## 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:

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| *N/A.* |

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 Medicaid state plan, as described below:

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| 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.

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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:

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      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:

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| Disregard changes in circumstance, except for moves out of state or death, unless the change allows for more comprehensive coverage, until the next redetermination after the public health emergency ends. |

   Less restrictive resource methodologies:

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| Disregard increases in resources until the next redetermination following the emergency period. |

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

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

**Section B – Enrollment**

1. ____ 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.

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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.

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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.

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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:

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

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

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

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**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):

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

a) Breast and Cervical Cancer Program: Allow beneficiaries who are determined by a "qualified entity" as defined in 1920B (b) based on preliminary information to be eligible to receive coverage who are diagnosed with breast and cervical cancer. (ATTACHMENT 2.2-A Page 23e)
b) Reimburse ambulance providers and suppliers to treat beneficiaries in place without transporting. (Attachment 3.1-A.1 Page 18; Attachment 4.19-B Section 23, Page 1)
c) Add Immunotherapy and Hydration as covered Home Infusion Therapies when self-administered. (Attachment 3.1-A.1 Page 13a.3)
d) Expand the definition of a visit for FQHC and RHC reimbursement purposes to include telephonic visits (G0071) for dates of service March 10, 2020 through March 31, 2020, inclusive. (Attachment 4.19B, Section 2)
e) Waive the requirement that service levels must be re-assessed and re-authorized at least annually for personal care services. (Attachment 3.1-A.1 Page 20)
f) Add a mailing and dispensing fee option for all Pharmacy claims. (Attachment 4.19-B Section 7, Page 7)
g) Waive the requirement that Medicaid Home Health Providers be Medicare Certified to qualify for enrollment as a Medicaid Home Health Provider, in order to mitigate access of care issues due to increase demand for Home Health services related to COVID-19. (Attachment 3.1-A.1 Page 13)
h) Remove the requirement that Tobacco Cessation Counseling Services be provided face-to-face. (ATTACHMENT 3.1-A Page 2)
i) Remove the requirement that the Tobacco Cessation Counseling Services Benefit Package for Pregnant Women be provided face-to-face. (ATTACHMENT 3.1-A Page 2)
j) Remove the requirement for Certified Registered Nurse Anesthetists Services that mandates prescribing a medical treatment regimen and making a medical diagnosis be under the supervision of a licensed physician. (Appendix 8 to Attachment 3.1-A Page 1)
k) Remove the mandatory services visit limit of 22. (Attachment 3.1-A.1 Page 5)
l) Allow prior approval for nursing facility services to be made by a Physician Assistant or Nurse Practitioner, in addition to the Attending Physician. (Attachment 3.1-A.1 Page 6a)
m) Remove the requirement for medical transportation assessment every twelve months for non-emergency medical transportation (NEMT). (Attachment 3.1-D Page 2)
n) Remove the requirement for counties and the federally recognized tribe to audit 2% of the trips made each month for NEMT. (Attachment 3.1-D Page 3)
o) Waive prior authorization (PA) for Mobile Crisis Management maximum length of service, training requirements, and allow for supervision by any licensed professional if Team Lead is sick/ unavailable. (Attachment 3.1-A.1 Page 7c.5a)
p) Waive concurrent PA (for re-authorization) for Intensive In-Home, waive training requirements, change the 2-hour minimum to 1-hour minimum. (Attachment 3.1-A.1 Page 7c.6a)
q) Waive concurrent PA (for re-authorization) for Multi-Systemic Therapy, 12 contacts within first month and 6 in month 2 and 3 (unless individual/family member becomes ill during month and cannot receive services), waive training requirements, allow supervision by another masters level qualified provider if team lead is sick/unavailable, waive 3-5 month duration of service. (Attachment 3.1-A.1 Pages 7c.7 - 7a)
r) Waive concurrent PA (for re-authorization) for Community Support Team. Waive requirements for team composition if staff is sick/unavailable. Waive requirement that associate licensed

professional team lead be fully licensed within 30 months. Waive maximum of 8 units for first and last 30 day period for beneficiaries transitioning to/from certain other services and allow for 40 units. (Attachment 3.1-A.1 Page 15a.6-6a)

s) Waive concurrent PA (for re-authorization) for Assertive Community Treatment Team (ACTT). Waive requirements for team composition if staff sick/unavailable. Waive staff/bene ratio. Waive fidelity to the model. (Attachment 3.1-A.1 Page 15a.7)

t) Waive minimum hours per day for Psychosocial Rehabilitation. Waive staff ratio if telephonic - not if facility. Waive initial PA and concurrent PA (for re-authorization). (Attachment 3.1-A.1 Pages 15a.3-3a)

u) Waive concurrent PA (for re-authorization) for Child and Adolescent Day Treatment. Waive requirement to provide in licensed facility. 31.41/hour. (Attachment 3.1-A.1 Page 7c.5)

v) Waive concurrent PA for Partial Hospitalization. Waive minimum per day - must have 10 hours per week. (Attachment 3.1-A.1 Page 7c.5)

w) Waive minimum hours per day to 1.5hrs/day, 3 days per week for Substance Abuse Intensive Outpatient Program. Waive staff ratio. Waive initial PA and concurrent PA (for re-authorization). Waive CCS or LCAS on site 50% of the hours open- available telephonically. Waive must be done in facility. Waive UDS. Waive family counseling if family is unavailable or unwilling to do telehealth or telephonic or is sick. (Attachment 3.1-A.1 Page 7c.8)

x) Waive prior approval for Substance Abuse Comprehensive Outpatient Treatment. Reduce minimum to 2 hours per day, 5 days per week. Waive UDS. Waive family counseling if family is unavailable or unwilling to do telehealth or telephonic or is sick. (Attachment 3.1-A.1 Page 15a.10)

y) Waive prior approval for Ambulatory Detoxification (Attachment 3.1-A.1 Page 15a.12)

z) Waive prior approval for Substance Abuse Non-Medical Community Residential Treatment. Waive more than 30 days in 12 months. (Attachment 3.1-A.1 Page 15a.11)

aa) Waive prior approval for Substance Abuse Medically Monitored Community Residential Treatment. Waive more than 30 days in 12 months. (Attachment 3.1-A.1 Page 15a.11-A)

bb) Waive prior approval for Non-Hospital Medical Detoxification. Waive more than 30 days in 12 months. (Attachment 3.1-A.1 Page 15a.12-A)

cc) Waive initial PA for Outpatient Opioid Treatment, Waive concurrent PA. (Attachment 3.1-A.1 Page 15a.9)

dd) Waive initial and concurrent prior approval for Peer Support Services. (Attachment 3.1-A.1 Page 15a.2a)

ee) Waive concurrent PA (re-authorization) for Research-Based Behavioral Health Treatment. Allow the observation to be provided via telehealth. (Attachment 3.1-A.1 Pages 15-A.1-A.2)

ff) Allow social worker, psychologist or psychiatrist to provide telehealth instead of coming to facility for Child Residential Level III. (Attachment 3.1-A.1 Page 15a.20)

gg) Allow social worker, psychologist or psychiatrist to provide telehealth instead of coming to facility for Therapeutic Foster Care. Waive concurrent PA (Re-authorization). Waive staff training. (Attachment 3.1-A Pages 15a.18d-35)

hh) Allow social worker, psychologist or psychiatrist to provide telehealth instead of coming to facility for Residential Level IV. Waive parent and legal guardian must participate in rehabilitation plan development and implementation if unavailable due to illness. Waive opportunity for beneficiary inclusion in community activities. Waive training except for sex offender-specific training. (Attachment 3.1-A Pages 15a.18d-35)

ii) Waive TL limits - up to 90 days for Therapeutic Leave for Psychiatric Residential Treatment Facilities (PRTF) and Levels II-IV Residential Facilities; Reimburse when the patient is hospitalized

as well as when they are absent from the facility at their family's home. (Attachment 4.19-C Page 2)

jj) Waive TL limits - up to 90 days for Therapeutic Leave for Nursing Facilities and Intermediate Care for the Mentally Retarded (ICF-MR); Reimburse when the patient is hospitalized as well as when they are absent from the facility at their family's home. (Attachment 4.19-C Page 1)

kk) Waive 30-day max with PA for Professional Treatment Services in Facility-Based Crisis Program. (Attachment 3.1-A.1 Pages 7c.9a-9e)

ll) Waive 30-day max with PA for Facility-Based Crisis Programs (FBC) (Attachment 3.1-A.1 Pages 7c.9a-9e)

mm) Waive concurrent PA for Medically Supervised or ADATC Detoxification Crisis Stabilization. Waive 30-day max within 12 months. (Attachment 3.1-A.1 Page 15a.13)

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. _____ 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:

*Telehealth:*

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

*Drug Benefit:*

6. ___ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

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

8. __X___ 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.

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| NC Medicaid is adding the following fees, **in addition** to the pharmacy reimbursement that is currently listed in our State Plan, for prescriptions where a Medicaid beneficiary has requested that a pharmacy provider mail or deliver their prescription to them:<br>- Add a $1.50 fee to the pharmacy claim if a prescription is mailed to a beneficiary through a postal carrier such as USPS, UPS, FedEx, etc. There is a maximum of one of these charges allowed per beneficiary per provider per day.<br>- Add a $3.00 fee to the pharmacy claim if a prescription is delivered to a beneficiary or their designee via a courier-type person-to-person delivery. There is a maximum of one of these charges allowed per beneficiary per provider per day.<br><br>Justification for the addition of these fees include the North Carolina Governor's Executive stay-at-home order for social distancing and the need for high risk patients to shelter at home, if at all possible, at all times during the COVID-19 Emergency order. Pharmacy providers are also having an increase in operational costs due to wanting to provide this service for our Medicaid beneficiaries. |

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. _____ 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:

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| *Describe methodology here.* |

*Increases to state plan payment methodologies:*

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

*Please list all that apply.*

An additional temporary 10% rate increase will be applied to the following FFS programs:

Skilled Nursing Facilities, PCS providers (Adult Care Homes and In-Home), Home Health Providers, Veteran Home Nursing Facilities, and tribal providers providing nursing facility, PCS, and home health services. This is on top of 5% rate increases requested in North Carolina's previous disaster SPA request and is submitted based on conversations with facilities about increased needs they face related to prevention of COVID-19 outbreaks in their facilities. The state will provide additional rate increases to providers with specific issues, for example, an outbreak within a nursing facility, as described the state's first disaster SPA submission. The methodology for calculating these targeted increases has not changed.

A 5% rate increase will be implemented for all Medicaid programs including tribal providers that did not receive the 5% increase previously awarded to specific programs targeted in the initial Disaster Relief SPA submitted by the state. This increase is per the North Carolina General Assembly's' unanimous approval of Session Law 2020-4, House Bill 1043, Section 4.6, an Act to Provide Aid to North Carolinians in response to the Coronavirus Disease 2019(COVID-19) Crisis and will support providers facing additional costs related to COVID-19.

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

*Please describe criteria.*
To support the infection prevention and management activities of providers serving beneficiaries at high risk of contracting COVID-19. Also addresses increased costs of Medicaid providers during the COVID-19 pandemic experiencing COVID-19 outbreaks and servicing COVID19+ Medicaid beneficiaries, and to provide aid to North Carolinians in response to the Coronavirus Disease 2019(COVID-19) Crisis.

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: ___5% and/or 10%_____

__X___ Through a modification to published fee schedules –

Effective date (enter date of change): _____03/01/2020_____

Location (list published location): _____ DHB website _____

_____ Up to the Medicare payments for equivalent services.

__X___ By the following factors:

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| *Please describe.*<br>Additional rate increases to support specific providers who may be experiencing a disproportionate impact (e.g., a Nursing Facility and Adult Care Homes experiencing an outbreak) and facilities volunteering to house COVID-19+ patients only. |

*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;

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| *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:

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| *Please describe.*<br>In Attachment 4.19B, Section 2, the definition of a visit for FQHC and RHC reimbursement purposes is temporarily expanded to include telephonic visits (G0071) for dates of service March 10, 2020 through March 31, 2020, inclusive.<br><br>Reimburse ambulance providers and suppliers to treat beneficiaries in place without transporting (Treat-No- Transport). |

Add a mailing and dispensing fee option for all Pharmacy claims.

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

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

    a. _____ The individual's total income

    b. _____ 300 percent of the SSI federal benefit rate

    c. _____ Other reasonable amount: _____

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

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

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

**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.