

COVID-19 Frequently Asked Questions (FAQs)
for State Medicaid and Children’s Health Insurance Program (CHIP) Agencies

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I. Emergency Preparedness and Response

1. What resources are available to assist states and territories in their response to COVID-19?

Medicaid and CHIP play a critical role in helping states and territories respond to public health events, as well as natural and human-made disasters. To assist states and territories in their preparedness efforts, the Centers for Medicare & Medicaid Services (CMS) developed a Disaster Preparedness Toolkit that is a longstanding resource that has been available to states and territories on CMS' website, Medicaid.gov. States and territories are encouraged to be familiar with this resource as part of their emergency preparedness planning. The toolkit outlines numerous strategies available to support Medicaid and CHIP operations and enrollees in times of crisis, and serves as a comprehensive disaster preparedness resource for states and territories. Many of the flexibilities described in the toolkit will help states and territories in their response to COVID-19. The toolkit is organized by operational areas, such as eligibility and enrollment, benefits, cost-sharing and provider workforce. The toolkit also outlines the legal authorities available to effectuate various strategies, including flexibilities in current statute, Medicaid and CHIP state plan amendments, section 1915(c) waiver Appendix K, and section 1115 demonstrations. The toolkit also describes authority that may be granted through section 1135 waivers, which are only available when the President declares an emergency or natural disaster under the National Emergencies Act or Stafford Act *and* the Secretary declares a Public Health Emergency Declaration under Section 319 of the Public Health Service Act. The toolkit is available at: <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/index.html>.

2. How can Appendix K support a state's response to COVID-19 for 1915(c) Home and Community-Based Services (HCBS) Waivers?

CMS developed Appendix K of the section 1915(c) waiver application for use by states during emergencies. It describes actions states can take under existing section 1915(c) HCBS waiver authority to respond to an emergency. The appendix may be approved retroactively, as needed, to the date of the event. A completed Appendix K should be submitted for each affected waiver and should be used to advise CMS of expected changes to state waiver operations. Changes may include establishing a hotline, increasing the number of individuals served under a waiver, creating an emergency person-centered service plan, expanding provider qualifications, increasing the pool of providers who can render services, instituting or expanding opportunities for self-direction, and/or permitting payment to HCBS providers when an individual is in a short-term hospital or institutional stay.

Appendix K also provides states with opportunities to:

- temporarily increase individual eligibility cost limits,
- modify service, scope, or coverage requirements,
- exceed service limitations,
- add services to the waiver,
- provide services in out-of-state settings, and/or

- permit payment for services rendered by family caregivers or legally responsible individuals.

A state or territory **may not** include changes in Appendix K that are not permitted by statute, such as the inclusion of room and board costs in non-institutional settings. CMS will work with states and territories to determine what changes may be needed and other key considerations, such as effective dates and impact to other programs.

Please see attached link for instructions and template:

<https://www.medicaid.gov/medicaid/home-community-based-services/downloads/1915c-appendix-k-instructions.pdf> and <https://www.medicaid.gov/medicaid/home-community-based-services/downloads/1915c-appendix-k-template.pdf>

3. What disaster response options do states have for separate CHIP programs?

States that anticipate needing disaster relief flexibilities in CHIP are encouraged to submit a disaster relief state plan amendment (SPA). **This may be submitted in advance of, or in response to, a disaster/public health crisis.** Through a CHIP SPA, states can add flexibilities such as waiving premiums and cost sharing, and extending timeframes for renewals. A CHIP SPA may be effective as early as the first day of the state's fiscal year as long as it is submitted by the end of a state's fiscal year. Please see the attached link for more information: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/childrens-health-insurance-program-chip/downloads/chip_disaster_relief_spa_sample_01102012.pdf

In addition to the disaster relief SPA, states may use CHIP Health Services Initiative (HSI) for additional COVID-19 related activities that are targeted to low-income children. Interested states should consult with CMS regarding the application process and parameters for HSIs.

4. Can states activate their existing CHIP disaster provisions due to a public health emergency such as COVID-19, or is this type of SPA limited to geographically localized natural, environmental, and man-made disasters?

Some states have disaster provisions in their state plan that say that the provisions may be activated up in "Governor or FEMA declared disaster areas." States may activate these disaster provisions in response to the public health emergency. CMS's Disaster Preparedness Toolkit gives examples of natural and human-made disasters such as hurricanes (e.g., Hurricanes Katrina, Maria, Harvey and Irma), wildfires (e.g., California wildfires), flooding (e.g., Hurricane Harvey floods in Texas), and public health emergencies (e.g., Flint, Michigan lead contamination crisis). For the purposes of CHIP disaster relief provisions, CMS deems a significant outbreak of an infectious disease to be a disaster.

To the extent that states have not yet incorporated disaster relief provisions into their CHIP state plans, CMS recommends including a federal or Governor declared emergency as events that can trigger the disaster provisions.

5. What options do states have for obtaining required signatures on SPA submissions, given that current state telework policies may present challenges with obtaining signatures?

Federal regulations at 42 C.F.R. § 430.12 set forth requirements for state plan amendments including the format and when the state plan must be amended. The regulations do not set forth requirements related to signatures on SPA submissions; as such, states have flexibility to utilize different options for signatures on the Form CMS-179, including electronic signature, scanned clearly legible signature, wet signature, and insertion of /s/. States need to ensure that the person “signing” is duly authorized to submit SPAs.

6. Are states granted any flexibilities with regard to public notice, effective dates and the submission of SPAs during the Public Health Emergency (PHE) period?

Yes. A state may request that CMS waive the requirement that a SPA be submitted no later than the last day of the same quarter as the requested effective date of the SPA, waive public notice requirements, and permit the state to modify the tribal consultation timeline, under section 1135 of the Social Security Act (the Act). Section 1135 of the Act allows CMS to permit 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. These flexibilities will be permitted only with respect to SPAs that provide or increase beneficiary access to items and services related to COVID-19 (such as cost sharing waivers, payment rate increases, or amendments to Alternative Benefit Plans (ABPs) to add services or providers) and that would not restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers. There is no waiver of the requirement that states must submit SPAs in order to amend their Medicaid state plan during this period.

For CHIP, states may request to modify their tribal consultation timeline for a disaster relief SPA by requesting a waiver under section 1135 when submitting the SPA. Because states have until the last day of their state fiscal year to submit a CHIP SPA, section 1135 authority is not needed to modify the submission date for CHIP disaster relief SPAs that are submitted by that date. Additionally, CMS does not require public notice of CHIP SPAs, except when they restrict eligibility or benefits under 42 C.F.R. § 457.65, and we do not anticipate that CHIP disaster relief SPAs will be restrictive.

The Medicaid SPA template and instructions for the COVID-19 pandemic and information on CHIP disaster relief SPAs are available at <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/state-plan-flexibilities/index.html>.

7. What are the effective and termination dates for the various Medicaid authorities that assist states with addressing the COVID-19 pandemic?

Effective and termination dates for the various authorities are provided in the table below.

Authority	Effective date	Termination date
Medicaid disaster relief SPA template for the COVID-19 PHE	March 1, 2020 or any later date elected by the state	End of PHE (including any extensions), or any earlier date elected by the state
CHIP disaster SPA (specific to COVID-19 PHE)	Start of state or federally declared emergency	End of PHE (including any extensions)
Appendix K	January 27, 2020 or any later date elected by the state	January 26, 2021 or any earlier date elected by the state
Medicaid and CHIP 1135 Waivers	March 1, 2020	End of PHE (including any extensions)
1115 demonstration to respond to the COVID-19 PHE	March 1, 2020	No later than 60 days after end of PHE (including any extensions)

8. What is the coverage period for the uninsured COVID-19 testing eligibility group, the new optional group authorized by sections 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Social Security Act?

Coverage for this optional Medicaid eligibility group begins no earlier than March 18, 2020, and terminates at the end of the PHE. States that want to take advantage of the 6.2% increase in the Federal Medical Assistance Percentage (FMAP) under section 6008 of the Families First Coronavirus Response Act (FFCRA), Pub L. No. 116-127 (2020) may need to keep this group enrolled until the end of the month in which the PHE period ends in order to comply with the conditions in section 6008(b)(3) of that legislation. However, the limited coverage for which this group is eligible also terminates at the end of the PHE (per statute), so states do not need to provide this group with any coverage after the PHE ends, even if they keep members of this group enrolled in order to comply with section 6008(b)(3) of the FFCRA. States may elect the COVID-19 testing eligibility group by completing the appropriate section of the Medicaid disaster relief SPA template, which can be found here: <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/state-plan-flexibilities/index.html>. The SPA is submitted to the relevant CMS SPA Mailbox for the state.

II. Eligibility and Enrollment

A. Application and Renewal Processing

1. Are there any exceptions to the federal timeliness standards for processing Medicaid and CHIP applications?

Yes. States are excused from meeting the timeliness standards for processing applications due to an administrative or other emergency beyond the agency's control. This would include a public health emergency, like COVID-19, during which workforce shortages may impact the agency's ability to process applications timely and/or impacted individuals may be unable to receive or respond to notices or provide information needed to complete the application process. To exercise this flexibility, a Medicaid SPA is not needed. States relying on a timeliness standard exception on a case-by-case basis must document the reason for the delay in the individual's case record.

States seeking to invoke a timeliness standard exception for a broader cohort of cases (for example, all applications in a defined geographic area) are advised to not only document the exception in the applicant's case record, but also to obtain CMS concurrence that the exception is warranted under the circumstances.

CHIP agencies should submit a disaster relief state plan amendment to utilize flexibilities related to application processing. States that already have a disaster relief state plan amendment that includes flexibilities related to application processing will just need to notify CMS that they are activating this flexibility.

2. Are there any exceptions to the timeliness standards for processing Medicaid and CHIP renewals?

Yes. States have flexibility in meeting the timeliness standards for renewing Medicaid eligibility during an administrative or other emergency beyond the agency's control. This would include a public health emergency, like COVID-19, during which workforce shortages may impact the agency's ability to complete timely renewals and/or impacted individuals may be unable to receive or respond to notices or provide information needed to complete the renewal process. In such cases, the state must continue to furnish Medicaid to eligible beneficiaries until they are determined ineligible.

A state plan amendment for Medicaid is not needed. States relying on a timeliness standard exception on a case-by-case basis must document the reason for the delay in the individual's case record. States seeking to invoke a timeliness standard exception for a broader cohort of cases (for example, all renewals in a defined geographic area) are advised to not only document the exception in the beneficiary's case record, but also to obtain CMS concurrence that the exception is warranted under the circumstances.

CHIP agencies should submit a disaster relief state plan amendment to utilize flexibilities related to redetermination processing. States that already have a disaster relief state plan amendment that includes flexibilities related to redetermination processing will just need to notify CMS that they are activating this flexibility.

3. Can a state extend eligibility for current beneficiaries subject to an emergency or disaster so that they can continue to receive coverage beyond their renewal date, even if no longer eligible?

As described above, states have flexibility in meeting the timeliness standards for renewing Medicaid eligibility during an administrative or other emergency beyond the agency's control. Beyond those flexibilities, for eligibility groups excepted from the modified adjusted gross income (MAGI)-based methodologies, states have the option to renew eligibility once every 12 months or more frequently than once every 12 months. States that have elected to conduct more frequent renewals for MAGI-excepted groups may submit a state plan amendment to extend the renewal period to 12 months.

Under the Medicaid state plan, states can also elect to extend coverage to certain additional individuals statewide by increasing effective income standards (and, for individuals subject to an asset test, resource standards) for some populations and/or adopt an optional eligibility group to cover other populations, when allowable under the statute. A state plan amendment would be needed to do so. However, income and resource standards and eligibility groups in the state plan may not apply narrowly to only those affected by a particular diagnosis, such as COVID-19. CMS is available to provide technical assistance to states seeking to extend coverage to additional populations during a disaster or other emergency.

CHIP agencies may extend eligibility through a disaster relief state plan amendment. States that already have a disaster relief state plan amendment that includes flexibilities related to extending eligibility will just need to notify CMS that they are activating this flexibility.

4. Can states stop acting on changes in circumstances during the COVID-19 public health emergency?

States are required under regulations at 42 C.F.R. § 435.916(d) to promptly redetermine eligibility whenever they receive information about a change in circumstances that may impact eligibility. However, CMS recognizes that the impact of the COVID-19 public health emergency is impacting the ability of state agencies to process changes in circumstances in a timely manner, such that what is considered "prompt" under the current circumstances may be longer than what typically would be expected. States that are unable to promptly process changes in circumstances that may impact eligibility are advised to obtain CMS concurrence that the delay is warranted under the circumstances. States must document the delay in the beneficiary's case record. Alternatively, if a large number of cases are affected and the state can clearly define the cohort of cases for which it seeks CMS' concurrence, CMS will not enforce compliance with the requirement that states document the delay in each case record included in the cohort described. States do not need to make a formal request for CMS concurrence, but may notify via email to the CMS state lead.

Further, in order to qualify for the increased FMAP provided under section 6008(a) of the FFCRA, through the end of the month in which the public health emergency ends, pursuant to section 6008(b)(3) of the FFCRA, states may not terminate individuals enrolled for Medicaid benefits as of March 18, 2020, or determined eligible on or after that date. This includes

continuing coverage for individuals who experience a change in circumstances that impacts eligibility or are determined eligible based on self-attestation for certain criteria, if the state has adopted post-enrollment verification of the criterion. Thus, if a state is able to process a change in circumstances prior to the end of the month in which the public health emergency ends, and determines that a beneficiary no longer meets all eligibility criteria for coverage, the state must postpone taking adverse action until after the end of the month in which the emergency ends in order to qualify for the temporary FMAP increase. See also Families First Coronavirus Response Act – Increased FMAP FAQ B.6, available at <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf>.

5. Are there exceptions to the requirement to obtain application signatures for individuals applying for Medicaid or CHIP during the public health emergency?

No. Regulations at 42 C.F.R. § 435.907 require that all applications must be signed under penalty of perjury by the applicant, an adult who is in the applicant's household or family, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant. States must accept electronic, including telephonically recorded, signatures and handwritten signatures. A record of the application signature must be stored in the individual's account. There is no flexibility to accept an application without the required signature. Without a signature, the application form is not considered a completed application for state processing.

6. Is there any flexibility with respect to requirements to obtain an applicant's signature when an individual is applying with the help of a third-party individual who is providing assistance by phone?

Consistent with regulations at 42 C.F.R. §§ 435.907(f) and 457.330, all initial applications for Medicaid and CHIP must be signed under penalty of perjury. Individuals may receive help from others, including certified application assisters under 42 C.F.R. § 435.908, Exchange Navigators, or authorized representatives, to complete an application for Medicaid or CHIP. While these types of assisters typically provide in-person assistance with applications, CMS recognizes that such assistance may need to be provided by phone during the current public health emergency if offices or other locations are closed or otherwise to minimize in-person contact. If an assister or other individual is completing and submitting an online application on behalf of an applicant, based on information the applicant has provided by phone, for the period of the emergency and subject to state law, the applicant may designate that individual be an authorized representative with limited authority to sign and submit the application on behalf of the applicant. Due to the public health emergency posed by COVID-19 and the urgent need to avoid transmission of COVID-19, for the duration of the COVID-19 public health emergency, CMS will not enforce compliance with requirements at § 435.923(a)(1) that designation of an authorized representative must be signed by the applicant or enrollee, and submitted to the state agency, provided that applicants provide authorization for an assister or other individual to be their authorized representative orally, in writing, or both. A record of such authorization must be submitted by the authorized representative, along with the application. The agency must accept such authorization through any of the available modalities described at § 435.907(a) and must include the record in the applicant's account held by the state Medicaid agency. Assistors or other individuals acting as authorized representatives in these circumstances must also abide by confidentiality and

conflict of interest requirements set out in regulation at 42 C.F.R. §§ 435.908(c) and 435.923(e), 45 C.F.R. §§ 155.210(d), 155.225(g)(2), 155.227, and 155.260, and the legal instrument establishing the assister's relationship with the Exchange or authorized representative's role with respect to the Exchange. We believe that this guidance is a statement of agency policy not subject to the notice and comment requirements of the Administrative Procedure Act (APA). 5 U.S.C. § 553(b)(A). For the same reasons explained above, in light of the PHE and the urgent importance of reducing the potential for transmission of COVID-19 through the authorization process, CMS additionally finds that, even if this guidance were subject to the public participation provisions of the APA, prior notice and comment for this guidance is impracticable, and there is good cause to issue this guidance without prior public comment and without a delayed effective date. 5 U.S.C. § 553(b)(B) & (d)(3).

As discussed above, assisters and other individuals serving as an authorized representative must obtain and record authorization from individuals to submit applications on behalf of the applicants they are helping. Options to do so can be found in the Federally Facilitated Marketplace's guidance for assisters on "How to Obtain a Consumer's Authorization before Gaining Access to Personally Identifiable Information (PII)" linked here:

<https://marketplace.cms.gov/technical-assistance-resources/obtain-consumer-authorization.pdf>.

Note that while Navigators are not prohibited from serving as authorized representatives under federal regulations, acting in this manner is not part of the duties and responsibilities of a Navigator. Therefore, service as an authorized representative by a Navigator must be as a private individual, separate from their Navigator duties, and cannot be funded using Navigator grant funds.

7. Can states consider all individuals with a COVID-19 diagnosis to be incapacitated for purposes of allowing a hospital worker to complete and sign a Medicaid or CHIP application on their behalf?

No. States must follow their state laws regarding determinations of capacity. If an individual is incapacitated, regulations permit a court appointed legal guardian or someone acting responsibly for the individual to apply on his or her behalf. However, this authority does not extend to organizations unless those organizations are a duly appointed guardian or other legal agent. Further, anyone acting on behalf of another person must have sufficient knowledge of the individual to provide accurate responses to application questions and attest to their veracity and must abide by confidentiality and conflict of interest requirements.

8. Can states in which the Federally-Facilitated Exchange (FFE) assesses potential eligibility for Medicaid or CHIP ("assessment states") temporarily accept the FFE assessments as final determinations of eligibility?

Yes. Per regulations at 42 C.F.R. § 435.1200(d)(4), assessment states have flexibility to accept findings from the FFE as final MAGI determinations and enroll individuals into coverage without additional verification if all eligibility criteria have been verified by the FFE. States will need to complete verification to determine eligibility for individuals for whom not all factors of eligibility have been verified by the FFE (i.e., the FFE has not resolved a discrepancy between

attested information and electronic data). No additional or express authority from CMS is needed.

B. Premiums and Cost-Sharing

1. What authority is available to not charge copayments during a public health emergency?

If a state wishes to stop charging copayments for particular items or services in Medicaid (e.g., doctor visits or inpatient hospital services), the state can submit a SPA. However, exempting individuals from copayments cannot be applied narrowly to only those affected by a particular diagnosis, such as COVID-19. Rather, a copayment exemption under the state plan would need to apply to everyone who accesses a particular item or service. Alternatively, the state could request section 1115 authority to temporarily suspend copayments only for individuals needing treatment for COVID-19 infection.

States can stop charging copayments for particular items or services in CHIP through a CHIP disaster relief SPA.

2. Can states suspend Medicaid and CHIP premiums and CHIP premium lockout requirements for enrollees affected by a disaster or public health emergency?

Yes. States can suspend premiums for the duration of the COVID-19 public health emergency. States can effectuate such a suspension, and other cost-sharing requirements, for the duration of the COVID-19 public health emergency through the Medicaid Disaster Relief for the COVID-19 National Emergency State Plan Amendment template available here <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/state-plan-flexibilities/index.html>. States can also use the Disaster Relief State Plan Amendment to suspend termination of eligibility for failure to pay premiums.

Even if a state does not suspend Medicaid and CHIP premiums, we note that in order to be eligible for the temporary FMAP increase under section 6008 of the FFCRA, states cannot disenroll Medicaid beneficiaries for failure to pay premiums. Section 6008(b)(2) of the FFCRA, as amended by section 3720 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, places additional restrictions on states' ability to increase premiums after January 1, 2020 in order to qualify for the temporary FMAP increase.

States may also waive premiums for CHIP enrollees, as well as premium lockout requirements for families impacted by a disaster or public health emergency. To waive CHIP premiums, states must submit a CHIP SPA. To waive premium lockout requirements, states must submit an updated CS21 SPA.

3. Can a state waive cost sharing for fee-for-service enrollees while maintaining cost sharing for managed care enrollees?

No. A state cannot waive copays for beneficiaries based on how they are furnished services (e.g., on a fee-for-service basis versus through enrollment in a managed care organization) under the state plan.

4. For states seeking to claim temporary increased FMAP, can states bill for premiums during the emergency period?

Yes. States may still charge premiums during the emergency period without violating section 6008(b)(2) of the FFCRA. However, a state may not terminate beneficiaries' eligibility or coverage due to unpaid premiums during the emergency period or terminate individuals' eligibility or coverage due to non-payment of premiums incurred during the PHE after the expiration of the emergency period. As discussed in Question F.22 of the FFCRA-CARES Act FAQs, available at <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-CARES-faqs.pdf>, states seeking to claim temporary increased FMAP may not terminate individuals' eligibility or coverage for failure to pay those premiums.

Effective the month in which the emergency ends, a state may resume implementation of its premium policy under 42 C.F.R. § 447.55(b)(2), which allows for termination after 60 days of non-payment. While states cannot terminate beneficiaries' eligibility or coverage following the end of the PHE for unpaid premiums accumulated during the PHE, states can terminate beneficiaries for unpaid premiums incurred prior to the PHE. To implement this termination, states would not be able to count the PHE time period as part of the 60 days of non-payment and states would have to provide beneficiaries with advance written notice of the termination (see 42 C.F.R. §§ 435.917 and 431.206–.214) and provide fair hearing rights (see 42 CFR § 431.220(a)).

5. Does section 6008 of the FFCRA prohibit states from increasing premium amounts on any beneficiary even when his/her income increases during the public health emergency and his/her premiums are supposed to be charged on a sliding scale basis?

Yes. Section 6008(b)(2) of the FFCRA requires states to maintain premiums at the same or lower level as assessed on January 1, 2020 for any beneficiary.¹ If a beneficiary reports an increase in income that would result in a higher premium after January 1, 2020, then assuming the individual still has an increase in income at the end of the public health emergency, the earliest date that a state could assess the increased premium would be the first day of the month following the end of the calendar quarter in which the public health emergency ends.

C. Eligibility

1. For the working disability eligibility groups, can states suspend the requirement that eligible individuals be receiving earned income?

¹ Pursuant to section 6008(d) of the FFCRA, as added by section 3720 of the Coronavirus Aid, Relief, and Economic Security Act, P.L. 116-136, if a state imposed a premium higher than any in effect on January 1, 2020, during the 30-day period beginning on March 18, 2020, CMS will not find a state ineligible for the temporary FMAP increase on this basis.

No. Receipt of earned income is an eligibility requirement for the working disability groups described in sections 1902(a)(10)(A)(ii)(XIII) of the Act (the “Work Incentives” group), and sections 1902(a)(10)(A)(ii)(XV) and 1902(a)(10)(A)(ii)(XVI) of the Act (respectively, the Ticket to Work and Work Incentives Act (TWWIA) “Basic” and “Medically Improved” groups). However, we note that states seeking to claim the 6.2 percent FMAP increase under section 6008 of the FFCRA must continue to treat as eligible for benefits individuals who were receiving coverage under a working disability group as of March 18, 2020 (or determined eligible for such a group after that date) through the end of the month in which the public health emergency ends, even if the individual ceases to have earned income.

2. Can a state consider an individual who is diagnosed with COVID-19 to meet the disability requirement for Medicaid eligibility?

In making disability determinations, a state must generally use the same definition of disability as used for supplemental security income (SSI). A positive diagnosis for COVID-19 is not a *per se* disability under SSI criteria and therefore cannot be the sole basis of a determination of disability for purposes of Medicaid eligibility.

3. Can states accept self-attestation to verify incurred medical expenses for purposes of determining eligibility for coverage in a “209(b) state” or medically needy coverage when income exceeds the applicable income standard, as described in 42 C.F.R. § 435.121(e) and 42 C.F.R. § 435.831(d).

States can permit individuals, consistent with 42 C.F.R. § 435.945, to self-attest to the amounts of their incurred medical expenses. This would allow individuals to avoid the collection and submission of documentation of their incurred medical expenses. States can permit this on a temporary basis through the end of the public health emergency. States would be expected to document such a change in the state's internal policies and procedures, along with the period for which such changes will be in effect.

Alternatively, states can adopt an income disregard under the authority of section 1902(r)(2) of the Act for individuals who must incur medical expenses in order to establish financial eligibility equal to the difference between the individual's countable income and the applicable income standard. This would have the effect of eliminating the requirement that these individuals collect and submit evidence of their incurred expenses. States can make this election in their disaster relief SPA such that the disregard only lasts for the period of the emergency.

4. Can a state apply income or resource disregards to medically needy individuals, or individuals seeking eligibility in other groups, who require testing for COVID-19, and/or who test positive for COVID-19?

States may not target income and/or resource disregards that are otherwise authorized under section 1902(r)(2) of the Act at individuals based on either their medical conditions or their need for particular medical services. States may, however, target disregards based on particular types of expenses. For example, states could disregard from income the cost of an individual's incurred COVID-19 testing, or incurred COVID-19-related treatment.

5. Can a state allow for self-attestation or alternative verification of individuals' level of care when meeting a level of care need is an element of underlying eligibility?

For the eligibility group described at section 1902(e)(3) of the Act and 42 C.F.R. § 435.225 (sometimes referred to as the “Katie Beckett” group), states may accept self-attestation of the individual’s level-of-care need. However, for the eligibility groups described at sections 1902(a)(10)(A)(ii)(VI) and (XXII) of the Act, and, respectively, 42 C.F.R. §§ 435.217 and 435.219, states may not accept self-attestation of level-of-care need. The methods of the level-of-care determinations inherent to these groups are dictated by regulations outside the scope of Medicaid’s eligibility regulations.

6. Do managed care plans have the option to discontinue the mailing of notices and other documents to enrollees, and utilize only phone and email notices, for a period of 45 days or longer to prevent spread of COVID-19 on the physical documents?

We note that the Centers for Disease Control and Prevention (CDC) and United States Postal Service (USPS) guidance indicates that there is no evidence COVID-19 is spreading through US mail. See <https://www.cdc.gov/coronavirus/2019-ncov/faq.html> and <https://about.usps.com/newsroom/statements/usps-statement-on-coronavirus.htm>. Therefore, we do not believe it necessary or appropriate to discontinue mailing all hard copy documents to enrollees. However, states and managed care plans have several options that can reduce the number of hard copy documents that are mailed. For public documents such as provider directories and enrollee handbooks, 42 C.F.R. § 438.10(c)(6) provides the criteria for the provision of required materials in electronic form. For notice of adverse benefit determinations which contain protected health information and are critical to enrollees receiving services, managed care plans can offer enrollees the option to elect to receive such notices electronically. This option can be promoted by including an explanation of the option and a link in each written document or in an email or text specifically to advertise the option. Managed care plan staff communicating with enrollees by phone can facilitate the use of this option by requesting email addresses from enrollees. The use of electronic communication is at the option of the enrollee and, consistent with 42 C.F.R. § 438.10(c)(6)(v), an enrollee must be informed that they may request information in paper form and without charge upon request. Additionally, all provisions of 42 C.F.R. § 438.10(d) apply to electronic communications.

7. Do states have the option to discontinue the mailing of hard copy notices to beneficiaries, and utilize only phone and email notices, for a period of 45 days or longer to prevent spread of COVID-19 on the physical documents?

We note that CDC and USPS guidance indicates that there is no evidence COVID-19 is spreading through US mail. See <https://www.cdc.gov/coronavirus/2019-ncov/faq.html> and <https://about.usps.com/newsroom/statements/usps-statement-on-coronavirus.htm>. Accordingly, we do not believe it necessary or appropriate for state Medicaid agencies to discontinue mailing hard copy notices to beneficiaries. Unless a beneficiary elects to receive communications from the state Medicaid or CHIP agency electronically, the state must provide communications by regular mail (see 42 C.F.R. §§ 435.918 and 457.110). Even if a beneficiary elects to receive

electronic notices, the beneficiary has the right to change his or her election from electronic to regular mail (42 C.F.R. § 435.918(b)(2)) and may request that any notice posted to the individual's electronic account also be provided through regular mail (42 C.F.R. § 435.918(b)(6)). Even in cases where a beneficiary does not elect to receive electronic notices, states have the option to post an electronic version of the notice to the beneficiary's electronic account, in addition to mailing a paper notice. This strategy may be appropriate when a beneficiary's whereabouts are unknown.

D. Notice and Fair Hearings

1. What flexibilities are available for Medicaid fair hearings?

In a disaster or public health emergency, there are several state fair hearing flexibilities states may utilize under current regulations. States may:

- Suspend adverse actions for individuals for whom the state has completed a determination but either: (1) has not yet sent the notice; or (2) who the state believes likely did not receive the notice. This is consistent with 42 C.F.R. § 431.211, which requires the state to provide at least 10-days advance notice before taking adverse action. See also Families First Coronavirus Response Act – Increased FMAP FAQ B.9 regarding the provision of continuous coverage during the emergency period as a condition for receiving the increased FMAP under that Act.
- Delay scheduling fair hearings and issuing fair hearing decisions under 42 C.F.R. § 431.244(f)(4)(i)(B), which allows states to delay taking final administrative action when there is an emergency beyond the state's control. States should prioritize completing hearings that meet the standard for an expedited fair hearing under 42 C.F.R. § 431.224. States may offer to continue benefits to individuals who are requesting a fair hearing if the request comes later than the date of the action under 42 C.F.R. § 431.230.
- Hold fair hearings via video conferencing or telephone, provided states adhere to other fair hearing requirements (42 C.F.R. part 431, subpart E), including ensuring that the hearing system is accessible to persons who are limited English proficient and persons who have disabilities (see 42 C.F.R. §§ 431.205(e) and 435.905(b)).
- Reinstate services or eligibility if discontinued because the beneficiary's whereabouts were unknown due to displacement, after the beneficiary's whereabouts become known (if still eligible), consistent with 42 C.F.R. § 431.231(d).

States using any of these flexibilities should seek concurrence from CMS. A formal request is not necessary, and can simply be sought by email to the CMS state lead. States should also maintain appropriate documentation in accordance with the state's record keeping practices. Delays in fair hearings must also be documented in each case file.

2. Can states allow individuals additional time to request a fair hearing?

Yes. States may request a waiver under section 1135 authority to allow beneficiaries and applicants to have more than 90 days to request a fair hearing for eligibility or fee-for-service appeals. In March 2020, CMS created a Medicaid & CHIP checklist for section 1135 waivers to

assist states during public health emergencies, which is available here:

<https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/section-1135-waiver-flexibilities/index.html>. The timeframe in 42 C.F.R. § 431.221(d) provides that states can choose a reasonable timeframe for individuals to request a fair hearing not to exceed 90 days for eligibility or fee-for-service appeals.

3. Do states have flexibility in fair hearing timelines in response to a disaster or public health emergency?

Yes. States must take final administrative action on a fair hearing request within the timelines described at 42 C.F.R. § 431.244(f), except in unusual circumstances, which may include an administrative or other emergency beyond the agency's control. States may extend the timelines for both Medicaid fair hearings and CHIP reviews in such circumstances. For CHIP, states should include such an extension in a CHIP SPA. For Medicaid, a SPA is not needed. However, states should seek concurrence from CMS that the hearings for which the state may exceed the time generally permitted for taking final administrative action is reasonable. A formal request is not necessary, and can simply be sought by email to the CMS state lead.

4. Can CMS provide a clarification to their previous answer in Question D.1. concerning what flexibilities are available for Medicaid fair hearings related to delaying of scheduling of fair hearings, issuing hearing decisions, and taking certain adverse actions?

In FAQs issued on April 2, and republished in the "COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies" on May 5, we provided four flexibilities for fair hearings and adverse actions that can be utilized during the PHE and indicated that states should request concurrence if utilizing such flexibilities. We are revising the information related to flexibilities for fair hearings below to clarify that states may implement two of these policies without a request for concurrence from CMS: 1) holding fair hearings via video conference or telephone; and 2) reinstating services or eligibility if discontinued because the beneficiary's whereabouts are unknown due to displacement, after the beneficiary's whereabouts become known. States may implement these policies consistent with current regulations without any additional authority (see Questions D.5. and D.6., below).

In a disaster or public health emergency, states may take the following actions with respect to state fair hearings and adverse actions under current regulations:

- Delay taking final administrative action, which could include scheduling fair hearings and issuing fair hearing decisions, due to an emergency beyond the state's control, consistent with 42 C.F.R. § 431.244(f)(4)(i)(B). States should prioritize completing hearings for individuals who meet the standard for an expedited fair hearing under 42 C.F.R. § 431.224.
- Suspend adverse actions for individuals for whom the state has completed a determination but either: (1) has not yet sent the notice; or (2) who the state believes likely did not receive the notice. This is consistent with 42 C.F.R. § 431.211, which requires the state to provide at least 10-days advance notice before taking an adverse action. We note that if the state is claiming the temporary FMAP increase under section 6008 of the FFCRA, the state will need to continue to provide coverage to beneficiaries

receiving coverage as of or after March 18, 2020 through the end of the month in which the PHE ends, whether or not the state has sent an adverse action notice and/or the individual has received such notice. For additional information on continuing coverage, see FAQ II.I regarding Continuing Coverage under section 6008 of the Families First Coronavirus Response Act in the “COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children’s Health Insurance Program (CHIP) Agencies,” published May 5, 2020.

States seeking to invoke an exception to the fair hearing timeframe standard or suspend adverse actions when a state has not sent notice or has reason to believe individuals have not received notice for a broad cohort of cases are advised to obtain concurrence from CMS that the exception is warranted under the circumstances. A formal request is not necessary, and can simply be sought by email to the CMS state lead. The reason for any delay in fair hearings must also be documented in the appellant’s record, in accordance with 42 C.F.R. § 431.244(f)(4)(ii).

5. Can states hold fair hearings via video conferencing or telephone during a disaster or public health emergency?

Yes. State fair hearing regulations at 42 C.F.R. Part 431, Subpart E do not require that states provide fair hearings in a particular manner (e.g., in person). Therefore, states can hold fair hearings via video conference or telephone at any time, including during a disaster or public health emergency without additional authority from CMS. Regardless of how hearings are conducted, states must ensure compliance with all fair hearing requirements (see 42 C.F.R. Part 431, Subpart E), including ensuring that the hearing system is accessible to persons who are limited English proficient and persons who have disabilities (see 42 C.F.R. §§ 431.205(e) and 435.905(b)). This includes providing auxiliary aids and services without charge upon request to address the effective communication needs of individuals with disabilities. States should maintain appropriate documentation regarding any policy and procedural changes to the state’s fair hearing process in accordance with the state’s policies.

If a state elects to hold all hearings via video conferencing or over the phone and an individual cannot participate in the hearing as a result of not having access to the tools needed to participate in such a hearing (e.g., computer or internet access) the state may not take final administrative action. The individual must be able to fully participate in the fair hearing process (42 C.F.R. § 431.242) and a state may then delay taking final administrative action beyond the time otherwise permitted under the regulations to accommodate the individual’s need for delay until an in person hearing can be conducted (42 C.F.R. § 431.244(f)(4)(i)(A)).

6. Should states reinstate services discontinued due to a beneficiary’s whereabouts being unknown?

Yes. Consistent with 42 C.F.R. § 431.231(d), states must reinstate services that were discontinued due to the beneficiary’s whereabouts being unknown if the beneficiary’s whereabouts become known prior to the beneficiary’s next regular renewal under 42 C.F.R. § 435.916. Note that this requirement applies whenever a beneficiary’s whereabouts are unknown; it is not limited to situations in which there is an administrative or other emergency beyond the

agency's control. No additional or express authority or concurrence is needed from CMS to implement this requirement.

7. Do states need to provide notice of reinstatement to beneficiaries whose Medicaid benefits were reinstated in order to comply with the terms of section 6008(b)(3) of the FFCRA?

Yes, states must provide notice to beneficiaries whose Medicaid benefits are reinstated. Under 42 C.F.R. § 435.917(a) states must provide written notice (including through electronic notices in accordance with 42 C.F.R. § 435.918) to all applicants and beneficiaries of any decision affecting their eligibility.

8. Will the receipt of testing or treatment for COVID-19 paid for by Medicaid or CHIP be considered a negative factor in a public charge determination?

No. U.S. Citizenship and Immigration Services (USCIS) has stated that it will not consider testing, treatment, or preventative care services (including vaccines, if a vaccine becomes available) related to COVID-19 as part of a public charge inadmissibility determination, even if such services are provided or paid for by public benefits as defined in DHS regulations at 8 C.F.R. §212.21(b), including Medicaid. See USCIS's website for more detail at <https://www.uscis.gov/greencard/public-charge>.

CHIP is not considered a public benefit for purposes of a public charge inadmissibility determination. Thus, testing or treatment for COVID-19 provided for or paid for by CHIP will also not be considered in a public charge determination.

States are encouraged to provide the information above to noncitizen applicants and beneficiaries so they have the information necessary to make decisions regarding testing and treatment for COVID-19. For additional information, about the Public Charge Final Rule issued on August 14, 2019, including policy related to COVID-19 testing, treatment or preventative services, states may refer individuals to USCIS's website at <https://www.uscis.gov/greencard/public-charge>.

E. Presumptive Eligibility

1. Can a state designate itself as a presumptive eligibility (PE) qualified entity to presumptively enroll individuals?

Yes. A qualified entity is an entity that is determined by the state to be capable of making PE determinations for eligibility groups based on MAGI, as authorized under sections 1920, 1920A, 1920B, and 1920C of the Social Security Act and 42 C.F.R. Part 435 Subpart L. A state agency may designate itself as well as a county or another local agency as a qualified entity. To elect this option, the state must submit a SPA and indicate the eligibility groups for which the agency or agencies will determine PE. States can do so through the Medicaid disaster relief SPA template, which can be found here: <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/state-plan-flexibilities/index.html>. Unlike for hospital presumptive eligibility (under section 1902(a)(47)(B) of the Act and 42 C.F.R. § 435.1110), states cannot designate a state agency as a qualified entity to make PE determinations for non-MAGI eligibility groups, which

includes the new Medicaid COVID-19 testing group. For technology to support eligibility and enrollment for presumptive eligibility qualified entities, 42 C.F.R. Part 433, Subpart C would apply.

2. Can states expand the eligibility groups for which hospitals can make PE determinations to include individuals who are in a hospital waiting for nursing home or long-term care placement?

Yes. Under Hospital Presumptive Eligibility (HPE), states must permit hospitals to make PE determinations for parents and caretaker relatives, children, pregnant women, and former foster care children, adults (in states that have adopted the adult group), individuals eligible for family planning services (if covered by the state), and individuals needing treatment for breast or cervical cancer (if covered by the state.) However, states have the authority to add additional Medicaid eligibility groups or populations (if covered by the state) to their HPE program. This includes eligibility groups based on being age 65 or older, having blindness or a disability, or being medically needy (ex., eligibility group for individuals in institutions eligible under a special income level). States may also permit hospitals to make PE determinations for demonstration populations covered under section 1115 authority. Participating hospitals must meet the state's qualification requirements and comply with the procedures and standards established by the state. CMS is available to provide technical assistance on the SPA changes needed to expand HPE to these and other eligibility groups.

3. Must a state apply the transfer-of-assets rules to institutionalized individuals receiving coverage during a presumptive eligibility period following a determination of presumptive eligibility made by a hospital in accordance with section 1902(a)(47)(B) of the Act and 42 C.F.R. § 435.1110((c)(2))?

States may not apply the transfer-of-asset rules against institutionalized individuals who are receiving services during a presumptive eligibility period and have not yet submitted a Medicaid application. Under section 1917(c)(1) of the Act, the transfer-of-asset rules are not implicated unless and until an individual has actually applied for medical assistance under the state plan.

4. If a state elects to permit hospitals to make presumptive eligibility determinations for institutionalized individuals, can the state apply the post-eligibility treatment-of-income (PETI) rules during a period of hospital presumptive eligibility?

Yes. States electing to permit hospitals to make PE determinations for coverage under an eligibility group subject to PETI rules have the option either to apply or not to apply the PETI rules set forth in the statute or regulations during the presumptive eligibility period. The applicable PETI rules include those under section 1924 of the Act for an "institutionalized spouse" who has been or is anticipated to be institutionalized for 30 days or more; 42 C.F.R. Part 435 Subpart H for other categorically needy individuals to whom the PETI rules apply; or 42 C.F.R. § 435.832 for the PETI rules that apply to medically needy individuals.

States electing to apply the PETI rules to an individual during a presumptive eligibility period under 42 C.F.R. § 435.1110 must provide clear instructions to hospitals on the specific questions

the hospital must ask in making a reasonable estimate of the individual's total income and deductions.

If the individual is subsequently not enrolled in Medicaid beyond the PE period, either because the individual did not submit an application for Medicaid prior to the end of the month following the month in which the PE determination was made, or the individual submitted an application but was determined to be ineligible for Medicaid, and the state determines, based on a regular application, that the PE income determination by the hospital was too high, the state must adjust its payment to the institution for the coverage provided during the PE period. If the state determines that the hospital underestimated the individual's income, the state may not adjust the payment to the institution, because such an adjustment would constitute a retroactive reduction in the individual's medical assistance, which is not permitted. FAQ #B.8 of the Families First Coronavirus Response Act – Increased FMAP FAQs found here <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf> explains that individuals who have been determined presumptively eligible for Medicaid, but who are not later determined eligible based on a regular Medicaid application, are not subject to the requirements for continuous coverage described under section 6008 of the FFCRA.

5. Can states change their hospital PE performance standards?

Yes. States have flexibility under regulations at 42 C.F.R. § 435.1110(d) to establish state-specific performance standards, which can be changed by the state for the duration of the public health emergency. States seeking to temporarily revise the performance standards for participating hospitals can do so through the Medicaid disaster relief SPA template available at: <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/state-plan-flexibilities/index.html>.

6. May states allow qualified hospitals to process HPE applications by phone or through online portals?

Yes. States have flexibility in the procedures to be used by hospitals making PE determinations as long as they establish a standardized process for hospitals to follow. States can direct hospitals to use a written application, a verbal screening tool (for use in person or by phone), a secure online portal, or any combination of these processes. Whichever process is used, the hospital is responsible for collecting and recording all information necessary to make a PE determination. States choosing to add new modalities for hospitals to collect information needed to make a PE determination will need to update their HPE program materials (provider training and procedures guides) to reflect the state's HPE application options.

7. Can hospitals make PE determinations for individuals who are not patients of the hospital?

Yes. HPE determinations under section 1902(a)(47)(B) of the Act and 42 C.F.R. § 435.1110 are not limited to patients of the hospital. Hospitals can assist with PE determinations for family members and may also presumptively determine eligibility for individuals from the broader community.

8. Are states required to monitor hospital performance for hospitals making PE determinations during the COVID-19 public health emergency?

States are expected to exercise appropriate oversight of all qualified entities making presumptive eligibility determinations, including hospitals, to ensure that PE determinations are being made consistent with the statute and regulations. See 42 C.F.R. § 435.1110(a), incorporating by cross reference 42 C.F.R. § 435.1102, including § 435.1102(b)(3). During the emergency period, states may choose to modify any performance standards for use in their HPE program, but may not eliminate HPE oversight. States should continue to collect data on hospital performance to fulfill their oversight responsibilities to ensure proper administration of HPE.

9. Can states use hospital presumptive eligibility (HPE) to determine eligibility for individuals seeking coverage on the basis of a disability?

States may be able to help expedite provision of medical assistance to applicants who must meet a disability test through extension of hospital presumptive eligibility to populations excepted from modified adjusted gross income (MAGI) methodologies. See COVID-19 FAQs for State Medicaid and Children’s Health Insurance Program (CHIP) Agencies, updated May 5, 2020, FAQ II.E., for additional information related to presumptive eligibility (PE). The requirements for continuous coverage under section 6008(b)(3) of the Families First Coronavirus Response Act do not apply to individuals receiving coverage during a presumptive eligibility period. Coverage for individuals receiving coverage during a presumptive eligibility period ends for individuals who do not timely submit a full Medicaid application or who are determined not eligible based on submission of a full application. See COVID-19 FAQs on implementation of Section 6008 of the Families First Coronavirus Response Act, updated April 13, 2020, Question B.8, available at <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf>, for additional information on the requirements for continuous coverage for individuals in a presumptive eligibility period.

F. Verification

1. Can states modify their verification policies to support ongoing eligibility and enrollment during a disaster or public health emergency?

States may modify their verification policies to use attestation for eligibility factors, if permitted under the statute; to adopt post-eligibility verification; or to change their reasonable compatibility standard for verification of income. States can make these changes through an update to their verification plan, or by submitting an addendum to their verification plan of policies to be in effect during a public health emergency or other disaster. CMS has developed a template which states interested in submitting a “disaster relief addendum” can use, available at <https://www.medicaid.gov/medicaid/eligibility/downloads/magi-based-verification-plan-addendum-template.docx>. States submit updated verification plans to CMS, but CMS approval is not required prior to implementing a change in a state’s verification processes. For CHIP, states must document in their disaster relief SPA that they will be temporarily modifying verification procedures.

2. Can states enroll applicants in Medicaid and CHIP based on self-attested information?

States are generally able to begin furnishing Medicaid or CHIP benefits to many applicants based on self-attested information and then follow up with required verification following the individual's affirmative eligibility determination and enrollment, as described in more detail below. States may elect such "post-enrollment verification processes" for the duration of the PHE by using the disaster-related verification plan addendum discussed in FAQ # II.F.7. States should be advised, however, that once an individual is enrolled for benefits in the state's Medicaid program, the state must continue to furnish benefits through the end of the month in which the public health emergency ends, even if the post-eligibility verification processes establishes that the individual does not meet all eligibility requirements—except for ineligibility due to residency—in order to claim the temporary FMAP increase available under section 6008(b)(3) of the FFCRA.

Eligibility criteria that can be verified using attested information only. Consistent with regulations at 42 C.F.R. § 435.945(a), states have flexibility to accept self-attestation of the following eligibility criteria: age or date of birth, state residency, and household composition. Per 42 C.F.R. § 435.956(e), states must accept self-attestation of pregnancy, unless the state has information that is not reasonably compatible with the attestation. A state that currently requires additional verification for age, state residency or household composition can revise its verification procedures for the duration of the public health emergency. CMS has developed a disaster-related verification plan addendum which states can use for this purpose.

Financial eligibility criteria. The statute and regulations require that states access certain data sources in verifying financial eligibility for Medicaid. Sections 1137 and 1902(a)(46)(B) of the Act and implementing regulations at 42 C.F.R. § 435.948 require that states access information from certain other agencies and data sources to the extent the state determines the information useful to verifying financial eligibility. For individuals excepted from MAGI-based methodologies and subject to an asset test, section 1940 of the Act requires that states verify assets using the state's Asset Verification System. While states are required to comply with these requirements, states can do so within a reasonable period of time after an individual has been determined eligible for Medicaid and is enrolled for benefits. Additional information on conducting post-enrollment verification of income and assets for Medicaid as well as changes which states are permitted to make to their financial verification processes is found in FAQs # II.F.3-5. For CHIP, there is no asset test, and per 42 C.F.R. § 457.380(d), states have flexibility to either accept self-attestation of income or to follow Medicaid verification policies and processes.

Citizenship and immigration status. Provision of Medicaid and CHIP benefits pending verification of an individual's declaration of citizenship or satisfactory immigration status is addressed directly in the statute and regulations. Sections 1902(ee), 1903(x), 1137(d) and 2105 of the Act, and implementing regulations at 42 C.F.R. §§ 435.406, 435.956 and 457.380, require that states provide benefits during a 90-day reasonable opportunity period (ROP) to individuals with U.S. citizenship or satisfactory immigration status, based on their declaration, if the state is unable to promptly verify the citizenship or satisfactory immigration status and the individual meets all other eligibility requirements. Consistent with the information provided in these FAQs,

for purposes of providing benefits during the ROP, states can rely on self-attested information for other eligibility criteria, and then follow up with required verification following the initial provision of benefits.

3. When are states required to conduct post enrollment verification?

States are required to conduct post-enrollment verification when (1) the statute requires that states access specific data in verifying eligibility, but does not require that the data be accessed prior to a determination of eligibility (e.g., certain income data described in section 1137 of the Act); and (2) the state has elected to make an initial eligibility determination at initial application based on self-attested information and to conduct the required verification following the individual's enrollment in coverage.

For verification processes not required under the statute but adopted by the state in its verification plan (such as requiring proof of self-employment income), states also can elect to make a determination of eligibility based on attested information and complete these state verification processes post enrollment. See FAQ # II.F.7. regarding documentation of state verification policies.

Whenever a state has elected to conduct post enrollment verification, it must complete such processes as expeditiously as possible and within a reasonable timeframe following the initial determination of eligibility. CMS recognizes that due to workforce limitations and other operational challenges during the COVID-19 emergency, states may be unable to complete post-enrollment verification as expeditiously as typically would be expected. Further, we remind states that states seeking to claim the temporary FMAP increase under section 6008 of the FFRCFA may not terminate eligibility for individuals enrolled in Medicaid as of March 18, 2020, including those for whom verification is completed post-enrollment, until the end of the month when the emergency period ends, unless the beneficiary requests a voluntary termination of eligibility, or the state determines that the individual is no longer considered to be a resident of the state (see FAQ #B.1. of the Families First Coronavirus Response Act – Increased FMAP FAQs, found here: <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf>).

4. When can states accept attested information from an applicant or beneficiary, even if the state identifies an inconsistency between information provided on an application or renewal form and information available from electronic data sources?

Under 42 C.F.R. § 435.952(c)(2), states must resolve discrepancies when information from an electronic data source is not reasonably compatible with attested information from an individual. Such discrepancies may relate to any eligibility criteria for which electronic data has been obtained, including income, resources or state residency.

To resolve a discrepancy, states generally have the flexibility under § 435.952(c)(2) either to accept a reasonable explanation from the individual explaining the difference between the self-attestation and the data information or to require documentation from the individual supporting the self-attestation. For example, if an individual attests to monthly wage earnings of \$2,000 and

the quarterly wage data includes earnings of \$2,500, the state can accept an explanation that the individual has experienced a recent reduction in hours and make an income finding of \$2,000. Alternatively, the state could require the individual to provide a recent paystub that supports an income finding of \$2,000.

Further, consistent with federal regulations at 42 C.F.R. § 435.952(c)(3), states must accept attestation on a case-by-case basis when documentation that would ordinarily be required does not exist at the time of application or renewal, or is not reasonably available. This exception does not apply to eligibility criteria, such as citizenship and immigration status, for which documentation is statutorily required.

Note that the requirement to accept self-attestation under 42 C.F.R. § 435.952(c)(3) does not mean that states can ignore discrepancies between attested information provided on an application or renewal form and a required electronic data match. Rather, the requirement means, in the unusual circumstances described, that (1) states must accept self-attestation of eligibility requirements for which there is no data source to support electronic verification; and (2) states must accept a reasonable explanation attested by, or on behalf of, the individual explaining a discrepancy between attested information on the application or renewal and electronic data obtained by the agency. States must also document reliance on attested information under 42 C.F.R. § 435.952(c)(3) in the individual's case record.

5. If a state accepts self-attestation of information from an applicant or beneficiary due to the person's inability to provide documentation in accordance with 42 C.F.R. § 435.952(c)(3), must the state request documentation following the individual's initial enrollment or renewal?

No. If a state enrolls an individual based on self-attested information under the special circumstances exception provided at 42 C.F.R. § 435.952(c)(3), due to the applicant's inability to provide documentation, no additional post-enrollment verification is required (as explained in FAQ # II.F.4, states must document the reliance on attested information under 42 C.F.R. § 435.952(c)(3) in the individual's case record). At the beneficiary's next regular renewal, or following a change in circumstances, the state would verify eligibility in accordance with its usual processes, applying the special circumstances exception again only if the conditions warranted. As a state option, states also have flexibility to suspend or modify periodic data matching between initial application and regular renewals. To suspend periodic data matching for the period of the emergency, states can submit a Medicaid Disaster Relief MAGI-Based Verification Plan Addendum for MAGI-based beneficiaries. For beneficiaries excepted from MAGI-based methodologies, states must clearly document any changes in the state's verification policies and procedures, and the period for which such changes will be in effect, for MAGI-excepted determinations. See FAQ # II.F.7. regarding documentation of state verification policy changes.

6. Can states temporarily discontinue use of their Asset Verification Systems (AVS) or use the AVS post-enrollment to expedite hospital discharges in the event of a disaster or public health emergency?

States may not suspend use of their AVS under the state plan, which is required under sections 1902(a)(71) and 1940 of the Act. However, the statute does not require that states verify assets using their AVS prior to an initial determination. Instead, states may initially rely on self-attestation of assets and verify financial assets using their AVS post-enrollment in Medicaid. 42 CFR §435.945. Under regulations at 42 C.F.R. § 435.916(d), if a state obtains new asset information from the AVS post-enrollment that indicates an individual may not be eligible, the state must evaluate that information and redetermine eligibility as appropriate. However, we note that, pursuant to section 6008(b)(3) of the FFCRA, in order to be eligible for the temporary 6.2 percent FMAP increase under section 6008(a) of the FFCRA, states may not terminate an individual, once determined eligible, through the end of the month in which the public health emergency ends. This would include any individuals determined eligible for Medicaid based on self-attested asset information for whom verification using the state's AVS is done post-enrollment. See FAQ # II.A.4. for additional information on states' responsibility to redetermine eligibility whenever they receive information indicating a beneficiary may no longer satisfy the criteria for eligibility and for the implications of the FFCRA on this policy.

States may also be able to help expedite provision of medical assistance to applicants who must meet a resource standard as well as enrollment of applicants pending hospital discharge through extension of hospital presumptive eligibility to populations excepted from MAGI methodologies. See FAQ Section II.E. for additional information related to presumptive eligibility.

7. What changes to a state's verification policies and procedures during an emergency period must the state document in its verification plan?

Consistent with § 435.945(j), states must document the verification policies and procedures used by the state to implement the verification provisions set forth in 42 C.F.R. §§435.940 through 435.956, including the data sources determined by the state to be useful for verifying eligibility, use of self-attestation, post-enrollment verification and reasonable compatibility standards, where appropriate. States also must submit their verification plan to CMS upon request. CMS has requested that all states submit, and update as necessary, their verification plans for MAGI-based eligibility determinations, and has provided a MAGI-based verification plan template (<https://www.medicaid.gov/sites/default/files/2019-12/verification-plan-template.pdf>) to identify what specific information should be documented. Thus, states are required to update their MAGI-based verification plan when they make changes to the verification policies and procedures detailed in the plan. CMS has not requested that states submit their verification plan for eligibility determinations for MAGI-excepted individuals. States making changes to their verification policies and procedures which are permitted under the regulations for MAGI-excepted determinations during the public health emergency must document such changes in their non-MAGI verification plan and may, but are not required, to submit such documented changes to CMS.

States may use the Medicaid and CHIP MAGI-Based Disaster Relief Verification Plan Addendum (<https://www.medicaid.gov/medicaid/eligibility/downloads/magi-based-verification-plan-addendum-template.docx>) to capture verification policy and procedure changes that the state is implementing only for the emergency period for both MAGI and MAGI-excepted populations. For MAGI-based verifications, states must submit the addendum (or a revised

verification plan) to CMS for review. Any changes that a state intends to make to its non-MAGI-based verification policies must be documented in the state's internal policies and procedures, along with the period for which such changes will be in effect. States may include information about non-MAGI changes for an emergency period in the state's MAGI-based Disaster Relief Verification Plan Addendum in the "Other" section if the state chooses to do so.

G. Basic Health Program

1. Are states permitted to offer continuous eligibility for up to 12 months in their Basic Health Program (BHP)?

Yes, under 42 C.F.R. § 600.340(f), states operating a BHP have the option to offer continuous eligibility for up to 12 months as long as enrollees are under age 65, are not otherwise enrolled in minimum essential coverage, and remain residents of the state.

States must submit a BHP blueprint revision to exercise this flexibility in BHP because it is a significant change under 42 C.F.R. § 600.125. CMS published an interim final rule with comment period on May 1, 2020 that allows states to submit revised blueprints for temporary significant changes to their BHP that are directly tied to the COVID-19 PHE and are not restrictive in nature that could be effective retroactive to the first day the COVID-19 PHE and through the last day of the COVID-19 PHE or a reasonable amount of time after the COVID-19 PHE. The interim final rule is available here:

<https://www.federalregister.gov/documents/2020/05/08/2020-09608/medicare-and-medicaid-programs-basic-health-program-and-exchanges-additional-policy-and-regulatory>.

2. Are there any exceptions to the timeliness standards for processing BHP renewals?

Yes. Under 42 C.F.R. § 600.320(b), the regulation for timely determinations of eligibility under the Medicaid program at 42 C.F.R. § 435.912 (except for § 435.912(c)(3)(i)) applies to eligibility determinations for enrollment in a standard health plan. Therefore, as described in FAQ # II.A.2., states operating a BHP have flexibility in meeting the timeliness standards for renewing eligibility during an administrative or other emergency beyond the agency's control. This would include a public health emergency, like the COVID-19 PHE, during which workforce shortages may impact the agency's ability to complete timely renewals and/or impacted individuals may be unable to receive or respond to notices or provide information needed to complete the renewal process. States relying on a timeliness standard exception on a case-by-case basis must document the reason for the delay in the individual's case record.

States seeking to invoke a timeliness standard exception for a broader cohort of cases (for example, all applications in a defined geographic area) must submit a BHP blueprint revision to exercise this flexibility because it is a significant change under 42 C.F.R. § 600.125. CMS published an interim final rule with comment period on May 1, 2020 that allows states to submit revised blueprints for temporary significant changes to their BHP that are directly tied to the COVID-19 PHE and are not restrictive in nature that could be effective retroactive to the first day the COVID-19 PHE and through the last day of the COVID-19 PHE, or a later date as requested by the state and approved by CMS.

3. What flexibilities do states have to modify eligibility verification policies in their Basic Health Program?

Flexibility to modify eligibility verification policies in BHP, including accepting self-attestation and/or extending the 90-day reasonable opportunity period, will vary depending on whether the state elected to follow the Medicaid or Exchange eligibility verification process. *See* 42 C.F.R. § 600.345.

States that elect to follow the Medicaid eligibility verification process may modify their verification policies to use attestation for eligibility factors, unless the statute requires other verification (such as for citizenship and immigration status); to accept attested information for an initial determination and enrollment, and conduct other verification processes post-enrollment; or to change their reasonable compatibility standard for verification of income. See more information in FAQ # II.F.1. Regarding citizenship and immigration status, electronic verification is available through the Social Security Administration and the Department of Homeland Security US Citizenship and Immigration Services Systematic Alien Verification for Entitlement (SAVE) program. For otherwise eligible individuals who attest to U.S. citizenship or a lawfully present immigration status, but whose U.S. citizenship or lawfully present immigration status cannot be verified electronically, a reasonable opportunity period is provided while the verification process is completed. At state option, a good faith extension may be available for non-citizens verifying their lawfully present immigration status under 42 C.F.R. § 600.345, cross referencing 42 C.F.R. § 435.956(b)(2)(ii)(B).

For states that follow the Exchange eligibility verification processes, regulations at 45 C.F.R. § 155.315 provide significant flexibility. States are permitted to accept attestations of eligibility criteria that are verified post-enrollment, including social security numbers, citizenship, lawfully present immigration status, residency, and incarceration status. Individuals have up to 90 days to present documentary evidence, which can be extended if the applicant makes a good faith effort to obtain the documentation.

Regardless of whether a state uses the Medicaid or Exchange verification processes, they do not need to submit a revised BHP blueprint amendment to exercise these flexibilities in BHP, but should note any changes to their eligibility verification procedures in the state's 2020 annual report.

4. In states that operate a Basic Health Program, could a state cover testing for COVID-19 under the new Medicaid COVID-19 optional testing group, established by section 6004 of FFCRA, if a subsequent full eligibility determination finds the individual eligible for BHP?

Yes. States may enroll individuals into the COVID-19 testing group without first assessing eligibility for the state's BHP. However, states are encouraged to inform all individuals seeking coverage in the COVID-19 testing group that they may be eligible for comprehensive benefits. Individuals determined eligible for the COVID-19 testing group who are subsequently determined eligible for BHP should be disenrolled from the COVID-19 testing group under Medicaid and enrolled in the state's BHP.

H. Coverage for American Indians and Alaska Natives

1. Can state Medicaid programs consider students living in the state solely for the purposes of education whose parents or caretakers live out-of-state, including American Indian and Alaska Native (AI/AN) boarding school students, to be state residents?

Yes. Generally, per 42 C.F.R. § 435.403(i), a child's state of residency is the state where the child resides or the state of residency of her/his parent or caretaker. In the case of a student attending a boarding school, the state in which the school is located has the option under the regulations to consider students living at the school to be residents of the state. If a state chooses not to consider certain students living in the state as state residents, the state plan must indicate that policy. If a state that considers students living in their state only for the purposes of attending school as not being a state resident wants to change its policy only for the duration of the COVID-19 public health emergency, the state may submit a Medicaid disaster relief SPA to make that change.

2. What other options are available for State Medicaid programs to address payment for services provided to out-of-state students? Can states develop interstate residency agreements?

Yes. Under 42 C.F.R. § 435.403(k), states may enter into interstate residency agreements to coordinate payment for Medicaid services when out-of-state students access medical care. If a state establishes a new interstate residency agreement, it would document such an agreement through the standard SPA process.

Even if a state has not entered into an interstate residency agreement, under 42 C.F.R. § 431.52(b) a state must provide payment for services furnished out-of-state to its residents who are Medicaid beneficiaries when the services are needed because of a medical emergency or because the beneficiary's health would be in danger if s/he were required to travel to their home state for treatment, or it is determined that the needed services are more readily available in the other state. In such situations, under 42 C.F.R. § 431.52(c), the Medicaid agency in the state where the services are needed must facilitate furnishing the needed services to Medicaid beneficiaries from another state—for example, by helping to enroll the provider furnishing services in the home state's Medicaid program or entering into a payment arrangement with the home state for the reimbursement of claims paid on behalf of the beneficiary.

If an out-of-state provider declines to enroll in the home state's Medicaid program, the home state may still reimburse the out-of-state provider in accordance with the exception outlined in the *Medicaid Provider Enrollment Compendium* (1.5.1.C.2.), available at <https://www.medicaid.gov/sites/default/files/2019-12/mpec-7242018.pdf>. Additionally, a state may seek an 1135 waiver to pay a provider who is not enrolled in the state's Medicaid program. The 1135 waiver can be used to broaden the provider enrollment exception and waive the instances of care criteria outlined in the *Medicaid Provider Enrollment Compendium* for the duration of the public health emergency. Checklist and resources to request an 1135 waiver is

available at: <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/section-1135-waiver-flexibilities/index.html>.

I. Continuing Coverage under Section 6008 of the Families First Coronavirus Response Act

1. How does the requirement in section 6008(b)(3) of the FFCRA to continue to provide coverage through the end of the public health emergency apply to medically needy individuals who must meet a spenddown to establish eligibility?

For states seeking to claim the temporary FMAP increase, an individual who attains Medicaid eligibility through a “spenddown”—either in a state’s medically needy group or, in 209(b) states, in the mandatory eligibility group for individuals 65 years old or older or who have blindness or disabilities—must have his or her Medicaid eligibility maintained through the last day of the month in which the public health emergency period ends in order to obtain the temporary 6.2 percentage point FMAP increase. This is true even if the individual’s budget period ends before the month the public health emergency period ends and the individual would not have sufficient, incurred medical or remedial care expenses to meet his or her spenddown in the new budget period.

2. For the medically needy individual whose eligibility is maintained past his or her budget period solely on the basis of section 6008(b)(3) of the FFCRA, can the state, after the end of the emergency period, seek to recoup payments made from the individual?

No. A medically needy individual, or any other individual, whose Medicaid eligibility is maintained in order to comply with the conditions under section 6008(b) of the FFCRA to claim the temporary FMAP increase may not have his or her eligibility retroactively terminated or assistance retroactively reduced. In order to receive the temporary FMAP increase authorized under section 6008 of the FFCRA, states must maintain the eligibility, and benefits, of all individuals who are enrolled or determined eligible for Medicaid as of March 18, 2020, through the end of the month in which the public health emergency ends. Section 6008(b) of the FFCRA does not authorize recoupment of funds from any individual whose Medicaid eligibility was continued in order to comply with the terms of section 6008(b) of the FFCRA.

3. Are states prohibited from increasing cost-sharing during the emergency period as a condition of receiving the FFCRA enhanced FMAP?

Yes. A state is not eligible for the temporary FMAP increase authorized by section 6008 of the FFCRA if it reduces the medical assistance for which a beneficiary is eligible and if that beneficiary was enrolled as of March 18, 2020, or becomes enrolled after that date but not later than the last day of the month in which the emergency period ends. Such a reduction in medical assistance would be inconsistent with the requirement at section 6008(b)(3) of the FFCRA that the state ensure that beneficiaries be treated as eligible for the benefits in which they were enrolled as of or after March 18, 2020, through the end of the month in which the emergency period ends. Because an increase in cost-sharing reduces the amount of medical assistance for which an individual is eligible, a state is not eligible for the enhanced FMAP if it increases cost sharing for individuals enrolled as of or after March 18, 2020.

4. Can states modify their PETI rules during the emergency period in a way that increases an institutionalized individual's patient liability? For example, could a state reduce the personal needs allowance, impose a new reasonable limitation on incurred medical expenses, or reduce an existing home maintenance allowance deduction?

No. States that claim the temporary FMAP increase authorized by section 6008 of the FFCRA are prohibited from increasing the liability of institutionalized individuals enrolled as of March 18, 2020, or who become enrolled after that date but not later than the last day of the month in which the emergency period ends, for their institutional services. Like cost-sharing increases, increasing a beneficiary's liability reduces the amount of medical assistance for which an individual is eligible and is therefore inconsistent with the requirement at section 6008(b)(3) of the FFCRA.

J. Miscellaneous

1. Will CMS provide an extension for the upcoming preliminary second quarter and final first quarter reporting of Medicaid and CHIP enrollment data through the Statistical Enrollment Data System (SEDS) for Federal Fiscal Year 2020 due on April 30, 2020?

CHIP regulations at 42 C.F.R. § 457.740 require states to submit quarterly enrollment data within 30 days after the end of the fiscal quarter. States that allow retroactive eligibility will also report final data 30 days after the end of the following fiscal quarter. States must submit a final report for the first quarter of the federal fiscal year by April 30, 2020. Additionally, states must submit a preliminary report for the second quarter of the federal fiscal year by April 30, 2020, and a final report for that quarter by July 30, 2020. If a state needs additional time to submit their SEDS data due to the current PHE, they should email CMS through the SEDS technical assistance mailbox at SEDSHelp@cms.hhs.gov. CMS may provide states with an extension on a case-by-case basis.

2. Do the requirements in sections 6008(b)(1) and (b)(2) of the FFCRA to maintain eligibility and premiums apply to separate CHIPs?

The requirements in sections 6008(b)(1) and (b)(2) of the FFCRA to maintain eligibility and premiums in the FFCRA do not apply to separate CHIPs, but do apply to Medicaid beneficiaries funded by title XXI. We note, however, that existing statute at section 2105(d)(3) of the Act requires Maintenance of Effort (MOE) in CHIP. This provision, which was extended under the Bipartisan Budget Act of 2018 (Pub. L. 115-123), continues to apply through September 30, 2027. Under section 2105(d)(3) of the Act, states generally may not implement eligibility standards, methodologies, or procedures which are more restrictive than those in effect on March 23, 2010. Therefore, although the FFCRA requirements do not apply to separate CHIPs, states may not impose more restrictive eligibility standards, methodologies, or procedures in those programs in contravention of the Bipartisan Budget Act of 2018 (including but not limited to reducing eligibility levels or increasing premiums).

K. Optional COVID-19 Testing Group

1. Is there an age criteria associated with the new COVID-19 optional eligibility group?

No, there is no age criteria for eligibility in the new optional COVID-19 testing group. Individuals of any age, including children under age 19, adults ages 19–65, and individuals over age 65, may receive coverage under this group as long as they meet the definition of “uninsured individual” in section 1902(ss) of the Act, citizenship or satisfactory immigration status requirements, and the state’s residency requirements.

2. What steps are states required to take before terminating coverage for an individual in the optional COVID testing group? Are states required to provide advance notice of termination and fair hearing rights?

In general, most states will keep an individual enrolled in the COVID testing group until the last day of the month that the PHE ends in order to qualify for the 6.2 percentage point FMAP increase under section 6008 of FFCRA, unless one of the two exceptions provided for under subsection (b)(3) applies (i.e., the individual “requests a voluntary termination of eligibility” or “ceases to be a resident of the state”), or the beneficiary becomes eligible for another Medicaid eligibility group and moves to that other group. However, the authority for benefits available to the COVID testing group ends at the end of the PHE. Therefore, states may not claim FFP after the PHE ends for services provided to individuals who remain enrolled in the testing group after the PHE ends.

In accordance with regulations at 42 C.F.R. § 435.916(f), states generally must determine eligibility on all bases prior to determining a beneficiary ineligible and must provide advance notice at least 10 days prior to termination and fair hearing rights in accordance with 42 C.F.R. § 435.917, and 42 C.F.R. § 431.210 through § 431.214. States must also determine eligibility for other insurance affordability programs for an individual determined ineligible and transfer their account in accordance with 42 C.F.R. § 435.916(f). For beneficiaries disenrolled from the COVID-19 testing group on the last day of the PHE, or the last day of the month in which the PHE ends, there is not a right to a fair hearing to contest termination of coverage under that group, consistent with 42 C.F.R. § 431.220(b). However, such beneficiaries would have fair hearing rights if they submit an application for comprehensive coverage (i.e., using an application described in 42 C.F.R. 435.907) and are denied based on that application.

States have the flexibility to satisfy the requirement to determine eligibility on other bases prior to terminating eligibility at the end of the PHE and to provide fair hearing rights related to termination of coverage under the COVID-19 testing group as follows: First, in providing the notice of eligibility at the time of initial enrollment, informing the individual of their eligibility under the COVID-19 testing group, the state would include information (1) that coverage of any testing or diagnostic services under the COVID-19 testing group will be terminated at the end of the PHE; (2) that the individual may be eligible for comprehensive Medicaid coverage; and (3) how to submit an application for comprehensive coverage. Second, in the advance notice required prior to termination at the end of the PHE, the state would again inform the individual how to apply for comprehensive Medicaid coverage. Beneficiaries who submit an application for comprehensive coverage and whose eligibility is subsequently denied based on the application

for comprehensive coverage must be provided fair hearing rights if denied eligibility based on such application.

Individuals enrolled in the COVID-19 testing group who subsequently enroll in Marketplace coverage no longer meet the eligibility criteria for the COVID-19 testing group as they no longer meet the definition of “uninsured individual” in section 1902(ss) of the Act. Therefore, in order to meet the requirements under section 6008(b)(3) of the FFCRA, if it is determined that an individual may be potentially eligible for Marketplace coverage, the state must ensure that the individual is notified that submission of an application for and subsequent enrollment in Marketplace coverage constitutes the individual’s voluntary request for termination of eligibility from this COVID-19 testing group. If such an individual applies but is not found eligible for Marketplace coverage, the individual should not be considered to have requested termination of Medicaid eligibility.

CMS released additional information on how states may operationalize implementation of the COVID-19 testing group. That guidance is available at: <https://www.medicaid.gov/state-resource-center/downloads/potential-state-flexibilities-guidance.pdf>

III. Benefits

A. COVID-19 Testing

1. Are tests for the detection of COVID-19 coverable under Medicaid’s mandatory laboratory benefit?

Yes, tests for the detection of SARS-CoV-2 or diagnosis of COVID-19 are a mandatory laboratory service as described at 1905(a)(3) of the Act and 42 C.F.R. § 440.30. Section 6004(a) of the FFCRA added a new mandatory benefit in the Medicaid statute, at section 1905(a)(3)(B) of the Act, and this provision was amended by section 3717 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Section 1905(a)(3)(B) of the Act provides that, for any portion of the COVID-19 emergency period defined in section 1135(g)(1)(B) of the Act that begins on or after March 18, 2020, Medicaid coverage must include in vitro diagnostic products (as defined in Food and Drug Administration (FDA) regulations at 21 C.F.R. § 809.3(a)) for the detection of SARS-CoV-2 or diagnosis of COVID-19, and the administration of such in vitro diagnostic products. Section 1905(a)(3)(B) was an addition to the existing mandatory benefit for laboratory and X-ray services that was formerly at section 1905(a)(3) of the Act, and that is now at section 1905(a)(3)(A) of the Act. While the section 1905(a)(3)(B) benefit ends after the COVID-19 PHE period (and any extensions of it) ends, states can continue to cover COVID-19 testing under the section 1905(a)(3)(A) mandatory laboratory services benefit after the emergency period ends.

Furthermore, CMS issued an interim final rule with comment period (IFC) on May 1, 2020, amending 42 C.F.R. § 440.30 to offer greater flexibility to states with respect to coverage of COVID-19 tests, in the effort to minimize transmission of COVID-19. During the COVID-19 PHE and any subsequent period of active surveillance (as defined in the IFC), Medicaid coverage is available for certain laboratory tests and X-ray services that do not meet the conditions specified in § 440.30(a) or (b), provided that certain conditions are met. Section

440.30(a) requires that Medicaid-covered laboratory and X-ray services be ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by state law, or ordered by a physician but provided by a referral laboratory. Section 440.30(b) specifies that Medicaid will cover laboratory and X-ray services only if provided in an office or similar facility other than a hospital outpatient department or clinic. Flexibility under the amendments in the IFC is available with respect to testing to diagnose or detect SARS-CoV-2, antibodies to SARS-CoV-2, or COVID-19, and is available only if the deviation from the conditions specified in § 440.30(a) or (b) is intended to avoid transmission of COVID-19. Provided that this condition is met, the IFC permits states to cover COVID-19 tests conducted in non-office settings such as parking lots. Additionally, the IFC provides states with flexibility to cover laboratory processing of self-collected test systems that the FDA has authorized for home use, if available to diagnose or detect SARS-CoV-2, antibodies to SARS-CoV-2, or COVID-19, even if those self-collected tests would not otherwise meet the requirements in § 440.30(a) or (b), as long as the self-collection of the test is intended to avoid transmission of COVID-19. The IFC offers similar flexibilities for future PHEs resulting from an outbreak of communicable disease and any subsequent periods of active surveillance. The flexibilities available under the IFC will be effective retroactive to March 1, 2020.

This response has the effect of superseding prior FAQ guidance issued on this topic. Specifically, in light of the addition of section 1905(a)(3)(B) to the Social Security Act, states should cover the COVID-19 testing described in section 1905(a)(3)(B) under the mandatory laboratory benefit at section 1905(a)(3) and § 440.30, rather than under the optional diagnostic services benefit at § 440.130.

2. Are Medicaid home health agencies able to collect the samples necessary for the diagnostic testing for COVID-19?

If a physician orders the diagnostic test and the sample collection needed is within the scope of practice for the home health nurse or can be delegated to other practitioners, based on the state's nurse practice act, Medicaid may cover the collection under the home health benefit. If it is not within the scope of practice, CMS encourages states to explore state emergency or other authorities to remove these restrictions during this public health emergency. CMS is available for technical assistance.

Pursuant to 42 C.F.R. §440.70(f), if the sample collection is a beneficiary's first utilization of the home health benefit, a face-to-face encounter must have occurred no longer than 90 days before or 30 days after the start of services and must be related to the primary reason the beneficiary requires home health services. See FAQ # III.B.3. for additional information on flexibilities related face-to-face encounters.

3. Can CHIP pay for the caregiver of a CHIP beneficiary to be tested for COVID-19?

No. CHIP may only pay for services provided to the covered individual, in accordance with the CHIP state plan. CHIP covers COVID-19 testing for enrollees.

B. Telehealth

1. What flexibilities are available to provide care via telehealth for individuals who are quarantined or self-isolated to limit risk of exposure?

States have broad flexibility to cover telehealth through Medicaid, including the methods of communication (such as telephonic, video technology commonly available on smart phones and other devices) to use. Telehealth is important not just for people who are unable to go to the doctor, but also for when it is not advisable to go in person. No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services. A SPA would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.

With regard to 1915(i) face-to-face assessments, the use of telemedicine or other information technology medium is authorized under federal regulations at 42 C.F.R. § 441.720 under certain conditions. With regard to 1915(c) waivers, the state can complete an Appendix K to allow case management to be done via telephone or other information technology medium and, where personal care services only require verbal cueing and/or instruction, the personal care service can be expanded to permit information technology medium as a resource.

2. Will CMS consider adding telehealth flexibilities so residents in rural communities potentially exposed to the virus do not need to visit a Rural Health Clinic (RHC)?

RHCs billing Medicare are subject to Medicare's telehealth policies. The Medicare statute authorizes RHCs to serve as originating sites for telehealth services furnished by a remotely located "distant site" health care provider, but the statute does not authorize RHCs to furnish telehealth services as distant site health care providers. A distant site is a site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system. Only physicians and certain types of non-physician practitioners are authorized to furnish telehealth services as distant site health care providers. The Secretary's waiver authority under section 1135(b) of the Act does not extend to the scope of distant site health care providers that can furnish telehealth services. The newly added paragraph at section 1135(b)(8) gives the Secretary authority only to waive the requirements of 1834(m)(4)(C), which is the definition of "originating site" for purposes of Medicare telehealth services. There is no new authority to waive who/what can serve as the "distant site practitioner.

3. Are there any available flexibilities in implementing the requirement for face-to-face encounters under Medicaid home health? Can telehealth be utilized?

Yes. For initiation of home health services, face-to-face encounters may occur using telehealth as described at 42 C.F.R. §440.70(f)(6). A physician, nurse practitioner or clinical nurse specialist, a certified nurse midwife, a physician assistant, or attending acute or post-acute physician for beneficiaries admitted to home health immediately after an acute or post-acute stay may perform the face-to-face encounter. The allowed non-physician practitioner must communicate the clinical findings of the face-to-face encounter to the ordering physician. Those clinical findings must be incorporated into the beneficiary's written or electronic medical record. Additionally,

the ordering physician must document that the face-to-face encounter occurred within the required timeframes prior to the start of home health services and indicate the practitioner who conducted the encounter and the date of the encounter. A state plan amendment would only be necessary to revise existing state plan language that imposes telehealth parameters that would restrict this practice. As is discussed above and at <https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html>, states are not required to submit separate state plan amendments for coverage or reimbursement of telehealth services if they decide to reimburse for telehealth services in the same manner or at the same rate paid for face-to-face services. A state plan amendment would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.

4. Can Pre-Admission Screening and Resident Review (PASRR) Level 1 and Level 2 evaluations be conducted remotely as opposed to through a face-to-face visit?

Yes. The PASRR statutory provisions require all applicants to and residents of Medicaid-certified nursing facilities (NFs) be screened for mental illness and intellectual disability, and, if necessary, be provided specialized services while in the NF.

Federal regulations do not prohibit PASRR Level 1 and Level 2 evaluations from being conducted by telephone or through another electronic medium. Unless the state has a specific requirement that PASRR Level 2 evaluations be conducted in a face-to-face interview, there is no need to amend language in the state plan.

States can also request an 1135 waiver to temporarily suspend pre-admission screening and resident review Level 1 and Level 2 for 30 days.

5. How do the Medicaid flexibilities around use of telehealth as a service delivery mode interact with Medicare and commercial third party liability (TPL) requirements, which may be less flexible around telehealth? For example, a Medicare or commercial payer may require a face-to-face physician visit to order care or supplies.

Please note that Medicare has recently increased flexibilities related to telehealth due to the public health emergency, as summarized in the fact sheet available at <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>. While Medicare and commercial payers have increased flexibilities for telehealth, there may still be instances where coordination of benefits is necessary.

Medicaid payment allows for state plan flexibilities in the event Medicare or a commercial insurer denies payment. If the third party denied the claim for a substantive reason (e.g., service not covered) and the service is covered under the Medicaid state plan, Medicaid would review for payment accordingly. If at a later time, the state is made aware of a third party's coverage for these specific services, the state, as it currently does, would chase recovery of payment accordingly. Therefore, in the example above, once Medicare or a commercial payer reviews a claim and denies for a substantive reason, such as face-to-face physician visit requirement, Medicaid would review and pay according to the state plan. If telehealth is permitted under the Medicaid state plan, Medicaid would pay accordingly.

6. What flexibilities are available to provide dental care via telehealth for individuals who are quarantined or self-isolated to limit risk of exposure?

As with other services provided via telehealth, states have broad flexibility to cover teledentistry through Medicaid, including the methods of communication (such as telephonic, video technology commonly available on smart phones and other devices) to use. Providing services such as oral screenings, assessments, problem-focused evaluations, or re-evaluations via teledentistry can help to limit in-person visits, determine when dental procedures can be deferred, and avoid unnecessary trips to hospital emergency departments. No federal approval is needed for state Medicaid programs to reimburse providers for teledentistry services in the same manner or at the same rate that states pay for face-to-face services. A SPA would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.

States may use appropriate Healthcare Common Procedure Coding System (HCPCS) dental codes to identify, track and reimburse for teledentistry services. Additionally, a state may opt to cover synchronous (real-time) and/or asynchronous (store-and-forward) teledentistry services. The American Dental Association (ADA) issued [guidance](#) to address the delivery of dental services during the public health emergency that may be helpful to states, including the clinically appropriate use of teledentistry. ADA resources are located at <https://success.ada.org/en/practice-management/patients/practice-resources>.

7. Must Medicaid-eligible children continue to receive medically necessary Medicaid services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit while schools are closed during the public health emergency?

Yes. Medically necessary services under the EPSDT benefit must continue to be provided to children during the time that schools are closed during the public health emergency by qualified Medicaid providers. The EPSDT benefit at section 1905(r) of the Act, requires states to make available all medically necessary services included under section 1905(a) of the Act in order to correct or ameliorate defects and physical and mental illnesses or conditions. A determination of medical necessity entails an evaluation of the child by a qualified Medicaid practitioner, followed by a referral, order or prescription for a service.

Schools are one community-based setting in which Medicaid eligible children can receive services furnished by qualified Medicaid practitioners. In the school setting, a child's medically necessary Medicaid services can be included in an Individualized Education Program (IEP) pursuant to the Individuals with Disabilities Education Act (IDEA), a Section 504 plan pursuant to Section 504 of the Rehabilitation Act, or another school services plan. However, to be covered by Medicaid, there is no requirement that such services be specified in one of these plans. These medically necessary services must remain available to the child until such time as it is determined that the child no longer meets the medical necessity criteria for receipt of the services. Furthermore, because states are obligated under the IDEA to furnish a free, appropriate, public education to children who qualify for IDEA services, states should ensure that the services included in a child's IEP, including the Medicaid-covered services, continue to be provided to the child while at home as appropriate. States may wish to refer to the guidance issued by the Office of Special Education Programs (OSEP) in the Department of Education for

further information on the IDEA and other federal civil rights laws:

<https://www2.ed.gov/about/offices/list/ocr/frontpage/faq/rr/policyguidance/Supple%20Fact%20Sheet%203.21.20%20FINAL.pdf>. For other updates on the Department of Education website, see: <https://www.ed.gov/coronavirus>.

8. How can states ensure continuity of coverage for Medicaid services ordinarily delivered to children in schools while schools are closed due to COVID-19?

The use of telehealth can assist states in continuing to deliver Medicaid-covered services to eligible children. As a reminder, the Early and Periodic Screening, Diagnostic, and Treatment benefit requires states to make available to eligible children under age 21 all medically necessary services included under section 1905(a) of the Act in order to correct or ameliorate defects and physical and mental illnesses or conditions. (See FAQ immediately preceding this one for further discussion.) If the state establishes that a Medicaid service can be delivered via telehealth, states may generally use existing state plan methodologies to cover and pay for the service when delivered via telehealth, or to reimburse additional costs that are incurred by the provider because of telehealth delivery. If the state plan contains restrictions that would prevent an otherwise covered service from being provided via telehealth, the state may use the Medicaid Disaster SPA template issued on March 22, 2020, to temporarily remove such restrictions during the period of the public health emergency. If the state needs flexibilities beyond the period of the public health emergency, CMS is available for technical assistance to determine if a state plan amendment is needed. If telehealth is used, covered entities must provide effective communication to individuals with disabilities as per Section 1557 of the Affordable Care Act, Section 504 of the Rehabilitation Act and Title II of the Americans with Disabilities Act. For further information on Medicaid coverage and reimbursement of services delivered via telehealth, please refer to the Medicaid.gov web page:

<https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html>. This page includes the State Medicaid & CHIP Telehealth Toolkit *Policy Considerations for States Expanding Use of Telehealth* COVID-19 Version and a link to **Medicaid State Plan Fee-for-Service Payments for Services Delivered Via Telehealth**.

The Office for Civil Rights in the Department of Health and Human Services is exercising enforcement discretion to waive potential penalties for Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security, and Breach Notification Rules violations against health care providers that in good faith provide patient care through remote communications technologies during the COVID-19 public health emergency. Additional guidance is available explaining how covered health care providers can use remote video communication products and offer telehealth to patients responsibly. See:

<https://www.hhs.gov/hipaa/for-professionals/special-topics/hipaa-covid19/index.html>.

States may also refer to the guidance issued by the Office of Special Education Programs (OSEP) in the Department of Education for further information on the IDEA and other federal civil rights laws:

<https://www2.ed.gov/about/offices/list/ocr/frontpage/faq/rr/policyguidance/Supple%20Fact%20Sheet%203.21.20%20FINAL.pdf>. For other updates on the Department of Education website, see: <https://www.ed.gov/coronavirus>.

Additionally, see “Section 1557: Ensuring Effective Communication with and Accessibility for Individuals with Disabilities,” <https://www.hhs.gov/civil-rights/for-individuals/section-1557/fs-disability/index.html>; “Disability Resources for Effective Communication,” <https://www.hhs.gov/civil-rights/for-individuals/special-topics/hospitals-effective-communication/disability-resources-effective-communication/index.html>; and “ADA Requirements,” <https://www.ada.gov/effective-comm.htm>.

9. Would an IEP, an Individualized Family Service Plan (IFSP), Section 504 plan, or other plan that identifies Medicaid-covered services for a Medicaid-enrolled child need to expressly indicate that services can be delivered via telehealth as a pre-condition for receipt of Medicaid reimbursement for the services?

No. Medicaid considers telehealth to be a service delivery method, not a service. Services included in an IEP, IFSP, Section 504 plan, or other plan, can be covered by Medicaid only if they are Medicaid services provided to a Medicaid-enrolled child by a Medicaid qualified practitioner. If these requirements are met, and there is an approved payment methodology for the services in the state Medicaid plan, then Medicaid can reimburse for the services, including when they are delivered via telehealth.

Generally, states need to have current Medicaid state plan 4.19-B pages that set forth the reimbursement methodology for any covered Medicaid services that would be included in the child’s IEP, IFSP, section 504 plan, or other plan of services for a child. States do not need to refer to telehealth reimbursement methodologies in their state plans unless the reimbursement rate or methodology for a service provided via telehealth is different from the rate or methodology that applies when the same service is provided face to face.

Please also refer to the [Medicaid.gov](https://www.Medicaid.gov) and the OSEP and Department of Education links noted above.

10. Can early intervention services (EIS) under the IDEA be reimbursed by Medicaid when the services are delivered via telehealth?

If the state establishes that a Medicaid-covered service can be delivered via telehealth, states may generally use existing state plan methodologies to cover and pay for the service when delivered via telehealth, or to reimburse additional costs that are incurred by the provider because of telehealth delivery. If the state plan contains restrictions that would prevent an otherwise covered service from being provided via telehealth, the state may use the Medicaid Disaster SPA template issued on March 22, 2020 to temporarily remove such restrictions during the period of the public health emergency. States can cover and reimburse for EIS that are Medicaid-covered services provided to a Medicaid-enrolled child by a qualified Medicaid provider. As explained previously in the CMS telehealth FAQs (Section III. Benefits, Item B. Telehealth, Question 1) updated May 5, 2020, states have broad flexibility to cover services provided via telehealth under Medicaid, and also have flexibility regarding the methods of communication used to provide services via telehealth (such as telephonic, video technology commonly available on smart

phones and other devices). Telehealth is important not just for people who are unable to go to the doctor, but also for when it is not advisable to go in person. No federal approval is needed for state Medicaid programs to reimburse providers for Medicaid services provided via telehealth in the same manner or at the same rate that states pay for those same Medicaid services when provided face-to-face. A SPA would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs. The updated FAQs can be found here:

<https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>. Providers of EIS who are not being reimbursed for delivery of services via telehealth should contact their state Medicaid agency. Additional information may be found at the OSEP guidance noted above and [on the Department of Education website](https://www.ed.gov/coronavirus) at <https://www.ed.gov/coronavirus>.

11. Is Medicaid coverage available for evaluations to determine the need for EIS under the IDEA if providers conduct the evaluation via telehealth?

Yes. If a state establishes that evaluations for EIS that Medicaid would otherwise cover can be delivered via telehealth, Medicaid qualified practitioners can bill for their time spent in conducting evaluations via telehealth as an applicable practitioner service.

12. Can pediatric clinicians receive Medicaid reimbursement for well-child visits delivered via telehealth?

Yes. Well-child visits are coverable under EPSDT and states may elect to cover visits conducted via telehealth. Generally speaking, states can establish the same rate for Medicaid services delivered via telehealth that is paid when the same services are delivered face-to-face, but states may establish different rates. Each state has the discretion to set payment rates that are consistent with section 1902(a)(30)(A) of the Act. Accordingly, states may pay a different rate for services delivered via telehealth to account for differences between the cost of delivering the services face-to-face and the costs of delivering them via telehealth. If states choose to pay different rates for services when they are delivered via telehealth, a state plan amendment submission would be necessary to describe and receive CMS approval for the new payment methodology.

C. Home and Community Based Services

1. How can states provide home and community-based services (HCBS) in acute care hospitals under sections 1915(c), (i), (j), (k) or section 1115 demonstrations consistent with section 3715 of the CARES Act?

Under section 3715 of the CARES Act, states may now continue the provision of HCBS to individuals in acute care hospitals. The HCBS are in addition to, and may not substitute for, the services the hospital is obligated to provide. The services must be identified in the individual's person-centered service plan and should be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.

CMS clarifies that where a 30-day limitation has been approved under Appendix K, the state may request to remove or revise that limit in a subsequent Appendix K application with a request

that the approval be retroactive back to the effective date of the previously approved limitation under Appendix K.

CMS also clarifies that the state must describe what services would be provided by the HCBS provider or caregiver (for instance, habilitative services such as cuing and assistance with communication with a non-verbal individual, or personal assistant services for implementation of behavior support plans) that are not duplicative of services available in the hospital setting (such as medication administration), how the HCBS will assist the individual in returning to the community, and whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization.

2. Can states delay the level of care evaluation for new applicants and the annual level of care reevaluations for non-MAGI beneficiaries if required as a condition of eligibility?

States may seek section 1135 waiver authority to modify provisions of HCBS programs in accordance with the following parameters:

For section 1915(c) waiver programs, a state would need to request, pursuant to section 1135(b)(5) of the Act, a modification of the deadline for initial and annual level of care determinations required for the section 1915(c) HCBS waiver, as described in 42 C.F.R. § 441.302(c)(1) and (c)(2), respectively. With this modification, the initial determination of level of care would not need to be completed before the start of services and the annual level of care determinations that exceeds the 12-month authorization period will remain in place and services will continue until the assessment can occur. A reassessment may be postponed for up to one year.

For section 1915(i) state plan HCBS programs, states similarly may request, under section 1135(b)(5) of the Act, to modify the deadline for conducting initial evaluations of eligibility required for the section 1915(i) state plan benefit at 42 C.F.R. § 441.715(d) and initial assessments of need to establish a care plan at 42 C.F.R. § 441.720(a). With this modification, these activities would not need to be completed before the start of care.

In addition, pursuant to section 1135(b)(5) of the Act, CMS may allow the state to modify the deadline for annual redetermination of eligibility required for the section 1915(i) state plan benefit, as described in 42 C.F.R. § 441.715(e) and section 1915(i)(1)(I) of the Act, and annual reassessment of need required for the section 1915(i) state plan benefit, as described in 42 C.F.R. § 441.720(b). With these modifications, the annual eligibility determinations and reassessments of need that exceeds the 12-month authorization period will remain in place and services will continue until the re-evaluation and reassessment can occur. These actions may be postponed for up to one year.

For section 1915(k) Community First Choice programs, pursuant to section 1135(b)(5) of the Act, states may request a modification of the deadline for initial and annual level of care determinations required for the section 1915(k) state plan benefit, as described in 42 C.F.R. § 441.510(c). With this modification, the initial determination of level of care does not need to be completed before the start of services and the annual level of care determinations that exceeds

the 12-month authorization period will remain in place and services will continue until the assessment can occur. A reassessment may be postponed for up to one year.

3. What is the termination date of a state’s section 1915(c) waiver Appendix K?

An Appendix K approval expires one year from the effective date or any earlier approved date elected by the state. However, end dates cannot extend beyond one year from the last day of the month in which the President signed the proclamation of a national emergency (March 31, 2021). This FAQ has the effect of updating information in the table included in FAQ 7.

4. Can a state fund tablets and telephones to facilitate the delivery of services remotely under a section 1915(c) Home and Community-Based Services Waiver Using Appendix K?

Yes. States can fund devices such as tablets and telephones to enable the delivery of services remotely by adding Assistive Technology as a service available under the authority of section 1915(c)(4)(B) of the Act and/or expanding the current definition of assistive technology to include these devices. The state should establish policies in exercising its oversight responsibilities to ensure that the devices are being used to facilitate the delivery of services (e.g., verification that a waiver service(s) is being delivered remotely using the device). However, we note that phone cards and minutes, which are of general utility, cannot be funded. States should use Appendix K to indicate service expansions for the PHE.

5. Can a state fund Community Transition Services under a section 1915(c) Home and Community-Based Services Waiver Appendix K to allow for the set-up of a temporary residence for an individual required to be quarantined?

No. As discussed in the State Medicaid Director Letter #02-008 issued May 9, 2002, such usage of Community Transition Services is not supported. Please note that states are reminded that they still are responsible for compliance with the integration mandate of Title II of the ADA and the *Olmstead v. LC*, 119 S. Ct. 2176 (1999) decision to avoid subjecting persons with disabilities to unjustified institutionalization or segregation.

Therefore, states should strive to return individuals who were removed from their Medicaid-funded HCBS settings during the public health emergency to the community, and should consider what steps they can take to help individuals with disabilities who may require assistance in order to avoid unjustified institutionalization or segregation. CMS is available to provide technical assistance and to discuss available Medicaid resources to support these activities.

6. Can a state modify the requirements for the CMS-372 and three-year Evidentiary Report for 1915(c) Home and Community-Based Services Waivers through the Appendix K?

Yes. States can add language in the Appendix K in section K-2-m “Other Changes Necessary...” stating timeframes for the submission of the CMS 372s and the evidentiary package(s) will be extended as needed pursuant to the emergency. In addition, the state may suspend the collection of data for performance measures other than those identified for the Health and Welfare

assurance and note that as a result the data will be unavailable for this time frame in ensuing reports due to the circumstances of the pandemic.

7. Can a state add Legally Responsible Individuals to the provider pool that renders Personal Care Services authorized under section 1905(a) of the Social Security Act?

Yes, pursuant to section 1135(b)(1)(B) of the Act, a state can request to ensure critically needed services are furnished by expanding the pool of providers to include legally responsible individuals in the event the traditional provider workforce is diminished or there is inadequate capacity due to the public health emergency.

8. Can a state request a waiver of the HCBS settings requirements for specified settings to ensure that alternate sites for service delivery can be used?

Yes, pursuant to section 1135(b)(1)(B) of the Act, a state can request to waive settings requirements for settings that have been added since the March 17, 2014, which is the effective date of the HCBS final regulation (CMS-2249-F; CMS-2296-F (79 Fed. Reg. 2948)), to accommodate circumstances in which an individual requires relocation to an alternative setting to ensure the continuation of needed home and community-based services during the public health emergency. States are reminded that they are still subject to obligations under the integration mandate of Title II of the Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12131–1213 and the *Olmstead v. LC*, 119 S. Ct. 2176 (1999) decision, to avoid subjecting persons with disabilities to unjustified institutionalization or segregation. Therefore, States should strive to return individuals who were removed from their Medicaid-funded HCBS settings during the public health emergency to the community, and should consider what steps they can take to help individuals with disabilities who may require assistance in order to avoid unjustified institutionalization or segregation. CMS is available to provide technical assistance and to discuss available Medicaid resources to support these activities.

9. Can a state waive the Conflict of Interest requirements under HCBS state plan and waiver authorities?

Yes, pursuant to section 1135(b)(1)(B) of the Act, a state can request to waive HCBS conflict of interest provisions at 42 C.F.R. § 441.301(c)(1)(vi) for 1915(c) HCBS waivers, 42 C.F.R. § 441.555(c) for 1915(k) Community First Choice, and 42 C.F.R. § 441.730(b) for 1915(i) State Plan HCBS, thereby allowing the expansion of service providers when it is necessary to increase the provider pool by permitting the entity rendering case management to also render direct services. Normally, failure to separate case management entities and HCBS providers could result in limiting a beneficiary's access to the full range of HCBS providers. However, due to the current public health emergency, some HCBS providers are unable to furnish services, increasing reliance on fewer operational entities, which could mean those entities must also provide case management and/or that case management entities must temporarily provide direct services.

10. Can a state waive the requirement to obtain beneficiary and provider signatures of HCBS Person-Centered Service Plan?

Yes. Pursuant to section 1135(b)(1)(C) of the Act, a state can request to waive provisions at 42 C.F.R. § 441.301(c)(2)(ix) for section 1915(c) waiver programs, 42 C.F.R. § 441.725(b)(9) for section 1915(i) HCBS state plan programs, and 42 C.F.R. § 441.540(b)(9) for section 1915(k) Community First Choice programs to permit documented verbal consent as an alternate to the regulatory requirement for a signature on the person-centered service plans from beneficiaries and all providers responsible for its implementation. This will facilitate rapid authorization of critically needed services and reduce the risk of transferring communicable diseases through the process of receiving signed documents.

D. Pharmacy/Prescription Drugs

1. Will CMS issue guidance on loosening prior authorization requirements for medication and supplies for medically fragile children and other populations who may be quarantined?

The answer to this question depends on whether the child receives their care through Fee-For-Service (FFS) or managed care.

FFS / Supplies: States have flexibility to establish and manage prior authorization processes without CMS approval. Given that medically fragile children are subject to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements, there should be no hard limits on services provided to these children. A SPA may be needed, depending on the state's goals.

FFS/Pharmacy: States have flexibility to establish the prior authorization process without CMS approval, including length of time and units approved. A state may need to amend their SPA for a change in quantity dispensed.

Managed Care: Under Medicaid managed care, states may develop the specific standards and criteria that best meet the needs of their program, including accelerated or relaxed requirements during times of emergency. Federal law does not prohibit or limit states from requiring managed care plans to temporarily suspend prior authorization requirements, extend prior authorizations through the termination of the emergency declaration, and expedite processing of new prior authorizations with flexibility in documentation (e.g., physician signatures).

2. Can states provide an additional month of medication to a beneficiary when their Medicaid eligibility is ending?

States have flexibility to determine the quantity of medication covered per prescription fill. Federal financial participation (FFP) is available for a prescription if the date of service falls during the individual's Medicaid eligibility period.

3. Should a drug shortage develop, if a drug is provided by a manufacturer not participating in the national drug rebate program, will FFP be available?

Generally, if a state plan provides medical assistance for a drug that meets the definition of a covered outpatient drug (COD) as defined at §1927(k), section 1927 must be complied with in order for FFP to be available. So, if that COD is not provided by a manufacturer participating in the Medicaid drug rebate program, that is, the COD is not distributed by a manufacturer with a National Drug Rebate Agreement, the drug does **not** qualify for FFP. To be clear, it is not required that a drug meet the definition of a COD in order to qualify for FFP. If a drug is a prescribed drug, as defined in regulation at 42 C.F.R. §440.120, it may still qualify for FFP. However, if that prescribed drug meets the definition of a COD, it is not eligible for FFP unless section 1927 is also complied with (e.g., the manufacturer of the drug has in effect a National Drug Rebate Agreement). Please see State Release # 178. States can e-mail the CMS RxDRUGPolicy@CMS.HHS.gov resource mailbox with any questions related to the medication status.

4. Can states waive signature requirements for beneficiaries to receive their prescription drugs? Must beneficiaries continue to receive counseling on their medications?

There are currently no federal Medicaid rules that require beneficiaries to provide their signature in order to receive prescription drugs. Requirements for signatures are usually found in a state provider manual and are at the discretion of the state Medicaid program. Therefore, CMS encourages states to explore ways to ease state signature requirements in order to allow beneficiaries to access their medications during the public health emergency.

Pharmacists should follow state laws regarding counseling patients, which may permit counseling by phone.

5. Does a state have to cover drugs for COVID-19 in order to receive the enhanced FMAP? For example, do states have to cover the unapproved drug Remdesivir consistent with the FDA's Emergency Use Authorization (EUA) in order to receive the enhanced FMAP?

Yes. States must cover, under the state plan (or waiver), testing services and treatments for COVID-19, including vaccines, specialized equipment, and therapies, for any quarter in which the temporarily increased FMAP is claimed. For example, a state would have to cover any drug approved under an FDA Emergency Use Authorization (EUA) for COVID-19. In that regard, states must cover Remdesivir when used according to the EUA, which was issued on May 1, 2020. The FDA approved the use of this investigational drug for hospitalized COVID-19 patients with severe disease. While an unapproved drug, it would qualify for FFP as a prescribed drug under 42 C.F.R. § 440.120. *See also* 42 C.F.R. § 447.522 that describes optional coverage of investigational drugs and other drugs not subject to rebate.

6. Can the states receive FFP for covering prescription drugs that are used to treat COVID-19 if the use is a non-medically accepted indication?

In general, section 1927(k)(2) of the Social Security Act defines a covered outpatient drug as a prescribed drug, that is approved for safety and effectiveness as a prescription drug by the FDA under section 505 or 507 of the Federal Food Drug and Cosmetic Act. Additionally, such term does not include a drug used for a medical indication which is not a medically-accepted indication. *See* 42 C.F.R. § 447.502. The term “medically accepted indication” is defined at

section 1927(k)(6) of the Act to mean any use for a covered outpatient drug which is approved under the Federal Food, Drug, and Cosmetic Act or the use of which is supported by one or more citations included or approved for inclusion in certain statutorily defined compendia. If a prescribed drug does not meet the definition of a covered outpatient drug, states may still be permitted to cover such drugs at state option under section 1905(a)(12) of the Act as prescribed drugs, which are defined at 42 C.F.R. § 440.120(a). *See* 42 C.F.R. § 447.522(d). However, such drugs would not be subject to rebates under section 1927 of the Act, as noted at 42 C.F.R. § 447.522(e).

The regulations further provide for Medicaid coverage of investigational drugs at state option under section 1905(a)(12) when such drug is the subject of an investigational new drug (IND) application that has been allowed by FDA to proceed. A state electing to provide coverage of investigational drugs must include a description of the coverage and payment for such drugs in its state plan. Moreover, to the extent these drugs do not meet the definition of a covered outpatient drug, they are not subject to rebate.

Thus, states may be able to cover and claim FFP for certain prescribed drugs when used for non-medically accepted indications, as provided in 42 C.F.R. § 447.522. To the extent such a drug does not meet the definition of a covered outpatient drug, the state cannot claim rebates on these drugs under section 1927 of the Act. However, a State should assure that when these drugs are used for medically accepted indications as covered outpatient drugs that the state claims rebates, as appropriate.

E. Money Follows the Person (MFP) Program

1. What resources are available to assist MFP demonstration programs in their responses to COVID-19?

In response to the COVID-19 pandemic, CMS is providing information and guidance to ensure that HCBS services are uninterrupted and, if necessary, strengthened during this public health emergency. CMS encourages MFP grantees to work with their respective state Medicaid partners and to engage individuals and families in efforts to safely implement MFP demonstration transition activities and provide MFP demonstration services for participants living in the community.

We recommend that all states follow [CDC](#) recommendations and their own policies and procedures in order to reduce the risk of exposure and prevent the spread of the virus. We also recommend that states regularly monitor CMS's [Current Emergencies](#) webpage for responses to states' questions, information and guidance, and other updates on CMS's response to COVID-19. CMS materials and guidance that may help states stay informed on COVID-19 related to Medicaid beneficiaries receiving HCBS can be found on various Medicaid.gov and CMS.gov webpages, including: Home and Community-Based Services during Public Health Emergencies (<https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/hcbs/index.html>) and Coronavirus (COVID-19) Partner Toolkit (<https://www.cms.gov/outreach-education/partner-resources/coronavirus-covid-19-partner-toolkit>). Please visit these links and check back often for

the most up-to-date information. Contact your MFP Project Officer if you have any questions or need technical assistance related to any state-specific challenges or issues.

2. Can MFP programs use alternative communication methods such as telephone calls or video chat for transition activities that would normally be conducted on an in-person basis during the COVID-19 public health emergency?

MFP programs may leverage MFP demonstration flexibility and resources to make temporary programmatic changes that are consistent with their states' and local communities' responses to COVID-19. States may choose to implement strategies using alternative communication methods such as video chat or telephone calls for transition activities that would normally be conducted on an in-person basis. CMS encourages states to consider telehealth options as a flexibility in combating the COVID-19 pandemic and increasing access to care. Further guidance on telehealth/telemedicine may be found on Medicaid.gov:

<https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-telehealth-services.pdf> and <https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html>.

MFP grantees should notify their MFP Project Officer as soon as possible if they need to make programmatic changes, but states do not need to receive CMS approval before implementing programmatic changes to their MFP program's Operational Protocol if those changes are directly related to their response to COVID-19 and are otherwise allowable.

Please note that this pre-approval to implement MFP programmatic changes does not supersede any requirements that apply to section 1915(c) waivers or other Medicaid HCBS authorities. States should follow the applicable rules and processes of those authorities if they are making changes to an HCBS program that operates under section 1915(c) of the Act or another Medicaid authority, regardless of whether any of the service costs are funded under MFP. States should reach out to their CMS HCBS lead and request the [Appendix K](#) for the section 1915(c) waiver application if they need to request changes to a section 1915(c) waiver program or have any questions about how to request approval under another Medicaid authority.

3. How can MFP programs leverage the demonstration to acquire personal protective equipment (PPE) to protect MFP transition team members, home health workers, and direct support professionals/workers contracting COVID-19?

CMS encourages MFP programs to work closely with their respective state Medicaid partners to address PPE needs at the local and state levels and to operationalize strategies to respond to PPE shortages. During this emergency period, CMS will provide expeditious review of new requests to use grant funds for supplies or equipment that support the MFP program's efforts to serve MFP participants, including PPE. Grantees also have flexibility to transfer up to 10% of their MFP funds between budget line items for previously approved activities, as long as the use of the funds directly supports the goals and intent of the MFP program. Any use of grant funds must comply with grant regulations and the terms and conditions of your grant award. Grantees should review the MFP letter to grantees and related budget forms provided to grantees in the April 8, 2020 grant note for more information on the flexibilities provided to MFP grantees related to COVID-19 and how to request budget approval for new activities related to COVID-19. Please

contact your Grants Management Officer in the Office of Acquisition & Grants Management if you have any questions or need technical assistance related to MFP demonstration budget processes.

4. Is there any reason to suspend scheduled transitions from inpatient facilities to MFP-qualified community residences under the MFP program?

Please consult with your respective state partners on whether to suspend transition activities in nursing homes or other inpatient facilities during the COVID-19 public health emergency. CMS recently announced critical new measures to keep nursing home residents safe from COVID-19: <https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf>. CMS recommends that all states follow [CDC](#) recommendations and their own policies and procedures in order to reduce the risk of exposure and prevent the spread of the virus.

5. During the COVID-19 public health emergency, can MFP programs extend the 180-day billing period for transition coordination activities prior to the community transition of an individual in an institution?

MFP programs may leverage MFP demonstration flexibility and resources to make temporary programmatic changes that are consistent with their states' and local communities' responses to COVID-19. MFP grantees should notify their MFP Project Officer as soon as possible if they need to make programmatic changes, but states do not need to receive CMS approval before implementing programmatic changes to their MFP program's Operational Protocol if those changes are directly related to their response to COVID-19. These changes may include extending the 180-day period for transition coordination activities. Grantees should review the MFP letter to grantees and related budget forms provided to grantees in the April 8, 2020, grant note for more information on the flexibilities provided to MFP grantees related to COVID-19 and how to request budget approval for new activities related to COVID-19.

As in section 1915(c) waiver programs, transition coordination can be covered as a component of case management services. States should follow the applicable rules and processes of those authorities if they are making changes to an HCBS program that operates under section 1915(c) of the Act or another Medicaid authority, regardless of whether any of the service costs are funded under MFP. This includes any request to extend the time period for which transition coordination can be reimbursed prior to discharge from an institution. States should reach out to their CMS HCBS lead and request flexibility under [Appendix K](#) for the section 1915(c) waiver application if they need to request changes to a section 1915(c) waiver or have any questions about how to request approval under another HCBS authority. Information on Appendix K may be found on Medicaid.gov: <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/hcbs/appendix-k/index.html>.

6. Can the “qualified residence” requirement under the MFP demonstration be expanded to include other types of community settings during the COVID-19 public health emergency?

No, the qualified MFP community settings criteria is a statutory requirement for the MFP program and cannot be modified. Section 6071(b)(6) of the 2005 Deficit Reduction Act (DRA) defines an MFP qualified residence as: “(A) a home owned or leased by the individual or the individual’s family member; (B) an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual’s family has domain and control; and (C) a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.” CMS will work with MFP grantees to explore other options and considerations to identify resources for increasing MFP qualified residence opportunities.

7. Is it possible to reduce the required length of institutional stay from 90 days to 30–60 days and/or to count short-term rehab stays (including Medicare stays) toward the MFP demonstration institutional stay requirement?

No, the 90-day institutional stay requirement is a statutory requirement for the MFP program and cannot be modified. Section 2403 of the Patient Protection and Affordable Care Act (PPACA) amended section 6071(b)(2)(A) of the 2005 Deficit Reduction Act (DRA) to define an “eligible individual” as residing for a period of not less than 90 consecutive days in an inpatient facility and to indicate that “[a]ny days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for purposes of determining the 90-day period.”

8. Can MFP programs request funding for HCBS expenditures post-transition for more than the 12 months (365 days) currently allowed in statute?

No, the 12-month (365-day) limit on funding HCBS qualified services for MFP participants is a statutory requirement for the MFP program and cannot be modified. Section 6071(b)(7) of the DRA defines qualified expenditures as “expenditures by the State under its MFP demonstration project for HCBS for an eligible individual participating in the MFP demonstration project, but only with respect to services furnished during the 12-month period beginning on the date the individual is discharged from an inpatient facility.”

9. How does the CARES Act impact the Money Follows the Person (MFP) Demonstration Program?

Section 3811 of the CARES Act provides a short-term funding extension for the MFP Demonstration, increasing fiscal year (FY) 2020 MFP funding to \$337.5 million (from \$176 million) and appropriating a “pro rata” amount of the FY 2020 funding for FY 2021. While this provision of the CARES Act supports continued MFP program operations for current grantees, it does not make any other changes to the program.

For MFP grantees, the budget methodology process for calendar year (CY) 2020 remains the same and is not impacted by section 3811 of the CARES Act. As CY 2020 MFP budgets are reviewed and approved, and we are able to determine how the COVID-19 public health emergency is impacting MFP activities and spending, we will be able to better project how much

funding is remaining and how long states can continue transitions. Projections for funding availability for FY 2021 will be shared with MFP grantees as soon as possible.

MFP Project Officers are available to provide grantees with technical assistance related to supporting continued operations of MFP programs, identifying potential activities and programs that enhance and expand HCBS, and MFP program-specific challenges or issues related to COVID-19.

10. Can MFP programs obtain verbal informed consent to participate in MFP from participants in lieu of written consent during the COVID-19 public health emergency?

Yes. MFP programs may leverage MFP demonstration flexibility and resources to make temporary programmatic changes that are consistent with their state's and local communities' responses to COVID-19. As such, MFP programs may obtain verbal informed consent to participate in MFP from participants in lieu of written consent or other non-verbal forms of consent as documented in a state's Operational Protocol during the COVID-19 public health emergency. MFP grantees should notify their MFP Project Officer as soon as possible if they need to make programmatic changes, but states do not need to receive CMS approval before implementing programmatic changes to their MFP program's Operational Protocol if those changes are directly related to their response to COVID-19 and would be an allowable use of MFP funding and adhere to program requirements.

11. If CMS has approved a waiver of requirements under a section 1115, section 1135, or Appendix K 1915(c) waiver application, may we assume that approval would extend to the MFP services and processes as well?

Yes. If CMS has approved a section 1135 waiver, a section 1915(c) Appendix K application, or a section 1115 demonstration modifying the delivery of home and community based services (HCBS) available to eligible MFP participants, these changes would apply to MFP participants transitioning from MFP qualified inpatient facilities and to MFP participants receiving HCBS in MFP qualified community residences. MFP demonstration requirements for eligibility, furnishing of qualified HCBS services during the 365-day enrollment period, and assurance that the continuity of Medicaid covered HCBS is available to individuals after the 365-day period ends would remain unchanged. MFP programs should work with their respective state Medicaid agency partners to coordinate any changes to the delivery of HCBS that may affect MFP participants. MFP grantees should notify their MFP Project Officer as soon as possible of any changes to their MFP program's Operational Protocol.

12. Does the budget transfer flexibility related to COVID-19 under the MFP demonstration include supplemental demonstration services?

Yes. The budget transfer flexibility discussed in the April 8, 2020 letter sent to MFP grantees would extend to MFP "supplemental demonstration services." In addition to qualified HCBS and unique demonstration services, a state may choose to offer supplemental demonstration services reimbursed through grant funds at a rate based on the state's standard FMAP. The state may propose these services because they are essential for successful transition of MFP participants to

the community. These services should only be required during the transition period, or be a one-time cost to the program. These services are not expected to be continued after the demonstration period.

13. Are supplemental demonstration services available to individuals who are not MFP eligible?

No. MFP supplemental demonstration services are only available to eligible MFP participants.

14. Can a state request permission to provide certain equipment and supplies for MFP participants, above and beyond what would ordinarily be covered under a state's Medicaid program? If yes, would the state be able to continue them for the duration of the MFP participant's MFP enrollment?

Yes. Certain equipment and supplies above and beyond what would ordinarily be covered under a state's Medicaid program may be covered through MFP grant funds for activities that support the goals and intent of the MFP program and that directly support MFP participants. If an MFP grantee chooses to offer Medicaid home and community-based services (HCBS) not currently included in the state's HCBS program, MFP may cover the service as an MFP demonstration service. MFP demonstration services are different from qualified HCBS program services in that they are not required to continue after the conclusion of the demonstration program or, for the participant, after the end of the 365-day enrollment period. MFP demonstration services are documented in a state's approved Operational Protocol. Additionally, states are required to provide budget information and justification for demonstration services through supplemental budget submissions to the Office of Acquisitions and Grants Management (OAGM).

States can provide MFP demonstration services in response to COVID-19 for the 365-day MFP enrollment period, regardless of when the public health emergency terminates. However, MFP grant funds cannot be used to pay for services after an individual's 365-day MFP enrollment period ends.

15. If a state were to request permission to provide MFP demonstration services above and beyond what would ordinarily be covered under a state's Medicaid program would a state need to submit an Appendix K application?

No. States do not need to complete an Appendix K of the section 1915(c) waiver application if the equipment and services being offered to MFP participants are not being delivered through an HCBS program that operates under section 1915(c) of the Social Security Act (the Act).

However, states should follow the applicable rules and processes of those authorities if they are making changes to an HCBS program that operates under section 1915(c) of the Act or another Medicaid authority, regardless of whether any of the service costs are funded under MFP. In such cases, states should reach out to their CMS HCBS lead and request the Appendix K for the section 1915(c) waiver application if they need to request changes to a section 1915(c) waiver program, or have any questions about how to request approval under another Medicaid authority.

In general, MFP grantees should notify their MFP Project Officers as soon as possible if they need to make programmatic changes, but CMS reminds states that they do not need to receive

CMS approval before implementing changes to their MFP program's Operational Protocol if those changes are directly related to their response to COVID-19 and would be an allowable use of MFP funding and adhere to program requirements. Further, budget transfer flexibility is available to transfer up to 10% of MFP grant funds between budget line items for new activities as discussed in the April 8, 2020 letter sent to MFP grantees.

16. Can MFP demonstration programs use Medicaid funds to supply an MFP participant with shelf stable foods on a one-time basis? If an MFP program provides the supplies after the point of transition, is an Appendix K application needed for this change?

Yes. MFP demonstration programs covering one-time transition activities as a demonstration service for MFP participants may make a programmatic change to use MFP grant funds to offer food pantry stocking in response to COVID-19. After the point of an individual's transition from a facility, MFP demonstration services are furnished and grant funds are available for the individual's 365-day enrollment period. Demonstration services are not required to continue after the conclusion of the demonstration program or, for the participant, at the end of the 365-day enrollment period.

As previously noted, states do not need to complete an Appendix K of the section 1915(c) waiver application if the services being offered to MFP participants are not being delivered through an HCBS program that operates under section 1915(c) of the Act. Rather, states should follow the applicable rules and processes of those authorities if they are making changes to an HCBS program that operates under section 1915(c) of the Act or another Medicaid authority, regardless of whether any of the service costs are funded under MFP. Thus, states should reach out to their CMS HCBS lead and request the Appendix K for the section 1915(c) waiver application if they need to request changes to a section 1915(c) waiver program or have any questions about how to request approval under another Medicaid authority.

17. Under the MFP demonstration COVID-related budget transfer flexibility, are requests to transfer grant funds limited to serving only MFP participants?

Yes. Budget transfers under the MFP demonstration grant must be for activities that support the goals and intent of the MFP program and that directly support MFP participants. A service such as food delivery must directly support an MFP participant and supplies such as PPE must be for MFP participants or staff working with MFP participants.

Grantees should review the MFP letter and related budget forms provided to grantees in the April 8, 2020 grant note for more information on the flexibilities provided to MFP grantees related to COVID-19 and how to request budget approval for new activities related to COVID-19. Please contact your Grants Management Officer in the Office of Acquisition & Grants Management if you have any questions or need technical assistance related to MFP demonstration budget processes.

F. Miscellaneous

1. How can states best provide Medicaid services and supports to beneficiaries who are quarantined?

Through a 1915(c) Appendix K, if a Medicaid beneficiary already meeting an institutional level of care is quarantined in the community, states could add *Live in Caregiver* as a service, authorizing family members as providers. Therefore, a family member in the home who is not ill can render services to the quarantined individual and be funded as a live in caregiver. Home-delivered meals, such as Meals on Wheels, could be added to provide one meal per day to the individual. Additional services, such as private duty nursing, could also be added and payment rates could be increased to account for increased health risk to providers and to solicit a larger provider pool.

Access to Medicaid services provided in an individual's private home or group residential setting should not change because the beneficiary is quarantined. However, depending on the way the state has developed the benefit and description in the state plan, a SPA may be necessary to amend language to clarify where services may be provided. For benefits with federal requirements governing location, such as benefits that require services to be provided in a home and community based setting, CMS is available to provide technical assistance related to how states can comply with federal requirements in emergencies.

For individuals quarantined in institutional settings, regulations already require that nursing facilities (NFs) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) have an infection control policy, including policies for prevention, surveillance, and isolation. The facilities are already paid for this type of planning and care under their normal per diem rates.

Quarantine in an inpatient hospital setting could be considered an observation bed stay (for the period of observation to determine whether the individual needs an inpatient hospital stay), when covered by the state. Observation bed stays are not specifically mentioned in the federal Medicaid coverage regulations for inpatient or outpatient hospital services (42 C.F.R. §§440.2, 440.10, and 440.20), and states have discretion in whether to cover and how to pay for these services. Observation bed days of 24 hours or longer cannot be covered as an outpatient hospital service, but may be covered as an inpatient hospital stay (the Medicaid definition of outpatient described in 42 C.F.R. § 440.2 limits services to a less than 24-hour period).

If a service is tied to a specific setting, the service can be amended either through the state plan and/or through the Appendix K for 1915(c) programs.

2. Must states with existing Alternative Benefit Plan (ABP) programs take any action to receive the 6.2 percentage point increase in FMAP authorized under section 6008 of the Family First Coronavirus Response Act?

Yes, depending on the benefits provided under the ABP. In general, beginning March 18, 2020, the FFCRA requires states to cover COVID-19 diagnostic testing, including administration of the test, and testing-related services (COVID-19 testing), without cost sharing, for beneficiaries covered under the Medicaid state plan. Neither the FFCRA nor the CARES Act expressly

requires states to include this coverage for Medicaid beneficiaries who receive services under an ABP under section 1937 of the Act, although states may have designed such coverage to include COVID-19 testing. For example, many states have aligned their ABP benefits and cost sharing with state plan coverage; in these states, ABP coverage automatically will cover COVID-19 testing without cost sharing. As a result, no further action is necessary for these “state plan alignment” states. However, for non-state plan alignment states, additional action must be taken.

Section 6008(b) of the FFCRA establishes requirements that states must meet if they wish to qualify for the temporary 6.2% FMAP. These include providing coverage “under [the state] plan (or waiver), without the imposition of cost sharing for any testing services and treatments for COVID-19, including vaccines, specialized equipment, and therapies.” CMS interprets this to mean that, to qualify for the temporary 6.2% FMAP increase, the state would have to provide coverage for COVID-19 testing and treatment, without cost sharing, for beneficiaries receiving ABP coverage. Therefore, states operating ABPs that do not include the relevant services, without cost sharing in their programs must amend their ABPs in order to qualify for the enhanced FMAP. States may use the disaster SPA template, available at <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/state-plan-flexibilities/index.html>, to make these changes for the period of the public health emergency.

3. During the PHE, may states cover clinic services under 42 C.F.R. § 440.90 if the services are provided via telehealth and neither the patient nor clinic practitioner is physically onsite at the clinic?

Yes, but only if CMS provides the state with time-limited waiver authority pursuant to section 1135(b)(1)(B) of the Act. Under that provision, CMS can modify the requirement in 42 C.F.R. § 440.90 that clinic services be provided “by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients,” to permit services under 42 C.F.R. § 440.90 to be provided via telehealth when patients and clinic practitioners are in their respective homes or in another location. 42 C.F.R. § 440.90(a) requires that services covered under that benefit be provided “at the clinic” — that is, within the four walls of the clinic facility, with an exception at 42 C.F.R. § 440.90(b) for services furnished outside the clinic to people who are homeless. While states generally have broad flexibility to cover and pay for services provided via telehealth in their Medicaid program, unless states have a waiver of federal requirements applicable to specific Medicaid benefits, they must adhere to those federal requirements, including when benefits are provided via telehealth. Historically, states have covered clinic services under 42 C.F.R. § 440.90 that were provided via telehealth only if either the patient or the clinic practitioner was physically onsite at the clinic facility. However, under section 1135 of the Act, CMS could modify the “facility” requirement in 42 C.F.R. § 440.90 to permit the state and clinic to temporarily designate a clinic practitioner’s location as part of the clinic facility. This, in turn, would permit clinic services to be provided via telehealth when neither the patient nor practitioner is physically onsite at the clinic, because it would permit services provided via telehealth in clinic practitioners’ homes (or another location) to be considered to be provided at the clinic for purposes of 42 C.F.R. § 440.90(a). Such a waiver would help to ensure continued Medicaid coverage for clinic services during the PHE, and would also facilitate the urgent need for states to employ all measures to prevent the spread of COVID-19 during the PHE. To submit

a section 1135 waiver request, a state should send the request via email to its State Lead and to Jackie Glaze at Jackie.Glaze@cms.hhs.gov.

4. Can a state fund PPE for beneficiaries using state plan authority?

Yes. A state may cover PPE for Medicaid beneficiaries if determined to be medically necessary under the home health medical supplies, equipment, and appliances benefit (42 C.F.R. 440.70(b)(3)). States may apply limits on amount, duration, and scope of benefits as long as the benefit is sufficient in amount, duration, and scope to meet the purpose of the benefit.

5. Can a state fund PPE for beneficiaries or unpaid caregivers in a section 1915(c) Home and Community-Based Services Waiver Appendix K?

Yes. States can fund PPE for beneficiaries or unpaid caregivers to ensure the health and welfare of the recipient under the authority of section 1915(c)(4)(B) of the Act. As long as the PPE is being used to deliver care to the individual, it can be covered by adding a service such as Extended State Plan Services: Medical Supplies, Equipment and Appliances into the Appendix K.

6. Does the increased FMAP apply to the Phased-Down State Contribution (also referred to as the “clawback”) for prescription drug costs for full-benefit dual eligible individuals enrolled in Medicare Part D?

Yes, the State Contribution, which states are liable to pay each month under section 1935(c) of the Act, will incorporate the increased FMAP for the applicable period, provided the state meets the qualifying requirements in section 6008(b) and (c) of the FFCRA.

G. Non-Emergency Medical Transportation

1. Can a state temporarily allow non-enrolled, non-emergency medical transportation providers, including providers of non-emergency ambulance services, to furnish covered NEMT services?

A: No. There is no categorical waiver of provider enrollment requirements. CMS has provided guidance on how states may request and receive CMS approval for certain limited waivers concerning provider enrollment requirements, for example, to streamline enrollment requirements, waive certain conditions of participation, and waive state licensure requirements where the provider has an equivalent license in another state. See: <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/section-1135-waiver-flexibilities/index.html>. However, provider enrollment and screening are a condition of payment and as such cannot be waived by the agency. Furthermore, any abbreviated enrollment under an approved section 1135 waiver is temporary and must be either converted to a full enrollment (with the provider fully screened and appropriately licensed in the state), or deactivated within 6 months after the PHE is lifted.

2. Can a state use ride sharing companies to supplement the NEMT network?

Yes. There are no federal Medicaid rules that would prohibit otherwise qualified ride sharing companies from participating in the Medicaid program and providing transportation. To receive Medicaid payment, the ride sharing company must be enrolled as a provider in the Medicaid program. However, states may pursue a streamlined enrollment process using section 1135 flexibility, as described in the answer to the previous question.

3. Can the state suspend the requirement that a Medicaid-funded ride be the least costly and most appropriate vehicle for the beneficiary? Would this allow a state to utilize a non-emergency ambulance provider to furnish transportation in circumstances where this would not otherwise be the least costly and most appropriate form of transportation?

No, but states have flexibility under the state plan to determine the least costly and most appropriate vehicle for the beneficiary. Specifically, the requirement to utilize the least costly and most appropriate ride is based on the requirements in section 1902(a)(30)(A) of the Act, which requires the state plan to provide for methods and procedures relating to utilization of and payment for care and services as necessary to guard against unnecessary utilization and assure that to payment is consistent with “efficiency, economy and quality of care[.]” When transportation is assured as an administrative activity under the plan, rather than as an optional medical service, the methods of administration with respect to transportation must be necessary for the “proper and efficient” operation of the plan, as specified in section 1902(a)(4) of the Act. As specified in 42 C.F.R. § 431.53(a), the state must “ensure necessary transportation.” Accordingly, states have the flexibility and the responsibility to determine when a Medicaid-funded ride is “necessary,” which includes a determination whether the ride is the least costly and most appropriate mode of transportation available to meet the beneficiary’s need. Thus, a state can make the determination that the least costly and most appropriate vehicle for a given transport is a non-emergency ambulance provider when no other appropriate form of transportation is available, including in circumstances where this would not be the least costly and most appropriate form of transportation if another appropriate form of transportation were available to the beneficiary. For example, if a beneficiary who has been diagnosed with COVID-19 requires transportation to a dialysis facility or is ready for discharge from a hospital, in consideration of necessary infection control protocols in light of the patient’s COVID-19 diagnosis, it could be appropriate for the state to authorize an ambulance to transport the beneficiary if the state determines that the ambulance is the least costly and most appropriate mode of transportation available to meet the beneficiary’s need.

4. Can the NEMT benefit be used to deliver meals to vulnerable populations?

Yes, under limited circumstances for certain beneficiaries. The NEMT benefit requires states to assure that beneficiaries with no other transportation resources have access to Medicaid-covered medical services. Under section 1915(c) waiver and section 1915(i) state plan authority, the state can cover the delivery of meals to individuals served by those programs by adding home delivered meals as a service option and the NEMT providers can be included in the list of qualified providers (as indicated on page 53 of the “Application for a §1915(c) Home and Community-Based Waiver [Version 3.6, January 2019], Instructions, Technical Guide and Review Criteria” available at <https://wms-mmdl.cms.gov/WMS/faces/portal.jsp>). If there is an

issue with paying one provider for the meals and the transportation provider for transporting them, the state can have two components to the rate with different rates for each component.

5. If there is a shortage of NEMT providers, can the state prioritize NEMT for a subset of the Medicaid population according to who needs essential services?

No, not without a section 1115 waiver. The state is required to assure transportation for all Medicaid beneficiaries. However, a state can prioritize rides based on the medical necessity for a ride, as long as the transportation needs of all beneficiaries are met. In the event that there is a shortage of available NEMT providers, states can request CMS approval for a waiver of the Medicaid comparability requirement of sections 1902(a)(10)(B) and 1902(a)(17) under a section 1115 demonstration, which, if approved, could enable the state to triage the provision of NEMT to meet the needs of beneficiaries with the most critical requests.

6. Can the state request a temporary waiver of the requirement in 42 C.F.R. § 440.170(a)(4)(ii)(A), which currently prohibits contracted NEMT transportation brokers from directly providing trips to Medicaid clients in specified circumstances?

No, generally, the broker is prohibited from being a provider of transportation, as specified in the cited regulation. However, the current regulations in 42 C.F.R. § 440.170(a)(4)(ii)(B) allow four exceptions to this requirement: (i) when transportation is provided in a rural area as defined in 42 C.F.R. § 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the state to be qualified except the non-governmental broker; (ii) when transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the state to be qualified except the non-governmental broker; (iii) when the availability of other non-governmental Medicaid participating providers or other providers determined by the state to be qualified is insufficient to meet all the need for transportation; and (iv) the broker is a government entity and the individual service is provided by the broker, or is referred to or subcontracted with another government-owned or operated transportation provider generally available in the community, and specified conditions are met. When applicable and if needed, the state can submit a disaster SPA to implement one or more of these exceptions during the emergency period.

H. Health Resources and Services Administration (HRSA) Uninsured Provider Fund/Medicaid Coordination of Benefits

1. What is the difference between the funds available to reimburse providers for COVID-19 testing and treatment services furnished to uninsured individuals through the Health Resources and Services Administration (HRSA) and the funds available through the Families First Coronavirus Response Act (FFCRA) to provide Medicaid coverage of COVID-19 testing services for uninsured individuals?

The new optional COVID-19 testing eligibility group, added by section 6004(a)(3) of the FFCRA at section 1902(a)(10)(A)(ii)(XXIII) of the Social Security Act, is similar to other optional eligibility groups under which states can elect to furnish a targeted set of benefits to eligible individuals. To reimburse providers for the covered services, a state must elect to adopt

this group under its state plan. States that do so can then reimburse providers enrolled in their Medicaid program for in vitro diagnostic testing and other COVID-19 testing-related services furnished to individuals whom the agency has determined are eligible under the new group. For more information on the eligibility requirements for the optional COVID-19 testing eligibility group, covered benefits, the availability of hospital presumptive eligibility for the new group, and the availability of 100 percent FMAP for the testing services provided to individuals eligible under the optional COVID-19 testing eligibility group, see <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-CARES-faqs.pdf>

The Health Resources and Services Administration (HRSA) is administering a separate program, referred to as the COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured Program (COVID-19 Claims Reimbursement for Testing and Treatment of the Uninsured). This program provides reimbursement directly to eligible providers for uninsured individuals and has two components:

1. Reimbursement for COVID-19 testing services. This component, authorized via the FFCRA and the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139) (PPPHCA), reimburses providers for conducting COVID-19 testing for uninsured individuals. The FFCRA and the PPPHCA each appropriated funding for this purpose.
2. Reimbursement for COVID-19 treatment services. This component is authorized via the CARES Act and PPPHCA, which provide funds for hospitals and other health care providers, including those on the front lines of the COVID-19 response. A portion of this funding is being used to support healthcare-related expenses attributable to the treatment of uninsured individuals with COVID-19.

To access these funds, health care providers must enroll in the program as a provider participant. Once they have done so, they can submit claims for direct reimbursement for COVID-19 testing and treatment services furnished to uninsured individuals on or after February 4, 2020.

Additional information on the COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured Program can be found on HRSA's website at <https://www.hrsa.gov/coviduninsuredclaim>

Note that individuals who are enrolled in a state's Medicaid program, including otherwise uninsured individuals enrolled in the new optional COVID-19 testing eligibility group, are not considered uninsured for purposes of provider reimbursement of COVID-19 testing services through the HRSA-administered program. However, providers can submit claims through the HRSA-administered program for COVID-19 treatment services provided to individuals who are enrolled in the new optional COVID-19 testing eligibility group but who do not have any health care coverage for treatment services.

2. What steps should a provider take to ensure its claims for COVID-19 testing are paid using the appropriate federal funding source, Medicaid or HRSA's COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured Program?

In most cases, providers can utilize the Medicaid Eligibility Verification System (MEVS) to verify if an individual is enrolled under Medicaid. This may include the new optional COVID-

19 testing eligibility group in states that have adopted this new group. If an individual is not enrolled in the Medicaid COVID-19 testing eligibility group and is otherwise uninsured at the time of services, a participating provider may file a claim with the HRSA-administered program for COVID-19 testing services furnished to the individual as long as the services provided meet the [coverage](#) and [billing](#) requirements established as part of the program.

3. How will HRSA operationalize coordination of benefits with Medicaid for the new optional COVID-19 testing group?

Individuals with Medicaid coverage of COVID-19 testing and testing-related services are not eligible for coverage of testing and testing-related services through the COVID-19 Claims Reimbursement Program. To ensure appropriate billing, HRSA will coordinate benefits between the COVID-19 Claims Reimbursement Program and Medicaid, via HRSA's claims contractor, UnitedHealth Group (UHG). UHG will perform third party clearances at the initial receipt of a claim and conduct retrospective reviews periodically. If UHG has paid a claim for COVID-19 testing or testing-related services but determines that the individual to whom the services were furnished is eligible for and enrolled in Medicaid (including in the new optional COVID-19 testing group) with coverage effective dates that include the relevant date(s) of service, UHG will recover HRSA's claims payment(s) from the provider and will advise the provider to bill Medicaid, as primary payer. Providers may submit claims through the HRSA-administered program for COVID-19 treatment services provided to otherwise uninsured individuals who are enrolled in the new optional COVID-19 testing eligibility group but who do not have coverage for treatment services.

4. If the State Medicaid agency later determines the existence of a liable third party for an individual enrolled in the new optional COVID-19 testing group who received testing services, will States need to follow coordination of benefits requirements?

Yes, once an individual becomes Medicaid eligible, including Medicaid coverage received under the new optional COVID-19 testing group, the state must take steps to coordinate benefits with all identified liable third parties that pay primary to Medicaid, pursuant to generally applicable requirements for coordination of benefits/third party liability (COB/TPL). Examples of benefits/third parties subject to COB/TPL for health coverage include employer sponsored health plans, Medicare, and commercial/private insurers. If after Medicaid has paid, a liable third party is identified, the state must seek recovery of Medicaid payment(s). Pursuing payment of claims ensures Medicaid remains payer of last resort (see 42 C.F.R. § 433.139). Because Medicaid pays primary to the HRSA-administered COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured Program (COVID-19 Claims Reimbursement Program), states are not responsible for initiating COB/TPL processes to identify payment from that HRSA-administered program. See Question 3 regarding COB between Medicaid and the COVID-19 Claims Reimbursement Program.

IV. Financing

A. Administrative Claiming

1. Can states claim Medicaid administrative match for COVID-19 related activities, such as surveillance activities related to the spread of COVID-19?

Yes, to the extent states conduct COVID-19-related activities for the administration of the Medicaid program and can determine Medicaid costs through an allocation methodology that meets all applicable cost allocation requirements, administrative match is available. Amendments may be needed to the public assistance cost allocation plan to allocate additional costs to the Medicaid program. CMS will work with states on an expedited basis to assist in determining cost allocation methodologies and updating cost allocation plans.

2. From the perspective of State Program Administrative Claiming, what options do states have as far as supporting COVID-19 initiatives?

Increases in allowable and allocable state program administrative costs, resulting from COVID-19 initiatives, would be recognized as part of the state's expenditures necessary for proper and efficient administration of the state plan. If revisions to the Public Assistance Cost Allocation Plans and other CMS-approved cost allocation plans and methodologies, including time study methodologies, are needed specifically to address the impact of COVID-19 public health emergency, the state should reach out to CMS, and we will work with the state to process necessary revisions expeditiously. We note that administrative costs resulting from COVID-19 initiatives are not eligible for the 6.2% FMAP increase authorized under the FFCRA.

3. If school is in session but being conducted remotely, for the purposes of the Random Moment Time Study (RMTS) used in allocating Medicaid administrative cost, please confirm that eligible RMTS school staff may continue to respond to their sampled RMTS moment indicating their activity for their sampled date and time (even if they were working remotely).

Yes, even though the participant is working remotely, he or she may respond to the sampled RMTS moment.

4. For those individuals sampled for the RMTS who are not working, please confirm that the state or school district can report the time as paid or unpaid time not working.

For those individuals who are sampled, but are not working, the sample moment should be coded to paid time not working if they are salaried, or unpaid time if they are furloughed without pay or in some other unpaid status at the time of the sample moment. The moments that are coded to paid time not working should be reallocated across the other activity codes and a portion of the costs recognized.

5. The current Medicaid Administrative Claiming (MAC) Plan provides guidance for a situation when 85% percent RMTS compliance isn't reached, by allowing moments to be coded as non-Medicaid until compliance is reached. However, the plan also requires individual districts to reach 85 percent RMTS participation or potentially incur penalties and/or non-participation in claiming. Would CMS be willing to NOT impose individual district penalties while the school districts are working remotely during the pandemic?

We recognize that RMTS overall staff participation may be affected by the COVID-19 pandemic. During the timeframe of the declared Public Health Emergency, CMS would not ask states to impose any individual district penalties for districts that do not reach 85 percent RMTS participation. States could modify the MAC Plan to temporarily suspend this requirement during the public health emergency.

B. Advance and Retainer Payments

1. During the public health emergency period, can states receive federal funding to provide advanced payments to providers as an interim payment and reconcile the advanced payments with actual processed claims at a later point?

Under state plan authority, states can submit a SPA to add an interim payment methodology that says, under certain specified conditions, states will make periodic interim payments to the providers. The interim payment methodology must describe how states will compute interim payment amounts for providers (e.g., based on the provider's prior claims payment experience), and subsequently reconcile the interim payments with final payments for which providers are eligible based on billed claims. The interim payment methodology would not be a prepayment prior to services being furnished, but rather would represent interim payments for services furnished that are subject to final reconciliation. CMS will consider such SPAs on an expedited basis and additional flexibilities with respect to the SPA submission and approval process may be available pursuant to emergency authorities under section 1135 of the Act. States should contact their designated reimbursement contact for technical assistance with the SPA submission process.

2. Is there flexibility to request/implement temporary rate increases or retainer payments in a 1915(i) SPA similar to those found in Appendix K for 1915(c) HCBS waivers?

States may increase Medicaid payment rates to offset losses to providers during the COVID-19 pandemic, if consistent with all applicable requirements, including section 1902(a)(30)(A) of the Act. FFP is not available under the Medicaid state plan to pay providers directly for the time when care is not provided to beneficiaries. However, on March 22, 2020, CMS released a template that states may use to request a section 1115 demonstration to combat the COVID-19 public health emergency, which allows states to request authority to make retainer payments to certain habilitation and personal care providers to maintain capacity during the emergency consistent with the limitations set forth in Appendix K. The template may be downloaded at this link: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-application-process/index.html>.

3. What are the parameters for retainer payments authorized under section 1915(c) Home and Community-Based Services (HCBS) waivers, which may be used to maintain funding for providers not able to operate during the COVID-19 pandemic?

Retainer payments allow a provider to continue to bill for individuals who are enrolled in a program or who are receiving a HCBS service as specified in his/her person-centered service

plan when circumstances prevent the individual from receiving the service. Therefore, retainer payment amounts are tied to amounts reflective of the services that would have been provided to enrolled members should the pandemic not have occurred. Self-quarantining activities during the COVID-19 pandemic, which may lead to the temporary closure of a program, are circumstances that may prevent individuals from receiving their HCBS services.

Retainer payments have been used historically under the section 1915(c) HCBS waivers since 2000. A July 2000 State Medicaid Director's letter, available at <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/smd072500b.pdf>, announced specific parameters for the retainer payments, including that:

- Retainer payments are limited to providers of personal assistant services, and
- The length of time retainer payments could be used is the "lesser of 30 consecutive days or the number of days for which the state authorizes a payment for 'bed-hold' in nursing facilities.

The 2000 guidance did not place any restrictions on the number of time-limited periods (episodes) of retainer payments that could be authorized for a beneficiary. While retainer payments up to 30 days may be implemented within a section 1915(c) waiver application itself, consistent with prior disasters, states may authorize up to three 30-day episodes of retainer payments for an individual during the period of the disaster using the Appendix K. For all retainer payments, states will need to describe the methodology for determining the length of time retainer payments will be made available, and any limits on the number of episodes a state will fund (including specifying whether there will be a break in billing between episodes). CMS notes that the state can set the rate for retainer payments at a percentage below the full rate for the service.

CMS also notes that the references in the 2000 guidance to retainer payments being available for personal care services may also be viewed to incorporate the breadth of HCBS in which support for activities of daily living or instrumental activities of daily living occur. This would typically encompass most residential habilitation programs as well as many non-residential day programs providing services (because personal care is a component of the service).

CMS also clarifies that consecutive days are those days that are eligible for billing. As typical day habilitation services are rendered Monday through Friday, 30 consecutive billing days would encompass a 6-week period of time.

For states that are seeking to contractually require managed care plans to make retainer payments to providers where the authorized service is covered under the contract, states must seek approval under 42 CFR 438.6(c) for state directed payments. In order for states to seek approval under 42 CFR 438.6(c), the retainer payments must be authorized as part of the section 1915(c) HCBS waiver, section 1115(a) demonstration waiver for section 1915(c) HCBS services, or other Medicaid authority. Once the retainer payments are authorized under one of these authorities, a state directed payment preprint must also be submitted to effectuate the state directed retainer payments under a state's contract with its managed care plans. CMS published

detailed guidance on this approach at: <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051420.pdf>.

4. What controls should states set on retainer payments authorized under section 1915(c) Home and Community-Based Services waivers?

States interested in utilizing retainer payments for multiple (up to three) episodes of up to 30 days per beneficiary will be expected to include or add the following guardrails in their Appendix K submissions:

- Limit retainer payments to a reasonable amount and ensure their recoupment if other resources, once available, are used for the same purpose. In terms of setting a reasonable amount, a retainer payment cannot exceed the payment for the relevant service; the state may specify that a retainer payment will be made at a percentage of the current rate, or a state may specify retainer payments will not be made to a setting until attendance is below an identified percentage of the enrollment (e.g., 75 percent).
- Collect an attestation from the provider acknowledging that retainer payments will be subject to recoupment if inappropriate billing or duplicate payments for services occurred (or in periods of disaster, duplicate uses of available funding streams), as identified in a state or federal audit or any other authorized third party review. Note that “duplicate uses of available funding streams” means using more than one funding stream for the same purpose.
- Require an attestation from the provider that it will not lay off staff, and will maintain wages at existing levels.
- Require an attestation from the provider that they had not received funding from any other sources, including but not limited to unemployment benefits and Small Business Administration loans, that would exceed their revenue for the last full quarter prior to the PHE, or that the retainer payments at the level provided by the state would not result in their revenue exceeding that of the quarter prior to the PHE.
 - If a provider had not already received revenues in excess of the pre-PHE level but receipt of the retainer payment in addition to those prior sources of funding results in the provider exceeding the pre-PHE level, any retainer payment amounts in excess would be recouped.
 - If a provider had already received revenues in excess of the pre-PHE level, retainer payments are not available.

States utilizing retainer payments for one period that is the lesser of 30 consecutive days or the number of nursing facility bed-hold days will have the option of requiring providers to comply with these guardrails.

5. Can states request retainer payments for services in the section 1915(i) and section 1915(k) State Plan benefits?

Yes. Retainer payments may be used to allow a provider to continue to bill for services as specified in the beneficiary’s person-centered service plan when circumstances, including self-quarantining activities during the COVID-19 pandemic, prevent the individual from receiving the service. Therefore, retainer payment amounts are tied to amounts reflective of the services

that would have been provided to enrolled members should the pandemic not have occurred. Typically, retainer payments are limited to when there is an acute spell of illness or other medically necessary absence takes the individual out of the HCBS setting. However, the pandemic has presented unique situations such as the need to self-quarantine or isolate, which could prevent the personal attendant from entering an individual's home or place of service receipt.

Section 1915(i)(1) of the Act permits states to include HCBS that are within the scope of services at section 1915(c)(4)(B) of the Act. Likewise, 42 CFR § 441.700 permits states to offer HCBS listed under 42 CFR § 440.182. As indicated in previous guidance, retainer payments are permissible within the scope of section 1915(c) waiver personal care and habilitation services that include a personal care component. Therefore, they are also within the scope of what would be permissible for a state using the same services in a section 1915(i) state plan benefit. As an example, where the individual is unable to attend a qualified program such as a day habilitation program authorized under section 1915(i) because of the closure of the program due to social distancing/self-isolating requirements, retainer payment may be made.

In terms of section 1915(k), 42 CFR § 441.520(a)(3) requires the inclusion of backup systems or mechanisms (backup systems) in all Community First Choice (CFC) programs. Backup systems, as defined in 42 CFR § 441.505, are used to ensure continuity of CFC services and supports, and retainer payments could be used to meet this requirement. The retainer payment could be used to retain the availability of an individual's personal attendant when an event removes an individual from his or her home or place of service receipt, or prevents a personal attendant from providing services in the home or place of service provision. Such payments are useful in preserving the availability of the attendant upon the return to typical service provision. This serves to ensure continuity of services and supports. For example, an individual may need to receive a few weeks of rehabilitative services in a skilled nursing facility. The individual plans to return home and wants to receive services from his personal attendant who has been providing services for the past several years. Under this circumstance, a retainer payment could be made to ensure the personal attendant will be available to provide services upon the individual's return to his home. Although retainer payments could be used as part of the backup system for individuals, the backup system must also address how individuals will receive needed services in the absence of their attendant.

6. How does a state request retainer payments for services under the section 1915(i) and/or the section 1915(k) Community First Choice benefit?

The state can use either the Disaster Relief SPA or complete an amendment to an approved section 1915(i) or section 1915(k) using the appropriate template. See the following question for additional specifications on which submission vehicle will be more appropriate. Previous guidance had indicated states must use section 1115 authority to authorize retainer payments for services under sections 1915(i) and 1915(k); however, section 1115 demonstration authority is not required to authorize this flexibility.

7. What are the controls on retainer payments for services in the section 1915(i) HCBS State Plan benefit and section 1915(k) Community First Choice benefit?

If the state elects to make such payments, the applicable state plan must describe the circumstances under which such payments are authorized, and applicable limits on their duration. Consistent with retainer payment utilization in section 1915(c) waivers, retainer payments that are the lesser of 30 consecutive days or the number of nursing facility bed-hold days may be permanently authorized in a state's section 1915(i) or section 1915(k) state plan program, using the general state plan pre-prints. In addition, states may authorize up to three 30-day episodes of retainer payments for an individual during the pandemic. States interested in utilizing retainer payments for multiple (up to three) episodes of up to 30 days per beneficiary will be expected to include or add the following guardrails in their SPA submissions:

- Limit retainer payments to a reasonable amount and ensure their recoupment if other resources, once available, are used for the same purpose. In terms of setting a reasonable amount, a retainer payment cannot exceed the payment for the relevant service; the state may specify that a retainer payment will be made at a percentage of the current rate, or a state may specify retainer payments will not be made to a setting until attendance is below an identified percentage of the enrollment (e.g., 75 percent).
- Collect an attestation from the provider acknowledging that retainer payments will be subject to recoupment if inappropriate billing or duplicate payments for services occurred (or in periods of disaster, duplicate uses of available funding streams), as identified in a state or federal audit or any other authorized third party review. Note that “duplicate uses of available funding streams” means using more than one funding stream for the same purpose.
- Require an attestation from the provider that it will not lay off staff, and will maintain wages at existing levels.
- Require an attestation from the provider that they had not received funding from any other sources, including but not limited to unemployment benefits and Small Business Administration loans, that would exceed their revenue for the last full quarter prior to the PHE, or that the retainer payments at the level provided by the state would not result in their revenue exceeding that of the quarter prior to the PHE.
 - If a provider had not already received revenues in excess of the pre-PHE level but receipt of the retainer payment in addition to those prior sources of funding results in the provider exceeding the pre-PHE level, any retainer payment amounts in excess would be recouped.
 - If a provider had already received revenues in excess of the pre-PHE level, retainer payments are not available.

For states that document these authorizations in their Disaster SPAs, which terminate at or before the conclusion of the PHE, CMS is available for technical assistance on amending the underlying state plan to authorize retainer payments beyond the period of the PHE, if necessary.

8. Can CMS provide further guidance on the type of interim payment arrangements that are permissible under the state plan?

As discussed in Section IV. Financing, Question B.1, under state plan authority, states can submit a SPA to add an interim payment methodology that says, under certain specified conditions, states will make interim payments on a periodic, lump sum basis to qualifying providers during the public health emergency period. Such periodic, lump sum interim payments to providers would be in lieu of payments based on individual claims, with a reconciliation to actual services furnished to occur at the end of a defined interim payment period. During the interim payment period, the provider would continue to submit claims for the services it provides, and the state would adjudicate the claims to determine eligibility and coverage; however, no actual payments would be remitted to the providers based on those claims, which would be subtracted from the interim payment amounts to determine the balance due from (or to) the provider upon reconciliation.

Interim payment amounts could be set using the current state plan rate and anticipated utilization during the interim payment period. Regardless of whether prior period utilization is used as a reasonable proxy for current utilization during the interim payment period, we expect that providers (identified by the state in their SPA) receiving interim payments would continue to furnish services to Medicaid beneficiaries during the interim payment period and would not limit access to care. Interim payments are not a prepayment for services, meaning interim payments in a payment period do not represent payments for services in future payment periods. At the end of the defined interim payment period, for each provider, the state reconciles the interim payments to the amounts that would have been received for the billed claims for services provided to Medicaid beneficiaries. Any interim payments in excess of what the claims payments would have been are treated as provider overpayments, and the federal share of such overpayments are returned to CMS in accordance with 42 C.F.R. Part 433, Subpart F. Furthermore, the reconciliation of the interim payments to claims payment amounts are reported on the CMS-64 as prior period adjustments. The interim payment methodology does not waive applicable federal requirements, including those governing provider submission of claims and state processing of claims in 42 C.F.R. § 447.45, or state claiming of expenditures for federal financial participation in 45 C.F.R. Part 95, Subpart A.

9. What information does a state need to include in a Medicaid disaster relief SPA to effectuate a new interim payment arrangement during the PHE?

State proposals on periodic, lump sum interim payments should comprehensively specify within the SPA:

- Qualifications that providers must meet to receive interim payments in lieu of routine claims payments.
- The methodology for computing the interim payment for a qualifying provider.
- The service period interval each interim payment would represent (weekly, monthly, quarterly).
- The duration of the interim payments (e.g. the entire duration of the PHE).
- The timeframe the state will use to reconcile interim payments to actual claims data.
- An assurance that FFP related to interim payments in excess of actual claims will be returned to CMS in accordance with 42 C.F.R. Part 433, Subpart F.

CMS is available to provide technical assistance as states develop their SPAs related to interim payments.

10. Can states continue to make payments on a provider’s claims for Medicaid services at the same time as the provider is receiving interim payments?

No. Under the interim payment methodology, described in Section IV Financing, Question B.1, the interim payment becomes the state plan payment for services until the reconciliation occurs. To make an interim payment and a payment on a routine claim for services would result in a duplicate payment. Similarly, we note that “retainer payments” and “interim payments” are two separate payment concepts and are not to be interpreted as serving the same purpose. While retainer payments are made in the absence of care to a beneficiary, interim payments are made in advance for expected care and reconciled to payments for actual services delivered to beneficiaries.

11. How long do states have to reconcile the interim payments made during the PHE with the state plan payment rate for services?

Within the SPA, the state should establish a reasonable timeframe for the reconciliation to occur. Under the interim payment methodology, described in Section IV. Financing, Question B.1, the interim payment becomes the state plan payment for services, and the reconciliation would be considered a prior period adjustment for which the time limits under 45 C.F.R. §95.7 would apply. Any claims payments in excess of the interim payments would result in increasing prior period adjustments that are also subject to the time limits under 45 C.F.R. §95.7. If a state plan methodology pays providers via a reconciled cost methodology, payments under that methodology could continue to qualify for an exception under 45 C.F.R. §95.19(a), consistent with current CMS policy.

C. Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) Services

1. Are “telephonic services” provided by federally qualified health centers (FQHCs) or rural health clinics (RHCs) eligible for FFP during and immediately following a declared state of emergency?

Yes, FFP is available for telephonic services. If a state’s approved state plan excludes FQHC/RHC services from being provided telephonically, CMS can work with the state to expedite processing of a state plan amendment to lift this restriction.

2. Do states need to submit a SPA if they pay the same PPS rate for telephonic services provided by FQHCs or RHCs as they pay for services delivered in-person?

No state plan amendment is needed if the state plan does not specifically define a visit for the purpose of reimbursing FQHC services as a “face to face encounter” with an eligible provider type. If it does, and states would like to reimburse telephonically delivered services at the PPS rate, they would need to submit a SPA amending the definition of a visit.

3. Can states pay FQHCs and RHCs an amount less than the PPS rate on a FFS basis with an approved SPA or waiver? Additionally, if a service is provided telephonically, can the state pay the provider an amount lower than PPS for the telephonic service delivered via telehealth?

If a service is covered within the scope of the FQHC/RHC benefit, section 1902(bb) of the Act requires a state to pay a provider using the state plan prospective payment system (PPS) rate or an alternative payment methodology (APM) that pays at least the PPS rate. For services that are not covered as part of the FQHC/RHC benefit, a state may pay providers using the state plan fee-for-service payment methodology established for that service. Rates for those services may be lower than the PPS or an APM paid for FQHC/RHC services, provided the rate is consistent with all other applicable requirements, including section 1902(a)(30)(A) of the Act. This policy applies whether a service is delivered face-to-face or telephonically.

4. Do states need a SPA or waiver to authorize payment for FQHC or RHC services provided off the clinic premises, including at a temporary shelter, a beneficiary's home, or any location other than the clinic but within the boundaries of the state of emergency proclamation?

FQHCs and RHCs generally may provide services outside the four walls of the clinic. If a state is concerned that something in its existing state plan might prevent that, CMS can work with the state to determine whether a state plan amendment might be necessary. If a state plan amendment is necessary, CMS can work with the state to expedite processing it. We encourage states to maximize this flexibility during the emergency response to ensure necessary care is delivered within communities.

5. Healthcare Common Procedure Coding System (HCPCS) code G0071 is reimbursable to FQHC and RHCs for virtual communication activities, including telephone calls. Do states need to submit a SPA to activate that code?

States do not need to submit a state plan amendment to activate HCPCS code G0071 unless the state decides to pay a rate for that code that is different from the face-to-face encounter rate approved in the Medicaid state plan.

6. During the PHE, how can a state temporarily increase payments to FQHCs to recognize additional costs incurred or higher cost per encounter?

Using the Medicaid disaster template SPA, a state may propose to temporarily increase FQHC rates above the statutory PPS rates by proposing to implement a temporary alternative payment methodology (APM) under section 1902(bb)(6) of the Act. Each FQHC must individually agree to receive such an APM. The APM can be set in the form of a higher encounter rate or as an encounter rate add-on.

D. Payment Rates and Methodologies

1. In what ways might states use the Medicaid disaster relief SPA template to increase payments to providers during the PHE?

States can use the Medicaid disaster relief SPA template to increase payments to providers during the emergency period. This includes, but is not limited to: increasing payments to providers that are seeing an influx in Medicaid patients as a result of the PHE; recognizing additional costs incurred through the provision of Medicaid services to COVID-19 patients; increasing payments to recognize additional cost incurred in delivering Medicaid services, including additional staff costs and/or personal protective equipment; adjusting payments to providers to account for decreases in service utilization but an increase in cost per unit due to allocation of fixed costs or an increase in patient acuity as a result of the PHE; or increasing payments for Medicaid services delivered via telehealth to ensure that Medicaid services are delivered in a safe and economical manner. The payment increases can take the form of dollar or percentage increases to base payment rates or fee schedule amounts, rate add-ons, or supplemental payments, depending on the applicability to the state's payment methodology for the provider and service categories. Payments must comport with all applicable requirements, including those under section 1902(a)(30)(A) of the Act. SPA approvals and other COVID-19 related waiver documents may be found here: <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/coronavirus-disease-2019-covid-19/index.html>.

2. During the public health emergency, some providers are experiencing significant cost increases. Without knowing how much costs will increase right now, how should states approach making adjustments to Medicaid payment rates and methodologies to ensure that Medicaid costs are paid during the public health emergency period?

States have flexibility to make reasonable adjustments to Medicaid payments to better align Medicaid payments with the increased cost of providing services to Medicaid beneficiaries during the PHE under the Medicaid state plan through base and supplemental payments. Such adjustments could include, but are not limited to, an increase resource utilization to account for the need for more personal protective equipment or other increased safety measures, but we would consider state's justification for increases in payment rates during the PHE. We recognize the uncertainty and challenges states and providers are facing and will work with them on their proposals to increase Medicaid payments to help assure Medicaid patients have access to services. Payments must comport with all applicable requirements, including those under section 1902(a)(30)(A) of the Act.

3. If states have made supplemental payments to hospitals and nursing facilities in the past, can they make those payments to other provider types, including providers that are not subject to aggregate payment limits? How might those payments be structured?

States have considerable flexibility in establishing payment rates and methodologies for providers under the Medicaid state plan. Payments under the state plan must be consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area, as required under section 1902(a)(30)(A) of the Act. Unless there are limitations on provider payments otherwise specified

in statute or regulation, states may make supplemental payments to providers under the Medicaid state plan. States have considerable flexibility in how these payments may be structured, but they must be consistent with section 1902(a)(30)(A) of the Act.

4. We are experiencing an outbreak in some areas of our state but not others. Can we target Medicaid payment increases to certain geographic regions? Similarly, we would like to target additional payment to certain provider types, such as safety-net providers or rural providers. Can we target Medicaid payment increases to certain providers?

Yes. Section 1902(a)(30)(A) of the Act requires that payments under the state plan must be consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. If a state determines that it is necessary to target payment increases to certain geographic regions within the state, certain safety net providers, or rural providers in order to assure access to Medicaid services, then the state may do so under the Medicaid state plan.

5. Are states permitted to time limit payment increases? If so, is it permissible to revert back to the rates in effect prior to the PHE?

Yes. Authority for payment increases under the Medicaid disaster relief SPA template are time limited to the duration of the PHE. States can also choose a date prior to the end of the PHE to sunset the changes, but may not choose a date after the end of the PHE using the authority granted via a section 1135 waiver. When the PHE ends, the authority for increased payments under the Medicaid disaster relief SPA will terminate and authority will revert back to the regular Medicaid state plan authority. This is the case for both disaster relief template SPAs and non-template Medicaid COVID-related SPAs submitted during the PHE under the authority granted through the section 1135 waiver. If a state wants these changes to be permanent, it would be advisable to simply make these changes through the regular SPA submission process.

6. My state had planned to increase Medicaid payments to providers prior to the public health emergency. These changes would help providers during the emergency period. Can states use the Medicaid SPA disaster relief template to implement the changes?

Yes, however, the authority for payment increases under the Medicaid disaster relief SPA template are time limited to the duration of the PHE. When the PHE ends, the authority for increased payments under the Medicaid disaster relief SPA will terminate and authority will revert back to the regular Medicaid state plan authority. If a state wants these changes to be permanent, it would be advisable to simply make these changes through the regular SPA submission process. If the state is concerned that there is not enough time to conduct public notice and other administrative procedures for the SPA in order to maintain the desired effective date, states may use the disaster relief SPA template to implement rate increases during the PHE, and submit a regular SPA prior to the end of the quarter in which the PHE ends to extend authority for the payment increase after the end of the PHE. In this way, states will have the authority to increase provider payments back to the beginning of the PHE and after the public health emergency ends.

7. If my state temporarily increases payment rates during this PHE and those increases expire at the end of the PHE are we required to conduct a access to care analysis to ensure compliance with section 1902(a)(30)(A) of the Act?

No, state rate actions resulting from expiration of the Medicaid disaster relief SPA template would not require an extraordinary analysis of access to care when the PHE ends, however, states must still ensure that existing rates are sufficient to ensure beneficiary access as required under section 1902(a)(30)(A) of the Act.

8. My state is unsure of the level of resources that will be needed as this PHE continues. Would a state have authority under the state plan to increase payment rates to providers without submitting a state plan amendment, or would CMS approve general payment language in the Medicaid disaster relief SPA template?

No. If a state has determined that increased payments are necessary under the Medicaid state plan during the PHE, the state must submit a SPA to modify the approved payment or payment methodology. However, states are encouraged to use the Medicaid disaster relief SPA template to submit proposed rate increases. The state should still provide sufficient information in the SPA to allow CMS and stakeholders to understand the proposed payment changes, and to verify that all applicable legal requirements are met.

9. Do states need to fill out the form CMS-179 when submitting a Medicaid disaster relief SPA? What if states cannot estimate the federal budget impact during the PHE?

Yes. States are still required to submit a CMS-179 form with each SPA submission. To the best of their ability, states should estimate the fiscal impact of the SPA submission.

10. Should states still provide responses to the standard funding questions when submitting a Medicaid disaster relief SPA?

Yes. States should still provide responses to the standard funding questions when submitting a Medicaid disaster relief SPA. Additional resources for SPA submission documentation is located here: <https://www.medicaid.gov/resources-for-states/spa-and-1915-waiver-processing/medicaid-spa-processing-tools-for-states/index.html>.

11. Does the disaster relief SPA template offer any flexibility in financing the non-federal share of Medicaid payments?

No. The Medicaid disaster relief SPA template does not offer flexibilities in financing the non-federal share. Federal statute and regulations specifying how states may finance the non-federal share continue to apply.

12. Has CMS considered new costs states may encounter in NF fee for service (FFS) rate components, including labor costs related to overtime and other agency costs, supply costs

for items such as personal protective equipment, and childcare costs for NF employees, among others?

States may submit SPAs to adjust or supplement NF FFS rates to account for additional allowable costs of operation associated with furnishing patient care. Such costs can include increased labor costs, including overtime costs and additional fringe benefit costs, as well as supply costs, including additional costs associated with personal protective equipment. States can establish time limits applicable to such a payment adjustment or supplement and also establish criteria and conditions for facilities to qualify for the adjustment or supplement. CMS will consider these SPAs on an expedited basis, and additional flexibilities related to the SPA submission and approval process may be available pursuant to emergency authorities under section 1135 of the Act. States should contact their designated CMS official for technical assistance with the SPA submission process.

13. Would CMS permit states to implement Medicaid state plan payment methodologies that reimburse community programs for days in which members are absent from the program due to concerns about the spread of COVID-19 (e.g., Adult Day Health)?

States may increase Medicaid payment rates to offset losses to providers during the COVID-19 pandemic. However, FFP is not available under the Medicaid state plan to pay providers directly for the time when care is not provided to beneficiaries. On March 22, 2020, CMS issued a new section 1115 demonstration opportunity available to states under title XIX of the Act (Medicaid) (<https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20002-1115template.docx>). The demonstration opportunity allows states to request expenditure authority to make retainer payments to certain habilitation and personal care providers to maintain capacity during the emergency. For example, adult day sites have closed in many states due to isolation orders, and may go out of business and not be available to provide necessary services and supports post-pandemic; the demonstration opportunity could allow interested states to evaluate the effects on beneficiaries and the Medicaid program of making retainer payments to mitigate a possible long-term reduction in provider capacity and access to services. More information about this demonstration opportunity is available at <https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-application-process/index.html>.

CMS will work with states to review all relevant statutory authorities, which may be available to support Medicaid providers during the COVID-19 pandemic.

14. Would CMS permit states to implement payment methodologies that reimburse self-directed workers for loss of hours due to concerns about the spread of COVID-19?

States may increase Medicaid payments rates to offset losses to providers during the COVID-19 pandemic, if consistent with all applicable requirements, including section 1902(a)(30)(A) of the Act. However, FFP is not available to pay providers directly for time when care is not provided to beneficiaries. CMS will work with states on an expedited basis to review all relevant statutory authorities to find potential pathways to support Medicaid providers during the COVID-19 pandemic.

15. May states pay providers differently than the approved state plan rate/methodology during the COVID-19 emergency (i.e. higher rate and/or overtime wages)?

States would need state plan authority to increase provider rates or change payment methodologies that are specified in the state plan. States could implement these policies through a SPA. We recommend that any SPA be implemented for a defined period of time (e.g. through a state of emergency or ending on a specific date). On March 22, 2020, CMS released a Disaster Relief SPA template (<https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/state-plan-flexibilities/index.html>) that can be used by states for this purpose.

16. Can states make new acuity-based payments to providers who serve individuals with COVID-19 in community or institutional settings?

States could submit a SPA or an Appendix K for rates paid for services rendered in 1915(c) HCBS settings to make acuity adjustments for payments for care to individuals in community and institutional settings. For institutional settings, upper payment limits would apply.

17. Can states allow facilities to continue to receive full payment for a patient, even if there is a gap in treatment services, due to a client being quarantined or shortages in workforce for performing treatment activities (e.g., residential settings where the facility must still provide for the basic needs, but may not be able to meet the treatment requirements, such as 8 hours of treatment per day)?

As long as a service has been provided, CMS defers to states to determine whether an adjustment is warranted. In the case of patient quarantined away from a facility, states have the option to cover and pay for temporary absences under Medicaid reserve bed authority discussed at 42 C.F.R. 447.40. If such coverage is not currently provided for in the approved state plan, states would need to submit a SPA. If a quarantined Medicaid patient presents unique needs and resource demands, as indicated above, states could use the state plan process to adjust payment rates and/or methodologies to reflect the extra costs to provide services. On March 22, 2020, CMS released a Disaster Relief SPA template (<https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/state-plan-flexibilities/index.html>) that can be used by states for this purpose.

18. How should states that receive section 1135 waivers to provide care in alternative settings appropriately pay for Medicaid services provided within those settings?

States that receive waivers to allow providers to offer care in alternative settings should pay the qualified Medicaid billing provider using the Medicaid state plan payment methodology that would otherwise be paid to the provider. The qualified billing provider is responsible for arranging for and providing care in the alternative setting, including making arrangements to pay for costs associated with the alternative setting.

19. Can states increase Medicaid payment rates to accommodate additional costs incurred by the qualified billing provider to arrange for care in an alternative setting?

Yes, states may increase Medicaid payment rates to factor in increased costs associated with arranging care in an alternative setting, such as higher costs associated with room and board. In accordance section 1902(a)(30)(A) of the Act, such increases must be consistent with efficiency and economy and care costs that would have otherwise been paid to the qualified billing provider may not be duplicated through the payment increase. For example, to the extent costs associated with room and board would have been paid to a hospital through a Medicaid payment methodology, increases in payments may only account for additional costs for room and board at the alternative setting.

20. Can a state increase provider payments to recognize higher costs of delivering care due to personal protective equipment?

Yes. States may increase Medicaid and CHIP service payment rates to recognize increases in costs associated with personal protective equipment (PPE) and we encourage states to review their payment structures to determine whether such increases are warranted and would increase access to care during the public health emergency. Consistent with section 1902(a)(30)(A) of the Act, States may set Medicaid payment rates consistent with efficiency and economy and have the option of increasing service rates to incorporate PPE costs or paying an add-on to a service rate for PPE costs in instances when such equipment is necessary to deliver care to a beneficiary. PPE is not a distinct benefit under the Medicaid or CHIP programs and, therefore, payments to providers are only available when PPE is used in the delivery of a Medicaid or CHIP service. We note that regulations at 42 C.F.R. 447.15 require the Medicaid agency to limit participation in the Medicaid program to providers who accept, as payment in full, the amount paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual. Based on this requirement, providers are prohibited from charging beneficiaries for the cost of PPE when delivering Medicaid services.

E. Upper Payment Limits

1. My state is concerned that increases in costs or payments related to the PHE may not have been contemplated in our upper payment limit (UPL) demonstration. How should we accommodate those changes?

If states have already submitted UPL demonstrations to CMS for state fiscal year 2020 and believe the UPL is understated because it does not include additional costs or payments, as applicable to the demonstration, related to the COVID-19 pandemic, states may submit UPL demonstration adjustments for CMS review and approval. CMS realizes the cost and/or payment experience of providers may be vastly different than estimates projected from earlier periods not impacted by the pandemic. States believing an adjustment is warranted should inform CMS and we will work with them to modify their UPL demonstrations to include extra costs and/or payments, as applicable.

2. My state already makes supplemental payments under the state plan and has concerns that making these payments during the PHE might result in total payments that exceed the UPL demonstration(s) provided to CMS. Given the uncertainty around changes in costs

and/or payments relevant to our UPL demonstration(s), how could we structure the Medicaid state plan supplemental payment methodology?

States should structure Medicaid state plan supplemental payments in a manner that is consistent with section 1902(a)(30)(A) of the Act. If a state is concerned that payments under the approved state plan could result in exceeding the UPL, please inform CMS and we will work with you to ensure that when the UPL demonstration for the affected period is submitted, that the UPL is properly calculated to reasonably recognize any increases in Medicare payments (in a payment-based UPL) and increases in cost (in a cost-based UPL) in the demonstration.

3. My state makes supplemental payments under the Medicaid state plan up to the Medicaid upper payment limit. We anticipate that while inpatient hospitalizations will increase during the PHE, outpatient services may decrease, including certain particularly high-cost procedures, such as elective outpatient surgeries. What strategies might states employ to address these concerns?

CMS realizes the cost and/or payment experience of providers may be vastly different than estimates projected from earlier periods not impacted by the pandemic. States believing an adjustment is warranted should inform CMS and we will work with them to modify their UPL demonstrations to include extra costs and/or payments, as applicable. If a state is concerned that inpatient and/or outpatient supplemental payments under the approved state plan may exceed the applicable UPL, please inform CMS and we will work with you to ensure that the UPL is properly calculated and that all payments are accounted for in the demonstration.

4. Will CMS be including any increases to Medicare payment as a result of recently enacted legislation in any of the UPL demonstrations required by CMS?

Yes. CMS will consider any increases to Medicare payments during the PHE in any payment-based UPL demonstrations for services provided during this period.

5. Do states need to submit UPL demonstrations as part of the Medicaid disaster relief SPA submission to support proposed payment increases which are limited only to the PHE period?

No. States are not required to submit UPL demonstrations as part of the Medicaid disaster relief SPA submission supporting proposed payment increases that are only limited to the PHE period. However, approval of a Medicaid disaster relief SPA does not waive applicable UPLs, and all payments still must meet all applicable legal requirements. States should review the foregoing FAQ items regarding UPL demonstrations and adjustments to UPL demonstrations that already have been submitted. CMS is available to provide technical assistance to states regarding concerns that payment increases under a proposed Medicaid disaster relief SPA might result in total payments that exceed an applicable UPL.

6. How will CMS address UPLs when states increase rates for NFs? Will the NF UPL Demonstration Tools and Guidance change?

CMS UPL policy provides two general approaches to demonstrating compliance with the UPL ceiling. States can use a cost-based UPL approach to allow the UPL ceiling to fully recognize the provider's allowable costs of furnishing Medicaid services; therefore, an increase in allowable facility costs can be accounted for in the cost-based UPL ceiling. If a payment-based UPL approach is used, states' demonstrations can make adjustments to the payment-based ceiling to the extent Medicare payment equivalents have increased.

7. Given the COVID-19 emergency situation, are states still required to submit UPL demonstrations to CMS by June 30, 2020, or is there flexibility around that deadline, as there is for quarterly budget estimates (CMS-37) and expenditure reports (CMS-64)?

If states are unable to meet the annual UPL submission requirement as discussed in State Medicaid Director Letter 13-003 by the end of their state fiscal year, due to the COVID-19 emergency, please inform CMS and we will develop a state-specific compliance plan. Currently, CMS does not take immediate financial action against states based on a late UPL submissions.

8. Will CMS extend the deadline for states' Durable Medical Equipment (DME) UPL demonstration submissions as a result of COVID-19?

If states are unable to meet the DME UPL submission requirement due to the COVID-19 emergency, please inform CMS and we will develop a state-specific compliance plan. Currently, CMS does not take immediate financial action against states based on late UPL submissions.

F. Miscellaneous

1. What flexibilities are available in the event of a public health emergency impacting the availability of state Medicaid agency staff resulting in the state's inability to submit quarterly Medicaid budget estimates (Form CMS-37) 45 days before the beginning of the quarter, as required?

The state Medicaid agency should notify CMS as soon as possible that it expects a delayed Form CMS-37 submission. CMS will work with the state to ensure continued access to federal funds and uninterrupted Medicaid administrative activities and service delivery. If the state is unable to submit the form with enough time for CMS to review and process related grant awards, CMS may use the state's most recent budget estimate submission (Form CMS-37) as the basis for issuing the quarterly grant award to ensure continued availability of FFP. Additionally, states have an opportunity at any time throughout each quarter to request additional funding from CMS as necessary to cover allowable Medicaid administrative and service costs.

2. What flexibilities are available in the event of a public health emergency impacting the availability of state Medicaid agency staff resulting in the state's inability to submit its quarterly Medicaid expenditure report (Form CMS-64) within 30 days after the end of the quarter, as required?

The state Medicaid agency should notify CMS as soon as possible that it expects a delayed Form CMS-64 submission. Although federal regulations at 42 C.F.R. § 430.30(c)(1) require states to

submit the form CMS-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program) to CMS not later than 30 days following the end of each quarter, in the event of a public health emergency that impacts a state's ability to do so, CMS will work with impacted states to ensure the continued availability of FFP for allowable Medicaid services for the duration of the public health emergency. Additionally, CMS will provide technical assistance as necessary to assist the state with proper claiming of FFP and to ensure that funding provided is reconciled to actual incurred and allowable expenditures.

3. Will states continue to have secure access to the Medicaid Budget & Expenditure System (MBES)/State Children's Health Insurance Program Budget & Expenditure System (CBES) in the event that CMS buildings are closed?

Yes, CMS anticipates that states would have continued secure access to MBES/CBES, as it is a web-based application that is not dependent on whether CMS buildings are open.

4. Is CMS extending the due date for state plan rate year 2017 Medicaid DSH audits and reports required by section 1923 of the Act that are due to CMS on December 31, 2020?

No. CMS is not extending the audit and reporting submission deadline at this time, but CMS will continue to evaluate the situation. We recognize that some states and hospitals may experience challenges in completing audits and reporting timely during the public health emergency. We also recognize that hospitals might have limited resources to devote to working with states and auditors. States should follow the DSH audit and reporting timelines described in 42 C.F.R. § 455.304(b) and § 447.299(c), but may wish to take into consideration CMS' existing operational timeline for compliance enforcement. Specifically, if a state misses the annual audit and reporting deadline on December 31, 2020, CMS would begin deferring state claims for DSH expenditures reported on the CMS-64 beginning with the first quarter following the noncompliance; that is, beginning with the quarter ending March 31, 2021, consistent with the deferral timeframe specified in 42 C.F.R. § 447.299(e). Such deferrals would not occur until after March 31, 2021. This enforcement timeline effectively provides states extra time to submit their DSH audits and reporting before facing a deferral of federal funding.

V. Managed Care

A. Contracts and Rates

1. How can states implement or update Medicaid or CHIP managed care telehealth policies, including allowing remote monitoring and reimbursement of telehealth services at the in-person clinical services rate?

The Trump Administration encourages states to take advantage of broad flexibility to deliver services via telehealth in Medicaid and CHIP to help prevent the spread of the Coronavirus as is discussed at <https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html> and <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/covid19/index.html>. The available telehealth flexibility allows Medicaid beneficiaries to receive a wide range of healthcare services from their providers without having to travel to a health care facility so that

they can limit risk of exposure and spread of the virus. In fee-for-service, states are not required to submit separate state plan amendments for coverage or reimbursement of telehealth services if they decide to reimburse for telehealth services in the same manner or at the same rate paid for face-to-face services. Medicaid guidelines require all providers to practice within the scope of their State Practice Act, and states may have laws and regulations that govern the scope of telemedicine coverage. In fee-for-service, a state plan amendment would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.

If a benefit is covered under the state plan or Medicaid waiver (e.g., section 1915(b) or 1915(c)) or a state demonstration (e.g., section 1115), CMS encourages states to amend managed care contracts (if not already included in the contract) to extend the same telehealth flexibilities authorized under their state plan, waiver, or demonstration for services covered under the contract. Absent coverage under the state plan or otherwise authorized through a Medicaid waiver or demonstration, services furnished under telehealth through managed care could also be provided as:

1. In-lieu of services (42 C.F.R. §438.3(e)(2) and 42 C.F.R. §457.1201(e)). Under these regulations, alternate services or services furnished in an alternative setting covered by a managed care plan or entity in lieu of state plan-covered services must be: (i) authorized by the state as being a medically appropriate and cost-effective substitute for the covered service or setting under the state plan; (ii) authorized and identified in the managed care contract; and (iii) not required to be used by the enrollee in lieu of the state plan-covered service. In addition, there are specific rate development rules used when a managed care contract authorizes use of in-lieu of services.
2. Additional services, beyond those in the contract, voluntarily provided by managed care plans (commonly referred to as value-added services). No contract amendment is needed; however, *the cost of value-added services cannot be included when determining the capitation rates (per 42 C.F.R. §438.3(e)(1)(i) and 42 C.F.R. §457.1201(e)).*

Regarding Medicaid managed care payment, under 42 C.F.R. §§438.3(c)(1)(ii) and 438.4, final capitation rates must be actuarially sound and based only upon services covered under the state plan or waiver authority and represent a payment amount adequate to allow the managed care organization (MCO), prepaid inpatient health plan (PIHP) or prepaid ambulatory health plan (PAHP) to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements. If a state determines a retroactive adjustment to capitation rates under one or more of its managed care contracts is necessary for costs eligible for reimbursement, such as telehealth-related infrastructure costs, retroactive adjustments must be certified by an actuary in a revised rate certification and submitted as a contract amendment in accordance with 42 C.F.R. §438.7(c)(2). The rate certification must describe the rationale for the adjustment and the data, assumptions and methodologies used to develop the magnitude of the adjustment. For additional information about telemedicine, visit: <https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html>. For CHIP, rates must be based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles, as described in 42 C.F.R. §457.1203(a). States that update their CHIP capitation payments due to telehealth related costs would not need to submit a rate certification.

2. In emergency circumstances where utilization and/or costs cannot be estimated, will CMS permit payment for testing as a non-risk payment outside a capitation payment?

There are multiple approaches under which states can permit payment for COVID-19 testing in managed care programs. To be considered a mandatory laboratory service as described at 1905(a)(3) of the Act and 42 C.F.R. § 440.30, the COVID-19 test must be ordered and provided by or under the direction of a physician or other licensed practitioner within the appropriate scope of practice as defined by the state, or ordered by a physician, but provided by referral laboratory. To meet this definition, the test must be provided in an office or similar facility other than a hospital outpatient department or clinic and furnished by a laboratory that meets Clinical Laboratory Improvement Amendments (CLIA) requirements at Part 493 of the Code of Federal Regulations. Tests that do not meet these criteria may still be covered under the optional diagnostic benefit described at 1905(a)(13) of the Act and 42 C.F.R. § 440.130(a).

To the extent that health plans are responsible for providing laboratory services, they must cover the COVID-19 test. However, in the event the approved rates are not sufficient to cover the cost of these tests, states may wish to address through actuarially sound rate adjustments. States could amend their rates to include an adjustment for those costs, if such an adjustment is actuarially sound and the state determines that to be necessary, subject to compliance with 42 C.F.R. §§ 438.4 through 438.7 regarding rate development and amendment of capitation rates. States could also create a kick payment (consistent with actuarial soundness requirements) for managed care plans to cover the tests, which would require a contract amendment and rate certification.

States could also pay for the tests outside of the managed care capitation payment as a non-risk payment: either as a separate non-risk contract with its managed care plans (see the definition of “non-risk contract” at 42 C.F.R. §438.2² or as an amendment to its existing managed care plan contracts to include a non-risk payment. If a state chooses to amend its existing contracts to include a non-risk payment, the state would need to comply with upper payment limits outlined at 42 C.F.R. §447.362 consistent with the requirements for non-risk contracts. For CHIP, states could follow the same approach of paying for the tests outside of the managed care capitation payment as a non-risk payment.

Additionally, states have the option to pay for the tests under their Medicaid/CHIP fee-for-service programs, and carve this benefit out of the managed care program and contracts.

In general, CMS advises that states review their managed care contracts and rates carefully to identify any existing flexibilities to determine whether managed care contract or rate amendments are needed.

3. Do states need to continue to submit preprints for state-directed payments?

Yes, states are required to submit preprints for state-directed payments. As noted above, any state-directed payment preprints related to COVID-19 should be submitted to

² An amendment to the existing contract that includes coverage of these testing services to exclude them from the risk-contract would be necessary.

CMCSManagedCareCOVID19@cms.hhs.gov. CMS is committed to expediting and prioritizing such reviews.

B. Quality Measurement

1. Could the COVID-19 pandemic have an impact on state level managed care plan performance and quality measurement efforts?

States use quality measurement in many aspects of their managed care contracts to govern payment to the plans as well as to providers. The COVID-19 pandemic has been disruptive to clinical practices: for example, individuals have generally been advised not to seek routine or preventive care unless medically necessary at this time. Moreover, public health recommendations around social distancing may lead to reluctance to conduct performance measurement and external quality review (EQR) activities that require visiting health care or health plan facilities. These recommendations have led some health plan accrediting organizations, such as [National Committee for Quality Assurance](#) (NCQA), to advise that states with mandatory Healthcare Effectiveness Data and Information Set (HEDIS) reporting requirements allow health plans to use 2019 HEDIS rates rather than 2020 HEDIS rates for certain measures. All of these factors can affect the actual performance of health plans on these quality measures, as well as their ability to submit data to states on time. These factors can also limit the accuracy of that information and the ability for states to trend health plan performance rates over time.

2. Should states consider adjustments to their managed care contract quality measurement requirements to account for the changes in clinical practice resulting from the COVID-19 public health emergency?

CMS recognizes that the current COVID-19 pandemic is likely to affect clinical practices, and the timely and accurate reporting of quality data such that states may need or want to revise their contractual quality measurement requirements. Below are some of the common ways states implement and incentivize quality measurement in their managed care programs and issues to consider during this public health emergency.

- **Withholds:** Under 42 C.F.R. § 438.6(b)(3), states can implement a withhold, where a portion of a capitation rate is withheld from a managed care plan (MCO, PIHP, or PAHP) and a portion of or all of the withheld amount will be paid to the managed care plan for meeting targets specified in the contract. Withhold arrangements are frequently linked to quality performance measures or quality-based outcomes. CMS **strongly advises** states to work with their actuaries and their quality measurement staff to determine if any changes are needed to the data, assumptions and methodologies used to assess the ability to accurately trend the quality measurement data and to determine the portion of the withhold that is reasonably achievable. Should states believe a change or elimination of a contractual withhold arrangement is warranted due to the COVID-19 emergency, the state must submit a contract amendment and, depending on the nature of the change, a rate certification amendment.

- **Incentives:** Under 42 C.F.R. § 438.6(b)(2), states can implement an incentive arrangement, as long as total payment under the contract is not in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement. An incentive arrangement is an amount over and above the capitation rates the managed care plan was paid for meeting targets specified in the contract. Incentive payments are **in addition** to the actuarially sound capitation rates, so while changes in clinical protocols or access are likely to affect a plan's ability to earn the incentive payment, they do not affect the actuarial soundness of the underlying rates. States may elect to reexamine the specified targets for plans to earn the incentive payment; if a state chooses to do this, the state must submit a contract amendment and depending on the nature of the change, a rate certification amendment.
- **State-Directed Payments:** Under 42 C.F.R. § 438.6(c), states are prohibited from directing how a managed care plan pays its providers except for those payment methodologies that have been approved and reviewed by CMS to be in compliance with 42 C.F.R. § 438.6(c). For states that have approved directed payment proposals for this rating period that condition payment to providers upon performance on specific quality measures, states may want to reexamine these payment arrangements to determine if changes are necessary or desired in light of the COVID-19 emergency. If a state determines changes are necessary, states will need to submit an amended directed payment preprint and, depending on the nature of the change(s), contract and rate certification amendments,.
- **General Contract Requirements and Penalties:** In addition to the examples provided above, states may have several other contract requirements related to plan performance or quality measures, such as quality assessment and performance improvement (QAPI) requirements. Some of these requirements may result in penalties imposed on the plan(s) for failing to meet a certain performance level. It is within state discretion to revise their contracts to remove or lessen such penalties; however, states will need to submit contract amendments to reflect any revisions. Depending on the nature of the change, a rate certification amendment may be needed if such changes are expected to have a material impact on the actuarially certified rates.

CMS is working to prioritize and expedite reviews of COVID-19 related managed care actions. All managed care actions (contract amendments, rate amendments, state-directed preprints) needed to respond to COVID-19 should be submitted as soon as possible to CMCSManagedCareCOVID19@cms.hhs.gov.

3. Are there additional considerations for External Quality Review-related (EQR-related) activities?

Some states contract with External Quality Review Organizations (EQROs) to conduct the EQR-related activities, while other states undertake these EQR-related activities themselves. Given the extenuating circumstances presented by COVID-19, health plans may find it challenging to submit accurate data to states and to do so on time. Health plans may also request that external quality review activities be limited if they would compromise the ability to maintain social distancing, such as encounter data validation or performance measurement validation that require

onsite medical chart reviews. CMS encourages states to work with EQROs and health plans to rely as much as possible on quality data that can be submitted and validated electronically, consistent with the EQR protocols per 42 C.F.R. § 438.350(e) and 438.352, to enable quality activities to continue while minimizing the public health impacts of COVID-19. Where states determine that some accommodations may be appropriate, CMS recommends that states work with their quality measurement staff to determine the appropriate accommodations and to submit a contract amendment.

4. Will the current COVID-19 public health emergency impact timelines for states to submit Managed Care quality strategies to CMS for review?

Medicaid regulations at 42 C.F.R. § 438.340(c)(2) require that the state must review and update their quality strategy as needed, but no less than every three years. As such, there is no uniform timeline or required due date across all states. States due to submit an updated quality strategy during the current COVID-19 PHE should contact CMS through the Managed Care technical assistance mailbox at ManagedCareQualityTA@cms.hhs.gov if they need more time due to the COVID-19 PHE.

5. How will the public comment process and tribal consultation for quality strategy review be impacted?

Medicaid regulations at 42 C.F.R. § 438.340(c)(1) and (2) require that prior to finalizing the state's quality strategy, states must provide an opportunity for public comment and input as well as consulting with tribes in accordance with the State's tribal consultation policy.. The input from the public and tribes must be incorporated into the quality strategy, prior to submitting the draft to CMS for review and feedback.

States can hold this public comment and consultation process at any time as long as it occurs prior to submitting the state quality strategy to CMS. We understand that states may be concerned that holding this process during the COVID-19 pandemic would yield little stakeholder engagement and, in turn, have concerns that delaying the comment process will result in missed deadlines. However, public comment and tribal consultation are required. States should contact CMS through the Managed Care technical assistance mailbox at ManagedCareQualityTA@cms.hhs.gov if they have questions regarding the public comment and consultation process or need more time due to the COVID-19 PHE.

6. Will states receive an extension on the April 30th deadline for the submission of the annual External Quality Review (EQR) technical report?

Annually, states are required to conduct an EQR, which consists of three mandatory EQR-related activities: Validation of Performance Measures, Validation of Performance Improvement Projects and a compliance review against elements found in 42 C.F.R. Part 438, subpart D.³ Upon the completion of the EQR-related activities and EQR, an independent third party External Quality Review Organization (EQRO) must analyze the data and provide findings in an annual

³ The EQR-related activity for the validation against elements in 42 C.F.R. Part 438, subpart D is only required once every three years.

EQR technical report. This report is required to be submitted to CMS under Medicaid regulations at 42 C.F.R. § 438.364(c)(1) by April 30th of each year.

States that need more time due to the COVID-19 PHE should contact CMS at ManagedCareQualityTA@cms.hhs.gov with any concerns about completing the EQR or EQR-related activities, or submitting the annual EQR technical report by April 30, 2020.

7. How can states request technical assistance regarding managed care strategies and EQRO reporting?

Please email the managed care quality technical assistance mailbox at ManagedCareQualityTA@cms.hhs.gov.

C. Miscellaneous

1. Can states allow managed care plans to permit 90-day supplies of medication at retail and mail-order pharmacies in situations where 90-day medication supplies are clinically appropriate? Can states allow waivers of early refill requirements during public health emergencies?

States should review their state plans and managed care contracts to ensure they have no state restrictions in place. In general, states have flexibility to establish Medicaid and CHIP FFS prior authorization and drug utilization review processes that encompass extended day supplies and early refills for emergency situations without CMS approval. Some states may need to modify their state plans. Under CMS managed care regulations, the need for a contract amendment related to prior authorization, extended day supplies of medication, and early refills will be dependent upon the detail included in states' existing managed care contracts. If existing managed care contracts do not allow for 90-day supplies of medications or early refill requirements, states will need to submit a contract amendment. CMS will prioritize our review and approval of COVID-19 related state plan or contract amendments.

2. How can states and managed care plans educate beneficiaries on COVID-19, including CDC best practices for infection control and medical management, as well as provide COVID-19 information that can be shared with case managers and MCO disease management staff and partners?

We strongly encourage states and managed care plans to collaborate on communication of CDC best practices for infection control and medical management to their Medicaid enrollees. This information can be found at: <https://www.coronavirus.gov>. All relevant CDC guidance is also posted on the CMS website and new information will be shared with states as it becomes available. Current guidance is available at: <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>. States and managed care plans may share relevant information with case and care managers. Managed care plans providing written documents to Medicaid and CHIP beneficiaries will need to comply with information requirement regulations at 42 C.F.R. §438.10 and 42 C.F.R. §457.1207. CMS notes that the materials provided by the CDC are compliant with the "Plain Language Act of 2010"

(<https://www.cdc.gov/other/plainwriting.html>), which requires all federal agencies to write plainly when they communicate with the public. Therefore, for the purposes of 42 C.F.R. §438.10(c), CMS considers all CDC materials written in a manner and format that is easily understood and is readily accessible.

3. How can states collaborate with managed care plan partners and community-based organizations, including home-delivery services, to provide non-medical supports, such as meals and over the counter medications, to Medicaid and CHIP beneficiaries quarantined or self-quarantined in their homes?

As long as a benefit is covered under the state plan or waiver authority, states can add services to managed care contracts via a contract amendment. See FAQ # III.F.1. for information regarding adding benefits to state plans or waiver authorities. Managed care plans also have flexibility to voluntarily provide additional services beyond those in the contract, referred to as value-added services. No contract amendment is needed for value added services; however, the cost of such services cannot be included when determining the capitation rates.

4. Can states permit managed care organizations (MCOs) to expedite decisions of beneficiary functional eligibility for HCBS?

Federal regulations at 42 C.F.R. § 431.10(c)(2) require states to make functional beneficiary eligibility determinations for HCBS. As such, states can only delegate such determinations to another governmental entity. However, states could permit MCOs to conduct an assessment of eligibility and forward the assessment to states for final determination.

5. What flexibilities does a section 1135 waiver provide related to appeals of adverse benefit determination requirements in Medicaid managed care regulations at 42 C.F.R. Part 438?

Federal regulations at 42 C.F.R. Part 438 Subpart F establish appeals and grievance requirements for Medicaid managed care. Section 1135 of the Act does not provide authority to waive these requirements; however, CMS does have authority to modify timeframes for required activities during an emergency period under section 1135(b)(5) of the Act. For example: states can request a section 1135 waiver to modify timelines for managed care plans to resolve an appeal to no less than one day in order to permit earlier access to the state fair hearing level. If states use this authority, all appeals filed would allow managed care enrollees to quickly satisfy the exhaustion requirement in 42 C.F.R. § 438.408(f)(1) and proceed almost immediately to a state fair hearing. In addition, states can modify timeframes under 42 C.F.R. § 438.408(f)(2) requiring managed care enrollees to exercise their appeal rights within 120 days to allow more than 120 days to request a fair hearing during the authorized period of the immediate section 1135 waiver. In March 2020, CMS created a Medicaid & CHIP checklist for section 1135 waivers to assist states during public health emergencies, which is available here: <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/section-1135-waiver-flexibilities/index.html>.

6. Can states retroactively implement risk mitigation strategies (e.g. risk corridors) to mitigate risk in light of COVID-19?

CMS will consider, where appropriate, state requests to retroactively amend or implement risk mitigation strategies only for the purposes of responding to the COVID-19 pandemic. In the Notice of Proposed Rulemaking (NPRM); Medicaid Program: Medicaid and CHIP Managed Care (CMS-2408-P) published in November 2018, CMS proposed to prohibit states from implementing retroactive risk mitigation strategies. CMS continues to support the identification of all risk mitigation strategies in contracts prospectively. However, given that this NPRM has not been finalized, CMS recognizes that these are unique and unanticipated circumstances under which approving retroactive risk mitigation strategies may be appropriate given that other methods for making retroactive adjustments to capitation rates may be extraordinarily difficult for states to implement at this time.

States that utilize risk mitigation mechanisms must describe such arrangements in their contract(s) and they must be developed in accordance with all requirements in 42 C.F.R. Part 438, including §§ 438.4 and 438.5, and generally accepted actuarial principles and practices. The rate certification and supporting documentation must also describe any risk mitigation and how it may affect the rates or the final net payments to the health plan(s) under the applicable contract as part of complying with § 438.7. States should follow the guidance in the Medicaid Managed Care Rate Development Guide for documentation for risk-sharing mechanisms. See <https://www.medicaid.gov/Medicaid/downloads/2019-2020-medicaid-rate-guide.pdf>.

States submitting requests to retroactively amend or implement risk mitigation strategies will need to submit both contract and rate amendments as soon as possible to CMCSManagedCareCOVID19@cms.hhs.gov. CMS is working to prioritize and expedite reviews of COVID-19 related managed care actions. To facilitate this, CMS recommends that states submit only managed care actions needed to respond to COVID-19 to this mailbox and use normal processes for other managed care actions.

CMS notes that retroactive risk mitigation strategies are one of a number of strategies that states can consider implementing in response to COVID-19; states may want to consider implementing one or more strategies to get funding out to providers more quickly. CMS is available to provide technical assistance as states explore different strategies.

VI. Information Technology

A. Funding

1. Do states need prior approval to acquire additional IT systems services and staffing?

Typically, CMS requires prior approval for most expenditures to receive enhanced FFP for state IT systems. However, when expenses are expected to fall below minimum thresholds, prior approval may not be required. The thresholds are:

1. For enhanced FFP: Approval of contracts and associated funding is not required in instances where the contract is not anticipated to exceed a total federal and state acquisition cost of \$500,000.

2. For regular FFP: Approval of contracts and associated funding is not required in instances where the contract is not anticipated to exceed a total federal and state acquisition cost of \$5,000,000.
3. For sole source contracts: Approval of contracts and associated funding is not required in instances where the contract is not anticipated to exceed a total federal and state acquisition cost of \$1,000,000.

2. What flexibilities do states have to obtain additional funding to meet technology needs in response to COVID-19?

When requested by the state, FFP for IT systems can be provided in emergencies. The FFP request should include: (1) A brief description of the equipment and/or services to be acquired and an estimate of their costs; and (2) a brief description of the circumstances driving the state's need and the harm that will be caused if the state does not immediately acquire the requested equipment and/or services. FFP approved under this authority would be available from the date the state actually acquires the equipment and services. Additional information regarding this process can be found at 45 C.F.R. § 95.624.

3. May states request enhanced Mechanized Claims Processing and Information Retrieval Systems FFP for costs associated with information technology that facilitates telework capabilities for state staff and/or contractors?

States may request enhanced Mechanized Claims Processing and Information Retrieval Systems FFP for information technology (IT) expenditures that support the design, development, and installation (DDI) or operations of mechanized claims processing and information retrieval systems that constitute the Medicaid Enterprise System (MES). That includes expenditures that support telework infrastructure so that state staff or contractors can continue MES DDI or operation remotely. CMS understands and strongly supports the central role that telework may play in a state's ability to develop, enhance, and operate the MES during the COVID-19 public health emergency, as well as to continue to improve and maintain the efficient operation of the MES thereafter.

States can request FFP under section 1903(a)(3)(A)(i) and (B) of the Act for state IT expenditures to enable telework for personnel who are engaged in the DDI or operation of the MES (including a subsystem or component thereof), so long as states meet all other applicable requirements for claiming FFP under those provisions of the Act. States cannot receive enhanced FFP under section 1903(a)(3)(A)(i) and (B) of the Act for their expenditures related to telework infrastructure for staff who are not engaged in the DDI or operation of an MES; instead, those expenditures might be eligible for the administrative FFP authorized by section 1903(a)(7) of the Act (which is 50%).

For example, states may request 90 percent mechanized claims processing and information retrieval systems FFP to procure and install hardware and to enhance and/or configure existing or new software, as necessary to support a remote workforce that is engaged in the DDI or operation of mechanized claims processing and information retrieval systems, as discussed above. Likewise, 75 percent mechanized claims processing and information retrieval systems

FFP may be available thereafter to support the ongoing operations of that hardware and/or software, with respect to those staff.

Generally, states request enhanced FFP for the DDI or operations of mechanized claims processing and information retrieval systems through an Advance Planning Document, as described in 45 C.F.R. § 95.610. FFP to support these IT expenditures could also be requested through the emergency process described in 45 C.F.R. § 95.624, to rapidly expand teleworking capabilities during the COVID-19 public health emergency. States should consult with their MES State Officer for assistance.

4. Can the 100 percent FFP available for the new optional COVID-19 testing group be used for administrative costs related to systems development?

Yes. States that amend their state plans to cover the optional COVID-19 testing eligibility group under section 1902(a)(10)(A)(ii)(XXIII) of the Act can use the 100 percent FFP rate provided under section 6004(a)(3)(D) of the FFCRA for certain administrative expenditures, including systems development, described in section 1903(a)(7) of the Act that otherwise would be eligible for 50 percent FFP. To qualify for the 100 percent FFP, the state must demonstrate that the expenditures are attributable to administrative costs related to providing medical assistance to the COVID-19 testing eligibility group. This attribution must be performed in accordance with all applicable cost allocation requirements.

For example, a state could claim this 100 percent FFP for expenditures related to developing a portal for providers to submit claims for testing and testing-related services to individuals in this eligibility group. Similarly, a state could use this funding to support changes to their Presumptive Eligibility systems to adapt and expand that process to enroll individuals in the COVID-19 testing eligibility group.

Section 6004(a)(3)(D) of the FFCRA does not change the FFP rate or rules for mechanized claims processing and information retrieval systems under section 1903(a)(3) of the Act.

B. Health Information Exchange

1. Can states request that FFP be provided through the process described in 45 C.F.R. § 95.624 (emergency funding requests) to connect non-pediatric Medicaid providers to Immunization Information Systems?

Medicaid providers who do not treat children are much less likely to have direct electronic health record (EHR) connections or EHR integration with immunization information systems, and tracking the administration of a vaccine in the adult population is more difficult due to this lack of public health connectivity. These connections are potentially eligible for enhanced funding under 42 CFR part 433, subpart C, and states should begin planning for eventual vaccination efforts accordingly. Please reach out to your Medicaid Enterprise Systems (MES) State Officer for information on submitting an FFP request under 45 C.F.R. § 95.624.

2. What is the Patient Unified Lookup System for Emergencies (PULSE) and how can states request that FFP be provided through the process described in 45 C.F.R. § 95.624 (emergency funding requests) to deploy PULSE resources to support COVID-19 response efforts?

The PULSE system provides first responders with information critical to patient care through a nimble, easy to understand system with access to patient health data (e.g., medications a patient is taking) and is designed to be deployed immediately to assist in emergency response. The first PULSE system was developed in California and has been used for wildfire response within the state. A COVID-19 iteration of PULSE (PULSE-COVID) supporting some immediate use cases is now available. PULSE-COVID focuses on collaboration with private sector partners and supports basic ad hoc searches over the national health information exchange networks. These searches could help medical response teams access critical patient information via direct connections to the electronic health records where their information is kept. The solution is hosted on a web platform to enable quick and easy deployment to multiple states. Depending upon resources available for the project, up to several states can be on-boarded to PULSE-COVID at once by the public/private partnership overseeing the effort. There is a range of capacity across the nation and immediate engagement would focus on areas with the capacity to implement PULSE-COVID in the near term. Please reach out to your MES State Officer for information on submitting an FFP request under 45 C.F.R. § 95.624.

3. How can states establish, implement, and enhance telehealth technologies through the process described in 45 C.F.R. § 95.624 (emergency funding requests) as part of the COVID-19 response effort and in support of their Medicaid provider and beneficiary populations?

CMS is available to provide technical assistance regarding approaches to rapidly scale telehealth technologies. If states are granted waivers under section 1135 for federal requirements related to provider location or provider enrollment (<https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf>), complementary technology investments may be appropriate. CMS advises states to leverage existing infrastructure and technology. States should discuss any patient-facing telehealth proposals with their MES State Officer. Please reach out to your MES State Officer for information on submitting an FFP request under 45 C.F.R. § 95.624.

C. Transformed Medicaid Statistical Information System (T-MSIS)

1. How should COVID-19 related service codes be reported in the Transformed Medicaid Statistical Information System (T-MSIS)?

States should ensure that systems are coded to process the new codes and that providers have received updated billing guidance. States should report COVID-19 related procedure codes and diagnosis code information to T-MSIS as it is reported on the original claims form. Please contact your CMS Systems Officer with further questions. For information on COVID-19 testing HCPCS codes, please see [CMS's February 13, 2020 public health news alert](#). For information on

COVID-19 related diagnosis codes, please see the [CDC's announcement regarding new diagnosis coding effective April 1, 2020](#).

2. How should telehealth-related services be reported in T-MSIS?

States should ensure that providers are educated on the correct submission of telehealth claims. States should report COVID-19 telehealth services to T-MSIS as they are billed on the claim form, identified through the procedure code and procedure code modifier fields. Please contact your CMS State Systems Officer with further questions. For general information on Medicaid telehealth, see [Medicaid for Services Delivered Via Telehealth](#).

3. Will there be new federal reporting requirements in T-MSIS for the new COVID-19 testing optional Medicaid eligibility group?

To address the completeness and accuracy of T-MSIS reporting for states adopting the new COVID-19 testing optional Medicaid eligibility group, states should report the following two data elements in the Eligible file to document a beneficiary's enrollment in Medicaid as defined by the FFCRA: ELIGIBILITY-GROUP (ELG087) and RESTRICTED-BENEFITS-CODE (ELG097). An ELIGIBILITY-GROUP value of "76" should be reported for an uninsured individual eligible for COVID-19 testing. A RESTRICTED-BENEFITS-CODE value of "F" should be reported for an individual eligible for Medicaid but is only entitled to restricted benefits for medical assistance for COVID-19 diagnostic products and any visit described as a COVID-19 testing-related service for which payment may be made under the state plan. Additional information and comprehensive reporting guidance will be shared on the T-MSIS Coding Blog.

4. Will there be new federal reporting requirements in T-MSIS for reporting claims data for COVID-19 testing and testing-related visits for individuals enrolled in Medicaid and CHIP?

There are three data elements in the T-MSIS Claims files for state reporting of COVID-19 diagnostic products and testing-related services.

(1) In the CLAIM-HEADER-RECORD, a value of "17" should be reported in PROGRAM-TYPE for any COVID-19 diagnostic product or COVID-19 testing-related services as specified by the FFCRA;

(2) In the CLAIM-LINE-RECORD, a value of "136" should be reported in TYPE-OF-SERVICE, and a value of "107" should be reported in BENEFIT-TYPE for any COVID-19 diagnostic product as specified by the FFCRA;

(3) In the CLAIM-LINE-RECORD, a value of "137" should be reported in TYPE-OF-SERVICE, and a value of "108" should be reported in BENEFIT-TYPE for any COVID-19 testing-related services as specified by the FFCRA.

Additional information and comprehensive reporting guidance will be shared on the T-MSIS Coding Blog.

5. Will compliance timelines for the 2020 T-MSIS Priority Item (TPI) Data Quality Assessments be adjusted due to the COVID-19 emergency?

Timely, accurate, and complete T-MSIS data submission continues to be a CMS priority and is critical to national analyses of Medicaid and CHIP services, activities, and expenditures during the current Public Health Emergency. States should continue to submit monthly T-MSIS data and continue, as much as possible, to work towards the recommended timelines for resolving TPIs. CMS will continue to measure and report on T-MSIS data quality issues, and to provide ongoing technical assistance to states. Generally, we do not expect to use State Data Quality Assessment results as the basis to initiate state compliance actions during or immediately following the COVID-19 PHE.

D. Telework

1. Does CMS have recommendations for IT systems, services, networks, and tools to rapidly transition Medicaid and CHIP operations to a virtual environment and expand use of telework?

CMS encourages states to adopt and accelerate their implementation of capabilities for their work force to telework. While we do not have specific recommendations for technologies and tools to support a virtual environment, many of the IT vendors can support telework in their existing implementations. Our primary suggestion is for states to work with their existing IT vendors (eligibility, MMIS, etc.) to assess and possibly expand their ability to support a remote work force. CMS recommends that states use remote work as a way to both maintain healthy social distancing practices and maintain processing of workloads to the maximum extent practical. We also encourage states wishing to accelerate additional telework capabilities to contact their Medicaid Enterprise State Systems Officer.

2. Does CMS anticipate requesting any special reporting from states on the number of Medicaid applications, renewals, and case changes that are processed via telework during the COVID-19 emergency?

CMS welcomes states sharing best practices as they adopt more remote work capabilities, to inform other states and to help CMS support Medicaid agencies for this and future emergencies. We do not expect to ask for any special reporting regarding eligibility determination processing by remote workers during the COVID-19 PHE.

3. Is CMS planning to provide any technical assistance to help states rapidly expand Medicaid/CHIP eligibility processing through telework?

States that desire technical assistance with rapidly accelerating any of their telework capabilities may contact their Medicaid Enterprise State Systems Officer, who can help with obtaining any applicable authorization for funding and connecting states to other states that have already grappled with the policy, cultural and operations considerations associated with remote work. Reference also FAQ # VII.D.4., which has additional information regarding issues involved with temporary office closures.

E. Miscellaneous

1. Will CMS issue waivers under section 1135(b) of the Act to the timely claims submission and processing requirements of 42 C.F.R. § 447.45(d)?

By regulation at 42 C.F.R. § 447.45(d), Medicaid agencies must require providers to submit all claims no later than 12 months from the date of service. The Medicaid agency must then pay 90 percent of all clean claims within 30 days of receipt and 99 percent of all clean claims within 90 days of receipt. Generally, the Medicaid agency must pay all other claims within 12 months of receipt, with certain exceptions.

CMS is not issuing waivers under section 1135(b) authority for timely claims processing or claims submission requirements. Maintaining timely and accurate processing, submission, adjudication and payment of provider claims for Medicaid and CHIP services continues to be important during this Public Health Emergency. However, if a state has more stringent requirements for claims submission and payment, those requirements may be relaxed, as long as they continue to meet the minimum requirements of 42 C.F.R. § 447.45(d). If a state encounters problems with the functionality of information technology systems supporting the submission, processing and/or payment of claims, please contact your MES State Officer.

VII. Miscellaneous

A. Quality Reporting

1. In what ways will the COVID-19 pandemic affect FFY 2020 reporting for the Medicaid and CHIP Child Core Set and Adult Core Set?

While all Core Set reporting continues to be voluntary on the part of states, CMS encourages states that can collect and submit this information safely to continue doing so. To this end, however, CMS recommends temporarily suspending the types of measurement activities that could present a health risk to state employees or contractors, such as conducting on-site medical chart reviews. In addition, CMS expects that the COVID-19 pandemic could affect the accuracy of Core Set reporting in a number of ways. For example, state performance on preventive care Core Set measures may decline, since individuals have generally been advised [not to seek in-person routine or preventive care unless medically necessary at this time](#). Moreover, these services offered through telehealth may not be captured in the measure unless the measure specifications allow for telehealth. All of these factors can affect not only the ability of states to collect and submit Core Set data to CMS on time, but can also limit the accuracy of that information and the ability for CMS to trend state performance rates over time. To the extent those Core Set measures are also included in the Medicaid and CHIP Scorecard, state Scorecard performance and the ability to trend that information will also be affected.

2. How does CMS recommend states handle Core Set measures that require medical chart review—often referred to as “hybrid data collection methods”—due to the current public health emergency?

CMS recognizes that social distancing will make onsite medical chart reviews inadvisable during the COVID-19 pandemic. As such, hybrid measures that rely on such techniques will be particularly challenging during this time. While reporting of the Core Sets is voluntary, CMS encourages states that can collect information safely to continue reporting the measures they have reported in the past and to consider the following provisions for measures that include the [hybrid method](#) as an option. Doing so will enable CMS to fulfill its statutory obligation to report on the quality of healthcare in the Medicaid and CHIP programs while minimizing the adverse effects of the pandemic on quality reporting.

- CMS encourages states to review the quality and completeness of data collected using the hybrid method. If a state determines that it will not be able to report high-quality data for a measure using the hybrid method, CMS encourages the state to consider calculating the measure using the administrative method or electronic health records (EHRs), if applicable and permitted by the measure technical specification.
- When reporting hybrid measures to CMS for FFY2020, states should note if the FFY 2020 rate is worse than the FFY 2019 rate due to low chart retrieval and then indicate in MACPro whether the state would prefer to use the FFY 2019 rate instead, due to the COVID-19 pandemic. In this case, CMS encourages states to report both the FFY 2020 performance rate and the chart retrieval rate, if available, in MACPro.
- If an alternate method is not feasible and prior year data are not available, please report to CMS that the state was unable to report the measure due to challenges with data collection as a result of the COVID-19 pandemic.

3. How does CMS recommend states handle Experience of Care Surveys that require in-person interviewing?

CMS understands that current social distancing guidelines make in-person surveys inadvisable during this public health emergency. To the extent states can rely on other means of data collection such as electronic or telephonic methods, we encourage states to consider them so that quality measurement activities can continue while minimizing adverse public health impacts.

The measure stewards (Human Services Research Institute (HSRI), National Association of State Directors of Developmental Disabilities Services (NASDDDS), and Advancing States (AD)) for the National Core Indicator (NCI) surveys ([NCI and NCI-AD](#)) have “paused face-to-face surveying of any kind at this time.” Additionally, NCI does not currently support phone or videoconference surveys.

The HCBS CAHPS Survey is currently voluntary for state reporting. We encourage states and managed care organizations to continue to collect and report on the HCBS CAHPS survey at their discretion. The survey can be conducted through telephone or in-person interviews. Please note that, due to the public health emergency, the Agency for Healthcare Research and Quality has extended the deadline for [voluntary submission of HCBS CAHPS survey results to the HCBS CAHPS database](#) from March 13, 2020, to October 31, 2020.

4. How will CMS account for the impact of the COVID-19 pandemic when trending data over time?

When publishing Core Set data for FFY 2020 and FFY 2021, CMS will carefully note how care delivery and data collection methods may have been affected by the current public health emergency and urge caution when trending the data and making interpretations about the data.

To this end, CMS encourages states to document changes in how the data were collected for FFY 2020 and FFY 2021 due to the COVID-19 pandemic. As discussed earlier regarding hybrid measures, for example, states should document whether they used an alternate method in FY2020 than in FY2019 or would like CMS to consider using prior year data in public reporting. If chart review was conducted, states should document what percentage of charts were reviewed and how reviews were conducted (such as use of mail, fax, or online reviews).

5. How can states minimize the impact of the COVID-19 pandemic on quality measurement activities?

CMS encourages states to rely as much as possible on quality data that can be submitted and validated electronically to enable quality measurement and reporting activities to continue while minimizing the public health impacts of COVID-19.

Where preventive and elective services can be provided through telehealth, CMS encourages states to do so and to include those visits in their Core Sets data submissions where technical specifications allow for them (please refer to the [COVID-19 State Medicaid & CHIP Telehealth Toolkit](#) and FAQ # III.B.1, regarding the delivery of telehealth services).

6. Will the COVID-19 pandemic affect CMS's timeline for requesting states to submit their data on the Medicaid and CHIP Child and Adult Core Sets?

As in prior years, MACPro will be open between September and December 2020 for FFY 2020 Core Sets measure data. States that need more time due to the COVID-19 PHE should contact CMS at MACQualityTA@cms.hhs.gov.

7. How can states submit questions or request technical assistance specific to quality measurement activities?

Please email the quality measurement technical assistance mailbox at MACQualityTA@cms.hhs.gov

8. Will the current public health emergency impact CMS's timeline for requesting states to submit the Form CMS-416 which provides Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit data?

By statute, submissions of the Form CMS-416, which reflects the services delivered through the EPSDT benefit, were due to CMS on April 1st. States that need more time due to the COVID-19 PHE should contact CMS at EPSDT@cms.hhs.gov.

9. Can well-child screenings provided through telehealth be included in the Form CMS-416, which provides a count of EPSDT services?

The [American Academy of Pediatrics \(AAP\)](#) issued guidance to address the delivery of well-child screenings during the public health emergency, including the use of telehealth. To the extent it is clinically appropriate to conduct well-child screenings through telehealth and they can be provided according to the state's periodicity schedule, these screenings can be included in the count of EPSDT services on the Form CMS-416.

No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services provided in the same manner or at the same rate that states pay for face-to-face services. A SPA would be necessary to implement any revisions to payment methodologies to account for telehealth costs (please refer to the [COVID-19 State Medicaid & CHIP Telehealth Toolkit](#) and for example, please refer to FAQ Section III.B.1. regarding the delivery of telehealth services).

10. How can states request technical assistance specific to EPSDT reporting?

Please email the EPSDT technical assistance mailbox at EPSDT@cms.hhs.gov.

B. Workforce Issues

1. What options are available if a state experiences a shortage of health care workers because of COVID-19?

To address provider shortages for individuals receiving 1915(c) waiver services, states can use Appendix K to expand provider qualifications (e.g., where a provider must be 21 years old, states could modify the age requirement to 18); add additional providers (including allowance of payment to family members and legally responsible relatives); add services, such as a live-in care giver; and temporarily adjust rates to entice more individuals into the workforce.

For state plan services, a SPA can increase the types of providers a state authorizes to deliver services. As always, states should be mindful of state-level requirements that might impact provider flexibility in delegation of authority.

Additionally, states have broad ability to cover telehealth through Medicaid, and no federal approval is needed for state Medicaid programs to reimburse for telehealth services in the same manner or at the same rate paid for face-to-face services, visits, or consultations. A SPA is necessary to accommodate any revisions to payment methodology to account for telehealth costs.

To address state staff shortages, the Appendix K process can also be utilized for case managers under 1915(c) to permit the use of telehealth or telephonic consultations in place of typical face-to-face requirements. Under 1915(i), existing regulatory flexibility at 42 C.F.R. § 441.720(a) permits use of telehealth in place of face-to-face assessments when certain conditions are met.

2. What precautions can states take to protect home health workers, personal care workers, and eligibility workers from contracting COVID-19?

CMS supports the CDC guidance on workforce protections; more information can be found on the CDC website: <https://www.cdc.gov/coronavirus/2019-ncov/community/index.html>. CMS has also issued relevant guidance at the following link: <https://www.cms.gov/files/document/qso-20-17-all.pdf>. Any additional guidance will be posted to <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>. Any additional guidance will be posted to <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>.

To account for increased costs in PPE for home care workers, a SPA or Appendix K for a 1915(c) waiver could be submitted to amend payment methodologies for impacted services.

3. What flexibility exists to allow states to utilize first responders (emergency medical technicians (EMTs), fire fighters, etc.) to administer testing for COVID-19?

Depending on the specificity in the existing Medicaid state plan, a SPA may be necessary to add first responders as testing providers. CMS notes that state laws may have implications for the scope of providers able to perform these activities. In addition, third party liability provisions apply for services covered across the Medicaid program, and states could utilize existing mechanisms to ensure compliance.

C. 1115 Demonstrations

1. Can a state temporarily amend a section 1115 demonstration in conjunction with the public health emergency?

Yes, a state may submit a request to temporarily amend a demonstration in conjunction with the public health emergency. Demonstration special terms and conditions, as well as waivers and expenditure authorities, as applicable, may be authorized for a limited time, as needed. CMS will prioritize these requests for accelerated review.

2. If a state submits a demonstration amendment, is full public notice required or does this situation meet the criteria for an exemption?

A state would not need to complete full public notice. To the extent a requirement for a public notice process otherwise would apply with respect to the amendment, a Secretary-declared public health emergency would meet the criteria for an exemption described in the transparency regulations at 42 C.F.R. § 431.416(g). The state would be required to submit an application that CMS would post to Medicaid.gov. Transparency regulations at 42 C.F.R. § 431.416(g) state that CMS may expedite approval of a demonstration if the following conditions are met: i) the state acted in good faith, and in a diligent, timely, and prudent manner; ii) the circumstances constitute an emergency and could not have been reasonably foreseen; and iii) delay would undermine or compromise the purpose of the demonstration and be contrary to the interests of beneficiaries. CMS expects that COVID-19 related requests generally would meet these criteria.

3. Can an amendment request be retroactive?

CMS can provide 1115 demonstration authority connected to a public health emergency retroactive to the effective date of the public health emergency. Secretary Azar issued a public health emergency regarding COVID-19 on January 31, 2020, which was effective January 27, 2020. Therefore, CMS can provide authority for such a request back to January 27, 2020, as needed.

4. Federal regulations at 42 C.F.R. § 431.420(c) require a public forum to allow comment on the progress of a state’s section 1115 demonstration within six months of demonstration approval. Some state agencies have been directed to cancel in-person gatherings of constituency groups to prevent the spread of COVID-19. Does an alternate plan to host the forum as a webinar without an in-person audience, accepting comments via webinar and in writing, fulfill the 1115 demonstration requirements?

Yes, this alternate proposal would meet the public forum requirements for the section 1115 demonstration in the context of this declared public health emergency. States are reminded of their obligation to comply with applicable civil rights and other laws pertaining to accessibility, and should make these alternate public hearings as accessible as possible in the current environment. As another alternative, if a state would like to delay the post-award forum until a later time, CMS would also offer an extension of the deadline to meet this deliverable; a state interested in this option should contact the CMS-designated contact person for the demonstration to discuss the parameters of an extension.

5. Can alternative meeting formats fulfill the public hearing requirements at 42 C.F.R. § 431.408? For example, could two public meetings available only through telephonic and/or Web conference capabilities, without any in-person attendance, meet federal requirements?

Yes, in the context of this declared public health emergency, the state may be exempted from any of the normal public process requirements outlined in 42 C.F.R. § 431.408. Pursuant to 42 C.F.R. § 431.416(g), CMS has discretion to exempt the state from completing any aspect of the public notice process, including exemption from conducting any public notice, *when the State demonstrates to CMS the existence of unforeseen circumstances resulting from a natural disaster, public health emergency, or other sudden emergency that directly threatens human lives that warrant an exception to the normal public notice process.* To address the question above, in lieu of in-person meetings, the state may hold meetings in any alternative format (webinar, telephonic, written submission) that permits submission of public input; including using two telephonic conferences in lieu of in-person public hearings.

6. Can alternative meeting formats fulfill the medical care advisory committee participation requirements at 42 C.F.R. § 431.12? For example, could committee meetings available only through telephonic and/or Web conference capabilities, without any in-person attendance, meet federal requirements?

Yes, in lieu of in-person meetings, a state has discretion to hold meetings in any alternative format (webinar, telephonic, written submission) that provides committee members with the

opportunity to participate in policy development and program administration. States are reminded of their obligation to comply with applicable civil rights and other laws pertaining to accessibility, and should make these alternate meetings as accessible as possible in the current environment.

D. Other

1. What flexibilities will CMS provide states in the event that required deliverables cannot be submitted because of COVID-19 (i.e., SPA, waiver applications, renewals, or deliverables, etc.)?

CMS will monitor pending SPA submissions and 1915(c) waiver amendments and renewals and work closely with the state to ensure the appropriate approvals or temporary extensions are granted.

Regarding managed care reporting requirements, CMS is able to utilize enforcement discretion for managed care reporting requirements under 42 C.F.R. Part 438, with minimal exceptions (actuarial soundness, payments, and Medical Loss Ratio (MLR) requirements). The reporting requirements for MLR at 42 C.F.R. § 438.8(k) are determined by the state, as long as it is within 12 months of the end of the reporting year. CMS believes this provides states an ample window to meet MLR reporting requirements.

Regarding section 1115 demonstration deliverables or renewal requests (such as quarterly and annual monitoring or budget neutrality reports, evaluation designs, evaluation reports), states may e-mail their demonstration's CMS project officer requesting an extension to submit the deliverable/report or renewal application, along with an explanation of the rationale. As a general rule, if the state experiences challenges as a result of COVID-19, the state should notify CMS as soon as possible and CMS will work with the state to determine a reasonable timeline for compliance.

2. In the event of a public health emergency in which a healthcare facility experiences an acute critical staffing shortage, including a staffing shortage due to infectious disease, and temporarily utilizes federal health care workers (e.g., US Public Health Services Commissioned Corps Officers) in place of facility staff, may the facility continue to bill the Medicaid program for the services provided to beneficiaries?

Providers are generally prohibited from billing the Medicaid program and states may not receive FFP for practitioner services provided by federally employed health care workers. To the extent care provided by a federal employee supplants the costs of practitioner or non-practitioner services that are bundled into a rate that includes multiple service costs, the provider's payment would need to be allocated and the state's claim for FFP would need to be reduced to account for service costs associated with federally employed practitioners. For example, if a nursing facility is staffed in part by federally employed health care workers and is paid a per diem rate for Medicaid services, the state's claim of FFP for the per diem rate would need to be reduced for all care costs assumed for services provided by federal workers. In such instances, during a public emergency, the state may continue to pay the nursing facility the full per diem rate and recoup

funds from the provider once data is available to properly allocate service costs. Such an allocation may be conducted using cost data from a nursing facility's cost report or, if feasible, by reducing the per diem rates by cost factors associated with care costs assumed by the federal health care worker. The data used to allocate cost must be auditable and claimed FFP associated with the federally employed worker must be returned to CMS. CMS will work with state to ensure this process is conducted within an appropriate time frame following acceptance of federal assistance. In the interim, states may continue to pay providers in accordance with Medicaid state plan methodologies and CMS will work with the state on a case-by-case basis to ensure that a reasonable allocation method is developed in accordance with applicable cost allocation requirements.

3. What is CMS' coding guidance for laboratory testing of COVID-19 and what are the rates for testing?

CMS is working closely with the CDC to establish the appropriate coding practices related to COVID-19. CMS developed the first HCPCS code (U0001) to pay for claims and track testing for COVID-19. This code is used specifically for CDC testing laboratories to test patients for SARS-CoV-2. CMS has since added a second HCPCS billing code (U0002) which allows laboratories to bill for non-CDC lab tests for SARS-CoV-2/2019-nCoV (COVID-19). Medicare claims processing systems will be able to accept these codes starting on April 1, 2020, for dates of service on or after February 4, 2020. These codes serve to increase more testing and improve tracking. Because these HCPCS codes allow those labs conducting the tests to bill for the specific test instead of using an unspecified code, a descriptor is not required for Health Insurance Portability and Accountability Act (HIPAA) compliance.

On February 6, 2020, CMS also gave Clinical Laboratory Improvement Amendments (CLIA)-certified laboratories information about how they can test for SARS-CoV-2. To read more about those efforts, visit: <https://www.cms.gov/medicareprovider-enrollment-and-certificationsurvey/certificationgeninfo/policy-and-memos-states-and/notification-surveyors-authorization-emergency-use-cdc-2019-novel-coronavirus-2019-ncov-real-time-rt>.

CMS's 12 local administrative contractors process and pay the fee-for-service Medicare claims for each of their respective jurisdictions. The contractors use a variety of methodologies to price new tests that will be paid at the local level, until a national price is established through CMS's annual laboratory meeting process that includes the opportunity for public feedback. CMS is actively working with the contractors in this process and will provide information in separate guidance once it is available.

4. What should states do if they need to close Medicaid or CHIP state and local offices to applicants and beneficiaries during a disaster or emergency?

CMS recognizes that the COVID-19 public health emergency may impact states' normal operations, particularly in light of staff shortages and the recommendations that individuals socially distance themselves from others. As a result, we also acknowledge that this may limit states' ability to receive applications, reports of changes in circumstances, and renewal forms or provide assistance in-person.

While existing statute and regulation do not permit an exception to accepting information from applicants and beneficiaries through any of the required modalities (e.g., online, in person, via mail, and by phone), CMS recognizes that access to a particular modality may be temporarily limited due to an administrative or other emergency beyond the agency's control, including closure of public offices due to COVID-19. If an emergency impacts a state's ability to accept information from applicants or beneficiaries in person or through another modality, the state should make feasible adjustments to ensure that individuals still have the opportunity to apply. For example, if state and local offices are closed, a state could increase the capacity of other available modalities (e.g., by expanding call center capacity or placing additional out-stationed workers in specific locations), and ensure that individuals are informed of these other resources. Additionally, states should continue to ensure communication with applicants and beneficiaries are accessible to individuals with disabilities and those who are limited English proficient. CMS is available to assist states in identifying practical solutions when access to a particular modality may be limited due to the public health emergency.

Additionally, states may use contractors to perform certain Medicaid agency administrative functions, provided that the state exercises appropriate oversight consistent with federal regulations at 42 C.F.R. § 431.10. For example, states can use contractors to operate call centers, input data from paper applications into an eligibility system or serve as application assistors. For CHIP, states have broad flexibility to delegate functions to contractors as long as they maintain oversight.

5. What is the CMS coding guidance for laboratory testing of COVID-19?

CMS works in coordination with the CDC to establish the appropriate coding practices related to COVID-19, and to date, four new HCPCS codes have been created for COVID-19 testing. HHS has previously shared **Code U0001**: used specifically for CDC testing laboratories for CDC 2019 novel coronavirus (2019-NCOV) real-time RT-PCR diagnostic panel, and **Code U0002**: for non-CDC lab tests for SARS-CoV-2/2019-nCoV (COVID-19). See more information in FAQ # VII.D.3, available here <https://www.medicaid.gov/state-resource-center/Downloads/covid-19-faqs.pdf>.

Two new HCPCS codes have been established to identify clinical diagnostic laboratory tests for the detection of SARS-CoV-2 or the diagnosis of COVID-19 *that make use of high throughput technologies*:

- Code U0003 designates Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R. U0003 should identify tests that would otherwise be identified by CPT code 87635 but for being performed with these high throughput technologies.
- Code U0004 designates 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), for any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R. U0004

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should be used for tests that would otherwise be identified by U0002 but for being performed with these high throughput technologies.

It is important to note that neither U0003 nor U0004 should be used for tests that detect COVID-19 antibodies.

To ensure that Fee-For-Service claims and encounter data submitted to CMS as part of Transformed Medicaid Statistical Information System (T-MSIS) are accurate and complete, State Medicaid programs are encouraged to load the new codes (U0003 and U0004) into their systems and publish coding and billing guidance as soon as possible so that laboratories can submit claims timely. In addition, states with Medicaid managed care service delivery systems should communicate these codes to their managed care organizations.

Additional Questions

Please submit additional questions and requests to CMS' dedicated COVID-19 mailbox at MedicaidCOVID19@cms.hhs.gov.