STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

KODY H. KINSLEY
SECRETARY

December 10, 2024

Courtney Miller, Director
Medicaid and CHIP Operations Group
Center for Medicaid & CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

SUBJECT: Request For Disaster Relief State Plan Amendment Related To North Carolina's Disaster Declaration

Dear Director Miller:

North Carolina Governor Roy Cooper issued Executive Order 315 on September 25, 2024, which declared a state of emergency for North Carolina in anticipation of severe weather caused by Hurricane Helene. On September 28, 2024, the President of the United States approved North Carolina's disaster declaration.

Please find attached for your review the Medicaid Disaster Relief SPA, 24-0038. The State Medicaid agency (agency) seeks to implement the policies and procedures described in the amendment, 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 Hurricane Helene.

Additionally, a state may request a Section 1135 state plan amendment process waiver if the President has declared a major disaster or an emergency under the Stafford Act, or an emergency under the National Emergencies Act, and the Secretary of the Department of Health and Human Services has declared a public health emergency. The agency seeks the following under section 1135(b)(5) of the Social Security Act:

Tribal Consultation: Pursuant to section 1135 (b)(5) of the Act, allows modification of the required Tribal consultation timelines specified in the Medicaid state plan per section 1902(a)(73) of the Act.

The state requests to temporarily modify the Tribal consultation timeline to allow for the completion of the Tribal Consultation after the submission of the Disaster Relief SPA.

Justification: Given the urgency of this request to modify our policies and procedures to respond to Hurricane Helene, NC proposes to modify its Tribal consultation timeline, allowing the agency to receive feedback from its Tribal partners while submitting the Disaster Relief SPA in a timely manner.

State Plan Amendment Effective Date: Pursuant to section 1135 (b)(5) of the Act, allows modification of the requirements in 42 CFR § 430.20 that a SPA must be submitted by the last day of a quarter in order to take effect that quarter. The state requests to temporarily modify these requirements to allow for the SPA to take effect in the quarter prior to when it was submitted.

Justification: North Carolina's public health emergency related to Hurricane Helene was declared on 9/28/24, with a retroactive start date of 9/25/24. The agency requests for the policies and procedures in the Disaster Relief SPA to be retroactive back to the start of the public health emergency; however, it was not feasible for the agency to submit the Disaster Relief SPA before the end of the quarter (9/30/24).

Your approval of the state plan amendment and associated Section 1135 amendment process waivers is requested. If you have any questions or concerns, please contact me or Ashley Blango at 919-812-6145.

Sincerely,

DocuSigned by:
Jay Ludlam
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Jay Ludlam
Deputy Secretary for North Carolina Medicaid

cSection 7 – General Provisions
7._ Disaster Relief During a Public Health Emergency or Disaster Period

General Information

1. This Disaster Relief state plan amendment (SPA) is in response to: **2024 Hurricane Helene Public Health Emergency**

2. ☐ This SPA is adding to a previously approved Disaster Relief SPA in effect.

Include previously approved SPA Transmittal Numbers

3. ☐ This SPA is superseding a previously approved Disaster Relief SPA.

Include superseded SPA Transmittal Numbers

4. 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 **2024 Hurricane Helene Public Health Emergency** (or any renewals thereof), or for any shorter period described below:

1. Allow individuals to provide a reasonable explanation of inconsistencies in lieu of requiring a paper application.

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.

5. The agency modifies the following sections during the period of the public health emergency or disaster:

- ☒ A – Eligibility
- ☐ B - Enrollment
- ☐ C - Cost Sharing and Premiums
- ☒ D - Benefits
- ☒ E – Payment
- ☐ F - Post Eligibility Treatment of Income
- ☐ G - Other Policies and Procedures Differing from Approved Medicaid State Plan/Additional Information

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.

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. __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:

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. [Reserved]

5. [Reserved]

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

1. **Medical:**
a. Reimbursement for Medically Necessary Services during Hurricane Helene:
Reimburse providers for medically necessary drugs and services, equipment and supplies, provided during the Hurricane Helene emergency without prior authorization.

2. **Behavioral Health:**
a. Substance Abuse Comprehensive Outpatient Treatment:
i. Waive reauthorization after the initial 60-day pass through.

ii. Waive the required for minimum service availability of four hours per day, five days per week; but must provide two hours per day, five days per week.

iii. Waive Urine Drug Screening requirements.

iv. Waive requirement for family counseling if family is unavailable, sick or unwilling to participate in telehealth or telephonic interventions.

v. Waive beneficiary-to-staff ratio if provided outside of the facility.

b. Diagnostic Assessment: Waive prior authorization for additional units beyond one unmanaged Diagnostic Assessment per state fiscal year.

c. Psychosocial Rehabilitation: Waive initial prior authorization and reauthorization.

d. Peer Support Services: Waive the requirement for telehealth or telephonically, audio-only communication be limited to 20% or less of total service time provided per beneficiary per fiscal year.

e. Mobile Crisis Management:
i. Waive staff training requirements within 90 days of employment, if unable to be obtained during the state of emergency.

ii. Waive concurrent review after the first 32 units of service have been rendered.

f. Intensive In-Home:
i. Waive prior approval and reauthorization request.

ii. Waive staff training requirements within 30 and 90 days of employment, if unable to be obtained during the state of emergency.

iii. Waive the two-hour per day minimum service provision and reduce to one-hour per day in order to bill.

iv. Waive team-to-family ratio of 1:12.

v. Allow for the 12 contacts required in the first month to be provided via telehealth if the provider is unable to provide the service in person. If the service cannot be provided via telehealth, the service may be provided telephonically.

g. Multisystemic Therapy:
i. Waive prior approval and reauthorization request.

ii. Waive staff introductory and quarterly training requirements if unable to be obtained during the state of emergency.

iii. Waive minimum monthly contacts of 12 in the first month and six contacts in the second and third month.

iv. Waive the three to five-month maximum duration of service.

h. Psychosocial Rehabilitation:
i. Waive initial prior authorization and reauthorization.

ii. Waive requirement for a minimum of five hours per day, five days a week of service availability. Service must be available a minimum of 10 hours per week.

iii. Waive staff ratio of 1:8 only if provided by telehealth or telephonic modalities.

iv. Allow service to be provided outside of the facility by telehealth, telephonically or in-person, including in the person's residence.

i. Child and Adolescent Day Treatment:
i. Waive reauthorization.

ii. Waive minimum of three hours of service per day.

iii. Allow service to be provided outside of the facility by telehealth, telephonically or in-person, including in the person's residence.

j. Partial Hospitalization:
i. Waive prior approval and reauthorization requirements.

ii. Waive requirement of minimum service availability of four hours a day five days per week; but must provide 10 hours of treatment per week in order to bill.

k. Professional Treatment Services in Facility-Based Crisis Program:
Waive per person maximum of 45 days of treatment per calendar year.

l. Substance Abuse Intensive Outpatient Program:
i. Waive reauthorization after the initial 30-day pass through.

ii. Waive the required minimum service availability of three hours per day three days per week; but must provide 1.5 hours of treatment per day, three days per week to bill.

iii. Waive beneficiary to staff ratio if provided outside of the facility.

iv. Waive Urine Drug Screening requirements.

v. Waive requirement for family counseling if the family is unavailable, sick or unwilling to participate in telehealth or telephonic interventions.

vi. Allow service to be provided outside of the facility by telehealth, telephonically or in-person, including in the person's residence.

m. Substance Abuse Non-Medical Community Residential Treatment:
i. Waive prior authorization and reauthorization request.

ii. Allow LCAS and CCS to provide services by telehealth or telephonically in lieu of being provided in-person at the facility.

n. Medically Supervised or ADATC Detoxification Crisis Stabilization:
i. Waive authorization requirement after the first eight hours of service.

ii. Waive maximum of 30-days of treatment within 12 months.

o. Community Support Team:
i. Waive authorization requirement after the 30-day pass-through.

ii. Waive reauthorization requirement.

iii. Waive requirement that staff must be dedicated to the team.

iv. Waive requirement that associate licensed professional team lead be fully licensed within 30 months.

v. Waive maximum of eight units for first and last 30-day period for individuals transitioning to and from other services and allow for 40 units of service overlap.

p. Assertive Community Treatment:
i. Waive prior authorization and reauthorization request.

ii. Waive staff to beneficiary ratio of 1:8 for small teams and 1:9 for medium and large teams.

iii. Waive requirement that team must demonstrate fidelity to the latest tool for Measurement of ACT (TMACT) model of care.

iv. Waive median rate of service frequency and median rate of service intensity.

q. Level II – Program Type Residential Treatment Services:
Waive staff training requirements if unable to be obtained during the state of emergency, except for sex offender specific training.

r. Residential Treatment Services Level IV:
i. Waive staff training requirement if unable to be obtained during the state of emergency except for sex offender specific training.

ii. Waive opportunity for individual inclusion in community activities.

s. Residential Treatment Services 8D-2 Level II-Program Type:
Waive reauthorization.

t. Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers:
Waive initial and reauthorization.

u. Children's Developmental Services Agencies:
CDSA flexibilities for TH for CDSAs and applicable independent practitioners who provide individualized family service plan (IFSP) services on behalf of a CDSA, the following services can be provided via Telehealth. CPT/HCPCS codes: H0031, H0036, H0036-HI, H0036-HM, H0036-HQ, H0036-TL, T1017-HI.

v. Substance Abuse Medically Monitored Community Residential Treatment:
i. Waive prior authorization and reauthorization request.

ii. Allow LCAS and CCS to provide services by telehealth or telephonically in lieu of being provided in-person at the facility.

w. Medically Monitored Inpatient Withdrawal Management:
i. Allow LCAS and CCS to provide services by telehealth or telephonically in lieu of being provided in-person at the facility.

3. **Ancillary Services:**
a. Durable Medical Equipment:

i. All temporary DME prior authorization waivers.

ii. HCPCS A4928, surgical mask, per 20, added for coverage effective 9/26/2024 - 12/31/9999, PA not required during this period.

4. **Long Term Services and Supports:**
a. Home Health:
Waive prior authorization requirement for Home Health Skilled Nursing visits post hospitalization in order to expedite a hospital's ability to discharge patients to a lower level of care when medically appropriate. This applies to both NC Medicaid Direct and NC Medicaid Managed Care Plans. MC Plans are permitted to require notification within three calendar days of Home Health admission to facilitate care management and care transitions. Home Health providers can begin services with verbal orders from the physician or as per CMS Interim Final Rule 42 CFR 440.40, Licensed Practitioners, as defined by CMS.

b. Private Duty Nursing:
Lift prior authorization requirement for short-term increase in private duty nursing (PDN) hours (up to 4 weeks) for any PDN beneficiary that has a current PDN PA certification.

c. Staff Training:
Waive staff training requirements if unable to be obtained during the State of Emergency.

5. **Dental:**
a. Fluoride Varnish:
i. Allow the topical application of fluoride varnish (D1206) for all ages.

ii. Allow the topical application of fluoride varnish (D1206) once per three calendar month period (approximately every 90 days) for patients at high risk for caries (active disease or previous caries related treatment).

b. Overrides:
i. Allow an override of the one-year limit for bitewing radiographic images (D0270-D0272-D0273-D0274) and the five-year limit for panoramic radiographic images (D0330) by submitting a retroactive prior approval request with documentation about previous radiographs lost in Hurricane Helene.

ii. Allow override of the 8-year limit on partial dentures and the 10-year limit on complete dentures for appliances lost in Hurricane Helene with documentation from the Federal Emergency Management Agency (FEMA), the American Red Cross, or a homeowners insurance claim indicating loss of possessions.

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. _____ The agency increases payment rates for the following services:

Please list all that apply.

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

Please describe criteria.

    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: _____

_____ 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:

      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:

1. **Retainer Payments for 1915(i) services.** The State will make retainer payments for specific 1915(i) services, including Community Living and Supports, Supported Employment, Individual Placement and Supports, and Individual and Transitional Supports. Providers who are unable to deliver services due to the emergency may bill for services they would have

otherwise delivered to Medicaid enrollees. They will be reimbursed for such services at the normal Medicaid rate. Retainer payments are limited to a period of up to 30 days.

Retainer payments are time-limited and cannot exceed one (1) 30 billable day period.

The state confirms that retainer payments are for direct care providers who normally provide services that include habilitation and personal care but are currently unable to due to barriers caused by the impact of the hurricane.

The state has a distinguishable process to monitor payments to avoid duplication of billing, which includes the following listed requirements:

a. Individual workers or nurses are required to sign an attestation prior to claiming retainer payments, in which they must attest to the items listed below:
b. The employee who receives retainer payments will not be eligible for unemployment as to hours covered by the retainer payment
c. To retain their availability to the specified waiver participant when the impacts of Hurricane Helene that prevented the delivery of services to the waiver participant have abated.
d. To report any retainer payments billed, sought, or received in submitting any unemployment insurance claim during the period in which retainer payment is received.
e. To receive the maximum reimbursement rate or wages per the planned pay period for approved hours/units in an active service plan approved before the retainer agreement was initiated.
f. Retainer payments are for primary staff that provide regularly scheduled services and are unable to deliver services.
g. Staff members identified as back up staff are not eligible for retainer payments.
h. To agree to receive a maximum of one retainer agreement for one specified waiver participant.
i. Due to the impacts of Hurricane Helene, the waiver participant is not able to receive waiver services in the usual amount, frequency and duration from their current provider.

Provider organizations that accept a retainer payment agreement for a specified worker cannot receive duplicative payments and must adhere to the following requirements listed below:

a. The provider agency cannot bill retainer payments on behalf of staff who are laid off.
b. The provider agency's retainer payment claims must be adjusted to account for any layoffs if staff are laid off.

Provider Agencies must also attest that they have not received funding from other sources that would exceed their revenue for the last full quarter prior to the emergency event or that retainer payments would not result in them exceeding their prior revenue.

If a provider has not already received revenues in excess of the pre-PHE level but receipt of the retainer payment in addition to those prior sources of funding results in the provider exceeding the pre-PHE level,

any retainer payment amounts in excess will be recouped. If a provider had already received revenues in excess of the pre-PHE level, retainer payments are not available.

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