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State/Territory Name: Texas

State Plan Amendment (SPA) #: 21-0029

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages
July 28, 2021

Ms. Stephanie Stephens  
State Medicaid Director  
Texas Health and Human Services Commission  
Mail Code: H100  
Post Office Box 13247  
Austin, Texas 78711

Re: Texas State Plan Amendment (SPA) 21-0029

Dear Ms. Stephens:

We have reviewed the proposed amendment to add section 7.4 Medicaid Disaster Relief for the COVID-19 National Emergency to your Medicaid state plan, as submitted under transmittal number (TN) TX 21-0029. This amendment proposes to implement temporary policies, which are different from those policies and procedures otherwise applied under your Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof).

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 of the 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 this state plan provision will no longer be in effect, upon termination of the public health emergency, including any extensions.

Pursuant to section 1135(b)(5) of the Act, for the period of the public health emergency, CMS is modifying the requirement at 42 C.F.R. 430.20 that the state submit SPAs related to the COVID-19 public health emergency by the final day of the quarter, to obtain a SPA effective date during
the quarter, enabling SPAs submitted after the last day of the quarter to have an effective date in a previous quarter, but no earlier than the effective date of the public health emergency.

The State of Texas also requested a waiver of public notice requirements applicable to the SPA submission process. Pursuant to section 1135(b)(1)(C) of the Act, CMS is waiving public notice requirements applicable to the SPA submission process. Public notice for SPAs is required under 42 C.F.R. §447.205 for changes in statewide methods and standards for setting Medicaid payment rates, 42 C.F.R. §447.57 for changes to premiums and cost sharing, and 42 C.F.R. §440.386 for changes to Alternative Benefit Plans (ABPs). Pursuant to section 1135(b)(1)(C) of the Act, CMS is approving the state’s request to waive these notice requirements otherwise applicable to SPA submissions.

The State of Texas also requested a waiver to modify the tribal consultation timeline applicable to this SPA submission process. Pursuant to section 1135(b)(5) of the Act, CMS is also allowing states to modify the timeframes associated with tribal consultation required under section 1902(a)(73) of the Act, including shortening the number of days before submission or conducting consultation after submission of the SPA.

These waivers or modifications of the requirements related to SPA submission timelines, public notice, and tribal consultation apply only with respect to SPAs that meet the following criteria: (1) the SPA provides or increases beneficiary access to items and services related to COVID-19 (such as by waiving or eliminating cost sharing, increasing payment rates or amending ABPs to add services or providers); (2) the SPA does not restrict or limit payment or services or otherwise burden beneficiaries and providers; and (3) the SPA is temporary, with a specified sunset date that is not later than the last day of the declared COVID-19 public health emergency (or any extension thereof). We nonetheless encourage states to make all relevant information about the SPA available to the public so they are aware of the changes.

We conducted our review of your submittal according to the statutory requirements at section 1902(a) of the Act and implementing regulations. This letter is to inform you that Texas’ Medicaid SPA Transmittal Number 21-0029 is approved effective March 20, 2020. This SPA supersedes the previously approved DR SPA TX 20-0021.

Enclosed is a copy of the CMS-179 summary form and the approved state plan pages.

Please contact Ford Blunt at (214) 767-6381 or by email at Ford.Blunt@cms.hhs.gov if you have any questions about this approval. We appreciate the efforts of you and your staff in responding to the needs of the residents of the State of Texas and the health care community.

Sincerely,

Alissa M. DeBoy
On Behalf of Anne Marie Costello, Deputy Director
Center for Medicaid and CHIP Services

Enclosures
## TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

<table>
<thead>
<tr>
<th>1. TRANSMITTAL NUMBER:</th>
<th>21-0029</th>
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<tbody>
<tr>
<td>2. STATE:</td>
<td>TEXAS</td>
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| 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) |

| 4. PROPOSED EFFECTIVE DATE: | March 20, 2020 |

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<th>5. TYPE OF PLAN MATERIAL (Circle One):</th>
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<tr>
<td>☐ NEW STATE PLAN</td>
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<tr>
<td>☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN</td>
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<td>☒ AMENDMENT</td>
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| COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment) |

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<tr>
<th>6. FEDERAL STATUTE/REGULATION CITATION:</th>
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<td>Section XIX of the Social Security Act</td>
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<th>7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT</th>
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<tbody>
<tr>
<td>a. FFY 2020 $ 0</td>
</tr>
<tr>
<td>b. FFY 2021 $ 596,863</td>
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<tr>
<td>c. FFY 2022 $ 0</td>
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<tr>
<th>8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:</th>
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<tbody>
<tr>
<td>Section 7.4</td>
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<tr>
<th>9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):</th>
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<tbody>
<tr>
<td>Section 7.4 (TX SPA 20-0021)</td>
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<tr>
<th>10. SUBJECT OF AMENDMENT:</th>
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<tbody>
<tr>
<td>To request to pay an intermediate care facility for individuals with an intellectual disability (ICF/IID) to reserve a bed for eligible residents during temporary leaves of absence taken to reduce the risk of COVID-19 transmission. Payment will be made for up to 90 days per resident from March 20, 2020 through March 1, 2021. These payments are in addition to payments for therapeutic and extended therapeutic absences, as described in Attachment 4.19-C. Disaster SPA 20-0021 contains original costs for March 20, 2020 through October 23, 2020. This SPA includes costs to extend the allowable claiming period from October 23, 2020 to March 1, 2021 and language allowing for net profit comparisons in the attestation.</td>
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<tr>
<td>☐ GOVERNOR’S OFFICE REPORTED NO COMMENT</td>
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<tr>
<td>☐ COMMENTS OF GOVERNOR’S OFFICE ENCLOSED</td>
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<tr>
<td>☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL</td>
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<tr>
<th>12. SIGNATURE OF STATE AGENCY OFFICIAL:</th>
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<tr>
<td>Emily Zalkovsky</td>
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<tr>
<th>13. TYPED NAME:</th>
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<tbody>
<tr>
<td>Stephanie Stephens</td>
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<table>
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<tr>
<th>14. TITLE:</th>
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<td>State Medicaid Director</td>
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<td>6-3-21</td>
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<th>16. RETURN TO:</th>
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<tbody>
<tr>
<td>Stephanie Stephens</td>
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State Medicaid Director
Post Office Box 13247, MC: H-100
Austin, Texas 78711

<table>
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<th>17. DATE RECEIVED:</th>
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<th>18. DATE APPROVED:</th>
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<th>19. EFFECTIVE DATE OF APPROVED MATERIAL:</th>
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<tr>
<th>20. SIGNATURE OF REGIONAL OFFICIAL:</th>
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<tr>
<td>Alissa M. DeBoy</td>
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Date: 2021.06.03

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<th>21. TYPED NAME:</th>
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<tbody>
<tr>
<td>Alissa Mooney DeBoy</td>
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<th>22. TITLE:</th>
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<tbody>
<tr>
<td>On Behalf of Anne Marie Costello, Deputy Director Center for Medicaid and CHIP Services</td>
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| 23. REMARKS: |
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.
Effective period for this disaster state plan amendment is March 20, 2020 through March 1, 2021.

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 Texas Medicaid state plan, as described below:

Notification of the proposed SPA will be sent to the federally recognized tribes after the SPA packet is submitted to CMS.

**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.
State/Territory: Texas

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. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:
   
   The agency does not impose any cost-sharing on Medicaid clients.

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.

TN: 21-0029
Supersedes TN: 20-0021

Approval Date: 7/28/21
Effective Date: 3/20/20
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. _____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the state wideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application 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:

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.
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.

   a. _____ Payment increases are targeted based on the following criteria:
b. Payments are increased through:

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

Please describe criteria.

Please describe.

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.

_____ 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:

Please describe.
Payment will be made to eligible providers for reserving beds in an intermediate care facility for individuals with an intellectual disability (ICF/IID) for eligible residents during temporary leaves of absence taken to reduce the risk of COVID-19 transmission. Payment will be made for up to 90 days per resident from March 20, 2020 through March 1, 2021. These payments are in addition to payments for therapeutic and extended therapeutic leave as described in the current state plan Attachment 4.19-C. In order for a provider to receive payment, a resident’s individual program plan must provide for and specify that a temporary leave of absence was taken to reduce the risk of COVID-19 transmission.

To be eligible for the payment described in the preceding paragraph, an ICF/IID provider must acknowledge that payment will be subject to recoupment if a federal or state audit or any other authorized third party review identifies that: (1) inappropriate billing or duplicate payments for services occur; (2) more than one funding stream is used for the same purpose; or (3) the provider’s revenue or net profit for one or more of the quarters of March – May 2020, June – August 2020, September -November 2020; and December 2020-February 2021 was greater than its revenue or net profit, respectively, during the quarter of December 2019 to February 2020 or another pre-pandemic period approved by HHSC. In addition, an ICF/IID provider must attest that it: (1) did not lay off staff who were employed by or contracting with the provider on March 19, 2020; and (2) maintained staff wages at least at the levels that existed on March 19, 2020.

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.