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

___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 California Medicaid state plan, as described below:

Please describe the modifications to the timeline. To the extent there is a direct impact to Tribal Health Programs requiring a notice, California requests a 10 business-day notice period that will occur after the SPA is submitted to CMS for approval.

Section A – Eligibility

1. ___X__ 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 state elects to cover all uninsured individuals as defined under 1902(ss) of the Act pursuant to Section 1902(a)(10)(A)(ii)(XXIII) of the Act effective March 18, 2020.

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. __X__ 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:

California disregards income up to 138% FPL for the following eligibility groups: • Individuals Eligible For But Not Receiving Cash Assistance--section 1902(a)(10)(A)(ii)(I) • Age and Disability Poverty Level--section 1902(a)(10)(A)(ii)(X)

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. __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.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors. California allows HPE for the following eligibility groups: • Individuals Eligible For But Not Receiving Cash Assistance--section 1902(a)(10)(A)(ii)(I) • Individuals Receiving Home and Community-Based Services--section 1902(a)(10)(A)(ii)(VI) • Optional State Supplement Beneficiaries--section 1902(a)(10)(A)(ii)(XI) • PACE Enrollees--section 1934 • Age and Disability Poverty Level--section 1902(a)(10)(A)(ii)(X) • Work Incentives/BBA--section 1902(a)(10)(A)(ii)(XIII) • Uninsured individuals as defined under 1902(ss) of the Act pursuant to Section 1902(a)(10)(A)(ii)(XXIII) of the Act effective March 18, 2020

PE Period Limitations:
California intends to add an additional PE period to the above HPE coverage groups, specifically allowing for the following total number of PE periods within a 12-month period. California allows 2 PE periods in a 12-month period, beginning on the date of the first PE approval.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

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. __X___ 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). The state waives cost-sharing for testing services (including in vitro diagnostic products), testing-related services, and treatments for COVID-19, including vaccines, specialized equipment and therapies, for any quarter in which the temporary increased FMAP is claimed.

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

   a. _____ All beneficiaries

   b. __X__ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations. • Optional Targeted Low-Income Children (OTLIC) – see SPA 17-044; Attachment 4.18-F • Work Incentives/BBA--section 1902(a)(10)(A)(ii)(XIII)

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:

The state allows physicians and other licensed practitioners, in accordance with State law, to order Medicaid Home Health services as authorized in the COVID-19 Public Health Emergency Medicare interim final rule (CMS-1744-IFC).

The state modifies its rehabilitative services benefit in the Drug Medi-Cal State Plan to expand individual counseling visits to include visits focused on short-term personal, family, job/school or other problems and their relationship to substance use, in addition to the currently allowable visits for the purpose of intake, crisis intervention, collateral services, and treatment and discharge planning.

Remove utilization controls on covered benefits to the extent such limits cannot be exceeded based on medical necessity in the relevant approved State plan.

3. __X___ 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:

   Please describe.

Telehealth:

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

Please describe.

Face-to-face requirement: Modify face-to-face requirement for State Plan benefits/services to be provided via all forms of telehealth and telephone, regardless of originating or distant site. This affords providers the flexibility to safely and expeditiously render necessary care for people.

Drug Benefit:

6. __X___ 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. Removal of the six-prescription per calendar month limitation on covered outpatient drugs. This applies to all FFS Medi-Cal pharmacy providers and all covered outpatient drugs. Non-legend acetaminophen-containing drugs, non-legend cough, and cold drugs that are covered outpatient drugs will be included in the pharmacy benefit. Providers may dispense up to a 100-day supply at one time of all covered outpatient drugs.

7. __X__ 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. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

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

Please list all that apply.
Clinical laboratory or laboratory services, as generally described in State Plan Attachment 3.1-A, page 1, paragraph 3, that relate to the 2019 Novel Coronavirus (COVID-19). The COVID-19 procedure codes include U0001, U0002, and 87635 for diagnostic laboratory testing, G2023 and G2024 for the related specimen collection, and any COVID-19 diagnostic testing or collection procedure code, or equivalent code, adopted or established by CMS in the future. The payment increases will be effective for dates of service on or after March 1, 2020, or the date the procedure code is adopted or established by CMS. This change will affect the clinical laboratory or laboratory services methodology described on pages 3d and 3f of Attachment 4.19-B and authorize 100 percent of the Medicare rate as the reimbursement methodology for procedure codes related to COVID-19.

Skilled Nursing Facilities (SNFs), including Freestanding Nursing Facilities Level-B; Nursing Facilities Level-A; Distinct Part Nursing Facilities Level-B; Freestanding Adult Subacute facilities; Distinct Part Adult Subacute facilities; Distinct Part Pediatric Subacute facilities; Freestanding Pediatric Subacute facilities; and Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs), ICF/DD-Habilitative, and ICF/DD-Nursing as described in State Plan Attachment 4.19-D and Supplement 4 to Attachment 4.19-D. This would not apply to state-owned SNFs and state-owned ICFs, inclusive of Developmental Centers and Veterans Homes.

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

Please describe criteria.
Clinical laboratories and laboratory services are experiencing increased cost pressures to provide a high volume of COVID-19 diagnostic testing and related specimen collection services. The payment increases will provide sufficient reimbursement in order for providers to collect specimen and to conduct the necessary COVID-19 diagnostic testing during COVID-19 outbreak and national emergency.

SNFs and ICF/DDs are experiencing increased cost pressures in a variety of areas as a result of the COVID-19 response and the state is seeking flexibility to allow consideration of all costs being incurred by facilities to ensure the health and safety of residents. Increased costs related to the COVID-19 response could include, but are not limited to, increased staffing costs, medical equipment costs, and sanitizing costs.

b. Payments are increased through:

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

Please describe.

ii. __X__ An increase to rates as described below.

Rates are increased:

__X___ Uniformly by the following percentage: 10 percent of current SNF (including Freestanding Nursing Facilities Level-B; Nursing Facilities Level-A; Distinct Part Nursing Facilities Level-B; Freestanding Adult Subacute Facilities; Distinct Part Adult Subacute Facilities; Distinct Part Pediatric Subacute facilities; Freestanding Pediatric Subacute facilities) and ICF/DD (including ICF/DDs, ICF/DD-Habilitative, and ICF/DD-Nursing) per diem rates. This increase would not apply to state-owned SNFs or ICFs, including Developmental Centers and Veterans Homes. The SNF and ICF/DD per diem rates are inclusive of add-ons, the Freestanding Pediatric Subacute Facility supplemental payments described on page 37 of Attachment 4.19-D, and the ICF/DD supplemental payments as described on page 35 of Attachment 4.19-D, but exclusive of ancillary charges and other supplemental payments, including, the Quality and Accountability Supplemental Program described on pages 20-24 of Supplement 4 to Attachment 4.19-4, the ICF/DD day treatment supplemental payment described on page 30 of Attachment 4.19-D, and the Special Treatment Program (STP) Patch under 22 CCR § 51511.1. The state will provide demonstration that payments for the state fiscal year are within the applicable fee-for-service upper payment limits, including those as defined in 42 CFR 447.272 and 447.321, when the upper payment limit demonstrations are due for the fiscal year. If the demonstration shows that payments for any category have exceeded the upper payment limit, the state will take corrective action as determined by CMS.

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

__X__ Up to the Medicare payments for equivalent services.

The payment for clinical laboratory COVID-19 related procedure codes will be equal to the Medicare payment for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. __X___ For the duration of the emergency, the state authorizes payments for telehealth services that:

    a. __X__ Are not otherwise paid under the Medicaid state plan;

    b. _____ Differ from payments for the same services when provided face to face;

    c. __X__ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation. FQHC/RHC/Tribal 638 Clinic Telehealth/ Telephonic visit: Modify the face-to-face requirement for telehealth/telephonic visits as described in pages 6B.1 of Attachment 4.19 B [FQHC/RHC] and Supplement 6, page 1 [Tribal 638 Clinics]. Consequently, when the treating health care practitioner of the FQHCs/RHCs/Tribal 638 clinics satisfies all of the procedural and technical components of the Medi-Cal covered service or benefit being provided except for the face-to-face component, reimbursement will occur at a Prospective Payment Systems (PPS) rate for FQHC/RHC or All Inclusive Rate (Tribal 638 Clinic) for new or established patients irrespective of the date of the last visit. Virtual Communication: Modify the face-to-face requirement for virtual communications. Payment for communication technology-based services for 5 minutes or more between an FQHC/RHC/Tribal 638 Clinic practitioner and new or established patient, irrespective of date of last visit, that does not meet the criteria of a face-to-face visit and results in a determination that a face-to-face visit is unnecessary, will be reimbursed with HCPCS code G0071 at the Medicare reimbursement rate. Drug Medi-Cal State Plan: Suspend requirements for “face-to-face” contact in pages 38 through 41 of Attachment 4.19-B, and treat non-face-to-face contacts as equivalent to face-to-face contacts for these provisions.

    d. ___X__ 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. __X__ 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.

Payment for ancillary costs, as described in paragraph 3.d. above, is applicable to Drug Medi-Cal services only.

Other:

4. __X__ Other payment changes:

In accordance with the Emergency Paid Sick Leave Act under HR 6201, allow the In-Home Supportive Services (IHSS) Individual Provider Rate, which includes Wages, Payroll Tax, Benefits, Administrative Costs, and Paid Time Off within the negotiated rate, to include payment for paid time off of IHSS providers related to COVID-19 sick leave benefits for a limited time period, beginning April 2, 2020 through December 31, 2020, or the end of the COVID-19 public health emergency period if sooner.

The State approved county governmental, contracted, and private individual provider rates are documented in a fee schedule and that fee schedule has been updated to reflect the additional sick leave mandated pursuant to the Emergency Paid Sick Leave Act on April 2,2020, and is effective for services provided after that date through December 31, 2020, or the end of the COVID-19 public health emergency period if sooner. This fee schedule is published on the California Department of Social Services website at:
https://www.cdss.ca.gov/inforesources/ihss/county-ihss-wages-rates

For Drug Medi-Cal (DMC) non-Narcotic Treatment Program (non-NTP) services provided on or after March 1, 2020, until the COVID-19 public health emergency ends, the State will: (1) provide interim reimbursement equal to the lower of the county's billed amount or the Statewide Maximum Allowance (SMA) increased by 100 percent; and (2) in the settlement process described in Attachment 4.19-B at page 41b, settle these payments to allowable cost, and thereby waive the limitations of usual and customary charge or SMA. These updates are implemented as follows:

(1) Interim payments for non-NTP services provided to Medi-Cal beneficiaries are reimbursed up to the SMA for the current year increased by 100 percent. Interim payments for NTP services provided to Medi-Cal beneficiaries are reimbursed up to the USDR rate for the current year. This methodology supersedes the methodology described in paragraph E.1. on page 41 of Attachment 4.19-B, except for the methodology described in paragraphs E.1.a. and E.1.b. on pages 41 and 41a of Attachment 4.19-B.
(2) The reimbursement methodology for county and non-county operated providers of non-NTP services is the provider's allowable costs of providing these services. This methodology supersedes the methodology described in paragraph B.1. on page 39 of Attachment 4.19-B.

For Specialty Mental Health Services provided on or after March 1, 2020, until the COVID-19 public health emergency ends, the State will: (1) provide interim reimbursement to county owned and operated providers based upon the established interim rates for the current year increased by 100 percent; and (2) in the settlement process described in paragraphs C and D of Attachment 4.19-B, at pages 24 through 25.6, settle interim payments to private organizational providers and to private and state owned and operated hospital-based outpatient providers to allowable cost. These updates are implemented as follows:

(1) Interim payments for services delivered by county owned and operated providers are based upon interim rates, which are established by the State for those providers on an annual basis, increased by 100 percent.

(2) Total reimbursable costs for private organizational providers are equal to the provider's reasonable and allowable costs for the reporting period. Total reimbursable costs for private and state owned and operated hospital-based outpatient providers are equal to the provider's allowable costs determined in the CMS 2552 hospital cost report and supplemental schedules.
(3) The change in paragraph (1) above supersedes any conflicting portions of paragraphs C.1 and D.1 of Attachment 4.19-B, at pages 24 through 25.4. The change in paragraph (2) above supersedes any conflicting portions of paragraphs C and D of Attachment 4.19-B, at pages 24 through 25.6.

The Clinical laboratory COVID-19 diagnostic testing procedures codes mentioned above will be exempt from the 10 percent payment reductions in Welfare and Institutions Code section 14105.192, as described in Attachment 4.19-B, page 3.3, paragraph 13 of the State Plan.

Add Associate Clinical Social Worker (ACSW) and Associate Marriage and Family Therapist (AMFT) as billable provider types in addition to the provider types listed on pages 6B.1 and 6C of Attachment 4.19-B for FQHCs and RHCs. Doing so allows the services of ACSWs and AMFTs furnished within their scope of practice in accordance with California state law to be billable services in Federally Qualified Health Centers and Rural Health Clinics (RHCs). Licensed practitioners will supervise and assume the professional liability of services furnished by the unlicensed ACSW and AMFT practitioners. The ACSW/AMFT services in RHCs are included under 42 CFR 440.20(c):Other ambulatory services furnished by a rural health clinic.
Allow the State to supersede the scope of service change requirements for MFTs on page 6W of Attachment 4.19-B .

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.