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:

March 1-September 30, 2020

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 North Carolina’s Medicaid state plan, as described below:

*Medicaid will notify the Tribe of all SPA changes on or before submission to CMS, and offer a telephonic meeting to discuss.*

Section A – Eligibility

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

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

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

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

   Income standard: ________________

   -or-

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

   Income standard: ________________

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

*Less restrictive income methodologies:*
Less restrictive resource methodologies:

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

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

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

Section B – Enrollment

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

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

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

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

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

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

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

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

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

Section C – Premiums and Cost Sharing

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

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

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

   a. _____ All beneficiaries
   b. _____ The following eligibility groups or categorical populations:
Please list the applicable eligibility groups or populations.

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

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

Section D – Benefits

Benefits:

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

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

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

4. Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).
   a. The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.
   b. Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

   Please describe.
State/Territory: ________NC_____

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): ______________

TN: 20-0011          Approval Date:
Supersedes TN:  NEW          Effective Date: 03/01/2020
b. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

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

<table>
<thead>
<tr>
<th>Inpatient and outpatient hospital services</th>
</tr>
</thead>
</table>

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

Separate methodologies described below for non-state owned, non-critical access hospitals; hospitals owned or controlled by the University of North Carolina Healthcare System; and critical access hospitals

b. Payments are increased through:

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

<table>
<thead>
<tr>
<th>Non-State Owned, Non-Critical Access Hospitals (“PPS” Hospitals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each month during which the payment methodology is in effect, calculate a monthly “deficit payment adjustment” to ensure hospitals are paid up to their full Medicaid costs as projected in the FFY 2020 North Carolina supplemental payment “MRI/GAP Plan”, after accounting for substantially lower-than expected actual FFY 2020 claims revenue. For each PPS hospital, perform the following calculation:</td>
</tr>
<tr>
<td>Inpatient Services</td>
</tr>
<tr>
<td>1. Identify monthly deficit payment reflected in approved FFY 2020 MRI/GAP Plan, calculated as the difference between 2018 Medicaid costs and base payments, trended forward to FFY 2020 and divided by 12.</td>
</tr>
<tr>
<td>2. Identify monthly deficit payment taking into account COVID impact, calculated as the difference between 2018 Medicaid costs (trended forward and divided by 12) and actual FFY 2020 claims payments for the applicable month as identified in the State’s Medicaid Management Information System (MMIS), adjusted for an Incurred But Not Reported (IBNR) completion factor based on historical claims experience.</td>
</tr>
</tbody>
</table>
3. Calculate deficit payment adjustment, equal to up to 100% of the
difference between Step 2 and Step 1.

**Outpatient Services**

For each month during which the payment methodology is in effect, each PPS
hospital shall receive a cost settlement based on the difference between 70% of
monthly outpatient Medicaid costs contained in the approved FFY 2020
MRI/GAP Plan (2018 Medicaid costs trended forward, divided by 12 and
multiplied by .7) and actual FFY 2020 outpatient claims payments for the
applicable month as identified in the State’s Medicaid Management
Information System (MMIS), adjusted for an Incurred But Not Reported (IBNR)
completion factor based on historical claims experience. In calculating the
traditional cost settlement under the State’s regular payment methodology for
outpatient hospital services, the months during which this SPA is applicable
shall be excluded.

**Hospitals Owned or Controlled by the University of North Carolina Health Care System (UNCHCS)**

For each month during which the payment methodology is in effect, calculate a
monthly payment adjustment for hospitals owned or controlled by the
University of North Carolina Healthcare System as follows:

**Inpatient**

1. Identify monthly Medicaid inpatient claims payments for each applicable
   hospital based on column Q of the “20_Enhanced Payment” tab of the
   approved FFY 2020 MRI/GAP Plan (annual amount divided by 12).

2. Identify actual FFY 2020 Medicaid inpatient claims payments for the
   applicable month as identified in the State’s Medicaid Management
   Information System (MMIS), adjusted for an IBNR completion factor based
   on historical claims experience.

3. Calculate payment adjustment, equal to up to 100% of the difference
   between Step 2 and Step 1.

**Outpatient Services**

1. Identify monthly Medicaid outpatient claims payments for each applicable
   hospital based on the “52_PS&R” tab of the approved FFY 2020 MRI/GAP
   Plan (annual amount divided by 12).

2. Identify actual FFY 2020 Medicaid outpatient claims payments for the
   applicable month as identified in the State’s Medicaid Management
Information System (MMIS), adjusted for an IBNR completion factor based on historical claims experience.

3. Calculate payment adjustment, equal to up to 100% of the difference between Step 2 and Step 1.

**Critical Access Hospitals and Vidant Medical Center**
For each month during which the payment methodology is in effect, each critical access hospital shall receive a cost settlement based on the difference between monthly Medicaid costs contained in the approved FFY 2020 MRI/GAP Plan (annual costs divided by 12) and actual FFY 2020 claims payments for the applicable month as identified in the State’s Medicaid Management Information System (MMIS), adjusted for an IBNR completion factor based on historical claims experience. In calculating the traditional cost settlement under the State’s regular payment methodology for critical access hospitals, the months during which this SPA is applicable shall be excluded.

Notes: For all hospital types, payment adjustments described above shall not constitute net patient revenue. Payment amounts will be calculated monthly, and paid in regular installments. The State intends to make all other payments to hospitals based on the amounts included in the approved FFY 2020 MRI/GAP Plan.

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.*
State/Territory: ________ NC ______

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:
   a. ____ Are not otherwise paid under the Medicaid state plan;
   b. ____ Differ from payments for the same services when provided face to face;
   c. ____ Differ from current state plan provisions governing reimbursement for telehealth;
   
   Describe telehealth payment variation.

   d. ____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
      i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
      ii. ____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _____ Other payment changes:

   Please describe.

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
   a. ____ The individual’s total income
   b. ____ 300 percent of the SSI federal benefit rate
   c. ____ Other reasonable amount: __________

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

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

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.