

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

A. Emergency Preparedness and Response

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

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

<https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/index.html>.

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

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

Appendix K also provides states with opportunities to:

- temporarily increase individual eligibility cost limits,
- modify service, scope, or coverage requirements,
- exceed service limitations,
- add services to the waiver,

- provide services in out-of-state settings, and/or
- permit payment for services rendered by family caregivers or legally responsible individuals.

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

Please see attached link for instructions and template:

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

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

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

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

B. Eligibility and Enrollment Flexibilities

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

Yes. Under Hospital Presumptive Eligibility (HPE), states must permit hospitals to make PE determinations for parents and caretaker relatives, children, pregnant women, and former foster care children, adults (in states that have adopted the adult group), individuals eligible for family planning services (if covered by the state), and individuals needing treatment for breast or cervical cancer (if covered by the state.) However, states have the authority to add additional Medicaid eligibility groups or populations (if covered by the state) to their HPE program. This includes eligibility groups based on being age 65 or older, having blindness or a disability, or being medically needy (ex., eligibility group for individuals in institutions eligible under a special income level). States may also permit hospitals to make PE determinations for

demonstration populations covered under section 1115 authority. Participating hospitals must meet the state's qualification requirements and comply with the procedures and standards established by the state. CMS is available to provide technical assistance on the SPA changes needed to expand HPE to these and other eligibility groups.

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

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

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

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

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

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

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

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

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

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

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

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

C. Benefit Flexibilities

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

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

Access to Medicaid services provided in an individual's private home or group residential setting should not change because the beneficiary is quarantined. However, depending on the way the state has developed the benefit and description in the state plan, a SPA may be necessary to

amend language to clarify where services may be provided. For benefits with federal requirements governing location, such as benefits that require services to be provided in a home and community based setting, CMS is available to provide technical assistance related to how states can comply with federal requirements in emergencies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Is the test for the detection of COVID-19 coverable under Medicaid's mandatory laboratory benefit?

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

If a state's current Medicaid cost sharing policies include cost sharing for the test for the detection of COVID-19, the state can submit a SPA to eliminate the cost sharing for that test. For CHIP, states can stop charging copayments for particular items or services through a CHIP disaster relief SPA. More information on cost sharing flexibility is found in question D.1. below.

NEW

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

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

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

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

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

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

Yes. For initiation of home health services, face-to-face encounters may occur using telehealth as described at 42 C.F.R. §440.70(f)(6). A physician, nurse practitioner or clinical nurse specialist, a certified nurse midwife, a physician assistant, or attending acute or post-acute physician for beneficiaries admitted to home health immediately after an acute or post-acute stay may perform the face-to-face encounter. The allowed non-physician practitioner must communicate the clinical findings of the face-to-face encounter to the ordering physician. Those clinical findings must be incorporated into the beneficiary's written or electronic medical record. Additionally, the ordering physician must document that the face-to-face encounter occurred within the required timeframes prior to the start of home health services and indicate the practitioner who conducted the encounter and the date of the encounter. A state plan amendment would only be necessary to revise existing state plan language that imposes telehealth parameters that would restrict this practice. As is discussed above and at <https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html>, states are not required to submit separate state plan amendments for coverage or reimbursement of telehealth services if they decide to reimburse for telehealth services in the same manner or at the same rate paid for face-to-face services. A state plan amendment would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.

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

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

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

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

D. Cost-Sharing Flexibilities

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

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

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

E. Financing Flexibilities

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

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

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

The state Medicaid agency should notify CMS as soon as possible that it expects a delayed Form CMS-64 submission. Although federal regulations at 42 C.F.R. § 430.30(c)(1) require states to submit the form CMS-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program) to CMS not later than 30 days following the end of each quarter, in the event of a public health emergency that impacts a state's ability to do so, CMS will work with impacted states to ensure the continued availability of FFP for allowable Medicaid services for the duration of the public health emergency. Additionally, CMS will provide technical assistance as necessary to assist the state with proper claiming of FFP and to ensure that funding provided is reconciled to actual incurred and allowable expenditures.

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

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

1. For enhanced FFP: Approval of contracts and associated funding is not required in instances where the contract is not anticipated to exceed a total federal and state acquisition cost of \$500,000.
2. For regular FFP: Approval of contracts and associated funding is not required in instances where the contract is not anticipated to exceed a total federal and state acquisition cost of \$5,000,000.
3. For sole source contracts: Approval of contracts and associated funding is not required in instances where the contract is not anticipated to exceed a total federal and state acquisition cost of \$1,000,000.

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

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

NEW

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

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

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

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

7. Can states pay FQHCs and RHCs an amount less than the PPS rate on a FFS basis with an approved SPA or waiver? Additionally, if a service is provided telephonically, can the

state pay the provider an amount lower than PPS for the telephonic service delivered via telehealth?

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

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

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

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

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

F. Workforce Flexibilities

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

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

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

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

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

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

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

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

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

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

G. Miscellaneous

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

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

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

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

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

Providers are generally prohibited from billing the Medicaid program and states may not receive FFP for practitioner services provided by federally employed health care workers. To the extent care provided by a federal employee supplants the costs of practitioner or non-practitioner services that are bundled into a rate that includes multiple service costs, the provider's payment would need to be allocated and the state's claim for FFP would need to be reduced to account for service costs associated with federally employed practitioners. For example, if a nursing facility is staffed in part by federally employed health care workers and is paid a per diem rate for Medicaid services, the state's claim of FFP for the per diem rate would need to be reduced for all care costs assumed for services provided by federal workers. In such instances, during a public emergency, the state may continue to pay the nursing facility the full per diem rate and recoup funds from the provider once data is available to properly allocate service costs. Such an allocation may be conducted using cost data from a nursing facility's cost report or, if feasible, by reducing the per diem rates by cost factors associated with care costs assumed by the federal health care worker. The data used to allocate cost must be auditable and claimed FFP associated with the federally employed worker must be returned to CMS. CMS will work with state to ensure this process is conducted within an appropriate time frame following acceptance of federal assistance. In the interim, states may continue to pay providers in accordance with Medicaid state plan methodologies and CMS will work with the state on a case-by-case basis to ensure that a reasonable allocation method is developed in accordance with applicable cost allocation requirements.

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

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

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

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

NEW

H. Managed Care Flexibilities

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

The Trump Administration encourages states to take advantage of broad flexibility to deliver services via telehealth in Medicaid and CHIP to help prevent the spread of the Coronavirus as is discussed at <https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html> and <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/covid19/index.html>. The available telehealth flexibility allows Medicaid beneficiaries to receive a wide range of healthcare services from their providers without having to travel to a health care facility so that they can limit risk of exposure and spread of the virus. In fee-for-service, states are not required to submit separate state plan amendments for coverage or reimbursement of telehealth services if they decide to reimburse for telehealth services in the same manner or at the same rate paid for face-to-face services. Medicaid guidelines require all providers to practice within the scope of their State Practice Act, and states may have laws and regulations that govern the scope of telemedicine coverage. In fee-for-service, a state plan amendment would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.

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

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

Regarding Medicaid managed care payment, under 42 C.F.R. §§438.3(c)(1)(ii) and 438.4, final capitation rates must be actuarially sound and based only upon services covered under the state plan or waiver authority and represent a payment amount adequate to allow the managed care organization (MCO), prepaid inpatient health plan (PIHP) or prepaid ambulatory health plan (PAHP) to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements. If a state determines a retroactive adjustment to capitation rates under one or more of its managed care contracts is necessary for costs eligible for reimbursement, such as telehealth-related infrastructure costs, retroactive adjustments must be certified by an actuary in a revised rate certification and submitted as a contract amendment in accordance with 42 C.F.R. §438.7(c)(2). The rate certification must describe the rationale for the adjustment and the data, assumptions and methodologies used to develop the magnitude of the adjustment. For additional information about telemedicine, visit:

<https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html>. For CHIP, rates must be based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles, as described in 42 C.F.R. §457.1203(a). States that update their CHIP capitation payments due to telehealth related costs would not need to submit a rate certification.

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

States should review their state plans and managed care contracts to ensure they have no state restrictions in place. In general, states have flexibility to establish Medicaid and CHIP FFS prior authorization and drug utilization review processes that encompass extended day supplies and

early refills for emergency situations without CMS approval. Some states may need to modify their state plans. Under CMS managed care regulations, the need for a contract amendment related to prior authorization, extended day supplies of medication, and early refills will be dependent upon the detail included in states' existing managed care contracts. If existing managed care contracts do not allow for 90-day supplies of medications or early refill requirements, states will need to submit a contract amendment. CMS will prioritize our review and approval of COVID-19 related state plan or contract amendments.

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

We strongly encourage states and managed care plans to collaborate on communication of CDC best practices for infection control and medical management to their Medicaid enrollees. This information can be found at: <https://www.coronavirus.gov>. All relevant CDC guidance is also posted on the CMS website and new information will be shared with states as it becomes available. Current guidance is available at: <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>. States and managed care plans may share relevant information with case and care managers. Managed care plans providing written documents to Medicaid and CHIP beneficiaries will need to comply with information requirement regulations at 42 C.F.R. §438.10 and 42 C.F.R. §457.1207. CMS notes that the materials provided by the CDC are compliant with the "Plain Language Act of 2010" (<https://www.cdc.gov/other/plainwriting.html>), which requires all federal agencies to write plainly when they communicate with the public. Therefore, for the purposes of 42 C.F.R. §438.10(c), CMS considers all CDC materials written in a manner and format that is easily understood and is readily accessible.

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

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

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

There are multiple approaches under which states can permit payment for COVID-19 testing in managed care programs. To be considered a mandatory laboratory service as described at

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

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

States could also pay for the tests outside of the managed care capitation payment as a non-risk payment: either as a separate non-risk contract with its managed care plans (see the definition of “non-risk contract” at 42 C.F.R. §438.2¹ or as an amendment to its existing managed care plan contracts to include a non-risk payment. If a state chooses to amend its existing contracts to include a non-risk payment, the state would need to comply with upper payment limits outlined at 42 C.F.R. §447.362 consistent with the requirements for non-risk contracts. For CHIP, states could follow the same approach of paying for the tests outside of the managed care capitation payment as a non-risk payment.

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

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

NEW

I. 1115 Demonstration Flexibilities

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

Yes, a state may submit a request to temporarily amend a demonstration in conjunction with the public health emergency. Demonstration special terms and conditions, as well as waivers and

¹ An amendment to the existing contract that includes coverage of these testing services to exclude them from the risk-contract would be necessary.

expenditure authorities, as applicable, may be authorized for a limited time, as needed. CMS will prioritize these requests for accelerated review.

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

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

3. Can an amendment request be retroactive?

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

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

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

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

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

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

Yes, in lieu of in-person meetings, a state has discretion to hold meetings in any alternative format (webinar, telephonic, written submission) that provides committee members with the opportunity to participate in policy development and program administration. States are reminded of their obligation to comply with applicable civil rights and other laws pertaining to accessibility, and should make these alternate meetings as accessible as possible in the current environment.

Additional Questions

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