

Table of Contents

State/Territory Name: The United States Virgin Islands

State Plan Amendment (SPA) #: 20-0002

This file contains the following documents in the order listed:

- 1) Approval letter
- 2) CMS-179 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



December 31, 2020

Gary Smith
Medicaid Director
Department of Human Services
1303 Hospital Ground
Knud Hansen Complex, Building A
St. Thomas, United States Virgin Islands 00802

Re: The United States Virgin Islands State Plan Amendment (SPA) 20-0002

Dear Mr. Smith:

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) 20-0002. 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 Territory of the United States Virgin Island 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 this notice requirement otherwise applicable to SPA submissions.

The waivers or modifications of the requirements related to SPA submission timelines and public notice 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 Alternative Benefit Plans (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/territories 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 The United States Virgin Island's Medicaid SPA Transmittal Number 20-0002 is approved effective March 1, 2020.

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

Please contact Ivelisse Salce at 212-616-2411 or by email at Ivelisse.Salce@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 Territory of the United States Virgin Islands and the health care community.

Sincerely,

Alissa M.
Deboy -S

Digitally signed by Alissa
M. Deboy -S
Date: 2020.12.31
08:28:19 -05'00'

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: CENTER FOR MEDICARE & MEDICAID SERVICES (CMS)		1. TRANSMITTAL NUMBER VI-20-0002	2. STATE U.S. Virgin Islands
		3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act (Medicaid)	
TO: REGIONAL ADMINISTRATOR Centers for Medicare & Medicaid Services (CMS) Department of Health and Human Services (HHS)		4. PROPOSED EFFECTIVE DATE March 1, 2020	
5. TYPE OF PLAN MATERIAL (Check One) <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> 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 Sections 1135 and 1902 of the Act		7. FEDERAL BUDGET IMPACT a. FFY <u>2020</u> \$ <u>861,000</u> b. FFY <u>2021</u> \$ <u>\$2,300,000</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Section 7.4 Medicaid Disaster Relief for the COVID-19 National Emergency, pages 1-11		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Section 7.4 from VI SPA 20-0001 Amendment 1	
10. SUBJECT OF AMENDMENT Amend the disaster state plan to clarify providers and provider qualifications of personal care attendant under the Personal Care Services benefit, and clarify 15-minute increment payment policy.			
11. GOVERNOR'S REVIEW (Check One) <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL <div style="background-color: black; width: 150px; height: 20px; margin: 5px 0;"></div>		16. RETURN TO Gary A. Smith Medicaid Director Department of Human Services 1303 Hospital Ground Knud Hansen Complex, Building A St. Thomas, United States Virgin Islands 00802	
13. TYPE NAME Gary A. Smith			
14. TITLE Medicaid Director			
15. DATE SUBMITTED October 31, 2020			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED 10/31/2020		18. DATE APPROVED 12/31/2020	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL 03/01/2020		20. SIGNATURE OF REGIONAL OFFICIAL <div style="text-align: right;"> Alissa M. Deboy -S Digitally signed by Alissa M. Deboy -S Date: 2020.12.31 08:28:52 -05'00' </div>	
21. TYPED NAME Alissa Mooney DeBoy On Behalf of Anne Marie Costello		22. TITLE Acting Director Center for Medicaid and CHIP Services	
23. REMARKS			

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

- The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:
- a. 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. 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. Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Please describe the modifications to the timeline.

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.

The Virgin Islands will add coverage for uninsured individuals defined under Section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Social Security Act, effective March 18, 2020. The medical assistance provided to these individuals will be limited to any in vitro diagnostic product described in section 1905(a)(3)(B) this is administered during the emergency period and any visit described in section 1916(a)(2)(G) furnished during this period.

- 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:

The Virgin Islands will increase its resources limit from \$2,000 to \$10,000 for the following populations:

- a. Aged, blind, disabled individuals eligible for but not receiving cash assistance—Section 1902(a)(10)(A)(ii)(1) of the Act.
- b. Aged, blind, disabled individuals eligible for cash except for institutionalization-Section 1902(a)(10)(A)(ii)(IV) of the Act.
- c. Medically needy (all populations)-Section 1902(a)(10)(C) of the Act.

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.

Section B – Enrollment

1. X 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.

The agency will extend presumptive eligibility already being performed in the hospitals to the following populations:

- a. Aged, blind, disabled individuals eligible for but not receiving cash assistance—Section 1902(a)(10)(A)(ii)(1) of the Act.
- b. Aged, blind, disabled individuals eligible for cash except for institutionalization-Section 1902(a)(10)(A)(ii)(IV) of the Act.
- c. Uninsured individuals defined under Section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Social Security Act
- d. Medically needy (all populations)-Section 1902(a)(10)(C) of the Act.

TN: VI-20-0002Supersedes TN: VI-20-0001Approval Date: 12/31/2020Effective Date: 03/01/2020

e. The hospitals will continue to perform PE determinations for the MAGI eligibility groups or populations as currently specified in SPA VI-15-0009.

The agency waives performance standards for its review of HPE and PE determinations

The agency will consider 2 PE periods during a calendar year as reasonable.

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.

The agency designates itself to perform PE for the following MAGI populations:

- a. Pregnant women.
- b. Infants and children under age 19.
- c. Parents and other caretaker relatives.
- d. Adult group.
- e. Individuals above 133% FPL, under age 65.
- f. Individuals eligible for family planning.
- g. Former foster care children
- h. Certain individuals needing treatment for breast and cervical cancer.

The agency will consider 2 PE periods during a calendar year as reasonable.

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.

The agency will continue to require the two FQHCS to perform PE determinations for the MAGI groups as specified in VI State plan VI-17-0008.

The agency waives performance standards for its review of HPE and PE

The agency will consider 2 PE periods during a calendar year as reasonable.

The agency will continue to require the Department of Health Clinics specified in VI State plan VI-17-0014 to perform PE determinations for the MAGI groups as specified in VI State plan VI-17-0014.

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):

The agency will add coverage for Personal Care Attendant Services to all Medicaid eligible clients. Personal Care Attendant services are covered under Section 1905(a)(24) of the Social Security Act. The purposes of providing such services are to:

- Provide supportive care to eligible clients in their place of residence,
- Maximize client independence,
- Prevent or delay premature or inappropriate need for institutionalization,
- Expand LTSS community services,
- Increase quality of personal care and member satisfaction.

These services include, but are not limited to:

- Assistance with nutrition and diet activities such as shopping, financial, meal preparation, and eating,
- Performance of household services such as changing bed linens, making beds, washing dishes, cleaning, dusting and vacuuming, and shopping for essential supplies,
- Assistance with basic personal care such as bathing, grooming, bathroom/toileting and/or bedpan routines, walking, transferring from bed to chair or wheelchair, positioning, and
- Assistance with self-administration of medications.
- Transportation to medical appointments and assistance in arranging and scheduling such appointments.

The amount, duration and scope for medically necessary personal care attendant services will be provided in accordance with the individual's plan of care as assessed and authorized by VI Department of Human Services.

The services will be provided by providers enrolled in the VI Medicaid Program who have, at a minimum, a High School diploma or GED. PCAs will receive additional training and supervision from Registered Nurses employed by the department of Human Services or the not-for-profit or private agency enrolled with the VI Medicaid Program to provide PCA services.

The PCAs receive training once every two years. For PCAs who are also CNAs, training is provided annually with recertification. PCAs are trained in assistance with ADLs and IADLs including but not limited to lifting, turning, bathing, light household chores, etc. In addition to the above trainings, CNAs are also trained in medication set-up, range of motion exercises, and wound care.

All PCAs receive nursing supervision.

- 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 state wideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).
- 4. Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).
 - a. The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.
 - b. Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

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

The VIMAP will cover medically necessary telemedicine services between a Medicaid beneficiary and their physician or, other medical practitioner, that is within their scope of practice under Virgin Islands law and Medicaid program requirements. These providers must be enrolled as Medicaid providers with VI MAP. Telemedicine services include a real-time, interactive electronic communication using interactive telecommunication equipment that includes at a minimum audio and video equipment (e.g., cell phones and computers and communications software such as face time, skype, zoom, etc.) in lieu of a face-to-face encounter at a health care facility. In this situation, the provider would be at a distant site and the Medicaid patient would be at the originating site.

The VIMAP will also cover medically necessary telehealth services between a Medicaid beneficiary and their physician or other medical practitioner that is within their scope of practice under Virgin Islands law and Medicaid program requirements. These providers must be enrolled as Medicaid providers with VI MAP. Telehealth services include using such technologies as telephones, facsimile machines, electronic mail systems, and remote monitoring devices, to collect and transmit medical data for monitoring and interpretation, and to perform follow-up and virtual check-ins with Medicaid patients.

DHS will reimburse providers for both telemedicine and telehealth services at the same rates as the service is currently reimbursed in the currently approved state plan as if the service was provided face-to-face.

Drug Benefit:

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

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

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

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

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

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

Section E – Payments

Optional benefits described in Section D:

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

- a. ____ Published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

- b. X Other:

VIDHS will reimburse providers for both telemedicine and telehealth services at the same rates as in the currently approved state plan as if the service was provided face-to-face.

VI DHS will reimburse personal care attendant services on a fixed hourly rate of \$19/hr. during the emergency period which may be billed in 15 minute increments (\$4.75/per 15 min). The hourly rate will be calculated based upon the total salary costs for the employees divided by the total visits performed in the most recent fiscal year for which the VI Department of Human Services Senior Services Division has complete information available. The hourly rate can be billed in 15 minute increments depending upon the actual time required for each service visit. Each provider providing personal care attendant services will maintain all necessary documentation in the beneficiary's case record to enable them to submit claims through the VI Medicaid Management Information System.

Increases to state plan payment methodologies:

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

Please list all that apply.

- a. ____ Payment increases are targeted based on the following criteria:

Please describe criteria.

- b. Payments are increased through:

- i. ____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

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

Rates are increased:

____ Uniformly by the following percentage: _____

TN: VI- 20-0002

Supersedes TN: VI-20-0001

Approval Date: 12/31/2020

Effective Date: 03/01/2020

"This SPA is in addition to the Disaster Relief SPA VI 20-0001 approved on 5/6/2020 and does not supersede anything approved in that SPA".

_____ 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. _____ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. ___ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
 - a. ___ The individual’s total income
 - b. ___ 300 percent of the SSI federal benefit rate
 - c. ___ Other reasonable amount: _____

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

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

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

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

PRA Disclosure Statement

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