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State/Territory Name: Minnesota

State Plan Amendment (SPA) #: 21-0014

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

February 2, 2022

Cynthia MacDonald, Medicaid Director
Minnesota Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

Re: Minnesota State Plan Amendment (SPA) 21-0014

Dear Ms. MacDonald:

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) 21-0014. 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 Minnesota 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 Minnesota 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 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 Minnesota's Medicaid SPA Transmittal Number 21-0014 is approved effective March 1, 2020. This SPA is in addition to Disaster Relief SPAs approved on April 6, 2020, April 20, 2020, May 4, 2020, May 22, 2020, June 25, 2020, July 15, 2020, November 20, 2020, December 1, 2020, March 4, 2021, May 14, 2021, July 21, 2021, August 4, 2021, September 22, 2021, December 10, 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 Sandra Porter at 312-353-8310, or by email at Sandra.Porter@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 Minnesota and the health care community.

Sincerely,

Alissa M. Deboy -S

Digitally signed by Alissa M. Deboy -S
Date: 2022.02.02 08:56:36 -05'00'

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

Enclosures

cc: Patrick Hultman, Deputy Medicaid Director, Minnesota DHS

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: CENTER FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER: 21-0014	2. STATE Minnesota
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTER FOR MEDICARE & MEDICAID SERVICES 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 X AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR §440.50, §440.20, and §440.80 . Section 201 and 301 of the National Emergency Act and Title XIX of the Social Security Act.	7. FEDERAL BUDGET IMPACT (in thousands): a. FFY '21 $ 512 b. FFY '22 $ 1,221
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Section 7.4.A Disaster Relief	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same

10. SUBJECT OF AMENDMENT:
Physician Payment Rates; reimbursement to Federally Qualified Health Centers and Rural Health Clinics; and private duty nursing limits.

11. GOVERNOR'S REVIEW *(Check One)*:
x 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 AGENCY OFFICIAL: [redacted]	16. RETURN TO: Patrick Hultman Minnesota Department of Human Services 540 Cedar Street, PO Box 64983 St. Paul, MN 55164-0983
13. TYPED NAME: Patrick Hultman	
14. TITLE: Deputy Medicaid Director	
15. DATE SUBMITTED: August 9, 2021	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: August 9, 2021	18. DATE APPROVED: February 2, 2022
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: March 1, 2020	20. SIGNATURE OF REGIONAL OFFICIAL: Alissa M Deboy -S Digitally signed by Alissa M. Deboy -S Date: 2022.02.02 08:57:01 -05'00'
21. TYPED NAME: Alissa Mooney DeBoy	22. TITLE: Acting Deputy Director On Behalf of Anne Marie Costello, Deputy Director, CMCS
23. REMARKS:	

FORM CMS-179 (07-92)

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:

Minnesota reserves the right to terminate any of the emergency provisions in this amendment prior to the end of the emergency period, via amendment to the state plan.

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 [insert name of state] Medicaid state plan, as described below:

Tribal consultation requirements described at section 1.4 of the state plan preprint provide that written notification must be sent to Tribal Health Directors and others at least 30 days prior to the submission of the state plan amendments that are likely to affect Indian people. During the emergency period, the state will consult with tribal representatives and tribal health directors no later than 10 days following submission.

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:

This SPA is in addition to all of Minnesota's other Disaster Relief SPAs previously approved by CMS. This SPA does not supersede any of Minnesota's Disaster Relief SPAs that were previously approved by CMS.

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.

This SPA is in addition to all of Minnesota's other Disaster Relief SPAs previously approved by CMS. This SPA does not supersede any of Minnesota's Disaster Relief SPAs that were previously approved by CMS.

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

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

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

    a. _____ All beneficiaries

b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

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

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

Section D – Benefits

Benefits:

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

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

   Effective November 12, 2020, parents of minor children and spouses of beneficiaries may provide home care nursing services in excess of 8 hours per day or 40 hours per week. Spouses and parents may also provide more than 50 percent of the total home care nursing hours authorized for a beneficiary.

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. __X___ 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. __X__ 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:

   c.

Please describe.

Telehealth:

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

Please describe.

Drug Benefit:

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

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

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

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

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

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

Section E – Payments

Optional benefits described in Section D:

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

This SPA is in addition to all of Minnesota's other Disaster Relief SPAs previously approved by CMS. This SPA does not supersede any of Minnesota's Disaster Relief SPAs that were previously approved by CMS.

a. ___ Published fee schedules –

b. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. ____ The agency increases payment rates for the following services:

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.

This SPA is in addition to all of Minnesota's other Disaster Relief SPAs previously approved by CMS. This SPA does not supersede any of Minnesota's Disaster Relief SPAs that were previously approved by CMS.

State/Territory: Minnesota

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:

The state is seeking adjustments to the Resource Based Relative Value Scale (RBRVS) conversion factor to implement the Medicare Relative Value Units (RVUs) for calendar year 2020. The Medicare RVUs are multiplied by the conversion factor used by the state to update rates for professional services. Effective for services provided between March 1, 2020 and January 19, 2021, the proposed RBRVS conversion factors are as follows:

* Evaluation and Management services $27.87
* Obstetric services $27.87
* Psychiatric services $31.53
* All other physician services $25.66

Except as otherwise noted in the state plan, state-developed fee schedule rates are the same for both governmental and non-governmental providers of services with payment rates subject to the conversion factor. Fee schedules are posted on the agency website at the following URL: https://mn.gov/dhs/partners-and-providers/policies-procedures/minnesota-health-care-programs/provider/billing/fee-schedule/mhcp.jsp

This SPA is in addition to all of Minnesota's other Disaster Relief SPAs previously approved by CMS. This SPA does not supersede any of Minnesota's Disaster Relief SPAs that were previously approved by CMS.

Effective January 1, 2021, a Federally Qualified Health Center or rural health clinic may be paid the following alternative payment methodology in accordance with §1902(bb)(6) of the Social Security Act. Eligible providers shall be reimbursed a separate encounter rate for each medical or dental service. If a medical service and a dental service are provided to the same patient on the same day, the clinic will be reimbursed both the medical and the dental encounter rate.

The medical encounter rate shall be computed based on the clinic's allowable base year(s) medical costs divided by the number of qualifying medical encounters in the base year(s). Allowable costs are determined in accordance with current applicable Medicare cost principles including direct patient care costs and patient-related support services costs. Qualifying encounters are encounters in which the patient is seen by a clinic practitioner eligible to independently bill for the services provided.

For federally qualified health center and rural health clinic payments, a "visit" means a face-to-face encounter between a clinic patient and any health professional whose services are paid under the State plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

The State uses the clinic's audited Independent Rural Health Clinic/Freestanding Federally Qualified Health Center worksheet, Statistical Data, and Certification Statement to establish payment rates. The State makes adjustments for:

A. Medicaid coverage of services that differs from Medicare coverage;
B. the applicable visits; and
C. the establishment of a separate dental payment rate, if dental services are provided.

The State limits like services for Medicare and Medicaid to the respective Medicare limit for the year. Time periods that span more than one calendar year are limited to the respective Medicare limit for each time period.

For purposes of this item, "rural health clinic services" means those services listed in 42 CFR §440.20(b); "ambulatory services" means those services listed in 42 CFR §440.20(c).

The encounter rate shall be computed based on the clinic's allowable base year(s) costs divided by the number of qualifying encounters in the base year(s). Allowable costs are determined in accordance with current applicable Medicare cost principles including direct patient care costs and patient-related support services costs. Qualifying encounters are encounters in which the patient is seen by a practioner eligible to independently bill for the services provided.

This SPA is in addition to all of Minnesota's other Disaster Relief SPAs previously approved by CMS. This SPA does not supersede any of Minnesota's Disaster Relief SPAs that were previously approved by CMS.

Payment rates for services delivered on or after January 1, 2021 will use the clinic's allowable costs as reported on the Medicare cost report and encounters for the clinic fiscal years ending 2017 and 2018. The base year rate shall be trended to the payment year using the CMS FQHC Market Basket inflation factor less the productivity adjustment.

Clinic encounter rates calculated under this APM shall be inflated annually using the FQHC Market Basket, less the productivity adjustment, until the next rebasing. Every two years these rates will be rebased using the allowable costs, as reported on the Medicare cost report, and encounters from the clinic fiscal years that are three and four years prior to the rebasing year.

A clinic's costs related to participation in health care education programs shall be considered allowable costs. The total allowable costs will be reduced by any Medical Education and Research (MERC) grants and supplemental pool payments received to compensate training facilities for a portion of the clinical training costs. The base rates as described in this item are adjusted to account for supplemental payments for medical education.

Payment adjustments due to changes in scope will not be implemented unless the change in scope results in a payment increase or decrease of 2.5 percent or higher. The effective date of the payment adjustment will be the later of:

a. The date the Health Resources and Services Administration (HRSA) approves the change in scope or
b. The effective start date of the services included in the change in scope.

If HRSA approval of the change in scope is not required. A clinic may submit a change in scope request directly to the Department of Human Services. The payment adjustment effective date for change in scope requests submitted directly to the Department will be the later of:

a. The date the Department received the clinic's change in scope request or
b. The effective start date of the services included in the change in scope.

Initial change in scope adjustments may be computed using estimated costs and encounters. Payment adjustments based on estimated costs or encounters will be reviewed no later than 45 days following the date that is one year after the effective date of the payment adjustment. If the rate determined using the estimated costs or encounters differs from the rate calculated using actual cost and encounters by more than 2.5 percent, the rate based on estimated costs or encounters shall be adjusted to the rate based on actual costs and encounters retroactive to the effective date of the scope change payment adjustment.

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

State/Territory: Minnesota

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.

This SPA is in addition to all of Minnesota's other Disaster Relief SPAs previously approved by CMS. This SPA does not supersede any of Minnesota's Disaster Relief SPAs that were previously approved by CMS.