STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

KODY H. KINSLEY
SECRETARY

May 18, 2022

James Scott, Director
Division of Program Operations
Department of Health & Human Services
Centers for Medicare & Medicaid Services
601 East 12th Street Room 355
Kansas City, Missouri 64106

SUBJECT: State Plan Amendment
Title XIX, Social Security Act
Transmittal #2022-0016

Dear Mr. Scott:

Please find attached an amendment for North Carolina's State Plan under Title XIX of the Social Security Act for the Medical Assistance Program. The affected page is the Medicaid Disaster Relief SPA Template.

- The State Plan Amendment requests authority to enact temporary rate increases for non-HCBS services in response to the current state of the public health emergency. These will be effective on July 1, 2021, and end at various points with the latest end date being June 30, 2022. This SPA replaces Disaster SPA 20-0008. Please see accompanying documentation for details on the specific proposed rates.

Your approval of this state plan amendment is requested. If you have any questions or concerns, please contact me or Cecilia Williams at (919) 270-2530.

Sincerely,

DocuSigned by:
D7816E4CBA6F4A8...

Kody H. Kinsley
Secretary

Enclosures

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:

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 the North Carolina 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 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. __X___The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

    The State waives cost-sharing for testing services (including in vitro diagnostic products), testing-related services, and treatments for COVID-19, including vaccines, specialized equipment and therapies (including drugs), for any quarter in which the temporary increased FMAP is claimed.

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

    a. _____All beneficiaries

    b. __X___The following eligibility groups or categorical populations:

Suspend enrollment fees and monthly premiums for the Health Care for Workers with Disabilities (HCWD) program.

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

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

Section D – Benefits

Benefits:

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

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

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

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

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

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

Please describe.

Telehealth:

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

Please describe.

Drug Benefit:

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

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

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

8. _____The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____Newly added benefits described in Section D are paid using the following methodology:

    a. ____Published fee schedules –

    Effective date (enter date of change): _____

    Location (list published location): _____

b. ____Other:

Describe methodology here.

Increases to state plan payment methodologies:

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

Please list all that apply. Effective March 10, 2020, through June 30, 2021 a 5% temporary Covid-19 rate increase applied to the following FFS programs: Skilled Nursing facilities, Hospice, Fee for Service Personal care Services (PCS), Private Duty Nursing, CDSAs, Local Health Departments, Home Health Providers, Veteran Home Nursing Facilities, Tribal Skilled Nursing Facility, Outpatient SpecializedTherapy Programs (Physical, Occupational, Respiratory, Speech Therapy and Audiology) and Community Alternatives for Children (CAP/C) PCS, Community Alternatives for Adults (CAP/DA) PCS.

Effective April 1, 2020 through September 30, 2021 an **a**dditional temporary Covid-19 rate increases will be applied to providers with specific issues, for example, an outbreak within a nursing facility. SNF rate increases are planned to be $86.64 increase to 4/1/2020 per diem base rates and $561.00 PPD for each Medicaid resident testing positive for COVID 19 during their treatment period.

Effective March 1, 2020 through June 30, 2021 a 5% temporary Covid-19 rate increase will be implemented for all Medicaid programs, including Indian Health Services and Cherokee Indian Health Association programs except for the services mentioned above that are already receiving specified COVID-19 rate increases.

a. __X___Payment increases are targeted based on the following criteria:

Please describe criteria.

Address increased costs for Medicaid providers during the COVID-19 pandemic. Facilities will be eligible for a targeted rate increase once they have two or more residents with laboratory confirmed cases of COVID-19 as determined by the Division of Public Health. Also, SNFs that designate themselves as 'COVID-19 Response Facilities" that will accept COVID-19 positive patient transfers from acute care facilities to address the pandemic surge will receive targeted rate increases. These targeted increases are based on inputs such as PPE equipment costs, increased staffing, and increased overall facility overhead (e.g., laundry, cleaning).

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%_____

_____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.

___X__By the following factors:

Please describe. Additional rate increases to support specific providers who may be experiencing a disproportionate impact (e.g., a nursing facility experiencing an outbreak).

Payment for services delivered via telehealth:

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

   a. __X_Are not otherwise paid under the Medicaid state plan;

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

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

Telehealth will be paid at the same rate as face-to-face visits for the relevant service though they will have separate billing codes.

Telehealth services will be paid at parity to face-to-face; however, telephonic codes will not be paid at full parity to incentivize telehealth and visual evaluation of patients. Telephonic rates have been increased to 80% of comparable telehealth and/or face to face code rates to narrow the spread in non-parity.

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

      i. __X___Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

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

Other:

4. __X___Other payment changes:

Please describe.

For the duration of the public health emergency, any Medicaid-enrolled provider may request that its reimbursement be converted to an interim payment methodology. Under the interim payment methodology, the requesting provider will receive an amount equal to two months' payment at the historical average monthly Medicaid payment, based on the months of January and February 2020. Critical access hospitals would be eligible to receive up to 125% of the historical payment amount. The State will subsequently reconcile the interim payments with final payments that the provider is eligible for based on billed claims. After reconciliation, payments will be equal to the actual utilization during the period at current Medicaid rates. NC has indicated that reconciliation would occur following implementation of the rate adjustment in our MMIS using our normal recoupment process. The provider recoupment process could begin as early as July 2020. Federal share on interim payments will be returned to CMS on quarterly CMS-64 reports.

Section F – Post-Eligibility Treatment of Income

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

   a. ____The individual's total income

   b. ____300 percent of the SSI federal benefit rate

   c. ____Other reasonable amount: _____

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

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

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

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

PRA Disclosure Statement

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