Medicaid Disaster Relief for the COVID-19 National Emergency
State Plan Amendment Instructions

Through this state plan amendment (SPA) template, states (including the District of Columbia and territories) can request approval of specific changes related to the national emergency declared due to the COVID-19 outbreak. See https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/.

For each change the state is requesting, please check the corresponding text box. Further instructions are provided for each item below. CMS staff are available to assist states with completion of the Medicaid Disaster SPA template. Please contact your State Lead to request technical assistance.

Period Covered

The COVID-19 disaster relief SPA allows states to establish time-limited changes to their state plan to address access and coverage issues during the COVID-19 national emergency. When submitting this SPA, states have the option to align the timeframe for these temporary changes with either the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewal thereof) or a shorter timeframe within this period.

Request for Section 1135 Waivers Needed for Submission of the Medicaid Disaster Relief SPA

CMS recognizes that during this national emergency, states must act expeditiously to protect and serve the general public. A state may submit a request under section 1135 of the Social Security Act (the Act) to waive, or modify, certain requirements that would otherwise be applicable to this SPA submission. These waivers are limited to SPAs that provide or increase beneficiary access to items and services related to COVID-19 (such as cost sharing waivers, payment rate increases, or amendments to Alternative Benefit Plans (ABPs) to add services or providers) and that would not restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Accordingly, in the Medicaid Disaster Relief SPA template, States may request the following: (a) a waiver to modify the submission date requirements if requesting this SPA to be effective during the first calendar quarter of 2020, (b) a waiver of applicable requirements to provide public notice prior to submitting this SPA, and/or (c) a waiver to modify timeframes associated with the tribal consultation requirements for this SPA. If a waiver to modify tribal consultation timeframes is selected, the state would need to describe the modifications requested, such as changing the deadline for tribal consultation before SPA submission or conducting consultation after submission of the SPA.

Section A - Eligibility

1. ***Expanding coverage to other optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act.*** This option allows a state to temporarily cover any optional Medicaid eligibility group, including the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals affected by

COVID-19. For example, a state may elect to cover the Age and Disability-Related Poverty Level group established by section 1902(a)(10)(A)(ii)(X) of the Act. This eligibility group covers individuals who are age 65 or older and/or who have a disability, and who have income and resources at or below the standard established by the state. To elect the Age and Disability-Related Poverty Level group, a state may enter:

- Name of the eligibility group and citation: Age and Disability-Related Poverty Level group at 1902(a)(10)(A)(ii)(X) of the Act
- Applicable options: the state may choose to limit coverage in this group one or more categorical populations described in section 1905(a) of the Act, such as individuals who are age 65 or older
- Income standard: the state may select an income standard that does not exceed, but may be less than, 100% of the FPL
- Resource standard: the state may elect either the resource limit for the SSI program or the resource limit used in the state's medically needy program, if higher
- Applicable income or resource disregards: the state may list any optional disregards it wants to apply or note that no additional disregards are applied

CMS staff are available to assist states with the applicable options, income and resource standards and optional disregards available for any optional eligibility group.

2. ***Expanding coverage to individuals with income above 133 percent of the federal poverty level (FPL).*** This option allows states to temporarily cover the eligibility group for Individuals with modified adjusted gross income (MAGI)-based Income above 133 percent of the FPL. The state may elect one of the following options:
    a. This option allows a state to temporarily cover all individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act (i.e., individuals under age 65 who are not otherwise eligible for full-Medicaid coverage), who have MAGI-based income above 133 percent of the FPL and at or below an income standard established by the state. To elect option a., a state must already cover the expansion group for adults described at 1902(a)(10)(A)(i)(VIII) of the Act. When electing this option, the state must specify the maximum income standard or specify no income standard.
    b. This option allows states to limit coverage under section 1902(a)(10)(A)(ii)(XX) of the Act to one or more categorical populations described in section 1905(a) of the Act, such as pregnant women or individuals under age 21. States that have <u>not</u> elected to cover the expansion group for adults may elect this option for specified populations, provided that the state already covers the population up to 133 percent of the FPL. To elect this option, the state must list the populations covered and define the income standard. As noted above, there is no maximum income standard for this eligibility group.

3. ***Establishing Income and Resource Disregards for MAGI-excepted eligibility groups.*** For populations excepted from use of the MAGI-based methodologies under section 1902(e)(14)(D) of the Act and 42 CFR 435.603(j) (primarily eligibility groups specific to individuals who are age 65 or older, or who have blindness or a disability), section 1902(r)(2) of the Act allows states to apply income and resource methodologies that are less restrictive than those that would otherwise be applicable. This means that states can elect to disregard certain amounts or types of income and/or resources that they would otherwise count when determining financial eligibility for Medicaid. States may also elect to disregard specific changes in income that occur after a determination of eligibility and before the next scheduled redetermination. States may,

for example, elect to disregard all changes in income that occur between redeterminations. This ensures a continuous period of eligibility between regularly-scheduled renewals. When electing this option, the state would enter the type of less restrictive income and/or resource methodology and the eligibility group(s) to which the less restrictive methodologies are applied.

4. ***Establishing Residency for Individuals Temporarily Out-of-State Due to a Disaster.*** As described at 42 CFR 435.403(j)(3), a state may not terminate a beneficiary's Medicaid eligibility because of a temporary absence from the state, if the individual intends to return to the state. States have the option to expand their definition of temporary absence and may elect to consider individuals who are impacted by the disaster or public health emergency and (1) are evacuated from the state, (2) leave the state for medical reasons, and/or (3) are otherwise absent from the state, to continue to be residents provided that they intend to return.

5. ***Extending Residency to Individuals who May be Considered Residents of Other States.*** Because state residency is not addressed as an eligibility requirement at section 1902(b)(2) of the Act, states have flexibility to extend eligibility in their state to individuals who may otherwise be considered residents of another state. At state option, this may include-individuals who are temporarily living in the state while they care for, or are cared for by, a relative. To elect this option, the state must describe the individuals whom the state will cover, even though they would otherwise be considered non-residents. When extending eligibility to such individuals, the state will need to work with the individual's home state to prevent duplicative coverage.

6. ***Extending the Reasonable Opportunity Period for Good Faith Effort.*** A reasonable opportunity period of 90-days is available to non-citizens who have attested to having a satisfactory immigration status, and are otherwise eligible for Medicaid, while their immigration status is being verified. States may elect the option to extend this period if the individual is making a good faith effort to resolve inconsistencies in the verification of their status or to obtain necessary documentation, or if the state needs more time to complete the verification process.

Section B – Enrollment

1. ***Extending Hospital Presumptive Eligibility to Individuals Excepted from MAGI-based Methodologies.*** Under the hospital presumptive eligibility (HPE) option, qualified hospitals may determine presumptive eligibility (PE) for any group of individuals described in the Medicaid state plan. This option is typically limited to MAGI-based eligibility groups, but states have the option to extend HPE to other state plan populations, including the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals affected by COVID-19 and individuals excepted from the MAGI-based methodologies, and to populations covered under approved section 1115 demonstrations. For example, states looking to transition individuals out of the hospital and into other institutional care settings may elect to extend HPE to the eligibility group for individuals in institutions who are eligible under a special income level (42 CFR 435.236). To temporarily extend HPE to a non-MAGI group, a state would enter the name of and citation for the group into text box. States making such an election may also consider other temporary changes to their approved HPE program, such as temporary revisions to the performance standards for participating hospitals, revisions to the number of PE periods allowed, and whether they will consider attested state residency and/or attested citizenship, status as a national, or satisfactory immigration status when making the PE determination. These changes would also be noted in the text box. CMS is

available to assist states with these updates, including any changes needed to their HPE application and information for qualified entities.

2. ***Designating the Medicaid Agency as a Qualified Entity for Presumptive Eligibility.*** A qualified entity is an entity that is determined by the state to be capable of making PE determinations for MAGI-based eligibility groups as authorized under sections 1920, 1920A, 1920B, and 1920C of the Act and 432 CFR Part 435 Subpart L. Many different types of entities, such as health care providers and community-based organizations can serve as a qualified entity. A state may also designate itself (including county or other local agencies) as a qualified entity. This allows the state to accept PE applications, along with the full single, streamlined application, and to provide access to Medicaid covered services while they complete an eligibility determination based on the full application. To elect this option, the state must indicate the eligibility groups for which it will determine PE, any limitations related to the number of allowable PE periods, and whether they will consider attested state residency and/or attested citizenship, status as a national, or satisfactory immigration status when making the PE determination. Unlike HPE, states cannot elect this option for non-MAGI eligibility groups.

3. ***Designating Additional Qualified Entities for Presumptive Eligibility.*** In addition to designating the state agency as a qualified entity, a state may also consider adding other health care providers and/or community agencies to its list of qualified entities. To elect this option, a state would list the qualified entities and the populations for which PE will be made available through these qualified entities. States may also wish to consider other temporary changes to their approved PE program, such as a temporary revision to the number of PE periods allowed or extension of PE to additional MAGI-based eligibility groups.

4. ***Adopting Continuous Eligibility for Children.*** Under Section 1902(e)(12) of the Act, states have the option to provide up to 12 months of continuous Medicaid eligibility to children under a specified age, not to exceed age 19. To temporarily elect continuous eligibility for children, states indicate the length of the continuous eligibility period (not to exceed 12 months) and the age under which children are covered.

5. ***Extending the Redetermination Period for Individuals Excepted from the MAGI-based Methodologies (Non-MAGI populations).*** States are required to redetermine the eligibility of individuals excepted from MAGI-based methodologies at least once every 12 months, as described at 42 CFR 435.916(b), and may redetermine eligibility more frequently. States that currently conduct more frequent renewals may wish to temporarily extend the redetermination period during this public health emergency. To elect this option, a state would need to indicate the temporary renewal frequency - once every 12 months (or less).

6. ***Implementing a Simplified Single, Streamlined Application.*** As described at 42 CFR 435.907(b), state agencies must utilize either the model single, streamlined application for all insurance affordability programs, or an alternative single, streamlined application approved by the Secretary. During the public health emergency, states may be interested in utilizing a simplified version of their alternative application(s). To elect this option, a state would need to indicate whether it is using (a) a simplified paper application, (b) a simplified online application, or both. In addition, states may extend use of their simplified paper or online application to telephonic applications by selecting option c. All simplified, alternative single, streamlined applications need to be submitted to CMS for review.

Section C – Premiums and Cost Sharing

1. ***Suspending deductibles, copayments, coinsurance, and other cost sharing charges.*** States may suspend copayments for particular items or services in Medicaid (e.g., doctor visits or inpatient hospital services) under this option. Such a suspension may be applied broadly to all cost sharing or limited to deductibles, copayments, coinsurance or other cost sharing charges for specified services. A more limited suspension cannot be applied narrowly to only those affected by a particular diagnosis, such as COVID-19. A copayment exemption under the state plan must either apply to everyone who accesses a particular item or service or may be limited to specified eligibility groups consistent with 42 CFR 447.52(d) or specified income levels consistent with 42 CFR 447.52(g). To elect this option, a state would need to describe the types of cost sharing and the individuals affected by the temporary cost sharing suspension.

2. ***Suspending enrollment fees, premiums and similar charges.*** Sections 1916 and 1916A of the Act as implemented at 42 CFR 447.55, allow states to impose premiums upon one or more specified eligibility groups and/or categorical populations of individuals. Because such premiums, enrollment fees, and other similar charges, along with the associated penalty for non-payment, are optional, states may suspend such election(s) at any time. A state may elect to suspend all premiums or may limit the suspension to one or more specific eligibility groups. If the suspension is limited, the state would need to specify the eligibility groups and/or categorical populations affected.

3. ***Establishing an Undue Hardship Waiver for Payment of Enrollment Fees, Premiums and Other Similar Charges.*** As described at 42 CFR 447.55(b)(4), states have the option to waive a premium payment in any case where they determine that such payment would impose an undue hardship on the individual or the individual's family. When electing this option, a state would need to describe their standard for determining undue hardship.

Section D – Benefits

Benefits:

1. ***Adding New Optional Benefits.*** States generally have flexibility to determine the type, amount, duration and scope of benefits available to beneficiaries within broad federal guidelines. While some benefits are mandatory, states have broad flexibility in their coverage of optional benefits such as diagnostic or screening services. To add new temporary optional benefits, the state needs to describe the temporary services, including provider qualifications and any limitations on amount, duration, or scope.

2. ***Adjusting Covered Benefits.*** In addition to adding new temporary benefits, states may need to make temporary adjustments to existing benefits that are currently approved under the state plan in order to respond to the COVID-19 emergency. A state may, for example, choose to increase the types of providers authorized to deliver certain services or adjust the limitations applied to certain services. To elect this option, the state needs to identify the benefit or service and describe the temporary adjustments applied through this SPA.

3. ***Compliance with Existing Requirements for New and Adjusted Benefits.*** The agency must attest that these newly added benefits or adjustments to benefits will comply with all applicable statutory requirements, including 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 of New or Adjusted Benefits to Alternative Benefit Plans (ABPs).*** In establishing new benefits and/or adjusting existing benefits, the state must adhere to all ABP provisions in 42 CFR Part 440, Subpart C. States would not make additions or modifications to their ABP here; this section simply applies the changes above to the state's existing ABPs, if any. Only states with existing ABPs should complete this section. A state would indicate compliance with these requirements by indicating that the newly added and/or adjusted benefits:
    a. Will be made available to individuals receiving services under ABPs, or
    b. Will not be made available to individuals receiving services under ABPs, or only a subset will be made available as described in the text box.

Telehealth:

5. ***Extending Utilization of Telehealth.*** States are generally not required to describe their telehealth policies in the state plan unless reimbursement for services provided via telehealth varies from reimbursement of the same services when provided face to face. Some states do have specific language regarding each benefit for which telehealth is available in coverage pages, in which case states may need a SPA submission. A temporary change to expand such state plan telehealth policies may be established through this state plan provision. To elect this option, the state would describe the changes, such as additional benefits for which delivery via telehealth would be available.

Drug Benefit:

6. ***Adjusting the Days' Supply or Quantity Limits.*** The agency may allow for larger quantities of certain categories of medication to be dispensed at a time to allow for social separation and quarantine periods, such as those for chronic conditions, respiratory therapies, and drugs that need a full course of therapy to be effective. This can include early refills to synchronize medication pick up or delivery by the pharmacy. The State may choose to keep limits in place for controlled substances and other drugs that have a high potential for abuse or diversion.

7. ***Expanding Prior Authorization.*** The state may remove the requirement for 1) clinical review for the dispensing of a medication; or 2) extending prior authorization approvals either for the duration they were approved or for the quantity of medication for which they were approved. The State may apply either approach depending on its current review and approval process.

8. ***Adding a Temporary Supplemental Payment to the Professional Dispensing Fee.*** The State may provide an additional temporary supplemental payment to the approved professional dispensing fee for the costs of delivery of medication to the beneficiary's residence or to another location to facilitate compliance with social separation or quarantine recommendations or requirements. The agency will need to provide documents and data to support the amount of the supplemental fee for the additional services.

9. ***Establishing Preferred Drug List Exceptions.*** The State may make modifications to the Preferred Drug List within the limits of section 1927(d) of the Act, for Covered Outpatient Drugs. This can include the use of a brand name drug in a multisource drug category if a generic drug is not available.

Section E – Payments

Optional benefits described in Section D:

1. ***Establishing a Payment Methodology for Newly Covered Optional Benefits Described in Section D.*** Within this section, please describe the payment methodologies the state will use during the emergency period to pay for newly covered services described under Section D. States that use fee schedules to pay for the newly covered services can simply add the effective date of the fee schedule and the published location (i.e. web site address) where providers may find the fees. If the state does not publish a fee schedule for the newly covered services, a text box is provided for the state to describe the payment methodology.

2. ***Increasing Payment Rates for Current State Plan Services.*** This section describes increases to existing state plan payment rates that will apply for the duration of the emergency. States may wish to target payment increases to certain geographic regions within the state or to certain providers and should describe the targeting criteria that will be used. Options are provided to describe how the state will increase payments, including providing a supplemental or add-on payment to providers. Supplemental or add-on payments are often paid separately from fee-for-service rates and the upper payment limits at 42 CFR 447.272 and 447.321 may apply depending upon the type of service payment the state is increasing. Alternatively, states may temporarily increase fee-for-service rates. Fee-for-service rate changes may be applied uniformly by increasing all rates by a percentage, by modifying a published fee schedule, or by increasing Medicaid rates to be consistent with Medicare rates. States that choose to increase rates using a methodology that is different from one of those three options may describe the factors used to increase rates in the provided text box. Rates must be consistent with efficiency, economy, and quality of care, as specified in section 1902(a)(30)(A) of the Act.

3. ***Payments for Telehealth Services.*** For the duration of the emergency, a state may authorize payments for telehealth services that are not otherwise paid under the Medicaid state plan, differ from payments for the same services when provided face to face, or differ from current state plan provisions governing reimbursement for telehealth. States that would like to pay for covered services delivered via telehealth using the Medicaid payment methodology established for the same services when delivered face to face generally do not need to submit a SPA to establish this payment methodology even if the state needs to recognize new billing codes for providers to bill a telehealth encounter. However, if the state currently pays for services delivered via telehealth through a different state plan payment methodology than is in place for the same services when delivered face to face and wishes to align telehealth payment with payment for face-to-face service delivery for the period of the emergency, a SPA would be required. This section allows states to describe variations from currently approved state plan payment methodologies for services delivered via telehealth during the public health emergency. States may describe any variation in telehealth reimbursement through the text box that is provided. Additionally or alternatively, options are provided for the state to

reimburse ancillary costs associated with the originating site that will be paid to the billing provider. Those costs may either be incorporated into the fee-for-service rates or paid separately through an administrative fee.

Other:

4. ***Other payment changes.*** Any other change to statewide method or standards that modify the existing state plan methodologies and that are not contemplated in Section E 1-3, may be described within this section. As in other sections, changes may not restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Section F - Post-Eligibility Treatment of Income

These options allow states to temporarily reduce or eliminate the post-eligibility treatment-of-income calculations for institutionalized individuals, and/or provide greater financial protection for institutionalized individuals who may be more financially disadvantaged during the disaster relief period. (Changes to the maintenance allowances for individuals receiving home and community-based services authorized under section 1915(c) of the Act would be made under the appropriate 1915(c) waiver.)

A state may elect under F.1. to temporarily modify the basic personal needs allowance that is currently approved under its state plan. States electing this option select one of the amounts described below the election. A state may also elect under F.2. to add a variance to the basic personal needs allowance. Such variances for institutionalized individuals who have greater needs are permitted under existing CMS policy. If a state wants to temporarily add a variance not currently approved under its state plan, it may select this option and describe both the group and the basic personal needs allowance for the groups. States are not required to elect F.1. to adopt F.2.

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

Other state plan flexibilities that do not restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers, which were not described in the previous sections, may be included here. We recommend that states consult with CMS prior to submitting additional policies or procedures to be applied only during the emergency period covered under this state plan amendment.