Medicaid State Plan – Attachment 7

General Provisions

Contents

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

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,

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 of federally assisted programs includes any education or training, any evaluation, guidance, counseling, or placement service, any health, welfare, rehabilitation, housing, or recr4eational 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

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 of 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 or 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

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

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

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;

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

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

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

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;

(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

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. _X___ 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. _X___ 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 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.

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

Section B – Enrollment

1. __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):

I. Dental services: D9992-care coordination allowed specifically for phone triage during the COVID-19 pandemic. Effective March 30th- April 30th (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.

2. __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.

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

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

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

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

Please describe.

Telehealth:

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

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:

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. __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 inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

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

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

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

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

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

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

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

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

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
    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. __X___ 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. __X_ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

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

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

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

Please describe.

Telehealth:

5. ____ 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. __X_ 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. _X_ 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. _X_ An increase to rates as described below.

Rates are increased:

_X_ 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.

_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. __X_ 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.

   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 (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

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. 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. __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 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

7. ____ 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.

8. _____ 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: _____

9. ____ 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:

10. _____ 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).

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

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

Section B – Enrollment

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:

10. _____ 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):

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

12. _____ 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).

13. _____ 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:

14. ____ 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:

15. _____ 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.

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

17. _____ 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.

18. ____ 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

13. _____ 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.

14. _____ 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: _____

15. _____ 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:

16. _____ 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).

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

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

Section B – Enrollment

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:

19. _____ 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):

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

21. _____ 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).

22. _____ 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:

23. _____ 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:

24. _____ 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.

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

26. _____ 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.

27. _____ 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. _X_ 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. __X__ 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).

l. __X__ 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

19. _____ 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.

20. _____ 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: _____

21. __x__ 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)

22. _____ 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).

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

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

Section B – Enrollment

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.

Section C – Premiums and Cost Sharing

10. _____ 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).

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

    g. _____ All beneficiaries

    h. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

12. _____ 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:

28. _____ 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):

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

30. _____ 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).

31. _____ 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:

32. _____ 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:

33. _____ 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.

34.

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

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

36. _____ 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.

37. _____ 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.

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:

m. __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.

n. __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

o. _X___ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Washington's Medicaid state plan, as described below:

Please describe the modifications to the timeline. Waive standard and expedited consultation timelines to be met prior to submission. Tribes were notified under the expedited process on September 16, 2021, with a response date of September 27, 2021. No responses were received.

Section A – Eligibility

25. _____ 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.

26. _____ 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:

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

Income standard: _____

-or-

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

Income standard: _____

27. _____ 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:

28. _____ 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).

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

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

Section B – Enrollment

25. _____ 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.

26. _____ 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.

27. _____ 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.

28. _____ 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.

29. _____ 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).

30. _____ 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).

    p. _____ The agency uses a simplified paper application.

    q. _____ The agency uses a simplified online application.

    r. _____ 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

13. _____ 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).

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

    i. _____ All beneficiaries

    j. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

15. _____ 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:

38. _____ 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):

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

40. _____ 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).

41. _____ 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).

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

    j. _____ 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:

42. _____ 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:

43. _____ 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.

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

45. _____ 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.

46. _____ 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:

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

    i. _____ Published fee schedules –

    Effective date (enter date of change): _____

    Location (list published location): _____

j. _____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

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

Please list all that apply.

i. _____ Payment increases are targeted based on the following criteria:

Please describe criteria.

j. Payments are increased through:

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

Please describe. Fee-for-service supplemental payments for inpatient and outpatient hospital services is increased to account for the enhanced Federal match due to the Covid Public Health Emergency. Effective March 1, 2020, supplemental payments are paid for Inpatient and outpatient Medicaid services not to exceed the upper payment limit as determined by available federal financial participation for fee-for-service claims. The supplemental payment is based on the distribution amount mandated by the legislature to the following hospital categories as defined in RCW 74.60.010: • Prospective payment hospitals other than psychiatric or rehabilitation hospitals, • Psychiatric hospitals • Rehabilitation hospitals, and • Border hospitals. Payments described above will be enhanced such that total payment will equal the non-federal share of payments based on Washington maintaining its level of effort (i.e. the same commitment of non-federal share funds) divided by the state medical assistance percentage after the FFCRA increase is applied to the federal FMAP for Washington State, through the end of the PHE.

x. _____ 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:

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

    q. _____ Are not otherwise paid under the Medicaid state plan;

    r. _____ Differ from payments for the same services when provided face to face;

    s. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

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

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

        x. _____ 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:

21. ____ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

m. ____ 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: _____

n. _____ 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

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

Please describe the modifications to the timeline. Waive standard and expedited consultation timelines to be met prior to submission. Tribes were notified under the expedited process on December 8, 2021, with a response date of December 16, 2021. No responses were received.

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:

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

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

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

Section B – Enrollment

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

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

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

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

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

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

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

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

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

    s. _____ The agency uses a simplified paper application.

    t. _____ The agency uses a simplified online application.

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

Section C – Premiums and Cost Sharing

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

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

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

    a. _____ All beneficiaries

    b. ___ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

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

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

Section D – Benefits

Benefits:

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

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

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

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

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

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

Please describe.

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:

    a. _____ Published fee schedules –

    Effective date (enter date of change): _____

    Location (list published location): _____

b. _____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

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

Small Rural Disproportionate Share Hospital (SRDSH) Program

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

Please describe criteria.

b. Payments are increased through:

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

Please describe. Fee-for-service supplemental small rural disproportionate share hospital (SRDSH) payments are increased to account for the enhanced Federal match due to the Covid Public Health Emergency. Effective March 1, 2020, SRDSH payments will be enhanced such that total payment will equal the non-federal share of payments based on Washington maintaining its level of effort (i.e. the same commitment of non-federal share funds) divided by the state medical assistance percentage after the FFCRA increase is applied to the federal FMAP for Washington State, through the end of the PHE.

ii. _____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

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

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

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

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

Describe telehealth payment variation.

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

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

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

Other:

4. ____ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

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

    a. _____ The individual's total income

    b. _____ 300 percent of the SSI federal benefit rate

    c. _____ Other reasonable amount: _____

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

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

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

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

PRA Disclosure Statement

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

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.

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.

Section 7 – General Provisions

7.4.C Temporary Policies to the Disaster Relief Policies for the COVID-19 National Emergency

Effective April 1, 2023, through December 31, 2023, the agency temporarily extends the following election(s) of section 7.4 (approved on 02/22/2022 in SPA Number WA-21-0038) of the state plan with modifications:

Section E – Payments

Increases to state plan payment methodologies:

2. _X___ agency increases payment rates for the following services:

Small Rural Disproportionate Share Hospital (SRDSH) Program

b. Payments are increased through:

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

Please describe.

Fee-for-service supplemental small rural disproportionate share hospital (SRDSH) payments are increased to account for the enhanced Federal match due to the Covid Public Health Emergency.

Effective April 1, 2023, through December 31, 2023, SRDSH payments will be enhanced at the following percentages such that total payment will equal the non-federal share of payments based on Washington's maintenance of effort (MOE) (i.e., the same commitment of non-federal share funds) plus applicable federal matching funds:

- April 1, 2023, through June 30, 2023: 55.0%
- July 1, 2023, through September 2023: 52.5%
- October 1, 2023, through December 31, 2023: 51.5%

Section 7 – General Provisions

7.4.C Temporary Policies to the Disaster Relief Policies for the COVID-19 National Emergency

Effective April 1, 2023, through December 31, 2023, the agency temporarily extends the following election(s) of section 7.4 (approved on 11/10/2021 in SPA Number WA-21-0036) of the state plan with modifications:

Payments

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

j. Payments are increased through:

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

Please describe.

Fee-for-service supplemental payments for inpatient and outpatient hospital services is increased to account for the enhanced Federal match due to the Covid Public Health Emergency.

Effective April 1, 2023, through December 31, 2023, supplemental payments are paid for inpatient and outpatient Medicaid services not to exceed the upper payment limit as determined by available federal financial participation for fee-for-service claims. The supplemental payment is based on the distribution amount mandated by the legislature to the following hospital categories:

- Prospective payment hospitals other than psychiatric or rehabilitation hospitals
- Psychiatric hospitals
- Rehabilitation hospitals
- Border hospitals

Payments described above will be enhanced at the following percentages such that total payment will equal the non-federal share of payments based on Washington's maintenance of effort (MOE) (i.e., the same commitment of non-federal share funds) plus available federal matching funds:

- April 1, 2023, through June 30, 2023: 55.0%
- July 1, 2023, through September 30, 2023: 52.5%
- October 1, 2023, through December 31, 2023: 51.5%

Vaccine and Vaccine Administration at Section 1905(a)(4)(E) of the Social Security Act

During the period starting March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage

_X__ The state assures coverage of COVID-19 vaccines and administration of the vaccines.[1]

_X__ The state assures that such coverage:

1. Is provided to all eligibility groups covered by the state, including the optional Individuals Eligible for Family Planning Services, Individuals with Tuberculosis, and COVID-19 groups if applicable, with the exception of the Medicare Savings Program groups and the COBRA Continuation Coverage group for which medical assistance consists only of payment of premiums; and
2. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(H) and section 1916A(b)(3)(B)(xii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

_X_ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing or similar charge, pursuant to section 1937(b)(8)(A) of the Act.

_X__The state provides coverage for any medically necessary COVID-19 vaccine counseling for children under the age of 21 pursuant to §§1902(a)(11), 1902(a)(43), and 1905(hh) of the Act.

_X__ The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration, with respect to the providers that are considered qualified to prescribe, dispense, administer, deliver and/or distribute COVID-19 vaccines.

Additional Information (Optional):

[1] The vaccine will be claimed under this benefit once the federal government discontinues purchasing the vaccine.

Reimbursement

_X_ The state assures that the state plan has established rates for COVID-19 vaccines and the administration of the vaccines for all qualified providers pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

List Medicaid state plan references to payment methodologies that describe the rates for COVID-19 vaccines and their administration for each applicable Medicaid benefit:

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_X_ The state is establishing rates for COVID-19 vaccines and the administration of the vaccines pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

__X_ The state's rates for COVID-19 vaccines and the administration of the vaccines are consistent with Medicare rates for COVID-19 vaccines and the administration of the vaccines, including any future Medicare updates at the:

_X__ Medicare national average, OR

____ Associated geographically adjusted rate.

____ The state is establishing a state specific fee schedule for COVID-19 vaccines and the administration of the vaccines pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

The state's rate is as follows and the state's fee schedule is published in the following location:

As published on the COVID fee schedule published on the agency's website at https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules

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The state's fee schedule is the same for all governmental and private providers.

____ The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 vaccines and the administration of the vaccines are described under the benefit payment methodology applicable to the provider type:

____The payment methodologies for COVID-19 vaccines and the administration of the vaccines for providers listed above are described below:

_

__The state is establishing rates for any medically necessary COVID-19 vaccine counseling for children under the age of 21 pursuant to sections 1905(a)(4)(E), 1905(r)(1)(B)(v) and 1902(a)(30)(A) of the Act.

___The state's rate is as follows and the state's fee schedule is published in the following location

PRA Disclosure Statement *Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

COVID-19 Testing at section 1905(a)(4)(F) of the Social Security Act

During the period starting March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage

_X_ The states assures coverage of COVID-19 testing consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.

_X_ The state assures that such coverage:

1. Includes all types of FDA authorized COVID-19 tests;
2. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
3. Is provided to the optional COVID-19 group if applicable; and
4. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

Please describe any limits on amount, duration or scope of COVID-19 testing consistent with 42 CFR 440.230(b).

Limited to 12 tests per month for; COVID PCR, antigen and OTC tests. Limited to one test per year for COVID antibody tests. The amounts can be exceeded with prior authorization (known as a limitation extension).

_X_ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

_X_ The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Reimbursement

_X__ The state assures that it has established state plan rates for COVID-19 testing consistent with the CDC definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.

List references to Medicaid state plan payment methodologies that describe the rates for COVID-19 testing for each applicable Medicaid benefit:

COVID-19 testing rates were established using the methodology described in Attachment 4.19-B III Physician Services

____ The state is establishing rates for COVID-19 testing pursuant to pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

____ The state's rates for COVID-19 testing are consistent with Medicare rates for testing, including any future Medicare updates at the:

____ Medicare national average, OR

____ Associated geographically adjusted rate.

____ The state is establishing a state specific fee schedule for COVID-19 testing pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

The state's rate is as follows and the state's fee schedule is published in the following location:

_X__ The state's fee schedule is the same for all governmental and private providers.

____ The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 testing is described under the benefit payment methodology applicable to the provider type:

Additional Information (Optional):

____The payment methodologies for COVID-19 testing for providers listed above are described below:

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COVID-19 Treatment at section 1905(a)(4)(F) of the Social Security Act

During the period starting March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage for the Treatment and Prevention of COVID

_X_ The states assures coverage of COVID-19 treatment, including specialized equipment and therapies (including preventive therapies).

_X_ The state assures that such coverage:

1. Includes any non-pharmacological item or service described in section 1905(a) of the Act, that is medically necessary for treatment of COVID-19;
2. Includes any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations;
3. Is provided without amount, duration or scope limitations that would otherwise apply when covered for purposes other than treatment or prevention of COVID-19;
4. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
5. Is provided to the optional COVID-19 group, if applicable; and
6. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

_X_ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

_X_ The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Coverage for a Condition that May Seriously Complicate the Treatment of COVID

_X_ The states assures coverage of treatment for a condition that may seriously complicate the treatment of COVID-19 during the period when a beneficiary is diagnosed with or is presumed to have COVID-19.

_X_ The state assures that such coverage:

1. Includes items and services, including drugs, that were covered by the state as of March 11, 2021;
2. Is provided without amount, duration or scope limitations that would otherwise apply when covered for other purposes;
3. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
4. Is provided to the optional COVID-19 group, if applicable; and
5. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

_X_ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

_X_ The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Reimbursement

__X_ The state assures that it has established state plan rates for COVID-19 treatment, including specialized equipment and therapies (including preventive therapies).

List references to Medicaid state plan payment methodologies that describe the rates for COVID-19 treatment for each applicable Medicaid benefit:

COVID-19 testing rates were established using the methodology described in Attachment 4.19-B III Physician Services

____ The state is establishing rates or fee schedule for COVID-19 treatment, including specialized equipment and therapies (including preventive therapies) pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

_X__ The state's rates or fee schedule is the same for all governmental and private providers.

____ The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 vaccines and the administration of the vaccines are described under the benefit payment methodology applicable to the provider type:

Additional Information (Optional):

PRA Disclosure Statement *Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*