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State/Territory Name: Florida

State Plan Amendment (SPA) #: 20-0004

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

November 24, 2020

Ms. Beth Kidder
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #8
Tallahassee, FL 32308

Re: Florida State Plan Amendment (SPA) FL 20-0004

Dear Ms. Kidder:

We have reviewed the proposed amendment to add section 7.4 Medicaid Disaster Relief for the COVID-19 National Emergency to your Medicaid state plan, as submitted under transmittal number (TN) 20-0004. 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.

Pursuant to section 1135(b)(5) of the Act, for the period of the public health emergency, CMS is modifying the requirement at 42 C.F.R. 430.20 that the state submit SPAs related to the COVID-19 public health emergency by the final day of the quarter, to obtain a SPA effective date during the quarter, enabling SPAs submitted after the last day of the quarter to have an effective date in a previous quarter, but no earlier than the effective date of the public health emergency.

The State of Florida requested a waiver of public notice requirements applicable to the SPA submission process. Pursuant to section 1135(b)(1)(C) of the Act, CMS is waiving public notice requirements applicable to the 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 Alternative Benefit Plans (ABPs). Pursuant to section 1135(b)(1)(C) of the Act, CMS is approving the state's request to waive these notice requirements otherwise applicable to SPA submissions.

The State of Florida also requested a waiver to modify the tribal consultation timeline applicable to this SPA submission process. Pursuant to section 1135(b)(5) of the Act, CMS is also allowing states 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 waivers or modifications of the requirements related to SPA submission timelines, public notice, and tribal consultation apply only with respect to SPAs that meet the following criteria: (1) the SPA provides or increases beneficiary access to items and services related to COVID-19 (such as by waiving or eliminating cost sharing, increasing payment rates or amending ABPs to add services or providers); (2) the SPA does not restrict or limit payment or services or otherwise burden beneficiaries and providers; and (3) the SPA is temporary, with a specified sunset date that is not later than the last day of the declared COVID-19 public health emergency (or any extension thereof). We nonetheless encourage states to make all relevant information about the SPA 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 Florida's Medicaid SPA Transmittal Number 20-0004 is approved effective March 9, 2020. Please note that the effective date for Florida's nursing facility rates is effective April 13, 2020 through June 20, 2020.

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

Please contact Tandra Hodges at 404-562-7409 or by email at Tandra.Hodges@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 Florida and the health care community.

Sincerely,

Alissa M. Deboy -S

Digitally signed by Alissa M. Deboy -S
Date: 2020.11.24 09:46:39 -05'00'

Alissa Mooney DeBoy
Acting Deputy Director
Center for Medicaid and CHIP Services

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 20 — 0004

2. STATE: FL

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: March 9, 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
Title XIX and Section 1135 of the Social Security Act, CFR 42

7. FEDERAL BUDGET IMPACT
a. FFY 20 $ 19,706,736
b. FFY 21 $ 9,282,267

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Pages 90-101 of Section 7

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

10. SUBJECT OF AMENDMENT
COVID-19 Disaster Relief

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

12. SIGNATURE OF STATE OFFICIAL
[redacted]

13. TYPED NAME
Beth Kidder

14. TITLE
Deputy Secretary for Medicaid

15. DATE SUBMITTED
9-10-20

16. RETURN TO
Ms. Beth Kidder
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #8
Tallahassee, FL 32308

Attention: Cole Giering

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
09/10/2020

18. DATE APPROVED
11/24/2020

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
03/09/2020

20. SIGNATURE OF REGIONAL OFFICIAL
Alissa M. Deboy -S
Digitally signed by Alissa M. Deboy -S
Date: 2020.11.24 09:47:30 -05'00'

21. TYPED NAME
Alissa Mooney DeBoy

22. TITLE
Acting Deputy Director, CMCS

23. REMARKS
The State authorizes the following Pen & Ink changes for 20-0004 CMS 179:
Revise Block 1 to read – 20-0004
Revise Block 6 to read – Title XIX and Section 1135 of the Social Security Act, CFR 42
Revise Block 7a to read – FFY 20
Revise Block 7b to read – FFY 21
Revise Block 8 to read – Pages 90-101 of Section 7
Update Block 9 to read – New

Instructions on Back

State/Territory: Florida

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.
The authorities listed in this State Plan Amendment are effective March 9, 2020 through the end of the Public Health Emergency.

Effective April 13 through June 30, 2020, COVID-19 Isolation Facilities shall qualify for a monthly lump sum supplemental payment.

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 Florida Medicaid state plan, as described below:

Please describe the modifications to the timeline. The State will notify the Florida tribes in accordance with the State's tribal consultation policy within 30 days of submission of the proposed SPA to CMS.

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:

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).

The State will suspend co-payments for all state plan services.

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:

• Allow ambulances to provide Non-emergency transportation services • Lift all service limits determined medically necessary to maintain access to critical, life sustaining covered services (examples include but are not limited to: the 45-day hospital inpatient limit, home health services, durable medical equipment, in-home physician's visits). Additionally, lift all service limits for prompt access to behavioral health services.

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

Please describe.

The State will utilize telemedicine for medically necessary services, remote patient monitoring and store and forward. Additionally, the State will expand telemedicine to include "audio only."

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

Section E – Payments

Optional benefits described in Section D:

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

   a. ____ Published fee schedules –

State/Territory: Florida

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.

Intermediate Care Facility Services:
Effective March 9, 2020 until the end of the PHE the State is allowing ICF/IIDs to request a change to their current reimbursement rates based on increased costs related to COVID-19. Requests for interim rate changes reflecting increased costs occurring as a result of resident care, administration changes will be considered if the change in cost to the provider is at least $5,000 and would cause a change of 1% or more based on the provider's annualized current total per diem rate. The current requirement to qualify for an interim rate adjustment is a 10% or more change annualized in the provider's current per diem rate. The State is allowing for a temporary change in this threshold. The provider must submit an interim rate request designating the Provider's effective date between March 9 and the end of the PHE and provide an estimate of the increased costs. A per diem add-on rate is calculated and reflects only the estimated additional costs. The total reimbursement rate paid to the provider shall be the sum of the previously established prospective rates plus the interim rate. The interim rate will end at the end of the PHE. When the cost report that covers the time period is submitted, a settlement of the interim rate will occur.

Nursing facilities:
Effective April 13, 2020 until June 30, 2020, nursing facilities under an active agreement with AHCA and authorized to operate a designated COVID-19 isolation facility or isolation wing shall qualify for a monthly lump sum supplemental payment, in addition to the COVID-19 specific Medicaid per diem for each Medicaid fee-for-service day of service, to ensure the continued viability of the service. The COVID-19 specific Medicaid per diem is the facility's per diem as established in Attachment 4.19-D prior to the facility's operation as a COVID-19 isolation facility, plus an add on of $325.70. Payments for COVID-19 Isolation Facilities, including the per diem and supplemental payments described below, will not exceed the Medicare payment for equivalent services.

The monthly lump sum supplemental payment will be reimbursed at an established Medicaid base rate and vary depending on the difference between the calculated Facility Occupancy Percentage of the designated COVID-19 isolation facility or isolation wing and the Maximum Occupancy Threshold Percentage for the supplemental payment.

a. Calculation of Facility Occupancy Percentage

(i).Each facility eligible for a supplemental payment must submit the required monthly census summary form and other required supporting documentation when requested by AHCA.

(ii). The Facility Occupancy Percentage will be determined utilizing anticipated paid residents days, including anticipated paid bed reservation days (regardless of payer), from the monthly census summary.

(1.) Resident days that were initially included in paid resident days, but are subsequently determined to be unpaid days will be used to reduce the anticipated paid resident days in the month in which the unpaid status is confirmed.

*(iii). The Facility Occupancy Percentage will be determined as follows: (Anticipated Paid Resident Days) / (Total Facility Licensed Beds * Calendar Days of Census Summary Period)*

b. Calculation of a Maximum Occupancy Threshold Percentage

(i). The Maximum Occupancy Threshold Percentage will be utilized to establish the upper bound for the supplemental payment calculation.

(ii). The Maximum Occupancy Threshold Percentage will be established on a provider by provider basis, at 100% occupancy.

c. Calculation of Medicaid Base Rate

(i). Each Medicaid provider's most recent Medicaid reimbursement rate prior to being designated as a COVID-19 isolation facility or isolation wing, will be utilized as the Medicaid Base Rate for the supplemental payment calculation.

d. Calculation of Supplemental Payment Amount

(i). The supplemental payment methodology will vary depending on whether the supplemental payment period is considered the transition period. The transition period supplemental payment will be made in the last month of the facility's agreement to operate as a COVID-19 isolation facility. The non-transition period supplemental payment is made in every month that the facility operates as a COVID-19 isolation facility except for the last month of the agreement.

(ii). ***Non-Transition Period****. The supplemental payment will be calculated as follows: ((Total Licensed Beds * Calendar Days in Month) * (Maximum Occupancy Threshold Percentage – Facility Occupancy Percentage)) * Medicaid Base Rate = monthly supplemental payment.*

(1.) Should the Facility Occupancy Percentage exceed the Maximum Occupancy Threshold Percentage, no supplemental payment will be made.

*(iii).**Transition Period. The transitional period to recognize a facility's ramp-down costs in operating as a COVID-19 isolation facility during the PHE is specified in each agreement. For an existing nursing facility that converted a wing of its operation to an isolation facility, the transitional period is one month following the end of the agreement. For a facilities that designated their entire facility as an isolation facility, the transition period is four months following the end of the agreement.** The transition period supplemental payment will be calculated as follows:*

*(1.) **Step One**. Calculate a monthly supplemental payment as if it is a non-transition period.*

*(2). **Step Two.** Calculate an additional supplemental payment as follows: ((Total Licensed Beds * Transition Period Days) * (Maximum Facility Occupancy Threshold Percentage – Estimated Average Transition Period Facility Occupancy Percentage)) * Medicaid Base Rate = Additional Supplemental Payment.*

(a). Should the Estimated Average Transition Period Facility Occupancy Percentage exceed the Maximum Occupancy Threshold Percentage, no supplemental payment will be made.

*(3). **Step Three.** Calculate an additional supplemental payment as follows: (Estimated Anticipated Medicaid Paid Days during the Transition Period * $325.70) = Additional Supplemental Payment.*

*(4). **Step Four.** Sum the calculated payments from step one through step three above to determine the final Transition Period supplemental payment*

*6. **Frequency of Payment.** The supplemental payment will be paid on a monthly basis in the form of a lump sum.*

(1). New nursing facility providers without a prior Medicaid reimbursement rate will have their Medicaid Base Rate established in accordance with the payment methodologies detailed in Medicaid state plan Attachment 4.19-D Part I, Sections IV - VI.

7. The above payments for COVID-19 isolation facilities/wings (including the COVID-19 specific per diem, the non-transition period supplemental payment, and the transition period supplemental payment) will not be made for services past the end of the declared PHE period. In case the agreement with a facility ends later than the end of the PHE, the transition period supplemental payment will be made in lieu of the non-transition period supplemental payment in the last month of the PHE. The payments are further limited to the effective date of this SPA (April 13, 2020 to June 30, 2020). For services furnished within the effective dates of the SPA, the COVID-19 specific per diem and the non-transition period supplemental payment will be made; the

transition period supplemental payment will not be made under this SPA if the end of the agreement falls outside of the effective date of the SPA.

8. The above payments for COVID-19 isolation facilities/wings (including the COVID-19 specific per diem, the non-transition period supplemental payment, and the transition period supplemental payment) are all payments for services furnished while the facilities are operating as COVID-19 isolation facilities/wings and will count towards the fee-for-service upper payment limit for the same service period. The state will ensure compliance with upper payment limit requirements at 42 CFR 447.272. If the demonstration shows that payments have exceeded the upper payment limit, the state will take corrective action as determined by CMS.

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:

Please describe.
The State will eliminate sanctions on nursing facilities for the late submission of Medicaid cost reports.

To accelerate payments, the State is proposing a change to the payment schedule in the reimbursement plan that will allow federally qualified health centers and rural health clinics to request supplemental wrap-around payments on a monthly basis, instead of quarterly, for the duration of the Public Health Emergency.

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 followingamounts:

    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.