept. In view of the fact that the mission of the department is to provide services and programs to all eligible persons, the plan set forth within shall be vigorously pursued.

## II. Purpose

This plan is designated to establish a policy and specific procedures by which the Department of Social and Health Services (hereafter referred to as the

## State Plan Under TITLE XIX of the Social Security Act

State WASHINGTON

Department) will ensure compliance in accordance with Title VI, Civil Rights Act of 1964 (42 USC 200 d. ct seq.) and the regulations issued there under by the US Department of Health, Education, and Welfare (45 Code of Federal Regulations 80).

## III. Policy

## A. General

In accordance with Title VI of the 1964 Civil Rights Act and the regulations issued there under by the Department of Health, Education, and Welfare, it is the policy of the Department that no person, on the grounds of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity receiving financial assistance from the Department, or for which the Department has responsibility.

This policy applies to every aspect of departmental programs and activities. Its provisions are equally applicable to vendors, grantees, contractors, and subcontractors of the Department.

In establishing this policy, it is recognized that the important language in the federal regulation governing nondiscrimination is that it is the *effect* and not the *intent* of discrimination that counts. That is, the regulations prohibit the operation of any program in a manner which has "the effect of subjecting individuals to discrimination because of their race, color, or national origin, or has the effect of defeating or substantially impairing the accomplishment of the objectives of the program as respects individuals of particular race, color, or national origin," 45 CFR 80.3(b)(2).

## B. Practices of the Department

More specifically, but not limiting the above:

## 1. Provision of Services, Financial Aid, or Other Benefits

The Department will make no distinction on the ground of race, color, or national origin in providing to individuals any service, financial aid, or other benefit under state or federally assisted programs. As used here and elsewhere in this Statement of Compliance:

- (a) "Distinction on the grounds of race, color, or national origin" includes
- (1) Any type of segregation, separate or different treatment, or other discrimination on that ground;
  - (2) The imposition of any admission, enrollment, quota, eligibility, or other requirement or condition which individuals must meet in order to be provided any services, financial aid, or other benefit under the program or to be afforded an opportunity to participate in the program, if the race,

## State Plan Under TITLE XIX of the Social Security Act

State WASHINGTON

color, or national origin of individuals is considered in determining whether they meet any such requirement or condition;

- (3) The use of membership in a group as a basis for the selection of individuals for any purpose if, in selecting members of the group, there is discrimination on the grounds of race, color, or national origin; and
  - (4) The assignment of personnel to provide services, or the assignment of time or places for the provision of services, on the basis of race, color, or national origin of the individuals to be served.
- (b) "Service, financial aid, or other benefit" under state or federally assisted programs includes any education or training, any evaluation, guidance, counseling, or placement service, any health, welfare, rehabilitation, housing, or recreational service, any referral of individuals for any of the foregoing services, any consultative, technical or information service, and any scholarship, fellowship, or traineeship stipend or allowance, and any loan or other financial assistance or benefit (whether in cash or in kind), which is made available
- (1) With the aid of state or federal financial assistance; or
  - (2) With the aid of nonfederal funds required to be made available for the program as a condition to the receipt of federal financial assistance; or
  - (3) In or through a facility provided with the aid of federal financial assistance or the funds referred to in (2) above.

## 2. Use of Facilities

The Department will make no distinction on the grounds of race, color, or national origin in making available the use of any facility provided under the state or federally assisted programs, including:

- (a) The use of any room, dormitory, or other space in the facility;
- (b) The use of any equipment in the facility;
- (c) The use of any office, waiting room, restroom, eating, recreational, concession, or other accommodation or convenience provided in the facility; and
- (d) The use of any facility not provided with the aid of state or federal financial assistance if the availability of such facility is required as a condition to the receipt of federal or state financial assistance.

## 3. Opportunities to Participate

The Department will make no distinction on the grounds of race, color, or national origin in affording opportunities to individuals to participate (other than as employees) in the program covered by the

## State Plan Under TITLE XIX of the Social Security Act

State WASHINGTON

---

Statement of Compliance, including opportunities to participate:

- (a) As providers of any services, financial aid, or other benefit to individuals under the program;
- (b) As conferees, observers, consultants, or advisors, or as members of advisory or planning groups or of technical review committees; or
- (c) As volunteers (e.g., as voluntary workers) or as patients or other subjects of study in survey or like programs.

4. Employment Practices

The Department will make no distinction on the grounds of race, color, or national origin in its employment practices (including recruitment or recruitment advertising, hiring, layoff, or termination, upgrading, demotion, or transfer, rates of pay or other forms of compensation and use of facilities) with respect to individuals seeking employment or employed under state or federally assisted programs, where a primary objective of state or federal financial assistance for the program is to provide employment to such individuals, including programs under which the employment is provided to students, fellows, interns, residents, or others in training for related employment (including research associates or assistants in training for research work).

5. Advantages, Privileges, and Accommodations

The Department will make no distinction on the grounds of race, color, or national origin in making available to individuals provided any service, financial aid, or other benefit under state or federally assisted program, or to individuals afforded an opportunity to participate in any such program, any advantage, privilege, or accommodation (such as housing, eating, health, cultural, or recreational services, facilities, or accommodations, or the use of offices, waiting rooms, or restrooms) which the Department makes available, with or without the aid of state or federal financial assistance, to any such individuals.

6. Use of Criteria and Method of Administration

The Department in determining the types of activities, services, financial aid, or other benefits, or facilities which will be provided or included under any such program (including community planning and coordination of programs or activities), or the class of individuals to whom, or the geographic areas, sites, or situations in which such activities, services, financial aid, or other benefits, or facilities will be provided or included (or planned for) under any such program, or the class of individuals to be afforded an opportunity to participate in any such program will not use any criteria or methods of

## State Plan Under TITLE XIX of the Social Security Act

State WASHINGTON

---

administration which result in or have the effect of distinction being made between individuals on the grounds of their race, color, or national origin, or which has the effect of defeating or substantially impairing accomplishment of the objectives of the program as respects individuals of a particular race, color, or national origin.

## 7. Application to Subgrantees

The Department will not approve any project for which state or federal financial assistance would be provided unless the Department has obtained from the applicant an assurance of compliance in a form approved for this purpose by the US Department of Health, Education, and Welfare or the Department. The Department will not approve any application for the provision of a facility, including the establishment of new or expansion of existing centers providing services, until it obtains from the applicant an Assurance of Compliance (HEW Form 44-1).

## 8. Agents and Contractors

The Department will require any individual, agency, organization or other entity which it uses or with which it contracts or otherwise arranges to provide services, financial aid, or other benefits under, or to assist it in the conduct of state or federally assisted programs or with which it contracts or otherwise arranges for the use of any facility purpose for which state or federal financial assistance was extended, to comply fully with Title VI, the Regulation and all policies and procedures contained in this Statement of Compliance.

## 9. Information to Beneficiaries, Participants, and Others

The Department will make available to beneficiaries, participants, and other interested persons such information regarding the provisions of Title VI and the Regulation, and made such information available in such manner, as may be required by the US Department of Health, Education, and Welfare to give adequate notice of the rights and remedies provided by Title VI, the Regulation and this Statement of Compliance.

## 10. Records, Reports, and Access to Facilities and Sources of Information

The Department will keep such records and from time to time submit such reports as the US Department of Health, Education, and Welfare may require ensuring compliance with the Regulation and this Statement of Compliance. For the same purpose, all facilities of the Department and all records, books, accounts, and other sources of information pertinent to ascertainment of the Department's compliance with the Regulation, will be available for the inspection at any time during normal business hours by an officer or employee of the US

## State Plan Under TITLE XIX of the Social Security Act

State WASHINGTON

---

Department of Health, Education, and Welfare authorized to make such inspections.

## IV. Methods of Administration

Set forth below are specific procedures to provide a framework for Departmental management and staff to follow in taking concrete measures to ensure nondiscrimination in all Departmental programs and activities

## A. Procedures to Ensure Nondiscrimination

## 1. Dissemination of Information and Training of Staff within the Department

The Department will inform and instruct its entire staff concerning their obligations under Title VI of the 1964 Civil Rights Act and the regulations there under, the Statement of Compliance filed by the Department, and the Minority Community Services Policy. The agency shall also ensure that members of its staff, who have contact with program beneficiaries, are aware of the ethnic, cultural, and language differences that may have important impact on the delivery of services to minority persons. This will be accomplished by:

- a. Making copies of all pertinent documents available to the entire staff;
- b. Issuing an "all staff" memo from the Secretary of the Department concerning Title VI, its intent and meaning, and the obligations there under;
- c. Issuing an informational article in the Departmental monthly publication, *An Overview*, concerning Title VI, departmental policy regarding nondiscrimination, the obligations there under;
- d. Providing, as part of a new employee's orientation training, information regarding the obligation, intent, and meaning of Title VI and the Department on discrimination plan.

## 2. Title VI and Departmental Nondiscrimination Compliance by Other Participants in the Departmental Programs

The Department recognizes that its obligation for compliance extends to its vendors, contractors, subcontractors, and other providers of services, financial aid, and other benefits under the Departmental program. The Department shall assure that such participants in its programs comply with Title VI and its regulations and the Departmental nondiscrimination policy by:

- a. Providing all vendors and other participants with a clearly

## State Plan Under TITLE XIX of the Social Security Act

State WASHINGTON

written explanation of their responsibilities under Title VI and its regulations, and the Departmental nondiscrimination policy;

- b. Requiring all vendors and other participants to execute in writing an assurance that they will comply with Title VI and its regulations and the Departmental nondiscrimination policy;
  - c. Recognizing that assurance of compliance serve primarily as notice to participants in the program that they must comply with Title VI and the Departmental nondiscrimination policy, and do not automatically indicate actual compliance with said policies;
  - d. Conducting Title VI and the Departmental nondiscrimination compliance reviews of all vendors and other participants, at least once every two years and more frequently in those cases where discrimination is alleged or suspected;
  - e. Requiring all vendors and other participants found to be not in compliance to take affirmative action to meet compliance;
  - f. Requiring all vendors, grantees, and other participants to submit annually a report showing:
    - (1) The number of potential clients, actual clients, and staffing patterns according to program areas, by race and sex;
    - (2) The number of potential non-English-speaking clients, actual clients, and staff according to program areas, by race;
    - (3) The number of discrimination complaints.
3. Dissemination of Information to Beneficiaries and the General Public
- The Department shall take steps to inform all beneficiaries, potential beneficiaries, and the general public of the fact that services, financial aid, and other benefits are provided on a nondiscriminatory basis as required under Title VI and the Departmental nondiscrimination policy. Further, such persons shall be notified of their right to file a complaint if they believe that they have been discriminated against on the basis of race, color, or national origin. This shall be accomplished by:
- a. Making copies of all pertinent documents available regarding the policy herein to all interested persons;
  - b. Displaying in prominent places posters explaining the nondiscrimination policy of the Department in each of the Department's offices, institutions, and vendor facilities through out the state;

## State Plan Under TITLE XIX of the Social Security Act

State WASHINGTON

- c. Including in all Departmental brochures which describe programs or services a statement of the Departmental nondiscrimination policy;
  - d. Communicating through posters and translated literature regarding Departmental program and/or services information regarding the Departmental nondiscrimination policy in Spanish, Chinese, Japanese, Tagalog, Ilocono, Korean, and Indian languages;
  - e. Notices with regard to their right to file a complaint and where and with whom to file such a complaint will be included in the aforementioned posters.
4. Complaint Policy and Procedures
- a. *Policy:* Any person who believes and he/she, or any specific class of persons, is subjected to discrimination on the basis of race, color, or national origin may, or by a representative, file a written complaint. The time period for filing a complaint is no less than 180 days from the date of the alleged discriminatory act(s). The Chief of the Office of Minority Affairs, however, may extend the time for filing a complaint. Further, no person who has filed a complaint, testified, assisted, or participated in any manner in the investigation of the complaint, shall be intimidated, threatened, coerced, or discriminated against.
  - b. *Procedure:* All complaints concerning discrimination because of race, color, or national origin shall be filed in writing, shall describe the type of discrimination alleged, and shall indicate when and where such discrimination took place, and describe any pertinent facts and circumstances surrounding the alleged discrimination. The complaint shall be signed by the person(s) making it. All complaints shall be addressed to the Chief of the Office of Minority Affairs who will assign them for prompt and thorough investigation and he/she shall bring the complaint to the attention of the Secretary of the Department.

After the complaint has been investigated, the Chief of the Office of Minority Affairs shall determine whether or not any discriminatory practice has been carried on and if he/she determines that one has, he/she will take such action(s) as may be necessary to correct past practices and to prevent the recurrence of such discrimination.

The complaint shall be advised in writing, in a timely manner, as to the findings of the Department regarding the complaint. If the complainant is not satisfied with the results of the Departmental investigation, he/she may request an opportunity for a hearing before a committee appointed by the Secretary of

## State Plan Under TITLE XIX of the Social Security Act

State WASHINGTON

---

the Department at which time, the complainant and/or his or her representative may present any pertinent information for consideration by this committee. The Department will maintain adequate records to show the nature of the complaint and the action taken as a result of each complaint and will make such information available to interested persons.

## 5. Recruitment and Employment Practices

Where the primary objective of the federal financial assistance to the Department is to provide employment and where the primary purpose of assistance is not to provide employment, the Department shall establish measure to assure that recruitment and employment practices do not discriminate and that the delivery of services and benefits provided do not have the effect of discrimination on the basis of race, color, or national origin. This will be accomplished by:

- a. Effective compliance with the Department's Affirmative Action Program with regard to employment and personnel matters;
- b. The employment of representative numbers of bilingual and/or bicultural workers (Blacks, Spanish, Chinese, Japanese, Philipino, Korean, Vietnamese, and Native American) in all social service delivery positions distributed according to the geographic distribution of each of the above ethnic groups throughout the state (see appendix);
- c. The employment of representative numbers of each of the minority groups (Asian, Blacks, Chicano, and Native American) in all social service delivery positions in all offices and institutions as reflected in their respective clientele and geographic distribution throughout the state;
- d. The translation and distribution of all the major program and services brochures of the Department to Spanish, Chinese, Japanese, Tapalog, Ilocano, Korean, and Vietnamese (see appendix);
- e. The provision of outstation services to each of the four major minority groups mentioned above.

## 6. Planning, Advisory, and Policy Boards

The Department shall assure that the opportunity to participate as members of planning, advisory, and policy boards, which are integral parts of its programs, is available to all persons in a nondiscriminatory manner. This will be accomplished by having members of each of the four major minority groups represented on the boards (see appendix).

## 7. Continuing Compliance with the Department

The Department shall establish procedures for the monitoring and

## State Plan Under TITLE XIX of the Social Security Act

State WASHINGTON

---

evaluation of all aspects of its operation to assure that no policy or practice is, or has the effect of, discriminating against beneficiaries or other participants on the basis of race, color, or national origin. Further, the Department shall collect and maintain racial/ethnic data, and information on its operation, which will show the extent to which minority persons are participating in all aspects of the Departmental programs and activities.

## 8. Corrective Requirements and Action

The Department shall take affirmative action to overcome the effects of prior discrimination in instances where the Department, or the participants in its programs have discriminated against persons on the grounds of race, color, or national origin.

## B. Responsibility

The overall responsibility for the implementation of the policy and plan herein lies with management, from the Secretary to the first-line supervisors of the Department. The Secretary of the Department, however, has the ultimate responsibility for implementing this plan and assuring that the Department complies with Title VI and its regulations, and the nondiscrimination policy and plan herein.

The implementation and operation of the plan will be accomplished as follows:

1. The Chief of the Office of Minority Affairs shall be appointed Civil Rights Coordinator for the Department. The Chief of the Office of Minority Affairs, with the assistance of his/her staff, shall be responsible for:
  - a. Handling of complaints of discrimination;
  - b. Dissemination of Title VI information to agency staff, beneficiaries, and interested members of the general public;
  - c. Preparation of compliance reports for submission to the Office for Civil Rights;
  - d. Conducting compliance reviews of vendors and vendor facilities;
  - e. Acting as liaison between the agency and the Office for Civil Rights
  - f. Acting as liaison between the agency and minority groups or other

## State Plan Under TITLE XIX of the Social Security Act

State WASHINGTON

community groups concerned with the delivery of services;

- g. Providing training and technical assistance to the agency staff on Title VI and cultural awareness;
  - h. Monitoring essential records and files relative to civil rights and the civil rights program of agency.
2. The following chart is a task matrix and timetable for the implementation of the plan: (see appendix)
  3. The Secretary of the Department shall be responsible for implementing corrective action measures within a reasonable amount of time. Each of Minority and Women's Desks or the Minority Affairs Office shall directly notify the Secretary when discrimination occurs, and determine the corrective actions needed to eliminate and to prevent further discrimination.

C. Monitoring and Evaluation

The Department will conduct annual reviews of its compliance with the policy and procedures contained herein to reaffirm and substantiate compliance. This will include both an internal and external review or a review of the Departmental program and activities and those of vendors, contractors, subcontractors, and grantees. Generally, the reviews will consist of a statistical analysis and on-site visits. This procedure will assure Departmental use of minority vendors, contractors, subcontractors, and grantees.

1. Internal Reviews

a. Statistical Report and Analysis

- (1) Statistical information and analysis of the Department and selected units by race and sex of:
  - (a) Potential participation in programs;
  - (b) Actual participation in programs;
  - (c) Staffing patterns or use;
  - (d) Membership in advisory boards;
  - (e) Number of discrimination complaints regarding discrimination;
  - (f) Number of non-English speaking persons, clients, and staff;
  - (g) Referral of clients to other agencies and facilities.
- (2) Analysis
  - (a) Comparative analysis of present and past situations according to the above factors;
  - (b) Comparison of the ratio of potential to actual participation;

## State Plan Under TITLE XIX of the Social Security Act

State WASHINGTON

- (c) Comparison between client and staff patterns according to ethnic background and sex.
- b. Review of policies and provision of services with regard to discrimination.
  - (1) Criteria for acceptance into the agency's program.
- c. On-site visitation to review practices that will include but no be limited to the following areas:
  - (1) The geographical location of the office or unit in comparison to other similar program units and the distribution of minorities;
  - (2) Dissemination of information and understanding among staff regarding nondiscrimination policy;
  - (3) Display of nondiscrimination posters(s);
  - (4) Availability and distribution of program brochures in languages other than English;
  - (5) Treatment of clients as indicated by their responses;
  - (6) Manner of assignment of applicants or clients to staff;
  - (7) Participation in clubs, organizations, etc.;
  - (8) Number of non-English speaking clients in comparison to staffing pattern;
  - (9) (1) and (2) under 1a above.
  - (10) Identification of problem areas and corrective actions needed to eliminate and prevent further discriminatory practices;
  - (11) Implementation of minority policies.

The on-site reviews will be conducted by the Operations Review Unit which will forward its findings regarding discrimination to the Minority Affairs Office for final determination. They will be assisted by the Minority Affairs staff when and where necessary. The Minority Affairs staff will also review certain units independent of the reviews conducted by the Operations Review teams, especially where discriminatory practices are suspect. Corrective actions, based on the findings of the Minority Affairs Office or one of its desks, will be taken where discrimination is found.

## 2. External Reviews

- a. Statistical information and analysis by race and sex of:
  - (1) Us of vendors;
  - (2) Use of paid consultants and volunteers;
  - (3) Use of contractors and subcontractors;
  - (4) Comparison of vendors, contractors, subcontractors; and

## State Plan Under TITLE XIX of the Social Security Act

State WASHINGTON

---

grantees agreeing (signing) written assurances of nondiscrimination;

- (5) Number of on-site- visitations regarding compliance with nondiscrimination;
- (6) Available number of potential clients, participants, and the staffing pattern by grant, contract, etc.;
- (7) Available number of potential non-English speaking clients, clients, and staff by grant, contract, etc.;
- (8) Number of discrimination complaints by grantee, contractors, etc.

b. On-site visitations (same as a (3)).

3. Noncompliance:

Any unit, program activity, vendor, contractor, or other participant which refuses to furnish assurances of nondiscrimination or fails to comply with the policy herein may be refused state or federal financial assistance. Such action, however, will be taken after an opportunity for a hearing before departmental officials and after a reasonable amount of time has been provided to comply with the policy. All incidences of noncompliance in program areas will be forwarded to DHEW, Office of Civil Rights, in a timely manner.

**Section 7 – General Provisions****7.4. 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.*  
Not requested.

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 rate

- 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. Effective 3/18/20, the uninsured group under sections 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act. No income or resource standard will be applied.*

- 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:

Disregard unemployment compensation benefits funded by the state or federal government, including those funded under the CARES Act of 2020, Public Law (Pub. L.) 116-136 Title II, Subtitle A: Pandemic Unemployment Assistance (PUA) (Sec. 2102); and Pandemic Emergency Unemployment Compensation (PEUC) (Sec. 2107) for these non-MAGI groups:

Qualified Medicare Beneficiaries – 1902(a)(10)(E)(i)

Qualified Disabled and Working Individuals – 1902(a)(10)(E)(ii)

Specified Low Income Medicare Beneficiaries – 1902(a)(10)(E)(iii)

Qualifying Individuals – 1902(a)(10)(E)(iv)

Individuals Eligible for but not Receiving Cash Assistance – 1902(a)(10)(A)(ii)(I)

Individuals Eligible for Cash Except for Institutionalization – 1902(a)(10)(A)(ii)(IV)

Individuals Receiving Home and Community Based Services under Institutional Rules - 1902(a)(10)(A)(ii)(VI)

Individuals Participating in a PACE Program under Institutional Rules – 1934

Individuals Receiving Hospice – 1902(a)(10)(A)(ii)(VII)

Work Incentives Eligibility Group – 1902(a)(10)(A)(ii)(XIII)

Ticket to Work Basic Group – 1902(a)(10)(A)(ii)(XV)

Ticket to Work Medical Improvements Group – 1902(a)(10)(A)(ii)(XVI)

Medically Needy Pregnant Women – 1902(a)(10)(C)(ii)(II)

Medically Needy Children under 18 – 1902(a)(10)(C)(ii)(I)

Medically Needy Aged – 1902(a)(10)(C)

Medically Needy Blind – 1902(a)(10)(C)

Medically Needy Disabled – 1902(a)(10)(C)

## Less restrictive resource methodologies:

Disregard the value of property essential for self-support (PESS) described in 42 CFR 416.1222 that is subject to the requirement of producing net annual income of at least 6% of the PESS value for these non-MAGI groups:

Qualified Medicare Beneficiaries – 1902(a)(10)(E)(i)

Qualified Disabled and Working Individuals – 1902(a)(10)(E)(ii)

Specified Low Income Medicare Beneficiaries – 1902(a)(10)(E)(iii)

Qualifying Individuals – 1902(a)(10)(E)(iv)

Individuals Eligible for but not Receiving Cash Assistance – 1902(a)(10)(A)(ii)(I)

Individuals Eligible for Cash Except for Institutionalization – 1902(a)(10)(A)(ii)(IV)

Individuals Receiving Home and Community Based Services under Institutional Rules - 1902(a)(10)(A)(ii)(VI)

Individuals Participating in a PACE Program under Institutional Rules – 1934

Individuals Receiving Hospice – 1902(a)(10)(A)(ii)(VII)

Medically Needy Pregnant Women – 1902(a)(10)(C)(ii)(II)

Medically Needy Children under 18 – 1902(a)(10)(C)(ii)(I)

Medically Needy Aged – 1902(a)(10)(C)

Medically Needy Blind – 1902(a)(10)(C)

Medically Needy Disabled – 1902(a)(10)(C)

4.  X  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.  X  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).
6.  X  The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:
- Individuals who are not residents but are quarantined in the state due to COVID-19.
7.   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 inconsistencies 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.

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

Individuals Eligible for but not Receiving Cash Assistance – 1902(a)(10)(A)(ii)(I)

Individuals Receiving Hospice – 1902(a)(10)(A)(ii)(VII)

Medically Needy Based on Age, Blindness, or Disability--1902(a)(10)(C)

Uninsured Individuals--1902(a)(10)(A)(ii)(XXIII)

Approval of HPE coverage is limited to twice in a calendar year. The agency waives performance standards for its review of HPE determinations.

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.  X  The agency suspends enrollment fees, premiums and similar charges for:
  - a.  X  All beneficiaries
  - b. \_\_\_\_ The following eligibility groups or categorical populations:

*Please list the applicable eligibility groups or populations.*  
All beneficiaries. The agency waives the requirement to pay the current premium obligation, including premium payments in arrears.

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.  X  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.

I. Dental services: D9992-care coordination allowed specifically for phone triage during the COVID-19 pandemic. Effective March 30<sup>th</sup>- April 30<sup>th</sup> (with the possibility of extension). This is a temporary code and is not considered tele-dentistry. \*Not to be used for normal operations such as appointment scheduling.

II. Allow pharmacists practicing within their scope of practice to: order, collect specimens, conduct and interpret necessary tests, initiate treatment when appropriate, and administer vaccines for the diagnosis, treatment, and prevention of COVID-19.

Allow pharmacists practicing within their scope of practice to administer any prescribed injectable covered outpatient drug during the COVID-19 pandemic.

3.  X  The agency makes the following adjustments to benefits currently covered in the state plan:

I. Allow licensed practitioners practicing within their scope of practice, including Advanced Registered Nurse Practitioners (ARNPs) and Physician Assistants (PAs), to order Medicaid Home Health services.

4.  X  The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewide 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).

5.  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:*

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

*Please describe.*

Any available electronic information and telecommunications technologies that supports any and all providers' ability to interact with a client for the purpose of delivering long-distance health care services and health related education that would have been provided during an in-person visit. Technologies include videoconferencing, store and forward, streaming media, and landline and wireless communications.

Telehealth services may be provided without any restriction on the type of technologies used.

*Drug Benefit:*

7.        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.*

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

9.        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.*

10.  X  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.  X  Newly added benefits described in Section D are paid using the following methodology:

- a.  X  Published fee schedules –

Effective date (enter date of change):  03/01/2020

Location (list published location): <https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules>

- b.        Other:

*Describe methodology here.*

*Increases to state plan payment methodologies:*

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

- I. Ambulance transportation
- II. Dental extractions

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

I. Ambulance transportation: Suspected or confirmed COVID-19 cases as well as interfacility transfers to clear beds in hospitals for COVID-19 cases.

II. Rates for CDT codes D7140, D7210, D7220, D7230, and D7240 were increased in direct response to COVID 19. With dental services related to only the most emergent and with the limited availability of Medicaid providers who perform emergency oral surgery, the Health Care Authority temporarily increased the fees to assist providers in increasing access to care. These codes are to be utilized for emergency dental procedures only when a client presents with pain, swelling, acute infection, or other emergency condition. It is NOT to be utilized during this time for asymptomatic teeth, including teeth in the same quadrant.

b. Payments are increased through:

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

*Please describe.*

ii. \_\_\_\_\_ 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): 3/1/2020

Location (list published location): <https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules>

\_\_\_\_\_ Up to the Medicare payments for equivalent services.

\_\_\_\_\_ By the following factors:

*Please describe.*

*Payment for services delivered via telehealth:*

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

- a. X 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. X Other payment changes:

*Please describe.*

Washington "unbundled" CMS bundled code 99001 and set a flat rate. This code is for handling and/or conveyance of specimen(s) for transfer from the patient, in other than an office, to a laboratory (distance may be indicated), which will aid drive-through testing facilities.

**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.

**Section 7 – General Provisions****7.4. 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.

*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 inconsistencies 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).
  - d. \_\_\_\_ The agency uses a simplified paper application.
  - e. \_\_\_\_ The agency uses a simplified online application.
  - f. \_\_\_\_ 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:

Under section 440.30(d), during the COVID-19 PHE, Medicaid coverage is available for laboratory tests and X-ray services that do not meet conditions specified in § 440.30(a) or (b) so long as the purpose of the laboratory or X-ray service is to diagnose or detect antibodies to COVID-19.

3.  The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewide 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.*

*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***Optional benefits described in Section D:*

1. \_\_\_\_ Newly added benefits described in Section D are paid using the following methodology (effective March 1, 2020, through the last day of the PHE):

- a. \_\_\_\_ Published fee schedules –

Effective date (enter date of change): \_\_\_\_

Location (list published location): <https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules>

- b. \_\_\_\_ Other:

*Describe methodology here.*

*Increases to state plan payment methodologies:*

2.  The agency increases payment rates for the following services (effective March 1, 2020, through the last day of the PHE):

I. Inpatient services paid via DRG method

II. Private Duty Nursing

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

I. Inpatient services paid via DRG method that include a COVID-19 diagnosis code and a DR condition code will receive a higher rate of reimbursement.

II. Increased rates for agencies that provide private duty nursing services and have had increased costs directly related to COVID-19.

- b. Payments are increased through:

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

*Please describe.*

- ii.  An increase to rates as described below.

Rates are increased:

Uniformly by the following percentage:

- 20% for inpatient services paid via DRG method when they include a COVID-19 diagnosis code and a DR condition code.

Through a modification to published fee schedules –

Effective date (enter date of change): 3/1/2020

Location (list published location): <https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules>

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:
- Are not otherwise paid under the Medicaid state plan;
  - Differ from payments for the same services when provided face to face;
  - Differ from current state plan provisions governing reimbursement for telehealth;

*Describe telehealth payment variation.*

A distant site will be paid a facility fee when that facility is eligible for that fee and the client's home is the originating site.

- Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
  - Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
  - 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 (effective March 1, 2020, through the last day of the PHE):

*Please describe.*

I. Washington currently reimburses nursing facilities for resident absences not to exceed eighteen (18) days. The state is extending social/therapeutic leave to more than eighteen (18) days per calendar year with prior written approval by the Appointing Authority or their designee (i.e. the Division Director, Regional Administrator, or Deputy Regional Administrator).

II. The state is adding code D1999 for dental PPE to align with the American Dental Association's recommendation to document the use and cost of additional PPE.

**Section F – Post-Eligibility Treatment of Income**

- 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:
  - The individual's total income
  - 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.

**Section 7 – General Provisions****7.4. 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.*

Not requested.

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:

- d.   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.
- e.   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).

- f.  Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Washington Medicaid state plan, as described below:

*Please describe the modifications to the timeline. Waive stated standard and expedited consultation timelines to be met prior to submission. Tribes were notified of this SPA on the day of submission, Feb. 18, 2021.*

**Section A – Eligibility**

- 8.  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.*

- 9.  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: \_\_\_\_\_

- 10.  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:

\_\_\_\_\_

11. \_\_\_\_ 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).
12. \_\_\_\_ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:
- 
13. \_\_\_\_ 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 inconsistencies 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

7. \_\_\_\_ 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.*

8. \_\_\_\_ 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.*

9. \_\_\_\_ 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.*

10. \_\_\_\_ 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.
11. \_\_\_\_ 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).
12. \_\_\_\_ 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).
- g. \_\_\_\_ The agency uses a simplified paper application.
  - h. \_\_\_\_ The agency uses a simplified online application.
  - i. \_\_\_\_ 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

4. \_\_\_\_ 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).*

5. \_\_\_\_ The agency suspends enrollment fees, premiums and similar charges for:
- c. \_\_\_\_ All beneficiaries
  - d. \_\_\_\_ The following eligibility groups or categorical populations:

*Please list the applicable eligibility groups or populations.*

6. \_\_\_\_ 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:*

11. \_\_\_\_ 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):

12. \_\_\_\_ The agency makes the following adjustments to benefits currently covered in the state plan:

13. \_\_\_\_ 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).

14. \_\_\_\_ 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).

- c. \_\_\_\_ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.
- d. \_\_\_\_ 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:*

15. \_\_\_\_ 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:*

16. \_\_\_\_ 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.*

17. \_\_\_ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

18. \_\_\_ 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.*

19. \_\_\_ 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:*

5. \_\_\_ Newly added benefits described in Section D are paid using the following methodology:

c. \_\_\_ Published fee schedules –

Effective date (enter date of change): \_\_\_\_\_

Location (list published location): <https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules>

d. \_\_\_ Other:

*Describe methodology here.*

*Increases to state plan payment methodologies:*

6. \_\_\_ The agency increases payment rates for the following services:

\_\_\_\_\_

- c. Payment increases are targeted based on the following criteria:

- d. Payments are increased through:

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

*Please describe.*

- iv.  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:*

- 7.  For the duration of the emergency, the state authorizes payments for telehealth services that:

- e.  Are not otherwise paid under the Medicaid state plan;
- f.  Differ from payments for the same services when provided face to face;
- g.  Differ from current state plan provisions governing reimbursement for telehealth;

*Describe telehealth payment variation.*

- h. \_\_\_\_ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
- iii. \_\_\_\_ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
  - iv. \_\_\_\_ 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:*

8.  X  Other payment changes:

*Please describe. Add codes for COVID-19 vaccine administration fees.  
 \*Effective 12/11/2020- 2/14/2021: Paid using the state's normal methodology  
 \*Effective 2/15/2021 – 3/31/2021: Paid at 100% of the Medicare rate (Note: Medicare changed its rate on 3/15/21, but HCA opted to wait until 4/1/21 to implement.)  
 \*Effective 4/1/2021 through the end of the PHE: Paid at 100% of the Medicare rate, including any future Medicare updates or changes to their rates.*

#### **Section F – Post-Eligibility Treatment of Income**

7. \_\_\_\_ 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:
- d. \_\_\_\_ The individual's total income
  - e. \_\_\_\_ 300 percent of the SSI federal benefit rate
  - f. \_\_\_\_ Other reasonable amount: \_\_\_\_\_
8. \_\_\_\_ 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.

**Section 7 – General Provisions****7.4. 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:

Effective date for SPA 21-0004 is 8/1/2020 through 12/31/2021 or the end of the PHE, whichever is first.

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:

- g.  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. Note: SPA 21-0004 to be effective August 1, 2020.
- h.  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).
- i.  X  Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Washington Medicaid state plan, as described below:

*Please describe the modifications to the timeline. Waive requirement for tribal notification 60 days prior to SPA submission.*

**Section A – Eligibility**

- 14. \_\_\_\_ 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.*

- 15. \_\_\_\_ 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:

- c. \_\_\_\_ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: \_\_\_\_\_

-or-

- d. \_\_\_\_ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: \_\_\_\_\_

- 16. \_\_\_\_ 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:

- 17. \_\_\_\_ 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).

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

19. \_\_\_\_\_ 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 inconsistencies 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**

13. \_\_\_\_\_ 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.*

14. \_\_\_\_\_ 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.*

15. \_\_\_\_\_ 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.*

16. \_\_\_\_\_ 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.
17. \_\_\_\_\_ 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).

- 18. \_\_\_\_ 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).
  - j. \_\_\_\_ The agency uses a simplified paper application.
  - k. \_\_\_\_ The agency uses a simplified online application.
  - l. \_\_\_\_ 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**

- 7. \_\_\_\_ 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).*

- 8. \_\_\_\_ The agency suspends enrollment fees, premiums and similar charges for:

- e. \_\_\_\_ All beneficiaries
- f. \_\_\_\_ The following eligibility groups or categorical populations:

*Please list the applicable eligibility groups or populations.*

- 9. \_\_\_\_ 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:*

- 20. \_\_\_\_ 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):

21. \_\_\_\_\_ The agency makes the following adjustments to benefits currently covered in the state plan:

22. \_\_\_\_\_ 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).

23. \_\_\_\_\_ 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).

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

f. \_\_\_\_\_ 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:*

24. \_\_\_\_\_ 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:*

25. \_\_\_\_\_ 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.*

26. \_\_\_\_\_ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

- 27.  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.*

- 28.  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:*

- 9.  Newly added benefits described in Section D are paid using the following methodology:

- e.  Published fee schedules –

Effective date (enter date of change): \_\_\_\_\_

Location (list published location): \_\_\_\_\_

- f.  Other:

*Describe methodology here.*

*Increases to state plan payment methodologies:*

- 10.  The agency increases payment rates for the following services:

Nursing Facilities

- e.  Payment increases are targeted based on the following criteria:

*Please describe criteria.*

- f. Payments are increased through:

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

Add-on payment to aid with additional costs resulting from the COVID-19 PHE. Add-on payments to nursing facilities are a flat, per client per day amount. The amount of this add-on is calculated based on caseload forecasts. Add-on rates:

August 1, 2020 through September 30, 2020	\$5.00
October 1, 2020 through December 31, 2020	\$7.50
January 1, 2021 through March 31, 2021	\$8.30
April 1, 2021 through December 31, 2021, or the end of the PHE, whichever is first.	\$8.33

vi.  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:*

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

- i.  Are not otherwise paid under the Medicaid state plan;
- j.  Differ from payments for the same services when provided face to face;
- k.  Differ from current state plan provisions governing reimbursement for telehealth;

*Describe telehealth payment variation.*

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

- v.  Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
- vi.  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:

12. \_\_\_\_\_ Other payment changes:

*Please describe.*

### Section F – Post-Eligibility Treatment of Income

9. \_\_\_\_\_ 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:
- g. \_\_\_\_\_ The individual's total income
  - h. \_\_\_\_\_ 300 percent of the SSI federal benefit rate
  - i. \_\_\_\_\_ Other reasonable amount: \_\_\_\_\_

10. \_\_\_\_\_ 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.

## Section 7 – General Provisions

### 7.4. 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:

- j.   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.
- k.   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).

- I.  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. Waive stated standard and expedited consultation timelines to be met prior to submission.*

**Section A – Eligibility**

- 20. \_\_\_\_\_ 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.*

- 21. \_\_\_\_\_ 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:

- e. \_\_\_\_\_ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: \_\_\_\_\_

-or-

- f. \_\_\_\_\_ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: \_\_\_\_\_

- 22.  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:

1) Disregard income that would have otherwise been part of an individual's liability for his or her institutional or home and community-based waiver services based on application of the post-eligibility treatment-of-income (PETI) rules but which became countable resources on or after March 18, 2020 for this non-MAGI group:

Individuals in Institutions under a Special Income Level – 1902(a)(10)(A)(ii)(V)

2) Disregard as a resource funds in a designated separate account that consists only of earnings resulting from work activity while enrolled in the Ticket to Work and Balanced Budget Act work incentives eligibility groups for this non-MAGI group:

Individuals in Institutions under a Special Income Level – 1902(a)(10)(A)(ii)(V)

23. \_\_\_\_ 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).

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

--

25. \_\_\_\_ 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 inconsistencies 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

19. \_\_\_\_ 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.*

20. \_\_\_\_\_ 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.*

21. \_\_\_\_\_ 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.*

22. \_\_\_\_\_ 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.
23. \_\_\_\_\_ 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).
24. \_\_\_\_\_ 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).
- m. \_\_\_\_\_ The agency uses a simplified paper application.
  - n. \_\_\_\_\_ The agency uses a simplified online application.
  - o. \_\_\_\_\_ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.



30. \_\_\_\_ The agency makes the following adjustments to benefits currently covered in the state plan:

31. \_\_\_\_ 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).

32. \_\_\_\_ 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).

- g. \_\_\_\_ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.
- h. \_\_\_\_ 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:**

33. \_\_\_\_ 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:**

34. \_\_\_\_ 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.

35.

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

36. \_\_\_\_ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

37. \_\_\_\_ 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.*

38. \_\_\_\_ 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:*

13. \_\_\_\_ Newly added benefits described in Section D are paid using the following methodology:

g. \_\_\_\_ Published fee schedules –

Effective date (enter date of change): \_\_\_\_\_

Location (list published location): \_\_\_\_\_

h. \_\_\_\_ Other:

*Describe methodology here.*

*Increases to state plan payment methodologies:*

14. \_\_\_\_ The agency increases payment rates for the following services:

15.

*Please list all that apply.*

g. \_\_\_\_ Payment increases are targeted based on the following criteria:

*Please describe criteria.*

h. Payments are increased through:

vii. \_\_\_\_ A supplemental payment or add-on within applicable upper payment limits:

*Please describe.*

viii. \_\_\_\_ 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:*

16. \_\_\_\_ For the duration of the emergency, the state authorizes payments for telehealth services that:

m. \_\_\_\_ Are not otherwise paid under the Medicaid state plan;

- n. \_\_\_ Differ from payments for the same services when provided face to face;
- o. \_\_\_ Differ from current state plan provisions governing reimbursement for telehealth;

*Describe telehealth payment variation.*

- p. \_\_\_ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
  - vii. \_\_\_ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
  - viii. \_\_\_ 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:*

17. \_\_\_ Other payment changes:

*Please describe.*

#### **Section F – Post-Eligibility Treatment of Income**

- 11. \_\_\_ 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:
  - j. \_\_\_ The individual's total income
  - k. \_\_\_ 300 percent of the SSI federal benefit rate
  - l. \_\_\_ Other reasonable amount: \_\_\_\_\_
- 12. \_\_\_ 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.

State/Territory: Washington

#### **7.4.A. Rescissions to the State's Disaster Relief Policies for the COVID-19 National Emergency**

Effective March 18, 2020, the agency rescinds the following which were approved on April 24, 2020, in SPA WA 20-0014:

- Election at A.1. to furnish medical assistance to the optional eligibility group described at section 1902(a)(10)(A)(ii)(XXIII) of the Social Security Act.
- Election of B.1. to allow hospitals to make presumptive eligibility determinations for the uninsured individuals described at section 1902(a)(10)(A)(ii)(XXIII) of the Social Security Act.

State/Territory: WASHINGTON

**7.4.A-1 Rescissions to the State's Disaster Relief Policies for the COVID-19 National Emergency**

Effective as indicated, the agency rescinds the following, which was approved on April 24, 2020, in SPA WA 20-0014:

- Increased rate per E.2. for certain codes for emergency dental extractions to assist providers in increasing access to care, effective through October 19, 2020.

Effective as indicated, the agency rescinds the following, which was approved on July 30, 2020, in SPA WA 20-0021:

- Added code D1999 per E.4 for dental PPE, effective through November 30, 2020.

---

TN# 20-0039

Approval Date 3/23/2021

Effective Date 10/20/2020

Supersedes

TN# NEW

This SPA is in addition to the Disaster Relief Rescission SPA approved on October 23, 2020 and does not supersede anything in that SPA.