Table of Contents

State/Territory Name: Nebraska

State Plan Amendment (SPA) #: 20-0010

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

April 24, 2020

Jeremy Brunssen, Interim Director
Division of Medicaid & Long-Term Care
Nebraska Department of Health & Human Services
301 Centennial Mall South
Lincoln, NE 68509

Re: Nebraska State Plan Amendment (SPA) NE-20-0010

Dear Mr. Brunssen:

We have reviewed the proposed amendment to add section 7.4 Medicaid Disaster Relief, pages 90-101 for the COVID-19 National Emergency to your Medicaid state plan, as submitted under transmittal number (TN) NE-20-0010. This amendment proposes to implement temporary policies, which are different from those policies and procedures otherwise applied under your Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof).

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 of the 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 this state plan provision will no longer be in effect, upon termination of the public health emergency, including any extensions.

The State of Nebraska requested a modification of the requirement to submit SPAs related to the COVID-19 emergency by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 C.F.R. §430.20. CMS is approving this request pursuant to section 1135(b)(5) of the Act.

The State of Nebraska requested a waiver of public notice requirements applicable to the state plan amendment (SPA) submission process. Public notice for SPAs is required under 42 C.F.R §447.205 for changes in statewide methods and standards for setting Medicaid payment rates, 42 C.F.R. §447.57 for changes to premiums and cost sharing, and 42 C.F.R. §440.386 for changes to ABPs. These requirements help to ensure that the affected public has reasonable opportunity to comment on these SPAs. CMS recognizes that during this public health emergency, Nebraska must act expeditiously to protect and serve the general public. Therefore, under section 1135(b)(1)(C) and 1135(b)(5) of the Act, CMS is approving the state's request to waive these notice requirements applicable to this SPA.

The State of Nebraska also requested a waiver to modify the tribal consultation timeline applicable to this SPA submission process. Under section 1135(b)(5) of the Act, CMS is also approving the State of Nebraska's request for flexibility to modify the timeframes associated with tribal consultation required under section 1902(a)(73) of the Act, including shortening the number of days before submission or conducting consultation after submission of the SPA.

These approvals under section 1135 only apply with respect to SPAs that provide or increase beneficiary access to items and services related to COVID-19 (such as cost sharing waivers, payment rate increases, or amendments to ABPs to add services or providers) and that would not restrict or limit payment or services or otherwise burden beneficiaries and providers, and that are temporary, with a specified sunset date that is not later than the last day of the declared COVID-19 emergency (or any extension thereof). Even though CMS is approving this waiver, we encourage the state to make all relevant information available to the public so they are aware of the changes.

We conducted our review of your submittal according to the statutory requirements at section 1902(a) of the Act and implementing regulations. This letter is to inform you that Nebraska's Medicaid SPA Transmittal Number NE-20-0010 is approved effective March 1, 2020.

Enclosed is a copy of the CMS-179 summary form and the approved state plan pages.

Please contact Barbara Cotterman at 816-426-6426 or by email at Barbara.Cotterman@cms.hhs.gov if you have any questions about this approval. We appreciate the efforts of you and your staff in responding to the needs of the residents of the State of Nebraska and the health care community.

Sincerely,

Anne M. Costello -S

Digitally signed by Anne M. Costello -S
Date: 2020 04.24 14:39:48 -04'00'

Anne Marie Costello
Deputy Director
Center for Medicaid & CHIP Services

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: NE 20-0010

2. STATE: Nebraska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
March 1, 2020

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1135 of the SSA
* Title XIX of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2020 $52,541,288
b. FFY 2021 $489,029,234

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Section 7, 7.4, Pages 90-101 (new)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Medicaid Disaster Relief for the COVID-19 National Emergency

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Governor has waived review

[redacted] OFFICIAL:

13. TYPED NAME:
Jeremy Brunssen

14. TITLE:
Interim Director, Division of Medicaid and Long-Term Care

15. DATE SUBMITTED:
April 21, 2020

16. RETURN TO:

Dawn Kastens
Division of Medicaid & Long-Term Care
Nebraska Department of Health & Human Services
301 Centennial Mall South
Lincoln, NE 68509

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
April 2, 2020

18. DATE APPROVED:
April 24, 2020

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
March 1, 2020

20. SIGNATURE OF REGIONAL OFFICIAL:
Anne M. Costello -S Digitally signed by Anne M. Costello -S Date 2020.04.24 14:40:16 -04'00'

21. TYPED NAME:
Anne Marie Costello

22. TITLE:
Deputy Director, CMCS

23. REMARKS:

* pen and ink change made per state email dated 4.23.20.

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:

Describe shorter period here.

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 Nebraska Medicaid state plan, as described below:

Nebraska will begin the tribal consultation period concurrently with submission of this SPA to CMS. Nebraska tribes will have 15 calendar days to initiate a tribal consultation in which Nebraska will immediately address any questions.

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. __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. __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.

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. __X___ 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.

The agency designates entities qualified to make determinations for pregnant women only, as defined in NE 13-0027, to expand to provide determinations for Parent/Caretaker Relatives, Former Foster Care Children, and Children under age 19. The policies and procedures for qualified entities applies to these determinations. There may be no more than one period of presumptive eligibility per pregnancy. Periods of presumptive eligibility are limited to no more than one period within two calendar years for Parent/Caretaker Relatives, Former Foster Care Children, and Children under age 19.

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

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

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

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

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

Section C – Premiums and Cost Sharing

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

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

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

    a. _____ All beneficiaries

b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

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

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

Section D – Benefits

Benefits:

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

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

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

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

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

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

Please describe.

Telehealth:

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

Nebraska Medicaid is offering reimbursement for telephonic evaluation and management for the following beneficiaries seeking care when they are already an established patient or the parent or legal guardian of an established patient:
-Beneficiaries who are actively experiencing mild symptoms of COVID-19 (fever, cough, shortness of breath) prior to going to the emergency department, urgent care, or other health care facility;
-Beneficiaries who need routine, uncomplicated follow up and who are not currently experiencing symptoms of COVID-19; and,
-Beneficiaries requiring behavioral health assessment and management.

The telephonic evaluation and management services must be rendered by a qualified health care professional, defined as a physician, nurse practitioner, or physician assistant actively enrolled in Nebraska Medicaid at the time of service. Telephonic evaluation and management by staff other than those listed should not be submitted for reimbursement and will not be reimbursed. Services are to be rendered only to established patients, and parents or legal guardians of established patients.

Telephonic evaluation and management of services may be utilized by the following behavioral health providers: Psychologist (PhD/PsyD), provisional psychologist (PHD provisional), licensed independent mental health worker (LIHMP), licensed mental health worker (LHMP), provisionally licensed mental health worker (PLMHP), licensed alcohol and drug counselor (LADC), and provisionally licensed alcohol and drug counselor (PLADC).

Home Health: Initial assessments and recertification assessments may be completed by using telehealth for physicians and nurse practitioners. Initial assessments, recertifications, and ongoing visits per individual plan of care may be completed by using telehealth for nurses. Telehealth may be used for supervisory visits for aide services.

Hospice: Initial assessments and recertification assessments may be completed by using telehealth for the appropriate physicians and nurse practitioners. Initial assessments, recertifications, and ongoing visits per individual plan of care may be completed by using telehealth for nurses.

Lactation Counseling Services provided through EPSDT: Comprehensive lactation counseling services may be provided by using telehealth.

Tobacco Cessation Counseling: Tobacco Cessation Counseling services may be provided by using telehealth.

Pediatric Feeding Disorder Outpatient Therapy: Pediatric Feeding Disorder Outpatient Therapy services may be provided by using telehealth.

Community Support: Community Support Services may be done via telehealth. As clinically appropriate, HIPPA compliant two-way real-time interactive audio and video telehealth may be offered to proceed with behavioral health interventions. All visits, regardless of modality of communication, must be clinically necessary to work on treatment goals as outlined in the beneficiaries plan of care. Visit documentation must include the modality of communication, the rationale for that modality and the duration of the intervention.

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. __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. _____ Differ from payments for the same services when provided face to face;

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

Indian Health Services, Tribal Clinics, and Urban Indian Health Centers (ITU's) may bill the encounter rate for telehealth services that would typically have been bill for a non-telehealth encounter. In order to remain in accordance with the four walls rule in federal statute, ITU's may bill encounters via telehealth the same as they would typically bill for a non-telehealth encounter, with the addition of the telehealth modifier to both the encounter and the corresponding procedure codes, as long as either the provider or the client is within the walls of the facility during the time of the visit.

Federally Qualified Health Centers and Rural Health Centers may bill the encounter rate for core services provided via telehealth during the emergency period.

The changes to telehealth described in section D. 5. make use of new rates and new separate billing codes.

Code G2012 is used for a brief communication technology-based service; for example, virtual or telephone communication by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days or not leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion. The rate for this code is $13.82.

Code 99441 is used for telephone evaluation and management service by a physician, nurse practitioner, or physician assistant who may report evaluation and management (E/M) services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days or leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion. The rate for this code is $14.47.

Code 99442 is used for telephone evaluation and management service by a physician, nurse practitioner, or physician assistant who may report E/M services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days or leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion. The rate for this code is $28.71.

Code 99443 is used for telephone evaluation and management service by a physician, nurse practitioner, or physician assistant who may report E/M services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days or leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion. The rate for this code is $46.60.

Code 98966 is used for Telephone assessment and management service provided by an enrolled behavioral health provider to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days not leading to an assessment and management service or procedure with the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion. The rate for this code is $11.75.

Code 98967 is used for telephone assessment and management service provided by an enrolled behavioral health provider to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days not leading to an assessment and management service or procedure with the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion. The rate for this code is $20.67.

Code 98968 is used for telephone assessment and management service provided by an enrolled behavioral health provider to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days not leading to an assessment and management service or procedure with the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion. The rate for this code is $32.42.

Code G0071 is used for Payment for communication technology-based services for 5 minutes or more of a virtual (not face-to-face) communication between an FQHC or RHC practitioner and a FQHC or RHC patient. The rate for this code is $46.40.

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:

Nebraska Medicaid is also adding new codes and rates associated with COVID-19 that do not appear currently on our fee schedule. These codes and rates are:

U0001 Test Price - $35.92
U0002 Test Price - $51.31
87635 - $51.33

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.