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State/Territory Name: **Massachusetts**

State Plan Amendment (SPA) #: **20-0023**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form
- 3) Approved SPA Pages

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



April 26, 2021

MaryLou Sudders, Secretary
The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, Room 1109
Boston, MA 02108

Re: Massachusetts State Plan Amendment (SPA) 20-0023

Dear Secretary Sudders:

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) 20-0023. 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 Massachusetts also 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 Massachusetts 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 Massachusetts's Medicaid SPA Transmittal Number 20-0023 is approved effective June 1, 2020. Please note that the effective dates for all other home health services are effective August 1, 2020. This SPA is in addition to Disaster Relief SPA 20-0008 approved July 16, 2020, Disaster Relief SPA 20-0007 approved July 20, 2020, Disaster Relief SPA 20-0006 approved August 18, 2020, Disaster Relief SPA 20-0018 approved October 27, 2020, Disaster Relief SPA 20-0020 approved December 10, 2020, Disaster Relief SPA 20-0025 approved January 19, 2021, Disaster Relief SPA 20-0017 approved February 12, 2021, Disaster Relief SPA 21-0002 approved March 25, 2021 and Disaster Relief SPA 20-0019 approved April 8, 2021 and does not supersede anything approved in those SPAs.

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

Please contact Marie DiMartino at 978-330-8063 or by email at marie.dimartino@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 Massachusetts and the health care community.

Sincerely,

Alissa M.
Deboy -S

Digitally signed by Alissa
M. Deboy -S
Date: 2021.04.27
08:07:54 -04'00'

Alissa Mooney DeBoy
On behalf of Anne Marie Costello, Acting Director
Center for Medicaid and CHIP Services

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

2 0 0 2 3

2. STATE

MA

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

4. PROPOSED EFFECTIVE DATE

06/01/20

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

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 19 of the Social Security Act; Section 1135 of the Social Security Act

7. FEDERAL BUDGET IMPACT

a. FFY 2020 \$ ~~950,000~~ 1,908,267b. FFY 2021 \$ ~~0~~ 1,439,021

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 7.4 Medicaid Disaster Relief for the COVID-19
National Emergency9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable)

Payment methodologies for home health and private duty nursing services

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

Not required under 42 CFR 430.12(b)(2)(i)

12. SIGNATURE OF OFFICIAL

13. TYPED NAME

Ma. Lou Sudders

14. TITLE

Secretary

15. DATE SUBMITTED

9/30/2020

16. RETURN TO

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, Room 1109
Boston, MA 02108

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED 9/30/2020

18. DATE APPROVED
04/26/2021

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
06/01/2020

20. SIGNATURE OF REGIONAL OFFICIAL

Alissa M. Deboy - Digitally signed by Alissa M. Deboy
S Date: 2021.04.27 08:08:31 -04'00'

21. TYPED NAME

Alissa Mooney DeBoy on behalf of
Anne Marie Costello

22. TITLE

Acting Deputy Director
Center for Medicaid and Chip Services

23. REMARKS

State/Territory: Massachusetts

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.

As described in further detail in Section E, the rate increases for home health services shall be effective 6/1/20 for the annualization adjustment that adds an add-on rate of \$2.03 per 15 minute unit for home health aide services effective 6/1/20 through 6/30/20, and 8/1/20 for all other home health services rate increases. The 8/1/20 rate increases for home health services shall be effective through 12/31/20. The rate increases for private duty nursing services shall be effective 8/1/20 through 12/31/20.

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:

TN: 020-023

Approval Date: 04/26/2021

Supersedes TN: NEW

Effective Date: 06/01/2020

This SPA is in addition to Disaster Relief SPA 20-0008 approved July 16, 2020, Disaster Relief SPA 20-0007 approved July 20, 2020, Disaster Relief SPA 20-0006 approved August 18, 2020, Disaster Relief SPA 20-0018 approved October 27, 2020, Disaster Relief SPA 20-0020 approved December 10, 2020, Disaster Relief SPA 20-0025 approved January 19, 2021, Disaster Relief SPA 20-0017 approved February 12, 2021, Disaster Relief SPA 21-0002 approved March 25, 2021 and Disaster Relief SPA 20-0019 approved April 8, 2021 and does not supersede anything approved in those SPAs.

State/Territory: Massachusetts

- a. X SPA submission requirements – the agency requests modification of the requirement to submit the SPA by June 30, 2020, to obtain a SPA effective date during the second 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 Massachusetts Medicaid state plan, as described below:

Please describe the modifications to the timeline.

The timeframe for tribal consultation in the State Plan is at least 30 days prior to SPA submission and an allowance of at least 14 days for feedback. We request to change the tribal consultation timeframe during the emergency period to conduct consultation the same date as submission of the SPA with an allowance of a week for feedback.

EOHHS consulted with the Massachusetts Indian Tribes by email on September 30, 2020 about the proposed state plan amendments included in this COVID-19 Disaster SPA Template. The Tribes were asked to respond with any advice or feedback regarding this state plan amendment by October 7, 2020.

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:

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State/Territory: Massachusetts

- 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 inconsistencies 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.

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State/Territory: Massachusetts

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).

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State/Territory: Massachusetts

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.

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State/Territory: Massachusetts

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.

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State/Territory: Massachusetts

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:

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Effective Date: 06/01/2020

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State/Territory: Massachusetts

- 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.

1. Home Health Rates
2. Private Duty Nursing Rates

- 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.

TN: 020-023

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Approval Date: 04/26/2021

Effective Date: 06/01/2020

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State/Territory: Massachusetts

- ii. X An increase to rates as described below.

Rates are increased:

X Uniformly by the following percentage: _____

1. Home Health Rates

- a. A 2.63% increase was provided to the rates for intermittent skilled nursing services effective 8/1/2020- 12/31/20.
- b. A 4.89% increase was provided to the rates for physical therapist, occupational therapist, and speech therapist services effective 8/1/2020 -12/31/20.
- c. A 10.33% increase was provided to the rates for home health aide services effective 8/1/2020-12/31/20.
- d. An annualization adjustment add-on rate for Home Health Aide services of \$2.03 per 15 minute unit effective 6/1/2020 through 6/30/2020.

2. Private Duty Nursing Services

A 1.57% increase was provided to the rates for Private Duty Nursing (CSN) services effective 8/1/2020 – 12/31/20.

X Through a modification to published fee schedules –

Effective date (enter date of change):

1. Home Health Rates: 6/1/20 for the annualization adjustment add-on rate for home health aide services and 8/1/20 for all other home health services

2. Private-duty Nursing Rates: 8/1/20

Location (list published location):

3. Link for Home Health Rates: https://www.mass.gov/doc/home-health-services-effective-april-1-2020-june-1-2020-and-july-1-2020-0/download?_ga=2.110030913.555459811.1614285053-1158028876.1609946455

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Effective Date: 06/01/2020

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State/Territory: Massachusetts

2. Link for Private-Duty Nursing (CSN) Rates:

<https://www.mass.gov/doc/rates-for-continuous-skilled-nursing-services-effective-july-1-2020/download>

_____ 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. _____ Other payment changes:

TN: 020-023

Supersedes TN: NEW

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State/Territory: Massachusetts

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,

TN: 020-023

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Supersedes TN: NEW

Effective Date: 06/01/2020

This SPA is in addition to Disaster Relief SPA 20-0008 approved July 16, 2020, Disaster Relief SPA 20-0007 approved July 20, 2020, Disaster Relief SPA 20-0006 approved August 18, 2020, Disaster Relief SPA 20-0018 approved October 27, 2020, Disaster Relief SPA 20-0020 approved December 10, 2020, Disaster Relief SPA 20-0025 approved January 19, 2021, Disaster Relief SPA 20-0017 approved February 12, 2021, Disaster Relief SPA 21-0002 approved March 25, 2021 and Disaster Relief SPA 20-0019 approved April 8, 2021 and does not supersede anything approved in those SPAs.

State/Territory: Massachusetts

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