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:

N/A.

The flexibilities described in this SPA shall be implemented throughout the duration of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof).

The effective date for this SPA is March 1, 2020

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)

c. __X__Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [Arizona] Medicaid state plan, as described below:

Current state plan language provides for an expedited Tribal Consultation process in situations that require immediate submission of a policy change to CMS. However, the current language details the Agency soliciting written comment "in the meeting notification with a description of the policy change and the date when the change will be submitted to CMS" at least 14 days prior to submission to CMS. While the Agency did hold an emergency Tribal Consultation meeting to discuss these policy changes, AHCCCS was not able to meet this 14 day requirement prior to submission to CMS, and are thus seeking relevant flexibility.

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.

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.

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. __X___The agency adopts a total of __12___months (not to exceed 12 months) continuous eligibility for children under age __19___(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:

Copays and premium requirements for all members are suspended for the duration of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof).

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

    a. __X___All beneficiaries

b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

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

Home Health: 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). Other Licensed Practitioners: Pharmacies are qualified providers of COVID-19 vaccinations per the HHS COVID-19 PREP Act Declaration and authorizations. Licensed Pharmacists employed by an AHCCCS-registered pharmacy and acting within the scope of their practice to order and administer AHCCCS covered vaccines and anaphylaxis agents to adults and children. As identified in their scope of practice, Licensed Pharmacists may order and prescribe Flu and COVID-19 related vaccines. Pharmacy Technicians and Pharmacy Interns employed by an AHCCCS-registered pharmacy and acting within the scope of their practice may also administer AHCCCS covered influenza and COVID-19 vaccines under the supervision of an immunizing pharmacist.

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

Please describe.

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.

The state is requesting to waive any signature requirements for the dispensing of drugs during the Public Health Emergency, effective March 1, 2020.

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.

9. __X___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. __X___ Newly added benefits described in Section D are paid using the following methodology:

   a. __X__ Published fee schedules –

      Effective date (enter date of change): _____

Location (list published location):
https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS (Physician fee schedule and Hospital Outpatient Fee Schedule (OPFS).)

a. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

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

1) In cases where vaccine administration is separately reimbursable at a fee amount, payment for administration of COVID-19 vaccinations is set at $83 per dose. 2) The Administration shall reimburse IHS/638 facilities non-FQHC clinics at the outpatient all-inclusive rate (AIR) for COVID-19 vaccine administration by registered nurses under an individual or standing order. 3) Payment for the Non-Emergency Medical Transportation (NEMT) services billable under HCPCS T2007 will be increased by $8.64 per unit for trips associated with a COVID-19 drive-through vaccination site. A COVID-19 drive-through vaccination site is any site at which an AHCCCS member arrives in vehicle and receives the COVID-19 vaccination without exiting the vehicle. The total payment for HCPCS T2007 will be $13.23 per unit when the TU modifier, denoting time spent at the COVID-19 drive-through vaccine site, is used.

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

Please describe criteria.

b. Payments are increased through:

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

Please describe.

ii. __X__ An increase to rates as described below.

Rates are increased:
_____ Uniformly by the following percentage: _____
___X__ Through a modification to published fee schedules –
Effective date (enter date of change): _____
Location (list published location): _____
___ Up to the Medicare payments for equivalent services.
_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

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

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

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

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

Describe telehealth payment variation.

    d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

        i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

        ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. __X__ Other payment changes:

- *The Administration shall make interim payments to each hospital to reflect a preliminary, estimated amount for each GME component. The interim payment amount shall be computed as 80.0% of the actual distribution to each hospital for the service period of July 1, 2018, to June 30, 2019. The Administration will then compute the final, actual GME amounts for the service period July 1, 2019, to June 30, 2020, and adjust the final distribution amounts by the amount of the interim payments already made. The final computation, reconciliation, and distribution will occur no later than one year from June 30, 2020. The federal share of any overpayments are returned to CMS in accordance with 42 CFR 433, Subpart F.*

- The Administration shall make two rounds of lump sum payments to registered network providers who provide nursing facility services with Arizona Fee for Service (FFS) Medicaid utilization for service periods during the PHE, and will use October 1, 2019 to December 31, 2019 as proxy utilization data for both rounds. Registered network providers which qualify for these increases include all Nursing Facilities (NF), except for Out-of-State nursing facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) and the Arizona Veteran's Homes. Both rounds of lump sum payments are to compensate providers for costs of covered services furnished to Arizona Medicaid beneficiaries to improve the member's experience of care. For each round of payments, each registered network provider's lump sum payment shall be determined as follows:

1. Determine each provider's actual Medicaid bed days based on approved and adjudicated FFS claims from October 1, 2019 to December 31, 2019.

2. The uniform dollar amount increase amount for nursing facilities is $30 per bed day

3. The Administration will multiply the appropriate uniform dollar increase amount listed in item two by the number of Medicaid bed days as determined in item one to calculate the lump sum payment for each provider

- The Administration shall make a lump sum payment to registered network providers who provide qualifying American Rescue Plan Act (ARPA) services with Arizona Fee for Service (FFS) Medicaid utilization for service periods during the PHE, and will use October 1, 2020 to March 31, 2021 as proxy utilization data for the lump sum payment. This payment is intended to supplement services provided from April 1, 2022 to June 30, 2022. Registered network providers which qualify for these increases are outlined in the following link- https://azahcccs.gov/AHCCCS/downloads/Initiatives/ARPA/EligibleProviderTypesNon-DDD.pdf . The purpose of the lump sum payment is to compensate providers for costs of covered services furnished to Arizona Medicaid beneficiaries to improve the member's experience of care. Each registered network provider's lump sum payment shall be determined as follows:

    1. Determine each provider's actual paid amounts for Medicaid state plan FFS utilization of qualifying services from October 1, 2020 to March 31, 2021.
    2. Multiply the actual Medicaid utilization determined in item 1 by two.
    3. The uniform percentage increase for providers will be 17.8%
    4. The Administration will multiply the appropriate uniform percentage increase listed in item three by the total utilization determined in item two to calculate the lump sum payment for each provider.

    AHCCCS will not make any payments to providers that have a total lump sum payment of less than $1,000.

Subsection 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

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).

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:

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

1) For the duration of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), payment for a reserved bed may be made if the absence does not exceed 30 days per contract year. This 30 day limit is cumulative of bed hold days and applies to all age groups. This change does not affect therapeutic leave policy, which remains at 9 cumulative days per contract year.

Payment for reserved beds is subject to all other requirements listed in Attachment 4.19-C.

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.

7.4.A. Rescissions to the State's Disaster Relief Policies for the COVID-19 National Emergency

Effective April 1, 2020, the agency rescinds the election at A.1. of section 7.4 (approved on 4/1/2020 in SPA Number AZ-SPA-20-0001 and approved on 5/22/2020 in SPA Number AZ-SPA-20-0005) of the state plan to furnish medical assistance to the optional eligibility group described at section 1902(a)(10)(A)(ii)(XXIII) of the Social Security Act.