



BRADLEY P. GILBERT, MD, MPP
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services



GAVIN NEWSOM
GOVERNOR

April 3, 2020

Mr. James G. Scott, Director
Centers for Medicare & Medicaid Services
Medicaid and CHIP Operations Group
Division of Program Operations
601 East 12th Street, Suite 0300
Kansas City, MO 64106-2898

REQUEST FOR ADDITIONAL STATE PLAN AMENDMENTS RELATED TO NOVEL
CORONAVIRUS DISEASE (COVID-19) NATIONAL EMERGENCY/PUBLIC HEALTH
EMERGENCY

Dear Mr. Scott:

The Department of Health Care Services (DHCS) writes to request approval for the below-detailed additional flexibilities under Section 1135 of the Social Security Act (42 U.S.C. § 1320b-5) as related to the Novel Coronavirus Disease (COVID-19). The COVID-19 outbreak was declared a national emergency on March 13, 2020, and was previously declared a nationwide public health emergency on January 31, 2020 (retroactive to January 27, 2020).

DHCS is submitting State Plan Amendment (SPA) 20-0024 for your review and approval. The below list represents California's additional requested flexibilities for amending the State Plan in connection with the COVID-19 outbreak and emergency based on further exploration of need. Because circumstances surrounding the COVID-19 emergency remain quite fluid, DHCS may subsequently request approval for additional flexibilities, which we can commit to doing promptly as soon as the need is discovered. DHCS seeks to align this SPA with the duration of the emergency period, starting with the effective date of March 1, 2020.

- **Drug Medi-Cal (DMC) services reimbursement methodology**
DMC state plan services may be rendered by DMC providers that contract directly with DHCS or with a county behavioral health department. Currently, interim payments for non-Narcotic Treatment Program (non-NTP) services are reimbursed up to the Statewide Maximum Allowance (SMA) rates. In addition, the State currently limits interim and final settlement for these services to the lower of allowable cost, usual and customary charges, or SMA rates. This

reimbursement methodology is described in Attachment 4.19-B, Pages 38-41d. DHCS proposes to raise interim reimbursement for non-NTP services up to the SMA increased by 100 percent and to settle these payments to allowable cost, thereby waiving the limitations of usual and customary charge or SMA.

DHCS also proposes to reimburse DMC state plan services described in pages 3–6a of Supplement 3 to Attachment 3.1-A when provided via telehealth as if the service had been provided face to face.

- **Specialty mental health services (SMHS) reimbursement methodology**
DHCS proposes to provide interim reimbursement to county owned and operated providers up to the established interim rates for the current year increased by 100 percent. This methodology would supersede any conflicting portions of Sections C.1, D.1, and E.1 in Attachment 4.19-B, Pages 21-25.11; Section D.a in Attachment 4.19-A, Pages 38-40.5; and any applicable CPE protocol.
- **Clinical laboratory and laboratory service reimbursement rates**
DHCS proposes to increase clinical laboratory and laboratory service reimbursement rates, as generally described in State Plan Attachment 3.1-A, page 1, paragraph 3, that relate to the COVID-19. The impacted 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 established by CMS in the future. The payment increases would be effective for dates of service, on or after February 4, 2020, or the date the procedure code is established by CMS. The proposed reimbursement rates will equal the Medicare payment for equivalent services and will also 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.
- **Long Term Care (LTC) facility rates**
DHCS seeks authority to provide an increase in reimbursement for the LTC facility types listed below, for increased costs related to the COVID-19 response.
 - Intermediate Care Facilities for the Developmentally Disabled (ICF/DD),
 - ICF/DD-Habilitative (ICF/DD-H),
 - ICF/DD-Nursing (ICF/DD-N)
 - Freestanding Skilled Nursing Facilities Level-B (FS/NF-B), and
 - Adult Freestanding Subacute Facilities Level-B (FSSA/NF-B)

DHCS is seeking the flexibility in the rate setting methodology for the ICF/DD, ICF/DD-H, ICF/DD-N facility types, as described in State Plan Attachment 4.19-D

and the FS/NF-B and FSSA/NF-B facility types as described in Supplement 4 to Attachment 4.19-D. DHCS is still evaluating the methodology for any reimbursement and will provide an update to CMS through the SPA review process. Any payment increases would be effective for dates of service, on or after March 1, 2020.

- **Establishment of an uninsured optional coverage group and an expansion of our Hospital Presumptive Eligibility (HPE) Program in terms of covered populations and coverage periods to allow the state to meet the needs of uninsured individuals who are in need of screening and testing services for COVID-19.**
 - DHCS proposes covering the optional group described in section 1902(a)(10)(A)(ii)(XXIII). The services covered will be limited to COVID-19 diagnostic testing and testing-related services.
 - DHCS also proposes expanding HPE to individuals that are 65 years or older, blind, or disabled under the income level of 138 percent of the Federal Poverty Level. There will be no resource test for this coverage group. DHCS is requesting the expansion of the number of HPE periods allowed in a given 12-month timeframe.
- **Suspension of premiums and cost sharing for applicable Medicaid and Children's Health Insurance Program beneficiaries for screening, diagnostic and treatment services related to COVID-19 to eliminate any fiscal challenges that may inhibit these populations from seeking these needed services.**
- **Benefit flexibilities including prescribers for select covered benefits, waivers of utilization controls, and waivers of face-to-face requirements for select covered benefits requiring such in order to increase access to covered benefits and applicable screening and diagnostic services in a manner that is consistent with social distancing requirements in order to protect both providers and covered populations.**
- **Elimination of the share of cost requirement for the medically needy program to eliminate any fiscal challenges that may inhibit this population from seeking screening and diagnostic services related to COVID-19.**
 - DHCS proposes eliminating cost requirements associated with the testing of COVID-19, and for those that test positive, all costs associated with the treatment of the virus for beneficiaries subject to a Share of Cost.

- **In-Home Supportive Services (IHSS)**
 - DHCS proposes to conduct reassessments via telephone or other remote option, extend the reassessment period to once every 18 months, and to suspend quality assurance home visits for the IHSS programs authorized under the Medicaid State Plan and sections 1915(j) and 1915(k) of the Social Security Act.
 - In accordance with the Emergency Paid Sick Leave Act under H.R. 6201, DHCS proposes to allow the IHSS Individual Provider Rate to include payment for paid time off of IHSS providers related to COVID 19 sick leave benefits for a limited time period, from April 2, 2020 through December 31, 2020. This rate currently includes Wages, Payroll Tax, Benefits, Administrative Costs, and Paid Time Off within the negotiated rate.

DHCS requests a waiver of public notice requirements that would otherwise be applicable to this SPA submission. To the extent there is an impact to Tribal Health Programs requiring a notice, the state requests a 10 business-day notice period that will occur after the SPA is submitted to CMS for approval. DHCS will post this SPA to its website as soon as possible.

DHCS submits the enclosed CMS 179 form and draft State Plan pages (redline and clean copies). The fiscal impact within the CMS 179 is the state's estimate at the time of this submission.

During such difficult times for California and the nation, DHCS greatly appreciates the prompt attention exhibited by CMS to these matters and we look forward to the continued partnership. If you have any questions or need additional information, please contact Ms. René Mollow, MSN, RN, Deputy Director of Health Care Benefits & Eligibility, by email at Rene.Mollow@dhcs.ca.gov or Ms. Lindy Harrington, Deputy Director of Health Care Financing by email at Lindy.Harrington@dhcs.ca.gov.

Sincerely,



Jacey Cooper
Chief Deputy Director
Health Care Programs
State Medicaid Director

Enclosures

cc: See next page

James G. Scott
Page 5
April 3, 2020

cc: Bradley P. Gilbert, MD, MPP, Director
Department of Health Care Services

Erika Sperbeck
Chief Deputy Director
Policy & Program Support
Department of Health Care Services

Anastasia Dodson
Associate Director for Policy
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Cheryl Young
Centers for Medicare & Medicaid Services
Medicaid and CHIP Operations Group
Division of Program Operations, West Branch
San Francisco Office

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

2 0 — 0 0 24

2. STATE

California

3. PROGRAM IDENTIFICATION:

Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

March 1, 2020

5. TYPE OF PLAN MATERIAL (*Check One*)

NEW STATE PLAN

AMENDMENT TO BE CONSIDERED AS NEW PLAN

AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION

42 U.S.C. § 1320b-5; 42 CFR Part 447, including Subpart F (see box 23)

7. FEDERAL BUDGET IMPACT

a. FFY 2020 \$ 8,784,000 (monthly)

b. FFY n/a \$ n/a

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Section 7.4 pages 90a-m

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (*If Applicable*)

Attachment 4.19-A, Pages 38-40.5, Section D.a

Attachment 4.19-B, p 3.3, 21-25.11,38-41d, 66

Attachment 4.19-B, Sections C.1, D.1, E.1

Attachment 3.1-A, Page 1

(see more in box 23)

10. SUBJECT OF AMENDMENT

Medicaid Disaster Relief for the Novel Coronavirus Disease (COVID-19) National Emergency - Request for Additional Flexibilities to Waive or Modify Certain Requirements of California's State Plan

11. GOVERNOR'S REVIEW (*Check One*)

GOVERNOR'S OFFICE REPORTED NO COMMENT

OTHER, AS SPECIFIED

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL



16. RETURN TO

Department of Health Care Services

Attn: Director's Office

P.O. Box 997413, MS 0000

Sacramento, CA 95899-7413

13. TYPED NAME

Jacey Cooper

14. TITLE

State Medicaid Director

15. DATE SUBMITTED

April 3, 2020

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

For Box 6, additional responses are: 1902(a)(47)(B) of the Act; 42 CFR 435.1110

For Box 9, additional responses are: Supplement 3 to Attachment 3.1-A, Pages 3-6a; Attachment 3.1K, Page 18; Attachment 4.19-D; Supplement 4 to Attachment 4.19-D

For Box 11 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment.

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. 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. 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.

Name of Optional Group:

Uninsured Optional Coverage Group (Group XXIII) for COVID-19

Income Standards for Uninsured Optional Coverage Group (COVID-19):

- Children (ages 0-19, above 266 percent Federal poverty level (FPL))
- Parent/Caretakers (above 109 percent FPL)
- Adults (age 19 or older, above 138 percent FPL)
- Pregnant Women (above 213 percent FPL)

No Resource Test for Uninsured Optional Coverage Group (COVID-19)

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:

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. 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.

Eligibility groups for individuals age 65 and over, with incomes from 0-138 percent of FPL
Eligibility groups for individuals who are blind, with incomes from 0-138 percent of FPL
Eligibility groups for individuals with disabilities, with incomes from 0-138 percent of FPL

Reasonable Eligibility Limitation: Expand the number of HPE periods allowed in a given 12-month timeframe. To the extent a beneficiary seeks care for coronavirus but has already used an HPE period in the last 12 months, or tests negative and then seeks care for a suspected episode later in the same 12-month period, they shall be afforded another HPE period.

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.
7. The agency elects to conduct reassessments via telephone or other remote option () in lieu of the in-home face-to-face and/or in-home requirement to determine authorized service hours for recipients for the following In-Home Supportive Services (IHSS) programs: Personal Care Services Program (PCSP), IHSS Plus Option (IPO) and Community First Choice Option Program (CFCO), programs which are authorized under the Medicaid State Plan and sections 1915(j) and 1915(k) of the Social Security Act.
8. The agency elects to extend the reassessment period to once every 18 months for the following IHSS programs: PCSP, IPO and CFCO, programs which are authorized under the Medicaid State Plan and sections 1915(j) and 1915(k) of the Social Security Act, and to suspend quality assurance home visits.

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).

California suspends all Medi-Cal and CHIP deductibles, copayments, coinsurance, and other cost sharing for screening, diagnostic, and treatment services related to COVID-19.

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. X 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):

Nonlegend acetaminophen-containing products, nonlegend cough, and cold products are added as covered outpatient drugs included in the pharmacy benefit. This applies to all fee-for-service (FFS) Medi-Cal pharmacy providers.

Providers may dispense up to a 100-day supply at one time.

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

Allow Tribal 638 clinics to provide services outside the clinic four walls as described in CMS Tribal FQHC guidance of January 2017. Tribal 638 clinics would be able to bill these visits at the federally established All Inclusive Rate (AIR) methodology.

Under the Home Health Agency (HHA) benefit, allow other licensed providers to establish a plan of care to prescribe home health services, including durable medical equipment and medical supplies, as well as pharmacy benefits within their scope of practice, and to enable those licensed providers to certify and recertify beneficiary eligibility. Allow a beneficiary who is considered homebound when their physician advises them not to leave the home because of a confirmed or suspected COVID-19 diagnosis and who needs skilled services, to receive HHA services.

Waive onsite visits for both HHA Aide Supervision: Waive the requirements at 484.80(h), which require a nurse to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time. Also temporarily suspend two-week aide supervision requirement at 42 CFR §484.80(h)(1) by a registered nurse for home health agencies, but virtual supervision is encouraged during the period of the waiver.

Prior authorization is not required for any preventive service in excess of the basic allowance provided by a comprehensive perinatal service program provider.

3. X The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewide 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. 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:

Please describe.

Face-to-face requirement: Waive face-to-face requirement for State Plan benefits/services that can be provided via telehealth, including telephonic services and individual and group counseling, regardless of originating or distant site. This affords providers the flexibility to safely and expeditiously render necessary care for people.

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.

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.

- 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. Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. 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 established by CMS in the future. The payment increases will be effective for dates of service on or after February 4, 2020, or the date the procedure code is established by CMS.

Skilled Nursing Facilities (SNFs), including Freestanding Nursing Facilities Level-B; Freestanding Adult Subacute facilities; Distinct Part Pediatric Subacute facilities; Freestanding Pediatric Subacute facilities; and Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), as described in State Plan Attachment 4.19-D and Supplement 4 to Attachment 4.19-D.

a. 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.
For ICFs and SNFs, DHCS continues to evaluate the reimbursement methodology and will provide any updates to CMS through the SPA review process.

- ii. An increase to rates as described below.

Rates are increased:

Uniformly by the following percentage: _____

Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

Up to the Medicare payments for equivalent services.

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. 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.

FQHC/HRC/Tribal 638 Clinic Telehealth/ Telephonic visit: Waive the face-to-face requirement for telehealth/telephonic visits as described in pages 6-11 of Attachment 4.19 B [FQHC/RHC] and Supplement 6 [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) or AIR rate for new or established patients irrespective of the date of the last visit.

Virtual Communication: Waive 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.

E-Consult: Payment for E-consultation services that provide an assessment and management service in which the patient's treating health care practitioner requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the patient's health care needs without patient face-to-face contact with the consultant for new and established patients, irrespective of date of last visit. Payment is made to the FQHC/RHC/Tribal 638 Clinic practitioner that functions as a consultant at the PPS/AIR rate.

Drug Medi-Cal State Plan: Waive provisions in Supplement 3 to Attachment 3.1-B, for individual or group counseling within the State Plan prohibiting the use of telehealth in the Drug Medi-Cal program and allow for group or individual counseling by telehealth. Allow for the provision of services by telephone and telehealth for the purposes of delivering Substance Use Disorder treatment services and allow all the counseling services permissible in group settings to be allowed in individual sessions.

DHCS will reimburse Drug Medi-Cal State Plan services described in pages 3–6a of Supplement 3 to Attachment 3.1-A when provided via telehealth as if the service had been provided face to face. These services are not currently reimbursed when provided via telehealth.

Adult Residential Treatment Services and Crisis Residential: Waive requirements for a "face-to-face contact between the beneficiary and a treatment staff person of the facility on the day service" for Adult Residential Treatment Services and Crisis Residential services [Supplement 2, to Attachment 3.1-B, pages 11 and 12 and

Supplement 3 to Attachment 3.1-A, pages 2i and 2k] and allow that requirement to be fulfilled by telephone or telehealth.

- 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.

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.

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. 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 (NTP) services provided throughout the duration of the emergency, the State will revise the reimbursement methodology to: (1) provide interim reimbursement to DMC State Plan counties equal to the lower of the county's certified public expenditure (CPE) or the Statewide Maximum Allowance (SMA) increased by 100 percent; and (2) in the settlement process described in State Plan Attachment 4.19B 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) The reimbursement methodology for county and non-county operated providers of non-Narcotic Treatment Program 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.

(2) 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.

For Specialty Mental Health Services provided throughout the duration of the emergency, the State will revise the reimbursement methodology to provide interim reimbursement to county owned and operated providers up to the established interim rates for the current year increased by 100 percent. This update is 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) This change supersedes any conflicting portions of Sections C.1, D.1, and E.1 in Attachment 4.19-B, Pages 21-25.11; Section D.a in Attachment 4.19-A, Pages 38-40.5; and any applicable CPE protocol.

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.

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

Additional Eligibility Flexibility Requested:

Social Security Act Section 1902(a)(10)(C)—Medically Needy Share-of-Cost Program:

Eliminate the cost requirements associated with the testing of the COVID-19 and, for those that test positive, all costs associated with the treatment of this virus for certain beneficiaries subject to a share of cost. California administers a Medically Needy share-of-cost program (Section 1902(a)(10)(C)) that provides Medi-Cal for several different coverage groups. These Medically Needy coverage groups include children under age 21, pregnant individuals, parents and other caretaker relatives and individuals that are aged 65 or older, disabled, or blind. Certain individuals in the Medically Needy program are required to pay a share-of-cost based on household income that exceeds the maintenance need level for their family size. A majority of the Medically Needy population with a share-of-cost are individuals at higher risk due to age, pregnancy, and chronic health conditions including heart, lung or kidney disease. Removing the share-of-cost for the COVID-19 testing, diagnosis and treatment for this population will guarantee there are no financial barriers to seeking medical services related to this public health emergency and potentially reduce the spread of the virus.

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.