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:

- **For Section E.4 regarding quarterly FFY2021 interim DSH and Hospital Supplemental Payments, the period is for the quarters October 1, 2020 – June 30, 2021 or 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:

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 the North Carolina Medicaid state plan, as described below:

NC 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 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).

    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:

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

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical 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. __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):

North Carolina will allow non-emergency medical transit providers to file claims for time their drivers have to wait for a beneficiary at an appointment (i.e., the trip would now include the current to and from trips but include a charge for the driver's time waiting in between these trips). This helps minimize the time beneficiaries would need to wait for their return transportation after the appointment, decreasing exposure to COVID-19 in the medical office or its related structures.

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

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:

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. ___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): _____4/1/2020_____

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:

Please list all that apply. Local Health Department Services

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

Please describe criteria. Increased cost due to COVID -19 pandemic

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: **40% increase above an earlier 5% increase approved in SPA 20-0009.**

_____ Through a modification to published fee schedules –

Effective date (enter date of change): **All LHD Services excluding Dental effective 3/1/2020, LHD Dental services effective 7/1/2020**

Location (list published location): __**DHB website/Special Bulletins**

_____ 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:

      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:

FFY 2021 interim DSH/MRI/GAP plan payments to hospitals

North Carolina Medicaid currently makes DSH and Supplemental payments to hospitals via an annual supplemental payment plan "DSH/MRI/GAP Plan" pursuant to the approved North Carolina State Plan. CMS most recently approved North Carolina's FFY2020 DSH/MRI/GAP Plan on April 3, 2020, and North Carolina subsequently executed the bulk of those transactions in the April / May 2020 time period.

Historically, North Carolina pulls from HCRIS and applicable data sources to annually build the DSH/MRI/GAP Plan between November and March and submits the DSH/MRI/GAP Plan to CMS on or before March 31 of the FFY for CMS review and approval; for example, the FFY2020 Plan was submitted to CMS on March 31, 2020. Upon CMS approval, North Carolina then typically executes the plan payments in two installments; the first installment is in the May/June timeframe representing Quarters 1-3 of the Plan; the second installment is in the September timeframe, representing Quarter 4 of the Plan. This typical annual cycle for model development and payment is dependent, in part, upon the availability of HCRIS data. Due to COVID-19, providers with December 31, 2019 fiscal year ends have been offered cost report extensions until August 31, 2020. These cost reports may not be fully available

in the 9/30/2020 HCRIS publication, forcing the State to hold off until the 12/31/2020 publication to obtain the most recent cost report data available.

To address the issues of (a) current decreased hospital revenue streams and (b) timing of available HCRIS data, rather than make a historical first installment payment in the May/June 2021 timeframe, North Carolina seeks to use the FFY2020 DSH/MRI/GAP Plan as a basis for making quarterly FFY2021 DSH and Supplemental interim payments to hospitals. Any interim payments would be reconciled to the final FFY2021 DSH/MRI/GAP Plan reviewed and approved by CMS in the normal cycle.

To calculate the quarterly DSH and Supplemental interim payments, North Carolina proposes to use the FFY2020 DSH/MRI/GAP Plan as approved by CMS on April 3, 2020 as the basis for quarterly FFY2021 DSH and Supplemental interim payments with the following adjustments:

1) Reduce DSH Allotment to North Carolina as used within the Plan to reflect the national Medicaid DSH Allotment reductions slated to occur December 1, 2020
2) Adjust Federal Medical Assistance Percentage used within the Plan to reflect FFY2021
3) Adjust the inpatient and outpatient teaching enhanced payment percentage of the hospital's deficit from 7.22% each to 1.01% of the hospital's estimated uncompensated care cost
4) Reverify DSH Eligibility of hospitals for FFY2021.

FQHC / RHC Core Service Billing Rate and Prospective Payment System (PPS) Rate

To stabilize critical safety net FQHC/RHC providers with lower volume and increased costs due to COVID-19, North Carolina will implement two rate changes. First, in North Carolina, FQHC and RHC providers have provider specific Core Service Billing Rates (T1015) to bill interim claims for Core Service encounters; effective April 1, 2020, these rates will be temporarily increased by 27%. Second, pursuant to the State Plan and Federal Regulations, each FQHC and RHC has a provider specific all-inclusive Medicaid PPS Rate to which they are reconciled annually to assure that each provider is paid no less than their Medicaid PPS Rate; effective April 1, 2020, each provider's Medicaid PPS Rate will be temporarily increased by 43%.

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

Allowing Local Health Departments to use prior year data for time reporting

For the Local Health Department (LHD) Medicaid Cost Report, the North Carolina State Plan, Attachment 4.19-B, Section 9, Page 1.3, Subparagraph A(9) currently reads: "*An actual time report is used to determine the percentage of time spent by medical service personnel on Medicaid covered services, administrative duties, and non-reimbursable activities."* CMS regulations state that time studies or time reports must be contemporaneous with the cost report data they support (e.g. a 2020 time study must support a 2020 cost report). Due to decreased volume in direct services due to COVID-19 (i.e. patients not coming in for office visits, lab services, well child visits, vaccines, etc.), the actual time spent by LHDs on direct patient care services during the pandemic is likely less than in a normal cost report year. Therefore, we are modifying this section of the State Plan so that for the LHD Medicaid cost report period 7/1/2019 – 6/30/2020, which is covered by the Public Health Emergency, the LHD provider may utilize their *prior* year (2019) actual time report percentages.

PRA Disclosure Statement

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