DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

OMB No. 0938-NEW
Expires: xx/xxxx

INITIAL REQUEST FOR STATE IMPLEMENTED MORATORIUM

§ 455.470 requires that the State Medicaid agency must notify the Secretary in writing in the event the State Medicaid agency

the moratoria.

PART I. ADMINISTRATIVE

State:	Agency:
Requester Name:	Title:
E-mail Adress:	Telephone Number:

PART II. PROPOSED MORATORIUM

Provider/Supplier Type:

Provider/Supplier Type Subgroups:

Provider Implementation Date:

Upon CMS concurrence, the State Medicaid agency must impose the moratorium for an initial period of 6 months. If the State Medicaid agency determines that it is necessary, the State Medicaid agency may extend the moratorium in 6-month increments. For each extension, the agency must document in writing the necessity for extending the moratorium and obtain the Secretary's concurrence.

Geographical Area:

☐ Entire State ☐ County Based ☐ Zip Code Based ☐ Other

List area included by county, zip code or other means, if not state based:

PART III. JUSTIFICATION FOR MORATORIUM

Provide the specific justification for the Moratorium:

Describe how proposed solutions will solve problem:

see

ks to impose a moratoria, including all details of the moratoria; and obtain the Secretary's concurrence with imposition of

Describe previous efforts to solve problem:

DRAFT

Explain why a different tool wouldn't be effective to solve this problem:

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PART IV. MORATORIUM DATA

Describe the data that has been generated to support the following:

Need for Moratorium:

Moratorium will not create access to care issues:

PART V. EFFICACY

List and describe the metrics that will be used to determine whether the moratorium is effective:

PART VI. ACCESS TO CARE

§ 455.470 requires that before implementing moratoria, caps, or other limits, the State Medicaid agency must determine that its action would not adversely impact beneficiaries' access to medical assistance.

Describe the ongoing review that will be done to identify potential access to care issues while the moratorium is in place:

Describe how access to care issues will be addressed:

PART VII. ENFORCEMENT

Describe how you will direct your efforts during the moratorium to review existing providers and suppliers:

Will there be an appeals process for providers/suppliers who are removed from the system as a result of moratorium related enforcement? If yes, describe below:

Is there any legal authority which allows for exceptions to the moratorium? If yes, include statute and describe the method of

implementation below:

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What parameters do you have in place to ensure that exceptions to the moratorium are not arbitrary?

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PART VIII. EDUCATION AND OUTREACH

List the Entities with whom you will collaborate during the Moratorium implementation:

State Agencies:

Provider/Supplier Organizations:

Community:

PART IX. CONTACT INFORMATION UPON IMPLEMENTATION OF MORATORIUM

Contact Person:	Name	Telephone Number	E-Mail Address
Moratorium Point of Contact:			
Data Analyst:			
Legal Analyst:			
State Medicaid Director:			

PART X. SIGNATURE

Signature Authority: The application must be signed by the State Medicaid Director.

Signature: Title:

Printed Name: Date:

XI: SUBMISSION CHECKLIST

You must submit the following documentation to CMS for your request to be considered:

☐ Completed Application

☐ Access to Care Analysis and Summary

Note: If approved, quarterly submission of moratoria-related access to care analysis will be required for the duration of the moratoria.

XII. SUBMISSION INSTRUCTIONS

Please submit your completed application to: Provider Enrollment Moratoria@cms.hhs.gov

DRAFT

OR

Division of Enrollment Operations, Moratoria Submission
Centers for Medicare & Medicaid Services
Provider Enrollment and Oversight Group
7500 Security Boulevard, Mail Stop AR-19-51
Baltimore, Maryland 21244-1850

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-NEW. The time required to complete this information collection is estimated to average X hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any 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, Baltimore, Maryland, 21244-1850. DO NOT MAIL APPLICATIONS TO THIS ADDRESS. Mailing your application to this address will significantly delay application processing.