NEW FAQs – Released June 30, 2020

COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies[1]

Eligibility and Enrollment

Presumptive Eligibility

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.

Notice and Fair Hearings

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.

[1] NOTE: These newly released FAQs have also been integrated into the previously released COVID-19 FAQ document, available at https://www.medicaid.gov/state-resource-center/Downloads/covid-19-faqs.pdf

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).

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)).

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.

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.

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.

Optional COVID-Testing Group FAQs

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.

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

Premiums and Cost Sharing

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)).

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.[2] 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.

Miscellaneous

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).

Benefits

Telehealth

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

[2] 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.

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.

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.

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 and the OSEP and Department of Education links noted above.

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 at https://www.ed.gov/coronavirus.

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.

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.

Home and Community-Based Services

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.

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.

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.

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.

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.

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.

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.

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.

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.

Pharmacy

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.

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.

Money Follows the Person (MFP) Program

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.

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.

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.

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

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

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.

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.

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.

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.

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

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

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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.

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.

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.

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.

Miscellaneous

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.

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.

Non-Emergency Medical Transportation (NEMT)

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.

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.

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.

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.

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.

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.

Phased-Down State Contribution for Medicare Part D Costs for Full Benefit Dual Eligible Individuals

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.

Information Technology

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.

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.

Miscellaneous

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 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.

Financing

Advance and Retainer Payments

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.

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.

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.

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.

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.

Financing

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.

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.

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.

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.

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.

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.

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.