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

The Centers for Medicare & Medicaid Services (CMS) released six sets of general Frequently Asked Questions (FAQs) to aid state Medicaid and Children's Health Insurance Program (CHIP) agencies in their response to the coronavirus disease 2019 (COVID-19) pandemic. CMS also released two sets of FAQs providing guidance to states on the implementation of the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act.

On January 6, 2021, CMS released an updated FAQ document that incorporates all eight sets of COVID-19 FAQs into one, comprehensive FAQ document. Additionally, on November 2, 2020, a provision implementing section 6008(b)(3) of the FFCRA in CMS-9912 Interim Final Rule with Comment (CMS-9912 IFC) became effective. CMS's original interpretation of the condition specified in section 6008(b)(3) was issued in FAQs in April, May and June 2020. While most of these FAQs remain in effect following the November 2, 2020 effective date of the IFC, some FAQs are applicable only through November 1, 2020. Each of the previously published FAQs in Section II.I. of this document has been updated to respond to questions about section 6008(b)(3) of the FFCRA and includes a note with a designation of applicability related to the IFC.

Table of Contents

I. Emergency Preparedness and Response

1. What is the emergency period described in sections 6004 and 6008 of the Families First Coronavirus Response Act (FFCRA)?

Sections 6004 and 6008 of the FFCRA refer to the emergency period defined in section 1135(g)(1)(B) of the Social Security Act (the Act). Section 1135(g)(1)(B) of the Act defines the emergency period as the period during which there exists a public health emergency under section 319 of the Public Health Service Act for COVID-19. The Health and Human Services (HHS) Secretary's public health emergency declaration for COVID-19 was effective on January 27, 2020, so the emergency period as defined in section 1135(g)(1)(B) began then, and continues through any renewal of the HHS Secretary's public health emergency declaration.[1] The emergency period expires after 90 days, unless further extended by the Secretary. The emergency period will terminate upon termination of the public health emergency, including any extensions. At the time the public health emergency period for COVID-19 ends, Centers for Medicare & Medicaid Services (CMS) will inform states.

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

Medicaid and the Children's Health Insurance Program (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.

[1] The emergency period is defined in paragraph (1)(B) of section 1135(g) of the Act, as amended by H.R. 6074—The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (Pub. L. 116-123). The Secretary's determination that a public health emergency exists was issued on January 31, 2020 with an effective date of January 27, 2020. The Secretary's declaration is available at https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx.

3. 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

4. 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

Coverage for this optional Medicaid eligibility group begins no earlier than March 18, 2020, and terminates at the end of the PHE. States that want to take advantage of the 6.2% increase in the Federal Medical Assistance Percentage (FMAP) under section 6008 of the FFCRA, Pub L. No. 116-127 (2020) may need to keep this group enrolled until the end of the month in which the PHE period ends in order to comply with the conditions in section 6008(b)(3) of that legislation. However, the limited coverage for which this group is eligible also terminates at the end of the PHE (per statute), so states do not need to provide this group with any coverage after the PHE ends, even if they keep members of this group enrolled in order to comply with section

6008(b)(3) of the FFCRA. States may elect the COVID-19 testing eligibility group by completing the appropriate section of the Medicaid disaster relief SPA template, which can be found here: https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/state-plan-flexibilities/index.html. The SPA is submitted to the relevant CMS SPA Mailbox for the state.

10. For states that have received a section 1135 waiver approval, how long will they have to complete Medicaid provider enrollments once the Public Health Emergency (PHE) ends?

The section 1135 waiver approval letter received by those states that had requested waivers of the provider enrollment and the authority to perform temporary abbreviated enrollment processes specified that states have up to six months from the end of the PHE (including any extensions) to cease payment to providers not fully screened and enrolled. CMS will request an assurance from states that they have taken the necessary steps to complete enrollments. If the provider enrollments are not complete by the end of the six-month period, states must cease payment to providers that were temporarily enrolled. CMS will continue to monitor and determine whether corrective action is warranted. The corrective action may include state reporting on the number of temporary providers that have pending applications but not enrolled permanently and those that do not have pending enrollments but continue to receive reimbursement.

11. For states that have received a section 1135 waiver approval, how long will they have to complete Medicaid provider revalidations once the Public Health Emergency (PHE) ends?

For states that have temporarily paused revalidation work per their 1135 waiver approval, revalidation work is expected to resume with the termination of the PHE. For those revalidation due dates that occurred during the PHE, the state may delay the revalidation due date by the amount of time the PHE is in place with an additional six months lead time to allow for notification to the provider of the new revalidation due date. The following example will illustrate the timeline assuming the PHE, which began on March 1, 2020, is terminated on November 1, 2020 (PHE in place for eight months). The provider's revalidation due date was March 2, 2020. Therefore, the state will move the provider's revalidation due date to May 2, 2021. In this example, the state has 14 months following the termination of the PHE to notify and revalidate this provider. However, this amount of time will continue to increase as long as the PHE remains in place.

12. Do the Medicare Blanket waivers apply to Medicaid and CHIP Programs?

To the extent that Medicare regulations apply to providers and suppliers in the Medicaid and CHIP programs, Medicare blanket waivers would also apply to Medicaid and CHIP providers and suppliers as long as those providers and suppliers continued to comply with any applicable non-waived federal and state law. In certain circumstances, the HHS Secretary, using section 1135 of the Act, can temporarily modify or waive certain Medicare, Medicaid, CHIP, or Health Insurance Portability and Accountability Act (HIPAA) requirements; these are generally referred to as "blanket waivers." There are different kinds of 1135 waivers, including Medicare blanket waivers. When there is an emergency, sections 1135 or 1812(f) of the Act allow the Secretary to issue blanket waivers to help beneficiaries access care. When a Medicare blanket waiver is issued, providers do not have to apply for an individual waiver of regulations under section 1135

of the Act. However, the federal government has no authority to waive state law, even if the state law cross-references federal law. Therefore, absent some state waiver activity, for example state laws waiving their own conditions of participation, the Medicare blanket waiver would not exempt a Medicaid facility from complying with its own state's laws, even if those laws address the same activities.

II. Eligibility and Enrollment

A. Application and Renewal Processing

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

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

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

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

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

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

A state plan amendment for Medicaid is not needed. States relying on a timeliness standard exception on a case-by-case basis must document the reason for the delay in the individual's case record. States seeking to invoke a timeliness standard exception for a broader cohort of cases (for

example, all renewals in a defined geographic area) are advised to not only document the exception in the beneficiary's case record, but also to obtain CMS concurrence that the exception is warranted under the circumstances.

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

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

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

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

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

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

States are required under regulations at 42 C.F.R. § 435.916(d) to promptly redetermine eligibility whenever they receive information about a change in circumstances that may impact eligibility. However, CMS recognizes that the impact of the COVID-19 public health emergency is impacting the ability of state agencies to process changes in circumstances in a timely manner, such that what is considered "prompt" under the current circumstances may be longer than what typically would be expected. States that are unable to promptly process changes in circumstances that may impact eligibility are advised to obtain CMS concurrence that the delay is warranted under the circumstances. States must document the delay in the beneficiary's case record. Alternatively, if a large number of cases are affected and the state can clearly define the cohort of

cases for which it seeks CMS' concurrence, CMS will not enforce compliance with the requirement that states document the delay in each case record included in the cohort described. States do not need to make a formal request for CMS concurrence, but may notify via email to the CMS state lead.

Further, in order to qualify for the increased FMAP provided under section 6008(a) of the FFCRA, through the end of the month in which the public health emergency ends, pursuant to section 6008(b)(3) of the FFCRA, states may not terminate individuals enrolled for Medicaid benefits as of March 18, 2020, or determined eligible on or after that date. This includes continuing coverage for individuals who experience a change in circumstances that impacts eligibility or are determined eligible based on self-attestation for certain criteria, if the state has adopted post-enrollment verification of the criterion. Thus, if a state is able to process a change in circumstances prior to the end of the month in which the public health emergency ends, and determines that a beneficiary no longer meets all eligibility criteria for coverage, the state must postpone taking adverse action until after the end of the month in which the emergency ends in order to qualify for the temporary FMAP increase. See also Question II.I.1.

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

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

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

Consistent with regulations at 42 C.F.R. §§ 435.907(f) and 457.330, all initial applications for Medicaid and CHIP must be signed under penalty of perjury. Individuals may receive help from others, including certified application assisters under 42 C.F.R. § 435.908, Exchange Navigators, or authorized representatives, to complete an application for Medicaid or CHIP. While these types of assisters typically provide in-person assistance with applications, CMS recognizes that such assistance may need to be provided by phone during the current public health emergency if offices or other locations are closed or otherwise to minimize in-person contact. If an assister or other individual is completing and submitting an online application on behalf of an applicant, based on information the applicant has provided by phone, for the period of the emergency and subject to state law, the applicant may designate that individual be an authorized representative with limited authority to sign and submit the application on behalf of the applicant. Due to the public health emergency posed by COVID-19 and the urgent need to avoid transmission of COVID-19, for the duration of the COVID-19 public health emergency, CMS will not enforce compliance with requirements at § 435.923(a)(1) that designation of an authorized representative

must be signed by the applicant or enrollee, and submitted to the state agency, provided that applicants provide authorization for an assister or other individual to be their authorized representative orally, in writing, or both. A record of such authorization must be submitted by the authorized representative, along with the application. The agency must accept such authorization through any of the available modalities described at § 435.907(a) and must be include the record in the applicant's account held by the state Medicaid agency. Assisters or other individuals acting as authorized representatives in these circumstances must also abide by confidentiality and conflict of interest requirements set out in regulation at 42 C.F.R. §§ 435.908(c) and 435.923(e), 45 C.F.R. §§ 155.210(d), 155.225(g)(2), 155.227, and 155.260, and the legal instrument establishing the assister's relationship with the Exchange or authorized representative's role with respect to the Exchange. We believe that this guidance is a statement of agency policy not subject to the notice and comment requirements of the Administrative Procedure Act (APA). 5 U.S.C. § 553(b)(A). For the same reasons explained above, in light of the PHE and the urgent importance of reducing the potential for transmission of COVID-19 through the authorization process, CMS additionally finds that, even if this guidance were subject to the public participation provisions of the APA, prior notice and comment for this guidance is impracticable, and there is good cause to issue this guidance without prior public comment and without a delayed effective date. 5 U.S.C. § 553(b)(B) & (d)(3).

As discussed above, assisters and other individuals serving as an authorized representative must obtain and record authorization from individuals to submit applications on behalf of the applicants they are helping. Options to do so can be found in the Federally Facilitated Marketplace's guidance for assisters on "How to Obtain a Consumer's Authorization before Gaining Access to Personally Identifiable Information (PII)" linked here: https://marketplace.cms.gov/technical-assistance-resources/obtain-consumer-authorization.pdf. Note that while Navigators are not prohibited from serving as authorized representatives under federal regulations, acting in this manner is not part of the duties and responsibilities of a Navigator. Therefore, service as an authorized representative by a Navigator must be as a private individual, separate from their Navigator duties, and cannot be funded using Navigator grant funds.

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

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

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

Yes. Per regulations at 42 C.F.R. § 435.1200(d)(4), assessment states have flexibility to accept findings from the FFE as final MAGI determinations and enroll individuals into coverage without additional verification if all eligibility criteria have been verified by the FFE. States will need to complete verification to determine eligibility for individuals for whom not all factors of eligibility have been verified by the FFE (i.e., the FFE has not resolved a discrepancy between attested information and electronic data). No additional or express authority from CMS is needed.

9. What is the responsibility of a state with respect to identifying Medicaid-eligible children and pregnant women who no longer meet the criteria to receive full Medicaid coverage under the "CHIPRA 214 option" if the state is delayed in conducting eligibility renewals and acting on changes in circumstance due to the public health emergency?

In Question II.I.6 of the Frequently Asked Questions available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf**,** we explained that once a noncitizen is no longer eligible for full Medicaid coverage due to no longer meeting the criteria for full coverage under Section 1903(v)(4) of the Act, as added by Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA 214 option) (under which states can elect to provide full benefits to lawfully residing children and pregnant women who are not otherwise in a satisfactory immigration status), Federal Financial Participation (FFP) is only available for payment for services necessary for the treatment of an emergency medical condition.

Regulations at 42 C.F.R. § 435.916(d) require that states promptly redetermine eligibility whenever the state receives information about a change in a beneficiary's circumstance that may affect eligibility. However, 42 C.F.R. § 435.912(e) outlines certain exceptions in meeting the timeliness standards for processing applications, renewals and changes in circumstance for Medicaid eligibility during an administrative or other emergency beyond the agency's control. The current COVID-19 PHE represents such a circumstance for many state agencies.

The exception to the timeliness requirements at 42 C.F.R. § 435.912(e) applies equally in the case of noncitizen beneficiaries who are no longer eligible for full Medicaid coverage because they no longer meet the criteria under the CHIPRA 214 option (e.g., the individual has turned age 21, is no longer pregnant and is past the 60-day post-partum period, or no longer meets the definition of lawfully residing). If a state is unable to process redeterminations and fails to identify a beneficiary in this situation FFP is available for full Medicaid coverage until such time as the state is able to process redeterminations. We note that, even with the exception at 42 C.F.R. § 435.912(e), states are still required to continue processing changes in circumstances and renewals as expeditiously as possible, and to provide Medicaid coverage only for treatment of an emergency medical condition for individuals who no longer have a satisfactory immigration status and who are otherwise eligible for assistance under the state plan. When the state does process such a change, the state must notify the beneficiaries that, while they are no longer

eligible for full Medicaid coverage, they may continue to be eligible for treatment of an emergency medical condition, if the individual is otherwise eligible for Medicaid under the state plan.

10. During the COVID-19 PHE, can states choose not to enforce the requirement under 42 C.F.R. § 435.608 that Medicaid applicants and beneficiaries apply for certain other benefits? Alternatively, can states automatically grant a good-cause exception to individuals for not applying for other benefits?

No. During the PHE, states must continue to require that Medicaid applicants and beneficiaries take all necessary steps to obtain other benefits for which they may be entitled, unless they can show good cause for not doing so, consistent with 42 C.F.R. § 435.608.

We note that enforcement of the requirement at 42 C.F.R. § 435.608 occurs post-enrollment and should not delay an applicant's eligibility determination. Once enrolled, states need to ensure that individuals are making a good faith effort to take the necessary steps to apply for other benefits. Generally, each individual must provide information to the state agency establishing the need for a good faith exception. However, we recognize that other benefit programs are experiencing delays processing applications due to the PHE, and individuals may not be able to complete the application process as timely. Therefore, if there is a specific benefit for which the state determines the application process would represent a hardship for all beneficiaries during the PHE – e.g., the application process requires an in-person interview which are not being conducted due to the PHE –it would be permissible for states to grant a good cause exception with respect to such benefit for all applicants and beneficiaries who may be eligible for such benefit during the PHE.

11. During the PHE, can states choose not to enforce the requirement that Medicaid applicants and beneficiaries assist the state agency in establishing the identity of a child's parents and obtaining medical support payments, or provide information on third parties who may be liable to pay for care and services provided under the state plan?

No. A state may not choose to forego implementing the requirements in 42 C.F.R. § 435.610(a) that applicants and beneficiaries assist the state agency with identifying absent parents, obtaining medical support and payments, and providing information on third parties who may be liable for care and services provided under the state plan. However, we note that enforcement of the requirement at § 435.610(a) occurs post-enrollment, and should not delay an applicant's eligibility determination. Regulations at 42 C.F.R. § 433.148 provides that states may only require applicants to attest that they will cooperate with this requirement. Once enrolled, absent a need to comply with the continuous enrollment requirement in section 6008(b)(3) of the FFCRA, states must terminate coverage if a beneficiary refuses to do so and the individual has not established good cause for not doing so per 42 C.F.R. §§ 433.147(c) and 435.610(a)(3); however, states claiming the temporary FMAP increase cannot, consistent with section 6008(b)(3) of the FFRCA, terminate the individual's enrollment for the failure to cooperate, through the end of the month in which the emergency period ends.

B. Premiums and Cost-Sharing

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

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

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

2. Is cost-sharing permitted for COVID-19 testing and testing-related services?

No. Section 6004 of the FFCRA amends sections 1916, 1916A, and 2103 of the Act to exempt from cost sharing in Medicaid and CHIP: (1) any in vitro diagnostic product described in section 1905(a)(3)(B) of the Act (and its administration); and (2) any other COVID-19 testing-related services for which payment may be made under the State plan, during the portion of the public health emergency period defined in section 1135(g)(1)(B) of the Act beginning on the date of enactment of FFCRA (March 18, 2020). See Question II.K.7. for more information on COVID-19 testing related services. States must submit a SPA if they currently charge cost sharing for services that would encompass any in vitro diagnostic product described in section 1905(a)(3)(B) of the Act (or its administration), or any COVID-19 testing related services. For Medicaid, the Medicaid Disaster Relief State Plan Amendment template can be used. For CHIP, states that impose cost sharing for the services at issue will need to submit a CHIP SPA unless the state already has an approved Disaster Relief SPA under which the required cost sharing exemption is effectuated, and the state has activated the cost sharing provisions.

If the state intends to qualify for the temporary 6.2 percentage point FMAP increase authorized under section 6008 of the FFCRA, it must also waive copays for testing services and treatments for COVID-19, including vaccines, specialized equipment, and therapies, for any quarter in which the temporary increased FMAP is claimed.

In order to comply with both the mandatory cost sharing exemption and the exemption required to receive the temporary FMAP increase, states can use the following language in the Medicaid Disaster Relief SPA template: "[Name of state] will not impose cost sharing for testing services (including in vitro diagnostic products, and including test administration), testing-related services, and treatments for COVID-19, including vaccines, specialized equipment and therapies, for any quarter in which the increased FMAP is claimed."

3. Are individuals covered through CHIP also exempt from cost sharing for testing related to COVID-19?

Yes. Section 6004(b)(3) of the FFCRA exempts from cost sharing: (1) any in vitro diagnostic product described in section 1905(a)(3)(B) of the Act; and (2) any other COVID-19 testing-related services. This requirement went into effect on March 18, 2020 and lasts through the duration of the public health emergency defined in section 1135(g)(1)(B) of the Act. See Question II.K.11. for more information on COVID-19 testing-related services. States will need to submit a CHIP SPA to effectuate the cost-sharing changes.

4. What services are considered COVID-19 testing-related services for purposes of the cost sharing exemptions under section 6004(a)(2) of the FFCRA?

Section 6004(a)(2) of the FFCRA amended sections 1916 and 1916A of the Act to prohibit Medicaid cost sharing both for the services described in section 1905(a)(3)(B) of the Act and for COVID-19 testing-related services, during the portion of the public health emergency period defined in section 1135(g)(1)(B) of the Act beginning on the date of enactment of FFCRA (March 18, 2020). CMS interprets the COVID-19 testing-related services language in section 6004(a)(2)(A) of the FFCRA as described in question II.K.7. COVID-19 testing-related services do not include services for the treatment of COVID-19.

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

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

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

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

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

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

7. Can a state terminate Medicaid coverage for beneficiaries for failure to pay premiums during the COVID-19 public health emergency period and still receive the temporary 6.2 percentage point FMAP increase?

No. Until the end of the month in which the public health emergency ends, states cannot terminate Medicaid coverage for beneficiaries for failure to pay premiums and still get the temporary increase in FMAP.

8. 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 II.B.7, 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)).

9. 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

[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.

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.

10. How did the CARES Act change the requirement that states may not increase premiums above the levels in effect on January 1, 2020, in order to be eligible for the temporary 6.2 percentage point FMAP increase? What is the impact on states that implemented a new premium after January 1, 2020? What about states that have not yet implemented their authority to collect premiums?

Section 3720 of the CARES Act added a new subsection (d) to section 6008 of the FFCRA in order to provide states which have increased premiums for any Medicaid beneficiaries above the amounts in effect on January 1, 2020, with a 30-day grace period to restore premiums to amounts no greater than those in effect as of January 1 without jeopardizing the state's eligibility for the temporary 6.2 percentage point FMAP increase. A state which has increased its premium charges after January 1, 2020, and before March 18, 2020 (the date of the FFCRA enactment), has 30 days to reduce its premiums to be no higher than the amount charged as of January 1, 2020. This 30-day grace period for returning premiums to no higher than the January 1 level begins on March 18 and ends on April 17. States also must reimburse beneficiaries for higher amounts charged after January 1, 2020, in order to obtain the temporary 6.2 percentage point FMAP increase. If a state has authority to charge higher premiums and has not done so as of March 18, 2020, the state may not begin charging the higher premiums authorized and still obtain the temporary 6.2 percentage point FMAP increase.

11. For an individual subject to a premium requirement who fails to pay, but whose eligibility is not terminated for failure to pay premiums on the basis of section 6008 of the FFCRA, can the state, after the end of the emergency period, seek recovery against the individual?

No. States seeking to claim the temporary FMAP increase may not collect premiums after the end of the emergency period for an individual who owed a premium during the emergency period but whose Medicaid eligibility is maintained solely on the basis of the FFCRA's enhanced FMAP provision. Effective the month following the month in which the emergency ends, a state may resume implementation of its premium policy under 42 CFR 447.55(b)(2) or other authorized policy with respect to premium non-payment, such as under an approved section 1115 waiver.

12. If an individual has an increase in income that would normally result in the individual becoming ineligible for his/her current eligibility group and moving to a new eligibility group that provides the same benefits but also charges a premium, can the state move forward with this change during the emergency period?

Section 6008(b)(2) of the FFCRA requires states to maintain premiums at the same or lower level as assessed on January 1, 2020, "with respect to an individual[.]" While the state could move the individual to the new eligibility group, it could not charge this individual the higher premium until the last day of the calendar quarter in which the PHE ends.

13. Are states permitted to adopt new eligibility groups that charge premiums during the public health emergency?

Yes. States are not precluded from adopting premiums during the emergency period if they are applied to new optional eligibility groups. While section 6008(b)(1) of the FFCRA prohibits changes in eligibility standards, methodologies or procedures under the state plan that are more restrictive than what was in effect on January 1, 2020, adopting a new eligibility group, with or without a premium, would not be more restrictive than the eligibility policies in effect on January 1, 2020 and therefore would be permissible. If the individual is a new Medicaid beneficiary, after the individual's enrollment and initial premium payment (if required for enrollment), the state (is claiming the temporary FMAP) could not, under section 6008(b)(3) of the FFRCA, *terminate* the individual's enrollment for the failure to make premium payments, through the end of the month in which the emergency period ends. However, in the case of an individual enrolled in a state's Medicaid program as of or after March 18, 2020 with no premiums who is no longer eligible in his/her current eligibility group, while the state could move the individual to the newly-adopted eligibility group, it could not charge a new premium until the last day of the calendar quarter in which the PHE ends.

14. In order to comply with the requirement in section 6008(b)(4) of the FFCRA to cover drugs used to treat COVID-19 without cost sharing, do states need to cover, without cost sharing, both Food and Drug Administration (FDA)–approved drugs with a new indication authorized under an FDA Emergency Use Authorization (EUA) to treat COVID-19, and unapproved drugs authorized under an FDA EUA to treat COVID-19?

Yes. CMS interprets the reference in section 6008(b)(4) of the FFCRA to "any testing services and treatments for COVID-19, including vaccines, specialized equipment, and therapies" to mean that the treatments that states must cover and exempt from cost sharing under this provision include: 1) FDA-approved drugs and licensed biologicals with a labeled indication to treat COVID-19 and FDA-approved drugs and licensed biologicals without a labeled indication for COVID-19, but for which an FDA EUA authorizes a new indication to treat COVID-19;[3] and, 2) unapproved drugs and biologicals authorized under an FDA EUA to treat COVID-19. In order to comply with FFCRA section 6008(b)(4), states must also cover the administration of the treatments for COVID-19 described in that provision without cost-sharing, such as costs related to an office visit in which a drug that must be covered under FFCRA section 6008(b)(4) is administered.

Because a given drug or biological may be prescribed for multiple conditions, states can operationalize the cost sharing exemption required under FFCRA section 6008(b)(4) in one of four ways:

[3] This means FDA-approved drugs or licensed biologicals without a labeled indication to treat COVID-19 would be used for a medically accepted indication to treat COVID-19 consistent with the definition of "medically accepted indication" in section 1927(k)(6) of the Act. That is because any use which is approved under the FFDCA (including pursuant to an FDA EUA) or which is supported by one or more citations included or approved for inclusion in a drug compendium described in 1927(g)(1)(B)(i) of the Act is considered a medically accepted indication.

(1) The state could require prior authorization for coverage of (a) any FDA approved drugs or licensed biologicals that either have a labeled indication for COVID-19 or that pursuant to an FDA EUA may be used for a medically accepted indication as defined in section 1927(k)(6) of the Act to treat COVID-19, and (b) unapproved drugs and biologicals that are authorized under an FDA EUA to treat COVID-19; this will enable the state to link the drug or biological to its use for treatment of a confirmed or suspected case of COVID-19;
(2) The state could use a two-part approach depending on whether a beneficiary has a confirmed COVID-19 diagnosis. (a) The state could presume any FDA approved drug or licensed biological that either has a labeled indication for COVID-19 or that pursuant to an FDA EUA may be used for a medically accepted indication as defined in section 1927(k)(6) of the Act to treat COVID-19 or an unapproved drug that is authorized under an FDA EUA to treat COVID-19 is being used as a treatment for COVID-19 based on the appearance of a COVID-19 diagnosis on the claim and exempt the drug or biological from cost sharing. (b) For beneficiaries who do not yet have a confirmed COVID-19 diagnosis or for claims which do not include COVID-19 diagnosis information, the state could require the prior authorization process described above;
(3) The state could exempt from cost sharing all FDA-approved drugs and licensed biologicals that either have a labeled indication for COVID-19 or that pursuant to an FDA EUA may be used for a medically accepted indication as defined in section 1927(k)(6) of the Act to treat COVID-19, or unapproved drugs and biologicals that are authorized under an FDA EUA to treat COVID-19, regardless of the purpose for which the drug or biological is used; or
(4) The state could establish another systematic methodology, which has been agreed upon by both CMS and the state, for exempting beneficiaries from cost sharing for any drug or biological that either has a labeled indication for COVID-19 or that pursuant to an FDA EUA may be used for a medically accepted indication as defined in section 1927(k)(6) of the Act to treat COVID-19 or that is authorized under an FDA EUA to treat COVID-19, and is being used as a treatment for COVID-19 following either a confirmed COVID-19 test or potential exposure to COVID-19.

15. Can CMS explain its previous answer in section II.B.1 of the COVID-19 FAQs issued on June 30, 2020 concerning targeting cost sharing exemptions to individuals diagnosed with COVID-19?

In an FAQ originally issued on March 12, 2020, and republished most recently on June 30, 2020, as Question II.B.1 in the "COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies," available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf, we discussed that states need to submit a SPA to stop charging cost sharing for particular items or services. We also explained that a SPA exempting individuals from cost-sharing could not be applied narrowly to only those affected by a particular diagnosis, such as COVID-19. It would be inconsistent with the comparability requirement at section 1902(a)(10)(B) of the Act for a state to apply different cost-sharing requirements to certain beneficiaries on the basis of their disease type or diagnosis. In addition, as described in CMS-2334-F (78 Fed. Reg. 42159, 42273 (July

15, 2013)), we believe that targeting cost-sharing based on disease type or diagnosis would constitute a discriminatory practice.

We are clarifying here that states are permitted (and in some cases, required) to exempt from cost-sharing drugs used to treat COVID-19, as also noted in the question above. Nothing in section 6008(b)(4) of the FFCRA alters this flexibility; indeed, that provision *requires* states to exempt such drugs from cost-sharing as a condition of claiming the temporary FMAP increase under FFCRA section 6008. To receive a drug for treatment of COVID-19, a beneficiary typically will have a COVID-19 diagnosis; this fact does not render the cost sharing exemption for drugs used to treat COVID-19 impermissible. However, the limitation on providing a blanket cost sharing exemption for a targeted group of beneficiaries based on diagnosis means that states cannot exempt from cost sharing all items or services only for beneficiaries with a COVID-19 diagnosis; in other words, the state cannot implement a cost-sharing exemption for COVID-19 treatments by exempting all persons with a COVID-19 diagnosis from cost-sharing for any covered Medicaid services, whether or not those services are used to treat COVID-19.

C. Eligibility

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

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

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

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

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

States can permit individuals, consistent with 42 C.F.R. § 435.945, to self-attest to the amounts of their incurred medical expenses. This would allow individuals to avoid the collection and

submission of documentation of their incurred medical expenses. States can permit this on a temporary basis through the end of the public health emergency. States would be expected to document such a change in the state's internal policies and procedures, along with the period for which such changes will be in effect.

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

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

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

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

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

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

We note that the Centers for Disease Control and Prevention (CDC) and United States Postal Service (USPS) guidance indicates that there is no evidence COVID-19 is spreading through US mail. See https://www.cdc.gov/coronavirus/2019-ncov/faq.html and https://about.usps.com/newsroom/statements/usps-statement-on-coronavirus.htm. Therefore, we do not believe it necessary or appropriate to discontinue mailing all hard copy documents to enrollees. However, states and managed care plans have several options that can reduce the number of hard copy documents that are mailed. For public documents such as provider directories and enrollee handbooks, 42 C.F.R. § 438.10(c)(6) provides the criteria for the provision of required materials in electronic form. For notice of adverse benefit determinations

which contain protected health information and are critical to enrollees receiving services, managed care plans can offer enrollees the option to elect to receive such notices electronically. This option can be promoted by including an explanation of the option and a link in each written document or in an email or text specifically to advertise the option. Managed care plan staff communicating with enrollees by phone can facilitate the use of this option by requesting email addresses from enrollees. The use of electronic communication is at the option of the enrollee and, consistent with 42 C.F.R. § 438.10(c)(6)(v), an enrollee must be informed that they may request information in paper form and without charge upon request. Additionally, all provisions of 42 C.F.R. § 438.10(d) apply to electronic communications.

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

We note that CDC and USPS guidance indicates that there is no evidence COVID-19 is spreading through US mail. See https://www.cdc.gov/coronavirus/2019-ncov/faq.html and https://about.usps.com/newsroom/statements/usps-statement-on-coronavirus.htm. Accordingly, we do not believe it necessary or appropriate for state Medicaid agencies to discontinue mailing hard copy notices to beneficiaries. Unless a beneficiary elects to receive communications from the state Medicaid or CHIP agency electronically, the state must provide communications by regular mail (see 42 C.F.R. §§ 435.918 and 457.110). Even if a beneficiary elects to receive electronic notices, the beneficiary has the right to change his or her election from electronic to regular mail (42 C.F.R. § 435.918(b)(2)) and may request that any notice posted to the individual's electronic account also be provided through regular mail (42 C.F.R. § 435.918(b)(6)). Even in cases where a beneficiary does not elect to receive electronic notices, states have the option to post an electronic version of the notice to the beneficiary's electronic account, in addition to mailing a paper notice. This strategy may be appropriate when a beneficiary's whereabouts are unknown.

8. What are the changes to Unemployment Insurance (UI) Compensation in the CARES Act, and how do they affect financial eligibility for Medicaid and CHIP?

The CARES Act makes a number of changes to Unemployment Insurance (UI) in response to the COVID-19 public health emergency.

- Section 2102 creates the Pandemic Unemployment Assistance program that provides benefits for eligible individuals who are self-employed, seeking part-time employment, or who otherwise would not qualify for unemployment benefits under state or federal law. To be eligible, among other requirements, individuals must demonstrate that they are otherwise able to work and available for work within the meaning of applicable state law, except that they are unemployed, partially unemployed, or unable or unavailable to work because of COVID-19 related reasons.
- Section 2104 provides that, under the Federal Pandemic Unemployment Compensation program, eligible individuals who are collecting certain UI benefits, including regular unemployment compensation, will receive an additional $600 in federal benefits per week for weeks of unemployment ending on or before July 31, 2020.

- Section 2107 creates the Pandemic Emergency Unemployment Compensation program that allows those who have exhausted benefits under regular unemployment compensation or other programs to receive up to 13 weeks of additional benefits. States must offer flexibility in meeting eligibility requirements related to "actively seeking work" if an applicant's ability to do so is impacted by COVID-19.

For more information, see: https://www.dol.gov/newsroom/releases/eta/eta20200402-0 and https://wdr.doleta.gov/directives/attach/UIPL/UIPL_14-20.pdf.

Unemployment benefits are typically countable income under both Modified Adjusted Gross Income (MAGI) and non-MAGI financial methodologies. However, section 2104(h) of the CARES Act states: "The monthly equivalent of any Federal pandemic unemployment compensation paid to an individual under this section shall be disregarded when determining *income for any purpose* under the programs established under titles XIX [the Medicaid program] and title XXI [the CHIP program] of the Social Security Act." (Emphasis added.) Consequently, states must disregard the $600 weekly Pandemic Unemployment Compensation (monthly equivalent of $2,580) in determining underlying income eligibility, and the scope of assistance (e.g., cost-sharing, post-eligibility treatment-of-income), for both Medicaid and CHIP.

Note that FFP at the 90 percent federal matching rate for the design and development of improvements to Medicaid eligibility determination systems might be available in accordance with applicable requirements,[4] and states can request such funding through the emergency process outlined at 45 C.F.R. 95.624. Likewise, seventy-five percent enhanced federal match also might be available for ongoing maintenance and operations, in accordance with applicable requirements.[5]

The section 2104(h) disregard applies specifically to Federal pandemic unemployment benefits. It does not apply to payments received based on regular UI, the expansion of eligibility for regular UI payments under the Pandemic Unemployment Assistance program, or extensions of regular UI payments under the Pandemic Emergency Unemployment Compensation program.

9. How do states identify the Unemployment Compensation payments that are subject to the disregard for Medicaid and CHIP?

State Medicaid/CHIP agencies may work with their state Unemployment Insurance agency to ascertain how the Unemployment agency will identify who qualifies for additional payments under the Pandemic Unemployment Compensation program. States may also be able to find ways to identify the additional payments. For example, state Unemployment Insurance agencies have flexibility to include the additional payment in the regular payment or as a separate payment, which may help identify the additional amount. If the Medicaid/CHIP agency becomes aware that all UI recipients will receive the additional payments, the agency can program its eligibility system to automatically reduce all unemployment income by $600 per week as

[4] 42 CFR Part 433, subpart C, 80 Fed. Reg. 75817-75843 (Dec. 4, 2015); and SMD# 16-004 RE: Mechanized Claims Processing and Information Retrieval Systems-Enhanced Funding, available at https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/SMD16004.pdf.

[5] *Id.*

countable income until the Pandemic Unemployment Compensation program expires July 31, 2020.

As a more immediate solution, or if states are not able to differentiate the regular UI payments from the Pandemic Unemployment Compensation increased payments, the state can provide help text/instructions on the application and renewal forms (as well as call center scripts and other help resources) that direct individuals not to include the $600 per week additional payments in their income for any purpose under Medicaid and CHIP. The state could also ask that individuals self-attest to whether or not their income from UI includes the non-countable $600 per week additional payments.

10. Do states need to submit a SPA to implement section 2104 of the CARES Act which disregards additional unemployment compensation as income for Medicaid and CHIP?

No, states do not need to submit a SPA. The statutory provision affects the operation of MAGI-based and non-MAGI financial methodologies but does not present policy that is documented in the state plan.

11. Is the relief payment to individuals and families provided by section 2201 of the CARES Act countable for Medicaid and CHIP eligibility?

No. Section 2201 of the CARES Act allows a refundable tax credit for 2020 to eligible individuals. It also directs the Internal Revenue Service to provide payments in 2020 as an advance refund of the credit to eligible individuals, called "Recovery Rebates." The payments are not taxable income, and are therefore not countable in MAGI-based eligibility determinations. Separately, 26 U.S.C. § 6409 prohibits the counting of federal tax rebates or advance payments with respect to refundable tax credits as income, and, for 12 months following receipt, resources, in the eligibility determination of any federal needs-based program (such as Medicaid). Thus, the Recovery Rebates may not be counted as income, and, for 12 months, as resources, in non-MAGI financial eligibility determinations.

12. Does the CARES Act affect any income counting rules for Medicaid/CHIP applicants and beneficiaries whose financial eligibility is based on MAGI?

The CARES Act makes some changes to individual income tax rules that may affect Medicaid and CHIP MAGI-based financial eligibility for some individuals.

- Section 2204: Tax filers who do not itemize their deductions are permitted to deduct from their MAGI up to $300 in charitable contributions made by an eligible individual in tax years beginning in 2020.
- Section 2202(a)(5): A tax filer who takes an early "Coronavirus-related distribution" from a retirement account (up to $100,000) may elect to spread out the inclusion in income of such a distribution over three years. Tax filers electing to spread the inclusion in income would also spread it for purposes of MAGI.
- Section 2206: Amounts that an employer pays in 2020 for an employee's student loan principal and interest are not counted in the employee's MAGI (similar to the treatment of employer-paid tuition and fees or employer-provided courses of instruction).

13. Are the $600/week Federal Pandemic Unemployment Compensation (FPUC) payments counted as a resource for Medicaid eligibility in the month following the month of receipt?

As noted in Question II.C.8 of the Frequently Asked Questions available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf, Federal Pandemic Unemployment Compensation (FPUC) authorized under section 2104 of the CARES Act is not counted as income for any purpose under Medicaid and CHIP including when determining eligibility. Any portion of an FPUC payment that is not spent in the month of receipt is countable as a resource in subsequent months for applicants and beneficiaries whose financial eligibility is based on non-MAGI methodologies and who are subject to a resource test. States have the option to disregard the amount of a FPUC payment that otherwise would be counted as a resource under section 1902(r)(2) of the Act. This would require a SPA.

14. Are the $400 per week Lost Wages Assistance payments under the August 8, 2020 Presidential Memorandum counted as income or a resource when determining Medicaid and CHIP eligibility?

No, the Lost Wages Assistance payments are considered neither income nor resources to the recipient for the purposes of Medicaid and CHIP eligibility. Lost Wages Assistance payments made consistent with the Presidential Memorandum of August 8, 2020 ("Memorandum on Authorizing the Other Needs Assistance Program for Major Disaster Declarations Related to Coronavirus Disease 2019"[6]) are provided through the authority of section 408(e)(2) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act ("the Stafford Act"). Because assistance under the Stafford Act is "major disaster assistance provided to individuals and households," section 312(d) of the Stafford Act and implementing regulations at 44 C.F.R. § 206.110(f) require that the assistance is not counted as income or a resource in determining eligibility or benefit levels for a federally-funded means-tested benefit. Medicaid and CHIP qualify as federally-funded means-tested benefit programs. As a result, Lost Wages Assistance is excluded from countable income considered in the eligibility determinations based on both MAGI-based as well as non-MAGI-based financial methodologies. Moreover, for applicants and beneficiaries whose financial eligibility is based on non-MAGI methodologies, the assistance is not counted as a resource for those subject to a resource test, nor is it counted for determining the amount of benefits for an individual. Regular state unemployment benefits are not excluded from income in determining Medicaid and CHIP eligibility.

The Lost Wages Assistance payments are inclusive of the federal share ($300/week) and the state share ($100/week) of assistance. Under Department of Labor guidance[7], states have flexibility in making a state contribution of $100 per week or using regular unemployment benefits as state match. For states choosing to provide an additional $100 weekly benefit, the total of $400 per week in Lost Wages Assistance is excluded from Medicaid and CHIP financial eligibility methodologies, as described above. Thus, in states that are not providing an additional $100 in

[6] https://www.whitehouse.gov/presidential-actions/memorandum-authorizing-needs-assistance-program-major-disaster-declarations-related-coronavirus-disease-2019/.

[7] https://wdr.doleta.gov/directives/attach/UIPL/UIPL_27-20.pdf; and https://wdr.doleta.gov/directives/attach/UIPL/UIPL_27-20_Change-1.pdf.

weekly benefits above regular state unemployment benefits, only the $300/week in Lost Wages Assistance funded through section 408(e)(2) of the Stafford Act is excluded.

15. In calculating the minimum monthly maintenance allowance of the spouse of an institutionalized beneficiary, should federal pandemic unemployment compensation payments the community spouse is receiving be excluded in the income determined available to the community spouse?

Yes, the requirement in section 2104(h) of the CARES Act that the monthly equivalent of any federal pandemic unemployment compensation be disregarded when determining income "for any purpose" means that such compensation is not counted when determining the income available to a community spouse in calculating the community spouse's monthly income allowance under section 1924(d)(2)(B) of the Act. A "community spouse" is defined in section 1924(h)(2) of the Act as "the spouse of an institutionalized spouse."

16. Are supplemental payments for workers – such as "hazard pay," "hero pay," supplemental payments to long-term services and supports (LTSS) direct care workers through Appendix K of an HCBS waiver, or other additional wages paid by employers – counted as income for Medicaid and CHIP eligibility?

As described, these payment classifications are not covered by a specific income exemption or exclusion under federal income tax rules or the methodologies of the supplemental security income (SSI) program. Such payments therefore would generally be included in determining Medicaid and CHIP eligibility in both MAGI and non-MAGI financial eligibility determinations. We note, however, that states have the option to disregard types of income, such as "hazard" or "hero" pay, or supplemental pay for direct care workers, under section 1902(r)(2) of the Act in non-MAGI financial eligibility determinations. This would require a SPA.

17. Can a state disregard earnings received under the Pandemic Unemployment Assistance program (CARES Act section 2102) for self-employed or part-time workers when determining eligibility for Medicaid and CHIP?

In contrast to the FPUC payments described above, the CARES Act does not explicitly disregard Pandemic Unemployment Assistance benefits. Pandemic Unemployment Assistance allows individuals who otherwise are ineligible for traditional unemployment benefits to obtain such benefits, such as individuals who are self-employed. For example, self-employed individuals who are independent contractors or gig economy workers can receive Pandemic Unemployment Assistance benefits.

Under section 1902(r)(2) of the Act, a state may elect to disregard this income type (or a portion thereof) for individuals applying for, or eligible for, coverage on a non-MAGI basis. This would require a SPA. However, states cannot disregard Pandemic Unemployment Assistance benefits when using MAGI-based methodologies because such disregards are prohibited in MAGI-based methodologies by section 1902(e)(14)(B) of the Act and 42 C.F.R. § 435.603(g)(2).

18. How are the recovery rebates, also known as economic impact payments, treated for purposes of Medicaid and CHIP eligibility, including treatment of income and assets and post-eligibility treatment of income?

As CMS generally noted in prior FAQs (see Question II.C.11 of the Frequently Asked Questions available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf), the recovery rebates authorized under section 2201 of the CARES Act are not considered income for Medicaid and CHIP financial eligibility determinations, and, for individuals whose Medicaid financial eligibility is based on non-MAGI methodologies, as a resource for the 12 months following receipt. As CMS also noted in the prior FAQs, this exclusion is required under 26 U.S.C. § 6409, which mandates that any federal tax refunds or advanced payments of a refundable credit may not be counted as income for purposes of determining the eligibility for, or the amount or extent of benefits or assistance under, any federal needs-based program. This means that, in addition to the eligibility-related income and resource exclusions of the recovery rebates, the recovery rebates also may not be included in determining beneficiary financial liability for institutional services or other LTSS under the post-eligibility treatment of income (PETI) rules.

19. If an employer obtains a loan through the Paycheck Protection Program (PPP) in order to continue meeting its payroll, do the payments received by employees count as income?

Yes. Income received from an employer that is using the PPP for its payroll is countable income under MAGI-based methodologies and non-MAGI methodologies. The compensation is countable to the same extent that it would be in the absence of the PPP.

20. Generally, if, after the PHE ends and during an individual's renewal, a beneficiary is determined to have accumulated resources that exceed the limit for the eligibility group for which the individual is enrolled, instead of terminating the beneficiary's coverage, could the state opt to recoup the excess resources from the individual (e.g., equal to the lesser of the amount of medical assistance paid by the state and the amount by which the individual's resources exceed the standard)?

No. States may not seek recoupment of medical assistance paid by the state on behalf of any individual whom the state determined eligible for coverage. Specifically, if a state that seeks to claim the temporary FMAP increase authorized under section 6008 of the FFCRA determines that an individual who was enrolled in coverage as of or after March 18, 2020 no longer meets eligibility requirements for any Medicaid eligibility category, the state must continue the individual's enrollment through the end of the month in which the PHE ends in order to meet the condition in section 6008(b)(3) of the FFCRA. After the PHE ends, such a state must take appropriate steps, consistent with 42 C.F.R. § 435.916 and 42 C.F.R Part 431 Subpart E, to terminate the individual's eligibility after the end of the month in which the PHE ends, unless a redetermination after the PHE ends establishes that the individual again meets Medicaid eligibility requirements. Any effort to seek recovery against such a beneficiary for the period during which he or she did not meet all eligibility requirements during the PHE would be tantamount to retroactively terminating an individual's enrollment, in violation of section 6008(b)(3) of the FFCRA, during the period when the state was required to keep the individual

enrolled in order to claim the temporary FMAP increase. Further, such a retroactive termination would be in violation of the requirement to provide beneficiaries with advance notice of termination under 42 C.F.R. § 431.211.

D. Notice and Fair Hearings

1. What flexibilities are available for Medicaid fair hearings?

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

- Suspend adverse actions for individuals for whom the state has completed a determination but either: (1) has not yet sent the notice; or (2) who the state believes likely did not receive the notice. This is consistent with 42 C.F.R. § 431.211, which requires the state to provide at least 10-days advance notice before taking adverse action. See also Question II.I.5. regarding the provision of continuous coverage during the emergency period as a condition for receiving the increased FMAP under that Act.
- Delay scheduling fair hearings and issuing fair hearing decisions under 42 C.F.R. § 431.244(f)(4)(i)(B), which allows states to delay taking final administrative action when there is an emergency beyond the state's control. States should prioritize completing hearings that meet the standard for an expedited fair hearing under 42 C.F.R. § 431.224. States may offer to continue benefits to individuals who are requesting a fair hearing if the request comes later than the date of the action under 42 C.F.R. § 431.230.
- Hold fair hearings via video conferencing or telephone, provided states adhere to other fair hearing requirements (42 C.F.R. part 431, subpart E), including ensuring that the hearing system is accessible to persons who are limited English proficient and persons who have disabilities (see 42 C.F.R. §§ 431.205(e) and 435.905(b)).
- Reinstate services or eligibility if discontinued because the beneficiary's whereabouts were unknown due to displacement, after the beneficiary's whereabouts become known (if still eligible), consistent with 42 C.F.R. § 431.231(d).

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

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

Yes. States may request a waiver under section 1135 authority to allow beneficiaries and applicants to have more than 90 days to request a fair hearing for eligibility or fee-for-service appeals. In March 2020, CMS created a Medicaid & CHIP checklist for section 1135 waivers to assist states during public health emergencies, which is available here: https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/section-1135-waiver-flexibilities/index.html. The timeframe in 42 C.F.R. § 431.221(d) provides that states can choose a reasonable timeframe for individuals to request a fair hearing not to exceed 90 days for eligibility or fee-for-service appeals.

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

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

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

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

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

- Delay taking final administrative action, which could include scheduling fair hearings and issuing fair hearing decisions, due to an emergency beyond the state's control, consistent with 42 C.F.R. § 431.244(f)(4)(i)(B). States should prioritize completing hearings for individuals who meet the standard for an expedited fair hearing under 42 C.F.R. § 431.224.
- Suspend adverse actions for individuals for whom the state has completed a determination but either: (1) has not yet sent the notice; or (2) who the state believes likely did not receive the notice. This is consistent with 42 C.F.R. § 431.211, which requires the state to provide at least 10-days advance notice before taking an adverse action. We note that if the state is claiming the temporary FMAP increase under section 6008 of the FFCRA, the state will need to continue to provide coverage to beneficiaries receiving coverage as of or after March 18, 2020 through the end of the month in which the PHE ends, whether or not the state has sent an adverse action notice and/or the individual has received such notice. For additional information on continuing coverage, see FAQ Section 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."

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

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

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

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

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

Yes. Consistent with 42 C.F.R. § 431.231(d), states must reinstate services that were discontinued due to the beneficiary's whereabouts being unknown if the beneficiary's whereabouts become known prior to the beneficiary's next regular renewal under 42 C.F.R. § 435.916. Note that this requirement applies whenever a beneficiary's whereabouts are unknown; it is not limited to situations in which there is an administrative or other emergency beyond the agency's control. No additional or express authority or concurrence is needed from CMS to implement this requirement.

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

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

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

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

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

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

9. Can a state reinstate coverage for a beneficiary who requests a fair hearing more than 10 days after the date of action in the notice?

Yes. A state can reinstate coverage for a beneficiary who requests a fair hearing more than 10 days after the date of action, provided it has been granted authority under section 1135 of the Act to do so. Regulations at 42 C.F.R. § 431.231(a) allow the state to reinstate services for beneficiaries who request a fair hearing not more than 10 days after the date of action. States that would like the flexibility to reinstate coverage for beneficiaries who request a fair hearing more than 10 days after the date of action must submit a section 1135 waiver request. This request should specify the number of days following the effective date of an adverse action during which the state will reinstate services for beneficiaries who request a fair hearing (i.e., the specific number of days, not to exceed the time permitted for beneficiaries to request a fair hearing). For example, a state has received section 1135 authority to allow individuals up to 120 days (instead of 90 days) from the date the notice of action is mailed, to request a fair hearing. This state sends advance notice 10 days prior to the date of action (e.g. a termination of coverage). The state wants to align the reinstatement period with the timeline the individual has to request a fair hearing. In this example, the state would request section 1135 authority to allow

it to reinstate benefits for individuals up to 110 days after the date of action (e.g. a termination), for a total of 120 days after the date the notice of action is mailed.

E. *Presumptive Eligibility*

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

Yes. A qualified entity is an entity that is determined by the state to be capable of making PE determinations for eligibility groups based on MAGI, as authorized under sections 1920, 1920A, 1920B, and 1920C of the Social Security Act and 42 C.F.R. Part 435 Subpart L. A state agency may designate itself as well as a county or another local agency as a qualified entity. To elect this option, the state must submit a SPA and indicate the eligibility groups for which the agency or agencies will determine PE. States can do so through the Medicaid disaster relief SPA template, which can be found here: https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/state-plan-flexibilities/index.html. Unlike for hospital presumptive eligibility (under section 1902(a)(47)(B) of the Act and 42 C.F.R. § 435.1110), states cannot designate a state agency as a qualified entity to make PE determinations for non-MAGI eligibility groups, which includes the new Medicaid COVID-19 testing group. For technology to support eligibility and enrollment for presumptive eligibility qualified entities, 42 C.F.R. Part 433, Subpart C would apply.

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

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

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

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

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

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

States electing to apply the PETI rules to an individual during a presumptive eligibility period under 42 C.F.R. § 435.1110 must provide clear instructions to hospitals on the specific questions the hospital must ask in making a reasonable estimate of the individual's total income and deductions.

If the individual is subsequently not enrolled in Medicaid beyond the PE period, either because the individual did not submit an application for Medicaid prior to the end of the month following the month in which the PE determination was made, or the individual submitted an application but was determined to be ineligible for Medicaid, and the state determines, based on a regular application, that the PE income determination by the hospital was too high, the state must adjust its payment to the institution for the coverage provided during the PE period. If the state determines that the hospital underestimated the individual's income, the state may not adjust the payment to the institution, because such an adjustment would constitute a retroactive reduction in the individual's medical assistance, which is not permitted. FAQ #II.I.4. explains that individuals who have been determined presumptively eligible for Medicaid, but who are not later determined eligible based on a regular Medicaid application, are not subject to the requirements for continuous coverage described under section 6008 of the FFCRA.

5. Can states change their hospital PE performance standards?

Yes. States have flexibility under regulations at 42 C.F.R. § 435.1110(d) to establish state-specific performance standards, which can be changed by the state for the duration of the public health emergency. States seeking to temporarily revise the performance standards for participating hospitals can do so through the Medicaid disaster relief SPA template available at:

https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/state-plan-flexibilities/index.html.

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

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

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

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

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

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

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

States may be able to help expedite provision of medical assistance to applicants who must meet a disability test through extension of hospital presumptive eligibility to populations excepted from modified adjusted gross income (MAGI) methodologies. See COVID-19 FAQs for State Medicaid and Children's Health Insurance Program (CHIP) Agencies, updated May 5, 2020, FAQ Section 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 FAQ II.I.4. for additional information on the requirements for continuous coverage for individuals in a presumptive eligibility period.

10. How should a state evaluate disability when utilizing hospital presumptive eligibility for disabled individuals?

States using hospital presumptive eligibility for non-MAGI populations must have hospitals ask questions, for those whose prospective eligibility is based on disability, that are sufficient to determine whether the individual's condition presumptively meets the state's definition of disability, consistent with 42 C.F.R. § 435.540. For example, at least the following questions would be appropriate for a hospital to ask of an individual whom the hospital is evaluating for presumptive eligibility on the basis of a disability: 1) does the individual have a medical condition for which he or she has been treated by a doctor; 2) has the individual had the condition for more than a year, or is the individual expected to have the condition for more than a year; and 3) has the condition served as an impediment to the individual engaging in employment, or reduced the number of jobs the individual can perform. CMS is available to provide additional technical assistance in helping states develop disability-related questions for the hospitals participating in their hospital presumptive eligibility programs.

11. May a state that is a section 1915(k) Community First Choice (CFC) state use the CFC functional assessment to meet disability determination requirements for a hospital presumptive eligibility determination?

No. Functional needs assessments to evaluate need for institutional or home and community-based services do not provide the information needed to evaluate disability status. Therefore, states may not use a favorable level-of-care determination for the CFC benefit or other LTSS as the basis for determining an individual to have a disability.

F. Verification

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

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

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

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

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

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

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

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

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

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

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

Whenever a state has elected to conduct post enrollment verification, it must complete such processes as expeditiously as possible and within a reasonable timeframe following the initial determination of eligibility. CMS recognizes that due to workforce limitations and other operational challenges during the COVID-19 emergency, states may be unable to complete post-enrollment verification as expeditiously as typically would be expected. Further, we remind states that states seeking to claim the temporary FMAP increase under section 6008 of the FFRCA may not terminate eligibility for individuals enrolled in Medicaid as of March 18, 2020, including those for whom verification is completed post-enrollment, until the end of the month when the emergency period ends, unless the beneficiary requests a voluntary termination of eligibility, or the state determines that the individual is no longer considered to be a resident of the state (see FAQ IV.F.1.).

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

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

To resolve a discrepancy, states generally have the flexibility under § 435.952(c)(2) either to accept a reasonable explanation from the individual explaining the difference between the self-attestation and the data information or to require documentation from the individual supporting the self-attestation. For example, if an individual attests to monthly wage earnings of $2,000 and the quarterly wage data includes earnings of $2,500, the state can accept an explanation that the individual has experienced a recent reduction in hours and make an income finding of $2,000.

Alternatively, the state could require the individual to provide a recent paystub that supports an income finding of $2,000.

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

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

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

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

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

States may not suspend use of their AVS under the state plan, which is required under sections 1902(a)(71) and 1940 of the Act. However, the statute does not require that states verify assets

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

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

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

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

States may use the Medicaid and CHIP MAGI-Based Disaster Relief Verification Plan Addendum (https://www.medicaid.gov/medicaid/eligibility/downloads/magi-based-verification-plan-addendum-template.docx) to capture verification policy and procedure changes that the state is implementing only for the emergency period for both MAGI and MAGI-excepted populations. For MAGI-based verifications, states must submit the addendum (or a revised verification plan) to CMS for review. Any changes that a state intends to make to its non-MAGI-based verification policies must be documented in the state's internal policies and procedures,

along with the period for which such changes will be in effect. States may include information about non-MAGI changes for an emergency period in the state's MAGI-based Disaster Relief Verification Plan Addendum in the "Other" section if the state chooses to do so.

G. Basic Health Program

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

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

States must submit a BHP blueprint revision to exercise this flexibility in BHP because it is a significant change under 42 C.F.R. § 600.125. CMS published an interim final rule with comment period on May 1, 2020 that allows states to submit revised blueprints for temporary significant changes to their BHP that are directly tied to the COVID-19 PHE and are not restrictive in nature that could be effective retroactive to the first day the COVID-19 PHE and through the last day of the COVID-19 PHE or a reasonable amount of time after the COVID-19 PHE. The interim final rule is available here: https://www.federalregister.gov/documents/2020/05/08/2020-09608/medicare-and-medicaid-programs-basic-health-program-and-exchanges-additional-policy-and-regulatory.

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

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

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

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

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

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

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

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

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

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

H. Coverage for American Indians and Alaska Natives

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

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

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

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

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

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

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

On November 2, 2020, a provision implementing section 6008(b)(3) of the FFCRA in CMS-9912 Interim Final Rule with Comment (CMS-9912 IFC) became effective. This interim final rule with comment (IFC) establishes a new section 433.400 in Part 433 of Title 42 of the Code of Federal Regulations (C.F.R.). This new provision contains CMS's reinterpretation of the continuous enrollment condition in section 6008(b)(3) of the FFCRA. Under this condition, states claiming the temporary FMAP increase under section 6008 of the FFCRA must maintain beneficiary enrollment through the end of the month in which the PHE for COVID-19 ends. CMS's original interpretation of the condition specified in section 6008(b)(3) was issued in guidance, in the form of FAQs, in April, May and June 2020. While most of these FAQs remain in effect following the November 2, 2020 effective date of 42 C.F.R. § 433.400, some FAQs are applicable only through November 1, 2020.

Each of the previously published FAQs below responds to questions about section 6008(b)(3) of the FFCRA and includes a note with one of the following three designations of applicability related to the IFC. For those FAQs no longer applicable in their entirety, one or more of the following clarifications is also included:

(1) This FAQ is applicable in its entirety both before and after the effective date of 42 C.F.R. § 433.400.
(2) This FAQ is applicable both before and after the effective date of 42 C.F.R. § 433.400; as of November 2, 2020:
    a. References to "coverage" or "benefits" in this FAQ should be read as "enrollment;"
    b. The continuous enrollment condition should be applied only to "validly enrolled" beneficiaries as defined at § 433.400(a); and/or
    c. States are permitted to reduce the amount, duration, and scope of benefits available in accordance with § 433.400(c)(2) and (c)(3) and therefore may transition a beneficiary to another group for which they are eligible that covers benefits of a lesser amount, duration, and/or scope, consistent with the limitations described in 42 C.F.R. § 433.400(c)(2).
(3) This FAQ is applicable only prior to the effective date of the IFC; it is not applicable on or after November 2, 2020, when 42 C.F.R. § 433.400 became effective; as of November 2, 2020:
    a. The state is no longer required to maintain the same amount, duration, and scope of benefits, consistent with the limitations described in 42 C.F.R. § 433.400(c)(2); and
    b. States may transition a beneficiary to another group for which they are eligible that covers benefits of a lesser amount, duration, and/or scope, consistent with the limitations described in 42 C.F.R. § 433.400(c)(2).

Continuous Coverage

1. Are states required to provide continuous coverage for all Medicaid beneficiaries through the end of the month in which the emergency period ends?

Yes. In order to receive the temporary FMAP increase provided under section 6008 of the FFRCA, states must provide continuous coverage, through the end of the month in which the emergency period ends, to all Medicaid beneficiaries who were enrolled in Medicaid on or after March 18, 2020, regardless of any changes in circumstances or redeterminations at scheduled renewals that otherwise would result in termination. States may terminate coverage for individuals who request a voluntary termination of eligibility, or who are no longer considered to be residents of the state. **NOTE:** This FAQ is applicable both before and after the effective date of 42 C.F.R. § 433.400; as of November 2, 2020, references to "coverage" in this FAQ should be read as "enrollment" and the continuous enrollment condition should be applied only to "validly enrolled" beneficiaries as defined at § 433.400(a).

2. If a state has already terminated coverage for individuals enrolled as of March 18, 2020, what actions should the state take? Must those individuals have their coverage reinstated?

To receive the increased FMAP, states may not terminate coverage for any beneficiary enrolled in Medicaid during the emergency period effective March 18, 2020, unless the beneficiary voluntarily requested to be disenrolled, or is no longer a resident of the state. States that want to qualify for the increased FMAP should make a good faith effort to identify and reinstate individuals whose coverage was terminated on or after the date of enactment for reasons other than a voluntary request for termination or ineligibility due to residency. At a minimum, states are expected to inform individuals whose coverage was terminated after March 18, 2020 of their continued eligibility and encourage them to contact the state to reenroll. Where feasible, states should automatically reinstate coverage for individuals terminated after March 18, 2020 and should suspend any terminations already scheduled to occur during the emergency period. Coverage should be reinstated back to the date of termination. **NOTE:** This FAQ is applicable both before and after the effective date of 42 C.F.R. § 433.400; as of November 2, 2020, references to "coverage" in this FAQ should be read as "enrollment" and the continuous enrollment condition should be applied only to "validly enrolled" beneficiaries as defined at § 433.400(a).

3. During the emergency period, should states still terminate Medicaid coverage for deceased individuals?

Yes. Individuals who are determined to be deceased are no longer residents of the state. States may terminate coverage for deceased individuals and remain eligible for receipt of the increased FMAP. States should communicate this clarification to their managed care plans. **NOTE:** This FAQ is applicable both before and after the effective date of 42 C.F.R. § 433.400; as of November 2, 2020, references to "coverage" in this FAQ should be read as "enrollment."

4. Does continuous coverage for the emergency period apply to individuals who are receiving benefits during a period of presumptive eligibility?

Individuals who have been determined presumptively eligible for Medicaid have not received a determination of eligibility under the state plan, and are therefore not "enrolled" and subject to the requirements for continuous coverage described under section 6008 of the FFCRA. **NOTE:** This FAQ is applicable both before and after the effective date of 42 C.F.R. § 433.400; as of November 2, 2020, references to "coverage" in this FAQ should be read as "enrollment."

5. Do the requirements to provide continuous coverage during the emergency period apply to individuals who were determined ineligible prior to March 18, 2020, but who continue to receive services pending an appeal?

Yes. Individuals who continue to receive services pending an appeal of a determination of ineligibility would be considered to be enrolled for benefits, if this was their status as of March 18, 2020 and therefore should not be terminated from enrollment until the end of the month when the emergency period ends. **NOTE:** This FAQ is applicable both before and after the effective date of 42 C.F.R. § 433.400; as of November 2, 2020, the reference to "coverage" in this FAQ should be read as "enrollment."

6. In order to comply with the condition under section 6008(b)(3) of the FFCRA for receiving the temporary FMAP increase, how should a state treat beneficiaries who would no longer be eligible for full Medicaid coverage as a lawfully residing child under 21 or pregnant woman under 1903(v)(4) (often referred to as the "CHIPRA 214 option"), when they no longer meet the criteria the state has elected under their state plan?

Once a noncitizen is no longer eligible for full Medicaid coverage due to no longer meeting the criteria for under the CHIPRA 214 option (i.e., a lawfully residing child has reached the age of 19, 20 or 21, or the post-partum period has ended for a lawfully residing pregnant woman) and is not otherwise in satisfactory immigration status as a qualified noncitizen under 42 CFR 435.4, FFP would only be available for payment for services necessary for the treatment of an emergency medical condition, due to the limitation on FFP for beneficiaries who are not in a satisfactory immigration status. Limiting the provision of medical assistance to noncitizens whose eligibility is continued in accordance with section 6008(b)(3) of the FFCRA to treatment of an emergency medical condition would not render a state ineligible for the temporary FMAP increase. **NOTE:** This FAQ is applicable in its entirety both before and after the effective date of 42 C.F.R. § 433.400.

7. If an agency has not been able to verify an individual's declared citizenship or satisfactory immigration status during a reasonable opportunity period, must the state keep the individual enrolled in Medicaid in order to qualify for the temporary FMAP increase?

When an otherwise eligible individual has made a declaration of citizenship or satisfactory immigration status in accordance with 42 CFR 435.406(a) and the agency is unable to verify citizenship or satisfactory immigration status, the agency must enroll the individual in Medicaid

for a reasonable opportunity period (ROP) under 435.956(b). Because such individuals are enrolled in Medicaid during the ROP if they otherwise meet all eligibility requirements, in order to satisfy the condition for receipt of the temporary FMAP increase under section 6008(b)(3) of the FFCRA, they must remain enrolled in Medicaid until the end of the month when the emergency period ends even if their citizenship or satisfactory immigration status has not been verified. At the end of the month in which the emergency ends, the state must terminate eligibility for any individuals whose status has not been verified prior to the end of their ROP. If and when the state determines that an individual is not a U.S. citizen or in a satisfactory immigration status, coverage would be limited to services necessary for treatment of an emergency medical condition, as defined in section 1903(v) of the Act. **NOTE:** This FAQ is applicable in its entirety both before and after the effective date of 42 C.F.R. § 433.400.

8. Does the requirement to continue coverage through the end of the emergency period apply to noncitizens receiving coverage of services necessary to treat an emergency medical condition?

Yes. There is no exception to the condition for states to receive the temporary FMAP increase described in section 6008(b)(3) of the FFCRA based on a limitation on the benefits for which FFP is available. The scope of such continued assistance would be limited to services necessary for treatment of an emergency medical condition, as defined in section 1903(v) of the Act. **NOTE:** This FAQ is applicable both before and after the effective date of 42 C.F.R. § 433.400; as of November 2, 2020, the reference to "coverage" in this FAQ should be read as "enrollment."

9. Under section 6008 of the FFCRA, can states suspend or terminate coverage of incarcerated beneficiaries and still qualify for the increase in FMAP?

Incarceration does not impact a beneficiary's eligibility for Medicaid; rather, incarceration limits the availability of FFP to inpatient services provided to the incarcerated beneficiary. (See paragraph (A) of the matter following section 1905(a)(30) of the Act, 42 CFR 435.1009–1010, and State Health Official (SHO) letter # 16-007)) (https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho16007.pdf). Therefore, in order to receive the temporary FMAP increase provided under section 6008 of the FFCRA, states must provide continuous coverage through the end of the month in which the emergency period ends to Medicaid beneficiaries who were enrolled in Medicaid on or after March 18, 2020, if they become incarcerated. However, the FFCRA does not supersede the limitation on FFP for inmates of a public institution, and states continue to be limited to claiming FFP for inmates for covered inpatient services.

We recognize that some states are able to suspend eligibility for Medicaid beneficiaries who become incarcerated, and this practice complies with the condition in section 6008(b)(3) of the FFCRA for receipt of the temporary FMAP increase. Many states, however, currently terminate eligibility upon incarceration, and re-enroll the inmate if the inmate is admitted to an inpatient facility. These states can comply with the terms of section 6008(b)(3) of the FFCRA by ensuring that inmates are re-enrolled in coverage when admitted to an inpatient facility and prior to release, if they are released before the end of the month in which the emergency period ends.

NOTE: This FAQ is applicable both before and after the effective date of 42 C.F.R. § 433.400; as of November 2, 2020, references to "coverage" in this FAQ should be read as "enrollment."

10. Does the Maintenance of Effort requirement to maintain benefits for an individual enrolled for benefits under a plan (or waiver) as of the date of enactment of the FFCRA through the last day of the month in which the emergency period ends apply to individuals who are eligible for Refugee Medical Assistance?

No. The conditions for states to be eligible to receive the temporary FMAP increase under section 6008(b) of the FFCRA apply only to medical assistance furnished under title XIX of the Social Security Act. Refugee Medical Assistance (RMA) is not furnished under title XIX of the Act. The Office of Refugee Resettlement (ORR) will be providing states with additional information on this issue. Contact John Cusey, Director Policy of ORR, at John.Cusey@acf.hhs.gov or Dee Daniels Scriven at Dee.DanielsScriven@acf.hhs.gov with additional questions. **NOTE:** This FAQ is applicable both before and after the effective date of 42 C.F.R. § 433.400; as of November 2, 2020, the reference to "benefits" in this FAQ should be read as "enrollment."

11. Do the requirements to provide continuous coverage apply to CHIP?

No. States do not need to maintain coverage in CHIP in order to receive the temporary increase in the Medicaid federal medical assistance percentage (FMAP) provided under section 6008 of the FFRCA. However, the Maintenance of Effort (MOE) required under section 2105(d)(3) of the Social Security Act continues to apply. **NOTE:** This FAQ is applicable both before and after the effective date of 42 C.F.R. § 433.400; as of November 2, 2020, references to "coverage" in this FAQ should be read as "enrollment."

Changes in Circumstances

12. Should states continue to conduct redeterminations and act on reported or identified changes in circumstances during the emergency period?

The FFCRA does not prohibit a state from conducting regular Medicaid renewals and redeterminations or acting on reported or identified changes in circumstances. States may also continue to conduct periodic data matching between regular beneficiary renewals, consistent with states' verification plans. However, to receive the increased FMAP, states may not terminate coverage for any beneficiary enrolled in Medicaid on or after March 18, 2020, until the end of the month in which the emergency period ends, unless such individual is no longer a resident of the state or requests voluntary termination. This requirement to maintain continued coverage applies to beneficiaries who might otherwise have coverage terminated after a change in circumstances, including individuals who age out of a Medicaid eligibility group during the emergency period, who lose receipt of benefits that may affect their eligibility (e.g., SSI, foster care assistance payments), and whose whereabouts become unknown. **NOTE:** This FAQ is applicable both before and after the effective date of 42 C.F.R. § 433.400; as of November 2, 2020, references to "coverage" in this FAQ should be read as "enrollment" and the continuous enrollment condition should be applied only to "validly enrolled" beneficiaries as defined at §

433.400(a). In addition, CMS guidance on the processing of renewals and changes in circumstances during the PHE is found on page 9 of the State Health Official Letter, Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency (SHO #20-004), available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf.[8]

Cost Sharing

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

Yes. A state is not eligible for the temporary FMAP increase authorized by section 6008 of the FFCRA if it reduces the medical assistance for which a beneficiary is eligible and if that beneficiary was enrolled as of March 18, 2020, or becomes enrolled after that date but not later than the last day of the month in which the emergency period ends. Such a reduction in medical assistance would be inconsistent with the requirement at section 6008(b)(3) of the FFCRA that the state ensure that beneficiaries be treated as eligible for the benefits in which they were enrolled as of or after March 18, 2020, through the end of the month in which the emergency period ends. Because an increase in cost-sharing reduces the amount of medical assistance for which an individual is eligible, a state is not eligible for the enhanced FMAP if it increases cost sharing for individuals enrolled as of or after March 18, 2020. **NOTE:** This FAQ is applicable only prior to the effective date of the IFC; it is not applicable on or after November 2, 2020 when 42 C.F.R. § 433.400 became effective because the state is no longer required to maintain the same amount, duration, and scope of benefits, consistent with the limitations described in 42 C.F.R. § 433.400(c)(2).

[8] SHO #20-004 provides: "*Redeterminations During the PHE for Individuals Continuously Enrolled:* It is important that states and territories receiving the temporary FMAP percentage point increase under the FFCRA begin processing renewals and redeterminations based on changes in circumstances during the PHE in accordance with 42 C.F.R. §435.916, to the extent possible, if they are not currently doing so, even though they may not send the final notice of termination or terminate coverage for beneficiaries who are found to no longer be eligible for Medicaid. After the month in which the PHE ends, states and territories will need to complete any outstanding renewals due during the PHE as well as redetermine eligibility for changes in circumstances reported or identified during the PHE. For states and territories that are able to complete some or all renewals and redeterminations based on changes in circumstances during the PHE, a second redetermination may need to be completed before a state may send advance notice and terminate coverage when the FFCRA continuous enrollment requirement expires. Section IV of this letter outlines the circumstances in which states may avoid repeating redeterminations for beneficiaries whom the state could not terminate despite a finding of ineligibility."

Home and Community-Based Services

14. If an individual is participating in a home and community-based services (HCBS) waiver program authorized under section 1915(c) of the Act, and the individual is determined to no longer meet the level-of-care (LOC) requirements (or other requirements) for the waiver, in order to claim the temporary FMAP increase, must the state maintain the individual's participation in the 1915(c) waiver and continue to provide 1915(c) services?

States seeking to claim the temporary FMAP increase are required to maintain an individual's eligibility for benefits (through the end of the month in which the public health emergency ends) for which an individual attained eligibility under the state plan or a waiver of the state plan. This means that the state should maintain an individual's participation in a 1915(c) waiver for which the individual is enrolled during the emergency period, even if the individual is determined to no longer meet the LOC or other requirements for waiver participation, such as receiving a service within the last 30 days. Moreover, if a state determined after enactment of the FFCRA that an individual had not received services within the previous 30 day time period and terminated the individual, the state should reinstate the individual to ensure that the state can receive the 6.2 percentage point FMAP increase. However, states should continue to apply any criteria that is used in determining the services included in the individual's 1915(c) person-centered service plan. Services would only be provided if they are reflected in the person-centered service plan and based on an assessment of functional need, per regulations at 42 CFR 441.301(c)(2). An individual's person-centered care plan can be updated to reflect updated assessments of functional need during the period of the public health emergency. Services should not be provided that are not based on an assessed need. **NOTE:** This FAQ is applicable only prior to the effective date of the IFC; it is not applicable on or after November 2, 2020 when 42 C.F.R. § 433.400 became effective because the state is no longer required to maintain the same amount, duration, and scope of benefits, consistent with the limitations described in 42 C.F.R. § 433.400(c)(2).

15. If an individual's Medicaid eligibility is connected to his/her need for, and receipt of, section 1915(c) waiver services (i.e., the individual is enrolled in the eligibility group described at 42 CFR 435.217, or the "217" group), and the individual is determined to no longer meet the requisite level-of-care (LOC) requirement for the waiver, in order to claim the temporary FMAP increase, must a state maintain the individual in the 217 group and continue to provide coverage for 1915(c) services?

Where an individual no longer meets the eligibility requirements for the group in which he or she is enrolled and the individual is not eligible for a separate eligibility group covered under the state plan that provides the same amount, duration and scope of benefits, a state must maintain the individual's enrollment in his or her original group in order to claim the temporary 6.2 percentage point FMAP increase. In the example of a 217 group enrollee who no longer meets the LOC requirement for the relevant 1915(c) waiver (or other eligibility requirements for the group), unless the individual is eligible for a separate eligibility group which provides the same amount, duration and scope of benefits, the state would have to maintain the individual's enrollment in the 217 group and participation in the 1915(c) waiver until the end of the month in

which the public health emergency ends. Covered services would be provided subject to limitations relating to assessments of functional need, as described in the question above. **NOTE:** This FAQ is applicable both before and after the effective date of 42 C.F.R. § 433.400; except that as of November 2, 2020: (1) the continuous enrollment condition should be applied only to "validly enrolled" beneficiaries as defined at § 433.400(a); (2) states are permitted to reduce the amount, duration, and scope of benefits available in accordance with § 433.400(c)(2) and (c)(3) and therefore may transition a beneficiary to another group for which they are eligible that covers benefits of a lesser amount, duration, and/or scope, consistent with the limitations described in 42 C.F.R. § 433.400(c)(2); and (3) the state is not required to maintain the beneficiary's enrollment in the 1915(c) waiver.

Medically Needy

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

For states seeking to claim the temporary FMAP increase, an individual who attains Medicaid eligibility through a "spenddown"—either in a state's medically needy group or, in 209(b) states, in the mandatory eligibility group for individuals 65 years old or older or who have blindness or disabilities—must have his or her Medicaid eligibility maintained through the last day of the month in which the public health emergency period ends in order to obtain the temporary 6.2 percentage point FMAP increase. This is true even if the individual's budget period ends before the month the public health emergency period ends and the individual would not have sufficient, incurred medical or remedial care expenses to meet his or her spenddown in the new budget period. **NOTE:** This FAQ is applicable both before and after the effective date of 42 C.F.R. § 433.400; as of November 2, 2020, references to "coverage" in this FAQ should be read as "enrollment."

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

No. A medically needy individual, or any other individual, whose Medicaid eligibility is maintained in order to comply with the conditions under section 6008(b) of the FFCRA to claim the temporary FMAP increase may not have his or her eligibility retroactively terminated or assistance retroactively reduced. In order to receive the temporary FMAP increase authorized under section 6008 of the FFCRA, states must maintain the eligibility, and benefits, of all individuals who are enrolled or determined eligible for Medicaid as of March 18, 2020, through the end of the month in which the public health emergency ends. Section 6008(b) of the FFCRA does not authorize recoupment of funds from any individual whose Medicaid eligibility was continued in order to comply with the terms or section 6008(b) of the FFCRA. **NOTE:** This FAQ is applicable both before and after the effective date of of 42 C.F.R. § 433.400; as of November 2, 2020, the reference to "benefits" in this FAQ should be read as "enrollment."

Post Eligibility Treatment of Income

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

No. States that claim the temporary FMAP increase authorized by section 6008 of the FFCRA are prohibited from increasing the liability of institutionalized individuals enrolled as of March 18, 2020, or who become enrolled after that date but not later than the last day of the month in which the emergency period ends, for their institutional services. Like cost-sharing increases, increasing a beneficiary's liability reduces the amount of medical assistance for which an individual is eligible and is therefore inconsistent with the requirement at section 6008(b)(3) of the FFCRA. **NOTE:** This FAQ is applicable only prior to the effective date of the IFC; it is not applicable on or after November 2, 2020 when 42 C.F.R. § 433.400 became effective because the state is no longer required to maintain the same amount, duration, and scope of benefits, consistent with the limitations described in 42 C.F.R. § 433.400(c)(2).

Eligibility Group Transitions and Ineligibility

19. In order to comply with the condition under section 6008(b)(3) of the FFCRA for receiving the temporary FMAP increase, how should states treat beneficiaries who age out of an eligibility group – for example, adolescents who turn 19 and age out of the eligibility group for children under age 19 described in 42 CFR 435.118; individuals eligible under the group for former foster care children, described in 42 CFR 435.150, when they turn age 26; and individuals eligible under the adult group described in 42 CFR 435.119 when they turn age 65?

The answer to this question depends on the coverage options under other eligibility groups under the state plan or waiver. If a beneficiary aging out of an eligibility group is eligible for another eligibility group which covers the same amount, duration and scope of benefits, the state would transition the beneficiary to that group. For example, in a state which has expanded coverage to the adult group, a child covered under section 42 CFR 435.118 whose household income is at or below 133 percent of the Federal poverty level would be transitioned to the adult group upon attaining age 19. If, however, there is no other eligibility group for which the individual is eligible under the state plan or waiver that provides the same amount, duration and scope of benefits as those available to beneficiaries in the group under which the individual has been receiving coverage (42 CFR 435.118, 435.119 or 435.150), then the state must continue to furnish the benefits available under such group in order to qualify for the temporary FMAP increase. **NOTE:** This FAQ is applicable only prior to the effective date of the IFC; it is not applicable on or after November 2, 2020 when 42 C.F.R. § 433.400 became effective because the state is no longer required to maintain the same amount, duration, and scope of benefits and therefore may transition a beneficiary to another group for which they are eligible that covers benefits of a lesser amount, duration, and/or scope, consistent with the limitations described in 42 C.F.R. § 433.400(c)(2).

20. To be eligible for the temporary FMAP increase, should an individual who is enrolled in the adult group described at 42 CFR 435.119, but who turns 65 and becomes eligible for Medicare, be retained in the adult group during the emergency period, or can the state transition the individual to a Medicare Savings Program group for assistance with his or her Medicare premiums and cost sharing?

To be eligible for the enhanced FMAP authorized by the FFCRA, states may not reduce benefits for any beneficiary enrolled in Medicaid on or after March 18, 2020, through the end of the month in which the emergency period ends, and still qualify for increased FMAP. This means that states must continue to provide coverage to such beneficiaries in the eligibility group in which the beneficiary is enrolled if transitioning the beneficiary to another eligibility group would result in a reduction in benefits. If there is a separate eligibility group for which the individual is eligible and which provides the same amount, duration and scope of benefits, then a state may shift the individual to that group; what is critical for ensuring eligibility for the temporary FMAP increase is that the same amount, duration and scope of medical assistance be maintained. If, in the scenario provided, an individual turns 65 while in the adult group and becomes enrolled in Medicare and eligible for assistance with Medicare premiums and/or cost sharing under one of the Medicare Savings Program (MSP) groups (which do not provide the full benefit package available to adult group beneficiaries), and the individual is ineligible for another eligibility group which confers the same amount, duration and scope of benefits, the state must continue to furnish services available to beneficiaries enrolled in the adult group until the last day of the month in which the emergency period ends, and also enroll the individual in the MSP group. In this case, Medicare would be the primary payer, with Medicaid providing secondary coverage. **NOTE:** This FAQ is applicable only prior to the effective date of the IFC; it is not applicable on or after November 2, 2020 when 42 C.F.R. § 433.400 became effective because the state is no longer required to maintain the same amount, duration, and scope of benefits and therefore may transition a beneficiary to another group for which they are eligible that covers benefits of a lesser amount, duration, and/or scope, consistent with the limitations described in 42 C.F.R. § 433.400(c)(2). Note also that the response to this question effective November 2, 2020 is addressed in the regulation at 42 C.F.R. § 433.400(c)(2)(i)(B).[9]

21. If a state receives information during the emergency period that would make a beneficiary eligible for a different eligibility group, must the state keep the beneficiary enrolled in the group in which he or she is currently enrolled?

To receive the increased FMAP under the FFCRA, states may not terminate coverage for beneficiaries enrolled in Medicaid on or after March 18, 2020, through the end of the month in which the emergency period ends, unless the beneficiary voluntarily requests termination from the program or is considered to no longer be a resident of the state. Further, while states may increase the level of assistance provided to a beneficiary who experiences a change in circumstances, such as moving the individual to another eligibility group which provides additional benefits, states may not reduce benefits for any beneficiary enrolled in Medicaid on or

[9] 42 C.F.R. § 433.400(c)(2)(i)(B) provides: "For beneficiaries described in paragraph (c)(2)(i)(A) whom the state subsequently determines are eligible for coverage under a Medicare Savings Program eligibility group, the state satisfies the requirement described in paragraph (c)(2) of this section if it furnishes the medical assistance available through the Medicare Savings Program."

after March 18, 2020, through the end of the month in which the emergency period ends, and still qualify for increased FMAP. **NOTE:** This FAQ is applicable both before and after the effective date of 42 C.F.R. § 433.400; except that as of November 2, 2020: (1) references to "coverage" in this FAQ should be read as "enrollment" and the continuous enrollment condition should be applied only to "validly enrolled" beneficiaries as defined at § 433.400(a); and (2) states are permitted to reduce the amount, duration, and scope of benefits available in accordance with § 433.400(c)(2) and (c)(3) and therefore may transition a beneficiary to another group for which they are eligible that covers benefits of a lesser amount, duration, and/or scope, consistent with the limitations described in 42 C.F.R. § 433.400(c)(2).

22. How should a state handle Medicaid beneficiaries who are eligible based on receipt of Supplemental Security Income (SSI) in 1634 states who become ineligible for SSI? Does the state need to continue Medicaid coverage if it receives a notification from State Data Exchange interface (SDX) that the individual was terminated from SSI?

An individual who is eligible for Medicaid based on his or her receipt of SSI as of March 18, 2020 or is determined eligible based on receipt of SSI after that date, and who becomes ineligible for SSI, may not be terminated from Medicaid prior to the end of month in which the emergency period ends if the state claims the temporary FMAP increase. If such an individual is eligible for a different eligibility group which offers at least the same benefits available to SSI beneficiaries, the state may transfer the individual to that group. **NOTE:** This FAQ is applicable both before and after the effective date of 42 C.F.R. § 433.400; except that as of November 2, 2020, states are permitted to reduce the amount, duration, and scope of benefits available in accordance with § 433.400(c)(2) and (c)(3) and therefore may transition a beneficiary to another group for which they are eligible that covers benefits of a lesser amount, duration, and/or scope, consistent with the limitations described in 42 C.F.R. § 433.400(c)(2).

23. Can a state, consistent with the requirement in section 6008(b)(3) of the FFCRA, move an individual from one MSP group into another? For example, could a state move an individual from the qualified Medicare beneficiary (QMB) group to the specified low-income Medicare beneficiary (SLMB) group?

A state must maintain, during the emergency period, an individual's eligibility for at least the same amount, duration, and scope of benefits as are covered for the group in which the individual is enrolled, including paying for Medicare Part A/B premiums through MSPs and other Medicaid categories. In the example of a QMB who is determined during the emergency period to no longer meet the QMB group eligibility requirements, the individual could not be shifted to the SLMB group, because the SLMB group offers a lesser amount of assistance with Medicare premiums and cost sharing than the QMB group. The state would have to maintain the individual's enrollment in the QMB group. **NOTE:** This FAQ is applicable only prior to the effective date of the IFC; it is not applicable on or after November 2, 2020 when 42 C.F.R. § 433.400 became effective because the state is no longer required to maintain the same amount, duration, and scope of benefits and therefore may transition a beneficiary to another group for which they are eligible that covers benefits of a lesser amount, duration, and/or scope, consistent with the limitations described in 42 C.F.R. § 433.400(c)(2).

J. Children's Health Insurance Program (CHIP)

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

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

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

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

3. Can a state that suspends CHIP enrollees' payment of premiums as part of an approved CHIP Disaster Relief SPA claim FFP for the additional capitation payments the state makes to managed care organizations as a result of the SPA?

Yes. States that have suspended premiums under an approved or activated CHIP disaster SPA may claim FFP for additional amounts included in a capitation payment to cover the premium amount that the beneficiary otherwise would have been required to pay. Existing requirements at 42 C.F.R § 457.224(a)(1) exclude FFP for any cost sharing amounts, including premiums, that beneficiaries are expected to pay; however, for the period during which the state has suspended premium charges, no premium payments are expected from beneficiaries and therefore this FFP exclusion does not apply. If the state accepts any voluntary premium payments during the public health emergency, the state would need to reduce its request for enhanced FMAP for such expenditures by the amount of premium payments received consistent with 42 C.F.R. § 457.224(b).

4. Can states continue coverage for the duration of the Public Health Emergency for individuals in a separate CHIP who are aging out of eligibility or ending their postpartum period?

No. The requirement in section 6008(b)(3) of the FFCRA to maintain coverage in Medicaid in order to receive the temporary increase in the Medicaid federal medical assistance percentage does not apply to separate CHIPs. Therefore, states may not continue to provide separate CHIP coverage to young adults aging out or women ending their postpartum period. If the state determines that the individual is eligible for Medicaid, they may be transitioned to the appropriate Medicaid eligibility group. States may not transition individuals to Medicaid without first determining them eligible in accordance with 42 C.F.R § 457.350(b). States are required to transfer the accounts of individuals losing CHIP eligibility who are determined to be ineligible for Medicaid to the Exchange, in accordance with 42 C.F.R § 457.350(b)(3) and (i).

5. If states maintained separate CHIP eligibility for young adults who aged out or pregnant women whose postpartum period ended for some portion of the PHE when should they terminate enrollment?

As mentioned above, the requirement in section 6008(b)(3) of the FFCRA to maintain coverage in Medicaid in order to receive the temporary increase in the Medicaid federal medical assistance percentage does not apply to separate CHIPs. States are expected to take steps needed to appropriately terminate separate CHIP enrollment of individuals who have aged out of coverage or whose postpartum period ended as expeditiously as possible. CHIP regulations at 42 C.F.R. § 457.340(e) require written notice of a termination that is sufficient to enable the enrollee to take any appropriate actions that may be required to allow coverage to continue without interruption. CMS recognizes that states may need time to process these terminations.

6. Can states choose to maintain coverage for all individuals enrolled in their separate CHIP for the duration of the public health emergency, even though the Medicaid continuous coverage requirements in section 6008(b)(3) of the FFCRA do not apply to separate CHIP programs?

No. As noted in the Eligibility FAQs, states are required to process renewals and changes in circumstances as expeditiously as possible. Under CHIP regulations at 42 C.F.R. § 457.340(d)(1), which cross reference Medicaid regulations at 42 C.F.R. § 435.912(e)(2), states that are unable to timely process eligibility renewals and redeterminations following a change in beneficiary circumstances within the period otherwise allowed due to an administrative or other emergency beyond the agency's control are not considered to be in violation of the timeliness standards. This exception to the timeliness standards, which applies equally to Medicaid and CHIP, could include a public health emergency, like the COVID-19 PHE, which may impact the agency's ability to complete timely renewals. In order to invoke this exception to the timeliness standards, states must submit and CMS must approve a CHIP disaster SPA.

We note that an approved CHIP disaster SPA does not grant states the authority to extend eligibility periods for separate CHIP enrollees who have been determined ineligible for coverage. If a state receives information from an enrollee, processes that information, and determines the

individual ineligible for a separate CHIP, the state would need to process the termination and transfer the individual to Medicaid or the Exchange, in accordance with 42 C.F.R. § 457.350(b) and (i).

K. Optional COVID-19 Testing Group

1. Does the FFCRA expand coverage under Medicaid?

Section 6004(a)(3) of the FFCRA adds a new optional Medicaid eligibility group for uninsured individuals during the COVID-19 public health emergency described in section 1135(g)(1)(B) of the Act that was declared by the HHS Secretary pursuant to section 319 of the Public Health Service Act for the COVID-19 pandemic. Coverage under this new optional eligibility group, including for covered services received during the retroactive eligibility period under section 1902(a)(34) of the Act and 42 C.F.R. 435.915(a), may be effective no earlier than March 18, 2020. This group was added at section 1902(a)(10)(A)(ii)(XXIII) of the Act. Individuals eligible for the new group receive a limited benefit package of services related to testing and diagnosis of COVID-19 that are rendered during the emergency period. See question II.K.5. for more information on the covered benefits for this group. We refer to the new group as the "COVID-19 testing" optional Medicaid eligibility group.

2. What are the eligibility criteria for the COVID-19 testing eligibility group?

In order to be eligible, individuals must meet the definition of an "uninsured individual" in section 1902(ss) of the Act, as amended by section 3716 of the CARES Act. Specifically, an individual must:

a. Not be eligible to receive coverage under a mandatory Medicaid eligibility group, except that in states that have not adopted the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act, individuals who would be eligible under the adult group, if the group had been adopted by the state, are not considered to be eligible for that group and therefore may meet the definition of uninsured individual;
b. Not be enrolled in Medicaid coverage, except that individuals who are enrolled in a limited-benefit Medicaid eligibility group will not be considered to be enrolled in health coverage as a result of such enrollment and therefore may meet the definition of uninsured individual. The limited-benefit Medicaid eligibility groups include the groups for:*
    i. Individuals infected with tuberculosis under section 1902(a)(10)(A)(ii)(XII) and 1902(z) of the Act; and 42 C.F.R. 435.215;
    ii. Individuals eligible for family planning and related services under section 1902(a)(10)(A)(ii)(XXI), 1902(ii) and clause (XVI) in the matter following section 1902(a)(10)(G) of the Act; and 42 C.F.R. 435.214 and 435.603(k);
    iii. Individuals eligible as medically needy under section 1902(a)(10)(C) of the Act; and 42 C.F.R. 435, Subpart D (to the extent that the individual's coverage is considered not to meet the requirements of minimum essential coverage, as defined under section 5000A(f)(1) of the Internal Revenue Code of 1986); and

c. Not be enrolled in another health care program funded by the federal government, including: CHIP, BHP, Medicare, TRICARE and Veterans Administration, and federal employee health plans; and
d. Not be enrolled in a group health plan or health insurance coverage offered by a health insurance issuer (as defined in section 2791 of the Public Health Service Act), including: a qualified health plan through an Exchange, employer-sponsored health insurance, retiree health plans and COBRA continuation coverage.

* Note that, although section 3716 of the CARES Act also amended section 1902(ss)(2) of the Act to exclude pregnant women enrolled for coverage under both sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act from the definition of a Federal health care program in the definition of "uninsured individual" for purposes of eligibility under the optional COVID-19 testing eligibility group, pregnant women described in the mandatory eligibility group for pregnant women in section 1902(a)(10)(A)(i)(IV) of the Act are not eligible for the new optional COVID-19 testing eligibility group under section 1902(ss)(1) of the Act (relating to exclusion of individuals who may be enrolled for coverage under a mandatory group from the definition of uninsured). CMS is not aware that any state currently covers pregnant women under the optional eligibility group described in section 1902(a)(10)(A)(i)(IX) of the Act, which is implemented along with the mandatory eligibility group described in section 1902(a)(10)(A)(i)(IV) of the Act at 42 C.F.R. 435.116. CMS will provide technical assistance to any state which believes that it currently covers some pregnant women under this optional eligibility group. States should contact their state lead for assistance if needed.

3. How do states elect the COVID-19 testing optional Medicaid eligibility group?

States may elect the COVID-19 testing eligibility group by completing the appropriate section of the Medicaid Disaster Relief State Plan Amendment template. The SPA is submitted to the relevant CMS SPA Mailbox for the state.

4. Are there financial or other eligibility requirements for coverage under the COVID-19 testing group?

There is no income or resource test for coverage under the COVID-19 testing eligibility group. Individuals must meet other non-financial eligibility requirements, including being a resident of the state and furnishing a Social Security Number (SSN). Recall that the state agency must assist individuals who do not have an SSN in completing an application to obtain one in accordance with 42 C.F.R. 435.910. For individuals who meet all eligibility criteria for the COVID-19 testing group, but are not a United States citizen or do not have a satisfactory immigration status, FFP is limited to payment for services that are necessary for treatment for an emergency medical condition as defined in section 1903(v)(3) of the Act.

5. What services are covered for this new eligibility group?

Effective no earlier than March 18, 2020, covered services for beneficiaries under the COVID-19 testing eligibility group are limited to medical assistance for:

- in vitro diagnostic testing (and administration of that testing) described in section 1905(a)(3)(B) of the Act, as added by section 6004(a)(1) of the FFCRA, and as amended by section 3717 of the CARES Act, and
- COVID-19 testing-related services described in 1916(a)(2)(G) of the Act, added by section 6004(a)(2)(A) of the FFCRA, furnished during a provider visit related to such testing during the public health emergency period.

The limitation on the benefits available to beneficiaries under this group is found in clause (XVIII) in the matter following section 1902(a)(10)(G) of the Act, as added by section 6004(a)(3)(A)(ii) of the FFCRA. See Question III.A.1. for information on the requirement to cover COVID-19-related testing and diagnostic services for all Medicaid beneficiaries.

6. Does Medicaid coverage for the optional COVID-19 testing eligibility group include coverage for serological tests for COVID-19?

Yes. Effective no earlier than March 18, 2020, covered services for beneficiaries under the COVID-19 testing eligibility group include the in vitro diagnostic testing benefit described in section 1905(a)(3)(B) of the Act, as added by section 6004(a)(1) of the FFCRA, and as amended by section 3717 of the CARES Act. Section 1905(a)(3)(B) of the Act defines "in vitro diagnostic products" through a cross reference to FDA regulations at 21 C.F.R. 809.3(a). FDA has advised that serological tests for COVID-19 meet the definition in 21 C.F.R. 809.3(a) of an in vitro diagnostic product for the detection of SARS-CoV-2 or the diagnosis of COVID-19.[10] Serological tests for COVID-19 are used to detect antibodies against the SARS-CoV-2 virus, and are intended for use in the diagnosis of the disease or condition of having current or past COVID-19 infection, which is caused by the presence of the SARS-CoV-2 virus. Therefore, states that elect the COVID-19 testing eligibility group must provide coverage for this group of serological tests for COVID-19.[11] FDA currently believes such tests should not be used as the sole basis for diagnosis, as noted in its Policy for Diagnostic Tests for COVID-19 Guidance.

7. What services are considered COVID-19 testing-related services?

CMS interprets the COVID-19 testing-related services language in section 6004(a)(2)(A) of the FFCRA to include items and services for which payment is available under the state plan that are directly related to the administration of an in vitro diagnostic product described in section 1905(a)(3)(B) of the Act or to the evaluation of a beneficiary for purposes of determining the need for such product, such as an X-ray. COVID-19 testing-related services do not include services for the treatment of COVID-19.

[10] 21 CFR 809.3(a) defines in vitro diagnostic products as "reagents, instruments, and systems intended for use in the diagnosis of disease or other conditions, including a determination of the state of health, in order to cure, mitigate, treat, or prevent disease or its sequelae. Such products are intended for use in the collection, preparation, and examination of specimens taken from the human body."

[11] To date, FDA has authorized one emergency use authorization for a serological test that is intended for use by clinical laboratories. See U.S. Food and Drug Administration, Letter to Cellex Inc. Regarding qSARS-CoV-2 IgG/IgM Rapid Test (Apr. 1, 2020), available at https://www.fda.gov/media/136622/download.

8. Are states required to verify that an applicant is uninsured in determining eligibility for the COVID-19 testing group?

States are permitted to accept self-attestation of uninsured status in determining eligibility for this new group. States can update their verification plans to indicate whether self-attestation will be accepted. Updates may take effect immediately and do not require CMS approval. Because income is not a factor of eligibility for this new optional eligibility group, no verification of income is required. States that accept self-attestation are expected to perform customary procedures to identify liable third parties, including other insurance coverage, and to bill such third-party sources first. States are also expected to notify all individuals found eligible for this coverage that the Medicaid agency may pursue and seek recovery from such third parties.

9. Are states required to determine that applicants are not eligible for any of the mandatory groups before enrolling them in the optional COVID-19 testing group?

States may enroll individuals into the COVID-19 testing group without first assessing eligibility for all other mandatory groups. States that choose to use a simplified application for the COVID-19 testing group are not required to determine that an applicant is ineligible for all mandatory eligibility groups before furnishing assistance under the COVID-19 testing group. However, states are encouraged to inform all individuals seeking coverage in the COVID-19 testing group that they may be eligible for comprehensive benefits. This language can be included in the state's application. Individuals determined eligible for the COVID-19 testing group who subsequently apply and are determined eligible for Medicaid in another group should be transferred into that other group. Individuals who apply for coverage through the regular single, streamlined application and are determined ineligible for other full-benefit eligibility groups should be screened for potential eligibility for Marketplace coverage, CHIP and coverage in the COVID-19 testing group.

10. If an applicant applies for Medicaid on a single streamlined application or alternative application, and is found eligible only for the COVID-19 testing group, how should the state explain in its eligibility notice that the individual is only eligible for the benefits associated with the COVID-19 group?

When an applicant applies for full benefit Medicaid coverage and is determined eligible for only the COVID-19 group, the eligibility determination notice must clearly explain that the beneficiary is only eligible for coverage of in vitro diagnostic testing and testing-related services furnished during a provider visit related to that testing during the public health emergency (see II.K.5. for more information on the benefit package for this group). States are encouraged also to include in their notices that if the beneficiary has a change in circumstances, such as a job loss or reduction in income, the beneficiary should notify the state so that the state can determine whether the individual is eligible for full benefits. Please see 42 C.F.R. 435.917 and 431.206 through 431.214 for additional requirements regarding notices.

11. What is the Federal Medical Assistance Percentage (FMAP) for the services provided for the COVID-19 testing group?

The FMAP for services provided to an individual enrolled in the COVID-19 testing group is 100 percent. The 100 percent match is only available for the testing and testing-related services provided to beneficiaries enrolled in the new COVID-19 testing group (and for related administrative expenditures); the 100 percent match is not provided for COVID-19-related testing and diagnostic services provided to individuals covered under other Medicaid eligibility groups. See question IV.G.3. for additional information.

12. What changes did the FFCRA make to the rules on outstation locations processing applications?

FFCRA amends section 1902(a)(55) of the Act to add the COVID-19 testing group to the list of groups for which outstation rules apply. Please refer to the outstation regulations at 42 C.F.R. 435.904 for more information about the out-stationing requirements.

13. 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.

14. 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

15. Is an individual enrolled in a limited-benefit section 1115 demonstration project eligible for the optional COVID-19 testing group under 1902(a)(10)(A)(ii)(XXIII) of the Act?

No. Individuals receiving limited benefits through section 1115 expenditure authority are not eligible for the optional COVID-19 testing group. The optional COVID-19 testing group authorized under section 1902(a)(10)(A)(ii)(XXIII) of the Act provides eligibility for individuals who are uninsured as defined in section 1902(ss) of the Act. Individuals enrolled in a Federal health care program, as defined in section 1128B(f) of the Act, are not considered "uninsured" for purposes of the optional testing group. Coverage funded through "expenditure authority" under section 1115(a)(2) of the Act is a "Federal health care program" as defined in section 1128B(f) of the Act. While section 3716 of the CARES Act (Pub. L. No. 116-136) amended the definition of an "uninsured individual" in section 1902(ss) of the Act for the purpose of the

COVID-19 testing group to include certain exceptions for limited-benefit Medicaid eligibility groups under the state plan, the CARES Act did not except limited-benefit section 1115 demonstration projects. Therefore, for example, a section 1115 demonstration that provides eligibility for limited family planning services coverage only is considered a Federal health care program and individuals enrolled for coverage under such demonstration are not considered to be "uninsured" for purposes of the Medicaid COVID-19 testing group.

16. Can a state enroll into the COVID-19 testing group individuals who are considered "under-insured?" Specifically, can a state enroll individuals into the COVID-19 testing group who have group health insurance coverage or individual health insurance coverage, such as a High Deductible Health Plan (HDHP), short-term, limited duration insurance, or an excepted benefits plan?

Individuals must be uninsured pursuant to the definition in section 1902(ss) of the Act to be eligible for the optional COVID-19 testing group. The definition of "uninsured individual" in section 1902(ss) of the Act specifies, in part, that the individual must not be enrolled in a group health plan, or group or individual health insurance coverage offered by a health insurance issuer as those terms are defined in section 2791 of the Public Health Service Act (PHSA). There is no exception for individuals enrolled in a group health plan, or group or individual health insurance coverage, on the basis that such insurance does not cover COVID-19 testing services. Therefore, in the event that an individual is enrolled in a group plan or group or individual health insurance coverage within the relevant definitions of section 2791 of the PHSA that does not cover COVID-19 testing, that individual would not fall within the definition of "uninsured individual" under section 1902(ss) of the Act for purposes of eligibility for the COVID-19 testing group, and thus would not be eligible for the COVID-19 testing group. We note, however, that group health plans and health insurance issuers offering group or individual health insurance coverage, including High Deductible Health Plans (HDHPs), are required to cover COVID-19 testing without cost-sharing requirements, prior authorization, or other medical management requirements under section 6001 of the FFCRA (Pub. L. No. 116-127), as amended by section 3201 of the CARES Act.

Individuals who are enrolled in short-term, limited-duration insurance are eligible for the COVID-19 testing group. This is because the definition of Individual Health Insurance Coverage under section 2971(b)(5) of the PHSA excludes short-term, limited-duration insurance. Thus, enrollment in short-term, limited-duration insurance would not be a basis for an individual to be ineligible for the COVID-19 testing group.

While we do not believe that this situation often would arise, it is possible that in limited circumstances an individual may not have coverage for COVID-19 testing if their plan provides only "excepted benefits" as defined under section 2791(c) of the PHSA, section 733(c) of ERISA, and section 9832(c) of the Internal Revenue Code. Examples of plans covering only excepted benefits include a limited benefit plan for vision or dental services or services provided through an Employee Assistance Program. These plans generally are exempt from the federal insurance market requirements, including the diagnostic testing requirements under section 6001 of the FFCRA, as amended by section 3201 of the CARES Act. However, individuals who are enrolled in excepted benefit plans would not fall within the definition of "uninsured individual"

under section 1902(ss) of the Act, and thus would not be eligible for the COVID-19 testing group. Please see FAQs at https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf and https://www.cms.gov/files/document/FFCRA-Part-43-FAQs.pdf for more information about the types of group health plans and health insurance coverage subject to the requirement in section 6001 of the FFCRA, as amended by section 3201 of the CARES Act, to cover COVID-19 testing as well as details on plans or coverage of excepted benefits.

17. Can a state enroll individuals enrolled in the optional state plan family planning group into the optional COVID 19 testing group in order to provide coverage of the testing benefit to those individuals without requiring a new application?

Yes, once the state has verified the individual does not have any other insurance. Section 3716 of the CARES Act, which amended section 1902(ss) of the Act, established that individuals eligible for the optional state plan family planning group under section 1902(a)(10)(A)(ii)(XXI) of the Act are considered "uninsured" for purposes of eligibility under the optional COVID-19 testing group and therefore may obtain COVID-19 testing coverage under that group in addition to coverage under the family planning group. Note that states may accept self-attestation of uninsured status.

States may enroll individuals eligible in the family planning group in the optional COVID-19 testing group and provide COVID-19-related testing and diagnostic services to them without requiring them to complete an application for the COVID-19 testing group if the state has sufficient information to determine they are eligible. Eligibility in the COVID-19 testing group requires that individuals be uninsured as defined in section 1902(ss) of the Act. Therefore, states must verify that family planning beneficiaries do not have other insurance coverage before administratively enrolling them in the COVID-19 testing group. States may verify that individuals do not have other insurance using information available to the state (for example, based on routine coordination-of-benefit processes to identify liable third parties). If there is not sufficient information available to the state to determine that the individual is uninsured, the state may not administratively enroll the individual and must request the necessary information to establish that the individual is uninsured prior to enrolling in the COVID-19 testing group.

States must provide appropriate notices to affected beneficiaries explaining that they have been enrolled in and may access services through the COVID-19 testing group while maintaining their eligibility for family planning services. For more information regarding the COVID-19 testing group, please visit: https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf.

18. Can a state administratively enroll parents of Medicaid children into the optional COVID-19 testing group without requiring them to complete an application?

No, states may not enroll parents of Medicaid children into the optional COVID-19 testing group without those parents first completing an application. Even though a state may have some of the relevant information about the parent from the child's application/case record, the state would need to obtain information to complete a determination for the COVID-19 testing group from the parents including citizenship and immigration status and whether or not the parent is uninsured.

Parents must also sign their own application to indicate their intent to apply for Medicaid. If a state would like to streamline the application process, it can send a pre-populated version of the simplified application for the optional COVID-19 testing group with whatever information it has on file about the parent and ask the parents to complete the required information, sign and return to the state.

L. Medically Needy and Post-Eligibility Treatment of Income/Transfer of Assets/Estate Recovery

1. Can a state count the amount that the MCO pays for COVID-19 related treatment and diagnosis toward the beneficiary's spenddown in the budget period, to help reduce barriers to overall care?

No. An individual's spenddown liability may not be reduced by medical bills paid by a third-party. The medically needy regulations, at 42 C.F.R. § 435.831(d), allow for deduction of incurred medical expenses only when they are not subject to payment by a third-party.

2. During the PHE, can states suspend the reduction of payments to Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IIDs) and nursing facilities by the amount of a beneficiary's share of the cost of care under the PETI rules?

States are required to reduce the payment for institutional services by the amount of income a beneficiary is determined to have available based on the post-eligibility treatment of income (PETI) calculation. However, states can effectively reduce or eliminate any required reduction in payments to the facility by reducing or eliminating beneficiaries' liability under the PETI rules. This can be accomplished by temporarily increasing the personal needs allowances (PNA) for beneficiaries subject to the PETI rules. Temporarily setting the PNA at the highest income standard applied to an eligibility group under which individuals may be eligible for institutional services or other LTSS subject to PETI would effectively eliminate all beneficiary liability for LTSS and any corresponding need to reduce payment to the provider. Any PETI-related changes can be made through the Medicaid disaster SPA template, available here: https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/state-plan-flexibilities/index.html. States may make similar changes to the PETI rules that are applied to certain recipients of home and community-based services authorized under section 1915(c) of the Act using Appendix K. CMS is available to provide technical assistance to states interested in making such changes to their PETI rules.

3. For individuals who were subject to PETI and whose liability for institutional services or other LTSS was unchanged from March 18, 2020, through November 1, 2020 despite income increases, due to state compliance with CMS guidance on section 6008(b)(3) of the FFCRA that was in effect before November 2, 2020, may states disregard assets that accumulated for such individuals as a result and which exceed relevant resource standards on or after November 2, 2020?

Yes, states can exercise authority provided under section 1902(r)(2) of the Act to disregard excess resources that accumulated from March 18, 2020 through November 1, 2020 due to

circumstances such as that described in this question. This would require a SPA, and CMS is available to provide technical assistance to states that may be interested in exploring this option.

4. Would an individual who is subject to Medicaid's transfer-of-asset rules and who transfers his or her recovery rebate received under section 2201 of the CARES Act without receiving something of equal value in return be subject to a penalty under section 1917(c) of the Act?

The answer depends on when the transfer occurs relative to receipt of the recovery rebate. As mentioned above, section 2201 of the CARES Act authorizes recovery rebates that are, pursuant to 26 U.S.C. § 6409, excluded from income, and, for the 12 months following their receipt, resources, in determining eligibility and the amount or extent of medical assistance. Applied to the transfer-of-asset penalties, this means that any portion of a recovery rebate which is transferred for less than fair market value more than 12 months following receipt of the rebate would be subject to the transfer of asset rules under section 1917(c) of the Act. If such a transfer occurs in the month in which the recovery rebate is received or within the 12 months following receipt of the rebate, no penalty under section 1917(c) of the Act would apply.

5. Are recovery rebate funds subject to estate recovery?

The answer depends on when the recovery rebate becomes part of the beneficiary's estate. Any portion of a recovery rebate which becomes part of a beneficiary's estate more than 12 months following receipt of the rebate would be subject to the estate recovery rules described in section 1917(b) of the Act. If the funds become part of the recipient's estate in the month the Recovery Rebate is received or within the 12 months following receipt, the recovery rebates would not be subject to Medicaid's estate recovery rules, in accordance with 26 U.S.C. § 6409. As explained above, § 6409 prohibits counting the recovery rebates as income or resources in determining eligibility or the amount or extent of medical assistance for 12 months following their receipt. As Medicaid's estate recovery rules directly relate to the amount of an individual's medical assistance, the estate recovery rules are superseded by § 6409 for the month in which an individual receives the recovery rebate and the 12 months following.

M. Expiration of Requirements for Claiming the Temporary FMAP Increase under Section 6008 of the FFCRA

1. Can CMS clarify its previous answer in the Families First Coronavirus Response Act – Increased FMAP FAQs, Question B.1 concerning the termination dates for the requirements defined in section 6008(b) of the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127)?

In the Families First Coronavirus Response Act – Increased FMAP FAQs issued on March 24, 2020, and updated on April 13, 2020, we provided guidance in Question B.1[12] that states and

[12] In January 2021, the FFCRA-Increased FMAP FAQs were integrated into this document (CMS' COVID-19 FAQs for State Medicaid and CHIP Agencies), and FAQ B.1. of the Increased FMAP FAQs is now question IV.F.1. in this document.

territories seeking the temporary FMAP increase must adhere to the requirements of section 6008(b) of the FFCRA through the end of the month when the public health emergency ends in order to qualify for the temporary FMAP increase. While the condition set forth in section 6008(b)(3) does terminate at the end of the month in which the public health emergency ends, we are correcting our guidance regarding the termination date for sections 6008(b)(1), (b)(2) and (b)(4), all of which end the last day of the calendar quarter in which the PHE ends. In the table below, we are providing updated guidance in accordance with the FFCRA on the termination dates for each of the section 6008(b) requirements.

FFCRA Authority	**Provision**	**Termination Date**
6008(b)(1)	Maintain eligibility standards, methodologies, or procedures that are no more restrictive than what the state had in place as of January 1, 2020 (maintenance of effort requirement).	Expires the first day of the month following the end of the calendar quarter in which the PHE ends.
6008(b)(2)	Not charge premiums that exceed those that were in place as of January 1, 2020.[13]	Expires the first day of the month following the end of the calendar quarter in which the PHE ends.
6008(b)(3)	Ensure that individuals who were enrolled for benefits under the Medicaid state plan or waiver as of or after March 18, 2020, are treated as eligible for such benefits through the end of the month in which the PHE ends, unless the individual voluntarily terminates eligibility or is no longer a resident of the state.	Expires the first day of the month following the month in which the PHE ends.
6008(b)(4)	Cover, without imposition of any cost sharing, testing, services and treatments for COVID-19— including vaccines, specialized equipment, and therapies.	Expires the first day of the month following the end of the calendar quarter in which the PHE ends.

2. When the PHE period ends and the authority approved through the Medicaid disaster SPAs sunsets, will states need to continue the cost sharing exemption for COVID-19 testing and treatment services through the last day of the calendar quarter in which the PHE ends to be eligible for the 6.2 percentage point FMAP increase?

Yes. In order to be eligible for the temporary FMAP increase under the FFCRA, states must cover, without any cost sharing, testing services, testing-related services, and treatments for COVID-19, including vaccines, specialized equipment and therapies, through the last day of any calendar quarter in which they claim the FMAP increase. If a state claims the FMAP increase during the quarter in which the PHE ends, it must comply with the condition in section

[13] 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, a state is not ineligible for the temporary FMAP increase on the basis that it imposed a premium higher than any in effect on January 1, 2020, during the 30-day period beginning on March 18, 2020, if such premium was in effect on March 18, 2020.

6008(b)(4) of the FFCRA through the end of that quarter. States will not be required to submit a new SPA to extend the cost sharing exemption through the last day of the quarter in which the PHE ends. However, by drawing funds from the increased FMAP account in the Payment Management System (PMS), each state must attest that it is eligible for the increased FMAP, that the expenditures for which it is drawing funds are those for which the increased FMAP is applicable, and that it has met the conditions required to claim the temporary FMAP increase. Additionally, if the COVID-19 PHE ends early in a quarter, a state may want to submit a new cost-sharing SPA to document that the cost-sharing exemption continues at least through the end of that quarter.

3. If premiums were required as of January 1, 2020, and were suspended under the disaster SPA effective March 1, 2020, can a state resume charging premiums in the month after the PHE ends, or is the state required to suspend premiums until the month following the end of the quarter in which the PHE ends?

The state may resume charging premiums at the level it charged as of January 1, 2020 the month after the expiration of the PHE. Because these premiums do not exceed those in place on January 1, 2020, resumption would not violate the condition described in section 6008(b)(2) of the FFCRA. However, the state may not charge beneficiaries' premiums that are higher than those charged as of January 1, 2020, until the month after the last day of the calendar quarter in which the PHE ends, unless the exception in section 6008(d) of the FFCRA applies.

III. Benefits

A. COVID-19 Testing

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

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

Furthermore, CMS issued an interim final rule with comment period (IFC) on May 1, 2020, amending 42 C.F.R. § 440.30 to offer greater flexibility to states with respect to coverage of

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

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

2. What benefits were added for targeted low-income children and targeted low-income pregnant women covered by CHIP?

Section 6004(b) of the FFCRA requires coverage of in vitro diagnostic products for the detection of SARS-CoV-2 or diagnosis of COVID-19 in the same way that such products are covered in Medicaid. This coverage is required beginning March 18, 2020 through the duration of the public health emergency defined in section 1135(g)(1)(B) of the Act. States will not need to submit a CHIP SPA to effectuate these changes if they already indicate in their state plan that they cover laboratory and radiological services in section 6.2.8 of their CHIP state plan.

3. Did the FFCRA make any changes to coverage through the BHP? Must BHP standard plans cover the diagnosis and treatment of COVID-19?

BHP standard health plans must cover the diagnosis and treatment of COVID-19. The FFCRA did not make any changes to BHP coverage because section 6001 of the FFCRA requires only a group health plan or a health insurance issuer offering group or individual health insurance coverage to cover diagnostic testing related to COVID-19. Section 6001 of the FFCRA does not apply to the BHP because as we explained in the March 2014 Basic Health Program Final Rule,

we determined that BHP should be excluded from the individual market. *See* 79 Fed. Reg. 14,111, at 14,131 (March 12, 2014).

However, 42 C.F.R. 600.405(a) requires that BHP standard health plan coverage "must include, at a minimum, the essential health benefits as determined and specified under 45 CFR 156.110." CMS released "FAQs on Essential Health Benefit Coverage and the Coronavirus (COVID-19)" on March 12, 2020, available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/EHB-Benchmark-Coverage-of-COVID-19.pdf. Q1 of these March 12, 2020 FAQs explains that Essential Health Benefits (EHB) generally includes coverage for the diagnosis and treatment of COVID-19. However, the exact coverage details and cost-sharing amounts for individual services may vary by plan, and some plans may require prior authorization before these services are covered.

States that operate a BHP may choose to enhance coverage for COVID-19 testing related services.

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

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

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

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

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

6. Did the FFCRA require state Medicaid and CHIP programs to cover any COVID-19-related testing and diagnostic services?

Yes. Subsections 6004(a) and (b) of the FFCRA, as amended by section 3717 of the CARES Act, require Medicaid and CHIP coverage of in vitro diagnostic products, including the administration of such products, for the detection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) or diagnosis of COVID-19 during any portion of the public health emergency period defined in section 1135(g)(1)(B) of the Act beginning on or after March 18, 2020.

7. Are X-rays considered an in-vitro diagnostic product, for purposes of the required benefit for COVID-19 testing at section 1905(a)(3)(B) of the Act?

Section 1905(a)(3)(B) of the Act defines "in vitro diagnostic products" through a cross reference to FDA regulations at 21 CFR 809.3(a). That regulation defines "in vitro diagnostic products (IVDs)" (in relevant part) as "those reagents, instruments, and systems intended for use in diagnosis of disease or other conditions, including a determination of the state of health, in order to cure, mitigate, treat, or prevent disease or its sequelae. Such products are intended for use in the collection, preparation, and examination of specimens taken from the human body." X-rays are not intended to collect, prepare, or examine specimens taken from the human body, and thus are not considered an in vitro diagnostic product under this regulation or for purposes of section 1905(a)(3)(B) of the Act. However, as indicated in question II.K.7., X-rays could be a component of "COVID-19 testing-related services." Additionally, X-rays continue to be a mandatory service in the Medicaid program, and should be utilized when medically necessary. For more information on the FDA definition, visit https://www.fda.gov/medical-devices/device-labeling/vitro-diagnostic-device-labeling-requirements.

8. Does in vitro diagnostic testing described in section 1905(a)(3)(B) of the Act, as added by section 6004(a)(1) of the FFCRA, and as amended by section 3717 of the CARES Act, include serological tests for COVID-19?

Yes. Section 1905(a)(3)(B) of the Act defines "in vitro diagnostic products" through a cross reference to FDA regulations at 21 CFR 809.3(a). FDA has advised that serological tests for COVID-19 meet the definition in 21 CFR 809.3(a) of an in vitro diagnostic product for the detection of SARS-CoV-2 or the diagnosis of COVID-19[14]. Serological tests for COVID-19 are used to detect antibodies against the SARS-CoV-2 virus, and are intended for use in the diagnosis of the disease or condition of having current or past COVID-19 infection, which is caused by the presence of the SARS-CoV-2 virus. Therefore, states must provide coverage for serological tests for COVID-19. [15] FDA currently believes such tests should not be used as the sole basis for diagnosis, as noted in its Policy for Diagnostic Tests for COVID-19 Guidance.

[14] 21 CFR 809.3(a) defines in vitro diagnostic products as "reagents, instruments, and systems intended for use in the diagnosis of disease or other conditions, including a determination of the state of health, in order to cure, mitigate, treat, or prevent disease or its sequelae. Such products are intended for use in the collection, preparation, and examination of specimens taken from the human body."

[15] To date, FDA has authorized one emergency use authorization for a serological test that is intended for use by clinical laboratories. See U.S. Food and Drug Administration, Letter to Cellex Inc. Regarding qSARS-CoV-2 IgG/IgM Rapid Test (Apr. 1, 2020), available at https://www.fda.gov/media/136622/download.

B. Telehealth

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

issued by the Office of Special Education Programs (OSEP) in the Department of Education for further information on the IDEA and other federal civil rights laws: https://www2.ed.gov/about/offices/list/ocr/frontpage/faq/rr/policyguidance/Supple%20Fact%20Sheet%203.21.20%20FINAL.pdf. For other updates on the Department of Education website, see: https://www.ed.gov/coronavirus.

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

The use of telehealth can assist states in continuing to deliver Medicaid-covered services to eligible children. As a reminder, the Early and Periodic Screening, Diagnostic, and Treatment benefit requires states to make available to eligible children under age 21 all medically necessary services included under section 1905(a) of the Act in order to correct or ameliorate defects and physical and mental illnesses or conditions. (See FAQ immediately preceding this one for further discussion.) If the state establishes that a Medicaid service can be delivered via telehealth, states may generally use existing state plan methodologies to cover and pay for the service when delivered via telehealth, or to reimburse additional costs that are incurred by the provider because of telehealth delivery. If the state plan contains restrictions that would prevent an otherwise covered service from being provided via telehealth, the state may use the Medicaid Disaster SPA template issued on March 22, 2020, to temporarily remove such restrictions during the period of the public health emergency. If the state needs flexibilities beyond the period of the public health emergency, CMS is available for technical assistance to determine if a state plan amendment is needed. If telehealth is used, covered entities must provide effective communication to individuals with disabilities as per Section 1557 of the Affordable Care Act, Section 504 of the Rehabilitation Act and Title II of the Americans with Disabilities Act. For further information on Medicaid coverage and reimbursement of services delivered via telehealth, please refer to the Medicaid.gov web page: https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html. This page includes the State Medicaid & CHIP Telehealth Toolkit *Policy Considerations for States Expanding Use of Telehealth* COVID-19 Version and a link to **Medicaid State Plan Fee-for-Service Payments for Services Delivered Via Telehealth.**

The Office for Civil Rights in the Department of Health and Human Services is exercising enforcement discretion to waive potential penalties for Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security, and Breach Notification Rules violations against health care providers that in good faith provide patient care through remote communications technologies during the COVID-19 public health emergency. Additional guidance is available explaining how covered health care providers can use remote video communication products and offer telehealth to patients responsibly. See: https://www.hhs.gov/hipaa/for-professionals/special-topics/hipaa-covid19/index.html. States may also refer to the guidance issued by the Office of Special Education Programs (OSEP) in the Department of Education for further information on the IDEA and other federal civil rights laws: https://www2.ed.gov/about/offices/list/ocr/frontpage/faq/rr/policyguidance/Supple%20Fact%20Sheet%203.21.20%20FINAL.pdf. For other updates on the Department of Education website, see: https://www.ed.gov/coronavirus.

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

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

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

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

Please also refer to the Medicaid.gov and the OSEP and Department of Education links noted above.

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

If the state establishes that a Medicaid-covered service can be delivered via telehealth, states may generally use existing state plan methodologies to cover and pay for the service when delivered via telehealth, or to reimburse additional costs that are incurred by the provider because of telehealth delivery. If the state plan contains restrictions that would prevent an otherwise covered service from being provided via telehealth, the state may use the Medicaid Disaster SPA template issued on March 22, 2020 to temporarily remove such restrictions during the period of the public health emergency. States can cover and reimburse for EIS that are Medicaid-covered services provided to a Medicaid-enrolled child by a qualified Medicaid provider. As explained previously in the CMS telehealth FAQs (Section III. Benefits, Item B. Telehealth, Question 1) updated May 5, 2020, states have broad flexibility to cover services provided via telehealth under Medicaid, and also have flexibility regarding the methods of communication used to provide services via telehealth (such as telephonic, video technology commonly available on smart phones and other devices). Telehealth is important not just for people who are unable to go to the

doctor, but also for when it is not advisable to go in person. No federal approval is needed for state Medicaid programs to reimburse providers for Medicaid services provided via telehealth in the same manner or at the same rate that states pay for those same Medicaid services when provided face-to-face. A SPA would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs. The updated FAQs can be found here: https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf. Providers of EIS who are not being reimbursed for delivery of services via telehealth should contact their state Medicaid agency. Additional information may be found at the OSEP guidance noted above and on the Department of Education website at https://www.ed.gov/coronavirus.

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

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

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

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

C. Home and Community Based Services

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

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

CMS clarifies that where a 30-day limitation has been approved under Appendix K, the state may request to remove or revise that limit in a subsequent Appendix K application with a request that the approval be retroactive back to the effective date of the previously approved limitation under Appendix K.

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

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

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

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

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

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

For section 1915(k) Community First Choice programs, pursuant to section 1135(b)(5) of the Act, states may request a modification of the deadline for initial and annual level of care determinations required for the section 1915(k) state plan benefit, as described in 42 C.F.R. § 441.510(c). With this modification, the initial determination of level of care does not need to be completed before the start of services and the annual level of care determinations that exceeds the 12-month authorization period will remain in place and services will continue until the assessment can occur. A reassessment may be postponed for up to one year.

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

An Appendix K approval expires one year from the effective date or any earlier approved date elected by the state. However, end dates cannot extend beyond one year from the last day of the month in which the President signed the proclamation of a national emergency (March 31, 2021). This FAQ has the effect of updating information in the table included in FAQ I.8..

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

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

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

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

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

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

Yes. States can add language in the Appendix K in section K-2-m "Other Changes Necessary…" stating timeframes for the submission of the CMS 372s and the evidentiary package(s) will be extended as needed pursuant to the emergency. In addition, the state may suspend the collection of data for performance measures other than those identified for the Health and Welfare assurance and note that as a result the data will be unavailable for this time frame in ensuing reports due to the circumstances of the pandemic.

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

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

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

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

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

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

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

Yes. Pursuant to section 1135(b)(1)(C) of the Act, a state can request to waive provisions at 42 C.F.R. § 441.301(c)(2)(ix) for section 1915(c) waiver programs, 42 C.F.R. § 441.725(b)(9) for

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

11. Would Personal Care and Home Health Care Services rendered in a home remotely via telehealth constitute a home visit under the purview of Electronic Visit Verification (EVV) as outlined in section 12006 of the 21st Century Cures Act?

No. The remote delivery of services via telehealth does not constitute an "in home visit" as described in the 21st Century Cures Act, and EVV requirements do not apply. However, states may choose to apply EVV requirements to such services.

12. May providers require beneficiaries to sign waivers of liability should the beneficiary or the beneficiary's family acquire COVID-19 through the receipt of services from the provider or at the provider's physical location? What role do states play in ensuring continued provision of services if a beneficiary does not sign such a waiver?

CMS is aware that some providers of Medicaid-covered services are requiring beneficiaries or their legal representatives to sign waivers of liability relieving the provider of any responsibility should the beneficiary or the beneficiary's family be exposed to or contract COVID-19 as a result of receiving services from the provider in their own home, and/or attending a physical location of the provider. CMS takes no opinion on the permissibility of these waivers of liability, or on the language they may contain.

However, we remind states of their continued obligation during the PHE to ensure appropriate service provision to beneficiaries, including when such a waiver of liability is not signed, and beneficiaries do not receive services from their usual provider. In such circumstances, states should ensure that beneficiaries receive needed services through alternative means, which could include temporary enlargements to the pool of providers to deliver services, utilization of family members to deliver appropriate services, utilization of telehealth, or other approaches. CMS is available to provide technical assistance to states on the utilization of Medicaid coverage authorities and PHE flexibilities to enable these mechanisms to operate efficiently.

D. Pharmacy/Prescription Drugs

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

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

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

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

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

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

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

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

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

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

There are currently no federal Medicaid rules that require beneficiaries to provide their signature in order to receive prescription drugs. Requirements for signatures are usually found in a state provider manual and are at the discretion of the state Medicaid program. Therefore, CMS

encourages states to explore ways to ease state signature requirements in order to allow beneficiaries to access their medications during the public health emergency.

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

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

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

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

In general, section 1927(k)(2) of the Social Security Act defines a covered outpatient drug as a prescribed drug, that is approved for safety and effectiveness as a prescription drug by the FDA under section 505 or 507 of the Federal Food Drug and Cosmetic Act. Additionally, such term does not include a drug used for a medical indication which is not a medically-accepted indication. *See* 42 C.F.R. § 447.502. The term "medically accepted indication" is defined at section 1927(k)(6) of the Act to mean any use for a covered outpatient drug which is approved under the Federal Food, Drug, and Cosmetic Act or the use of which is supported by one or more citations included or approved for inclusion in certain statutorily defined compendia. If a prescribed drug does not meet the definition of a covered outpatient drug, states may still be permitted to cover such drugs at state option under section 1905(a)(12) of the Act as prescribed drugs, which are defined at 42 C.F.R. § 440.120(a). *See* 42 C.F.R. § 447.522(d). However, such drugs would not be subject to rebates under section 1927 of the Act, as noted at 42 C.F.R. § 447.522(e).

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

Thus, states may be able to cover and claim FFP for certain prescribed drugs when used for non-medically accepted indications, as provided in 42 C.F.R. § 447.522. To the extent such a drug

does not meet the definition of a covered outpatient drug, the state cannot claim rebates on these drugs under section 1927 of the Act. However, a state should assure that when these drugs are used for medically accepted indications as covered outpatient drugs that the state claims rebates, as appropriate.

E. Money Follows the Person (MFP) Program

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

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

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

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

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

MFP grantees should notify their MFP Project Officer as soon as possible if they need to make programmatic changes, but states do not need to receive CMS approval before implementing

programmatic changes to their MFP program's Operational Protocol if those changes are directly related to their response to COVID-19 and are otherwise allowable.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For MFP grantees, the budget methodology process for calendar year (CY) 2020 remains the same and is not impacted by section 3811 of the CARES Act. As CY 2020 MFP budgets are reviewed and approved, and we are able to determine how the COVID-19 public health emergency is impacting MFP activities and spending, we will be able to better project how much funding is remaining and how long states can continue transitions. Projections for funding availability for FY 2021 will be shared with MFP grantees as soon as possible.

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

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

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

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

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

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

Yes. The budget transfer flexibility discussed in the April 8, 2020 letter sent to MFP grantees would extend to MFP "supplemental demonstration services." In addition to qualified HCBS and unique demonstration services, a state may choose to offer supplemental demonstration services reimbursed through grant funds at a rate based on the state's standard FMAP. The state may propose these services because they are essential for successful transition of MFP participants to the community. These services should only be required during the transition period, or be a one-time cost to the program. These services are not expected to be continued after the demonstration period.

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

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

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

Yes. Certain equipment and supplies above and beyond what would ordinarily be covered under a state's Medicaid program may be covered through MFP grant funds for activities that support the goals and intent of the MFP program and that directly support MFP participants. If an MFP grantee chooses to offer Medicaid HCBS not currently included in the state's HCBS program, MFP may cover the service as an MFP demonstration service. MFP demonstration services are different from qualified HCBS program services in that they are not required to continue after the conclusion of the demonstration program or, for the participant, after the end of the 365-day enrollment period. MFP demonstration services are documented in a state's approved Operational Protocol. Additionally, states are required to provide budget information and justification for demonstration services through supplemental budget submissions to the Office of Acquisitions and Grants Management (OAGM). States can provide MFP demonstration services in response to COVID-19 for the 365-day MFP enrollment period, regardless of when the public health emergency terminates. However, MFP grant funds cannot be used to pay for services after an individual's 365-day MFP enrollment period ends.

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

No. States do not need to complete an Appendix K of the section 1915(c) waiver application if the equipment and services being offered to MFP participants are not being delivered through an HCBS program that operates under section 1915(c) of the Act. However, states should follow the applicable rules and processes of those authorities if they are making changes to an HCBS program that operates under section 1915(c) of the Act or another Medicaid authority, regardless of whether any of the service costs are funded under MFP. In such cases, states should reach out to their CMS HCBS lead and request the Appendix K for the section 1915(c) waiver application if they need to request changes to a section 1915(c) waiver program, or have any questions about how to request approval under another Medicaid authority.

In general, MFP grantees should notify their MFP Project Officers as soon as possible if they need to make programmatic changes, but CMS reminds states that they do not need to receive CMS approval before implementing changes to their MFP program's Operational Protocol if those changes are directly related to their response to COVID-19 and would be an allowable use of MFP funding and adhere to program requirements. Further, budget transfer flexibility is available to transfer up to 10% of MFP grant funds between budget line items for new activities as discussed in the April 8, 2020 letter sent to MFP grantees.

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

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

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

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

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

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

F. Miscellaneous

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

Through a 1915(c) Appendix K, if a Medicaid beneficiary already meeting an institutional level of care is quarantined in the community, states could add *Live in Caregiver* as a service, authorizing family members as providers. Therefore, a family member in the home who is not ill can render services to the quarantined individual and be funded as a live in caregiver. Home-

delivered meals, such as Meals on Wheels, could be added to provide one meal per day to the individual. Additional services, such as private duty nursing, could also be added and payment rates could be increased to account for increased health risk to providers and to solicit a larger provider pool.

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

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

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

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

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

Yes, depending on the benefits provided under the ABP. In general, beginning March 18, 2020, the FFCRA requires states to cover COVID-19 diagnostic testing, including administration of the test, and testing-related services (COVID-19 testing), without cost sharing, for beneficiaries covered under the Medicaid state plan. Neither the FFCRA nor the CARES Act expressly requires states to include this coverage for Medicaid beneficiaries who receive services under an ABP under section 1937 of the Act, although states may have designed such coverage to include COVID-19 testing. For example, many states have aligned their ABP benefits and cost sharing with state plan coverage; in these states, ABP coverage automatically will cover COVID-19 testing without cost sharing. As a result, no further action is necessary for these "state plan alignment" states. However, for non-state plan alignment states, additional action must be taken.

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

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

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

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

Yes. A state may cover PPE for Medicaid beneficiaries if determined to be medically necessary under the home health medical supplies, equipment, and appliances benefit (42 C.F.R.

440.70(b)(3)). States may apply limits on amount, duration, and scope of benefits as long as the benefit is sufficient in amount, duration, and scope to meet the purpose of the benefit.

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

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

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

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

7. Do states have to request any kind of waiver to offer transitional case management longer than 180 consecutive days?

No. A waiver is not needed to extend the time in which case management services are provided to an individual transitioning to the community from an institutional stay. Further, there is no limit on how many times an individual can attempt to transition to the community from an institution. If the individual has not transitioned to the community by the end of the 180 consecutive days, the state should document why the transition was unsuccessful. If appropriate, the state could start a new 180 consecutive day period to assist someone with transitioning to the community. Furthermore, the state must ensure that the case management services do not duplicate the services required of the nursing home related to discharge planning, which are described at 42 C.F.R. § 483.21(c).

G. Non-Emergency Medical Transportation

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

No. There is no categorical waiver of provider enrollment requirements. CMS has provided guidance on how states may request and receive CMS approval for certain limited waivers concerning provider enrollment requirements, for example, to streamline enrollment requirements, waive certain conditions of participation, and waive state licensure requirements where the provider has an equivalent license in another state. See: https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/section-1135-waiver-flexibilities/index.html. However, provider enrollment and screening are a condition of payment

and as such cannot be waived by the agency. Furthermore, any abbreviated enrollment under an approved section 1135 waiver is temporary and must be either converted to a full enrollment (with the provider fully screened and appropriately licensed in the state), or deactivated within 6 months after the PHE is lifted.

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

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

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

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

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

Yes, under limited circumstances for certain beneficiaries. The NEMT benefit requires states to assure that beneficiaries with no other transportation resources have access to Medicaid-covered

medical services. Under section 1915(c) waiver and section 1915(i) state plan authority, the state can cover the delivery of meals to individuals served by those programs by adding home delivered meals as a service option and the NEMT providers can be included in the list of qualified providers (as indicated on page 53 of the "Application for a §1915(c) Home and Community-Based Waiver [Version 3.6, January 2019], Instructions, Technical Guide and Review Criteria" available at https://wms-mmdl.cms.gov/WMS/faces/portal.jsp). If there is an issue with paying one provider for the meals and the transportation provider for transporting them, the state can have two components to the rate with different rates for each component.

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

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

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

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

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

1. What is the difference between the funds available to reimburse providers for COVID-19 testing and treatment services furnished to uninsured individuals through the Health Resources and Services Administration (HRSA) and the funds available through the

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 FAQ Section II.K.

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

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

To access these funds, health care providers must enroll in the program as a provider participant. Once they have done so, they can submit claims for direct reimbursement for COVID-19 testing and treatment services furnished to uninsured individuals on or after February 4, 2020. Additional information on the COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured Program can be found on HRSA's website at https://www.hrsa.gov/coviduninsuredclaim

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

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

In most cases, providers can utilize the Medicaid Eligibility Verification System (MEVS) to verify if an individual is enrolled under Medicaid. This may include the new optional COVID-19 testing eligibility group in states that have adopted this new group. If an individual is not enrolled in the Medicaid COVID-19 testing eligibility group and is otherwise uninsured at the time of services, a participating provider may file a claim with the HRSA-administered program for COVID-19 testing services furnished to the individual as long as the services provided meet the coverage and billing requirements established as part of the program.

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

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

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

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

payment from that HRSA-administered program. See Question 3 regarding COB between Medicaid and the COVID-19 Claims Reimbursement Program.

IV. Financing

A. Administrative Claiming

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

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

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

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

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

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

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

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

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

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

B. Advance and Retainer Payments

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

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

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

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

3. What are the parameters for retainer payments authorized under section 1915(c) 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 C.F.R. 438.6(c) for state directed payments. In order for states to seek approval under 42 C.F.R. 438.6(c), the retainer payments must be authorized as part of the section 1915(c) HCBS waiver, section 1115(a) demonstration waiver for section 1915(c) HCBS services, or other Medicaid authority. Once the retainer payments are authorized under one of these authorities, a state directed payment preprint must also be submitted to effectuate the state directed retainer payments under a state's contract with its managed care plans. CMS published detailed guidance on this approach at: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051420.pdf.

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

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

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

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

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

Yes. Retainer payments may be used to allow a provider to continue to bill for services as specified in the beneficiary's person-centered service plan when circumstances, including self-quarantining activities during the COVID-19 pandemic, prevent the individual from receiving the service. Therefore, retainer payment amounts are tied to amounts reflective of the services that would have been provided to enrolled members should the pandemic not have occurred. Typically, retainer payments are limited to when there is an acute spell of illness or other medically necessary absence takes the individual out of the HCBS setting. However, the pandemic has presented unique situations such as the need to self-quarantine or isolate, which could prevent the personal attendant from entering an individual's home or place of service receipt.

Section 1915(i)(1) of the Act permits states to include HCBS that are within the scope of services at section 1915(c)(4)(B) of the Act. Likewise, 42 C.F.R. § 441.700 permits states to offer HCBS listed under 42 C.F.R. § 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 C.F.R. § 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 C.F.R. § 441.505, are used to ensure continuity of CFC services and supports, and retainer payments could be used to meet this requirement. The retainer payment could be used to retain the availability of an individual's personal attendant when an event removes an individual from his or her home or place of service receipt, or prevents a personal attendant from providing services in the home or place of service provision. Such payments are useful in preserving the availability of the attendant upon the return to typical service provision. This serves to ensure continuity of services and supports. For example, an individual may need to receive a few weeks of rehabilitative services in a skilled nursing facility. The individual plans to return home and wants to receive services from his personal attendant who has been providing services for the past several years. Under this circumstance, a retainer payment could be made to ensure the personal attendant will be available to provide services upon the individual's return to his home. Although retainer payments could be used as part of the backup system for individuals, the backup system must also address how individuals will receive needed services in the absence of their attendant.

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

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

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

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

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

- If a provider had already received revenues in excess of the pre-PHE level, retainer payments are not available.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Payment Rates and Methodologies

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

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

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

States have flexibility to make reasonable adjustments to Medicaid payments to better align Medicaid payments with the increased cost of providing services to Medicaid beneficiaries

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

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

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

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

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

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

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

granted through the section 1135 waiver. If a state wants these changes to be permanent, it would be advisable to simply make these changes through the regular SPA submission process.

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

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

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

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

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

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

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

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

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

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

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

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

12. Has CMS considered new costs states may encounter in NF fee for service (FFS) rate components, including labor costs related to overtime and other agency costs, supply costs for items such as personal protective equipment, and childcare costs for NF employees, among others?

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

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

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

to evaluate the effects on beneficiaries and the Medicaid program of making retainer payments to mitigate a possible long-term reduction in provider capacity and access to services. More information about this demonstration opportunity is available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-application-process/index.html.

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

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

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

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

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

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

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

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

As long as a service has been provided, CMS defers to states to determine whether an adjustment is warranted. In the case of patient quarantined away from a facility, states have the option to cover and pay for temporary absences under Medicaid reserve bed authority discussed at 42 C.F.R. 447.40. If such coverage is not currently provided for in the approved state plan, states

would need to submit a SPA. If a quarantined Medicaid patient presents unique needs and resource demands, as indicated above, states could use the state plan process to adjust payment rates and/or methodologies to reflect the extra costs to provide services. On March 22, 2020, CMS released a Disaster Relief SPA template (https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/state-plan-flexibilities/index.html) that can be used by states for this purpose.

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

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

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

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

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

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

E. Upper Payment Limits

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

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

2. My state already makes supplemental payments under the state plan and has concerns that making these payments during the PHE might result in total payments that exceed the UPL demonstration(s) provided to CMS. Given the uncertainty around changes in costs and/or payments relevant to our UPL demonstration(s), how could we structure the Medicaid state plan supplemental payment methodology?

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

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

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

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

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

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

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

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

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

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

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

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

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

F. FFCRA Temporary FMAP Increase

1. What must a state do to receive a 6.2 percentage point temporary increase to the federal medical assistance percentage (FMAP)?

To qualify for the temporary FMAP increase, states must, through the end of the month when the public health emergency ends:

a. Maintain eligibility standards, methodologies, or procedures that are no more restrictive than what the state had in place as of January 1, 2020 (maintenance of effort requirement).
b. Not charge premiums that exceed those that were in place as of January 1, 2020
c. Cover, without impositions of any cost sharing, testing, services and treatments—including vaccines, specialized equipment, and therapies—related to COVID-19.
d. Not terminate individuals from Medicaid if such individuals were enrolled in the program as of the date of the beginning of the emergency period, or becomes enrolled during the emergency period, unless the individual voluntarily terminates eligibility or is no longer a resident of the state (continuous coverage requirement).

These requirements became effective on March 18, 2020. More information on these conditions is provided below.

2. What is the maintenance of effort (MOE) requirement in the FFCRA? What types of eligibility and enrollment changes can states make to respond to the current emergency and still receive temporary increased FMAP?

States may not impose eligibility standards, methodologies, or procedures that are more restrictive than those that were in place on January 1, 2020, in order to receive increased FMAP during the emergency period. States may continue to make temporary or permanent eligibility and enrollment changes that are less restrictive during the emergency period, such as lowering premiums, easing burden associated with verification requirements, and streamlining the application process, as permitted by law, including under any applicable federal waiver or modification authorities. CMS is available to provide technical assistance to any state that implemented any such more restrictive standards, methodologies, or procedures between January 1, 2020 and enactment of the FFCRA.

3. Can states increase premiums under the state plan (or waiver) after January 1, 2020 and still receive temporary increased FMAP?

No. A state that increases premiums for any beneficiaries above the amounts in effect on January 1, 2020 is not eligible for the temporary increased FMAP.

4. Are states required to cover any COVID-related services as a condition of receiving the temporary increased 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 temporary increased FMAP is claimed.

5. Which items and services must states exempt from cost sharing in order to be eligible for the temporary increased FMAP?

States may not impose deductibles, copayments, coinsurance or other cost sharing charges for any services described in question IV.F.4., above – i.e., testing services and treatments for COVID–19, including vaccines, specialized equipment, and therapies – in the quarter in which the temporary increased FMAP is claimed.

6. Which states are eligible for the 6.2 percentage point FMAP increase?

All states and territories are eligible for the increased FMAP, provided they meet the requirements of section 6008(b) and (c) of the Families First Coronavirus Response Act. While CMS has not conducted reviews for state compliance, we believe that all states can take steps to be compliant and earn the enhanced funding, and CMS will provide technical assistance to states on this issue. The specific criteria that states and territories must meet in order to qualify for the increased FMAP is described in Section IV.F. of this FAQ document.

7. Does the 6.2 percentage point FMAP increase apply to all match rates used in determining how much FFP states receive for Medicaid expenditures?

In general, the increased FMAP is available for allowable Medicaid medical assistance expenditures for which federal matching is paid ordinarily at the state-specific FMAP rate defined in the first sentence of section 1905(b) of the Act. The increase does not apply with respect to the following Medicaid expenditures: Medicaid administrative expenditures, for which the matching rate is not defined in section 1905(b). ****Updated to remove Community First Choice.**

- Adult group expenditures matched at the "newly eligible" FMAP specified in section 1905(y) of the Act.
- Adult group expenditures matched at the "expansion state" FMAP specified in section 1905(z) of the Act.
- Expenditures for family planning services eligible for 90% match as specified in section 1903(a)(5).
- Expenditures for services "received through" an IHS facility (including an IHS facility operated by an Indian tribe or tribal organization), as the 100% match rate for these services is not the same as the state-specific FMAP defined in the first sentence of section 1905(b) to which the 6.2 percentage point FMAP increase applies.
- Expenditures matched at 100% for individuals in Qualifying Individuals programs.
- Health home services under section 1945 of the Act when these are matched at 90% as specified in section 1945(c)(1). After the initial enhanced FMAP period for these

services that is described in section 1945(c)(1), they will be matched at the state's regular FMAP, which might be subject to the 6.2 percentage point increase under section 6008(a).

- Any other expenditures not matched at the FMAP determined for each state that is defined in the first sentence of section 1905(b).

8. In question IV.F.7 (A.2. of the FAQs CMS previously issued on the FFCRA), CMS indicated that Community First Choice (CFC) 1915(k) service expenditures already eligible for the 6 percentage point in Federal match rate increase are not eligible for the 6.2 percentage point FMAP increase under section 6008 of the FFCRA. Is this accurate?

No. We incorrectly stated that the 6.2 percentage point FMAP increase under the FFCRA does not apply to Community First Choice (CFC) 1915(k) service expenditures, which are already eligible for a separate 6 percentage point FMAP increase. Expenditures for these services are, in fact, eligible for both the 6 percentage point FMAP increase under section 1915(k) of the Social Security Act and the 6.2 percentage point increase under section 6004 of the FFCRA, if the expenditures otherwise qualify. These FMAP increases are additive.

9. In question IV.F.7 (A.2. of the FAQs CMS previously issued on the FFCRA), CMS indicated that the 6.2 percentage point FMAP increase under section 6008 of the FFCRA does not apply to adult group expenditures matched at either the "newly eligible" FMAP specified in section 1905(y) of the Act or at the "expansion state" FMAP specified in section 1905(z) of the Act. Are other adult group expenditures that are matched at the state-specific FMAP in the first sentence of 1905(b) eligible for the 6.2 percentage point FMAP increase?

Yes. Adult group expenditures matched at the state-specific FMAP in the first sentence of 1905(b) are eligible for the 6.2 percentage point FMAP increase. For example, the 6.2 percentage point FMAP increase is available for most expenditures for services provided to "not newly" eligible individuals in a state that has expanded Medicaid, but does not qualify as an "expansion state" under section 1905(z)(3) of the Act. (Note, the FMAP increase would not apply to "not newly" expenditures already matched at rates not subject to the 6.2 percentage point FMAP increase, such as family planning services matched at 90%.)

10. Does the 6.2 percentage point FMAP increase apply to Children's Health Insurance Program expenditures and expenditures for individuals eligible on the basis of breast and cervical cancer that are matched at the "enhanced" FMAP (EFMAP) under section 2105(b) of the Act?

Not directly. The EFMAP in section 2105(b) of the Act is calculated using the FMAP as defined in the first sentence of section 1905(b) of the Act as a "base." Therefore, generally, as the 1905(b) FMAP increases for a state, the EFMAP also increases for the state, though not in the exact same amount. Therefore, the EFMAP will increase for states coinciding with the duration of the 6.2 percentage point increase to the FMAP.

Please note that under section 2105(b) of the Act, the EFMAP for CHIP expenditures only is increased by 11.5 percentage points for the Federal Fiscal Year (FY) 2020 (October 1, 2019 through September 30, 2020) with a cap of 100% for this same period. The 100% cap will still apply as the maximum match rate for CHIP expenditures. For FY 2021 and after, the EFMAP under section 2105(b) of the Act is capped at 85%. Optional Breast and Cervical Cancer expenditures are matched at the unincreased EFMAP (that is, the EFMAP without the 11.5 percentage point increase described above).

Optional Breast and Cervical Cancer expenditures under section 2105(b) of the Act are matched at the unincreased EFMAP (that is, the EFMAP without the 11.5 percentage point increase for CHIP expenditures described above).

Example of the Impact of the 6.2 percentage point FMAP Increase on the Section 2105(b) EFMAP Calculation

Federal Match Type	**Without** 6.2 percentage point FMAP Increase	**With** 6.2 percentage point FMAP Increase
1905(b) FMAP	50%	56.2%
EFMAP Calculation	(50% x 0.7) +0.3	(56.2% x 0.7) +0.3
EFMAP (non-CHIP)	65%	69.34%
EFMAP for CHIP (FY 2020)	76.5% (65% + 11.5%)	80.84% (69.34% + 11.5%)

11. In question IV.F.10 (A.4. of the FAQs CMS previously issued on the FFCRA), CMS indicated that although the 6.2 percentage point FMAP increase under section 6008 of the FFCRA does not apply directly to CHIP expenditures, it does have an indirect effect of increasing the "enhanced" FMAP (EFMAP) under section 2105(b) of the Act. Will there be a similar impact on the enhanced match rates for MFP demonstration expenditures and Certified Community Behavioral Health Clinic (CCBHC) expenditures?

Yes. Similar to CHIP expenditures, these expenditures are matched at rates that use the FMAP in the first sentence of section 1905(b) of the Act as a "base." Match rates for MFP and CCBHC expenditures will be indirectly increased as a result of the 6.2 percentage point FMAP increase under the FFCRA. Please note that the MFP match rate has a statutory limit of 90 percent.

12. Will CHIP allotments for FY 2020 increase as a result of the 6.2 percentage point increase to the FMAP provided under section 6008 of the FFCRA?

No. CHIP allotment formulas are set in statute under section 2104(m) of the Act and do not rely directly on the FMAP or enhanced FMAP (EFMAP) EFMAP in the calculation. Therefore, FY 2020 CHIP allotments will not increase as a result of the 6.2 percentage point increase FMAP. However, there is CHIP funding potentially available to states through contingency fund and/or redistribution payments should they exceed their allotments and if they meet the criteria provided in statute under sections 2104(n) and 2104(f) of the Social Security Act, respectively.

As stated in Question IV.F.10 (A.4. of the FAQs CMS previously issued on the FFCRA), the 6.2 percentage point increase to the FMAP results indirectly in an increase in the EFMAP (although

not the same amount) coinciding with the duration of the increase to the FMAP. The indirect increase to the EFMAP for applicable quarters in FY 2020 will affect the amount of each state's FY 2021 CHIP allotment, determined under a "rebasing" methodology provided in section 2104(m)(2)(b)(i) of the Act. Specifically, the FY 2021 CHIP allotments calculated under section 2104(m)(2)(b)(i) will be determined based on the previous fiscal year's Federal payments reported and applied to allotments (including contingency fund and redistribution payments if any) multiplied by the FY 2021 allotment increase factor. Any increases in the federal share of expenditures applied to available CHIP allotment funding for FY 2020 will be accounted for in the calculation of the FY 2021 CHIP allotments.

13. Does the 6.2 percentage point increase under the FFCRA have the same indirect effect on the match rate for CHIP administrative expenditures as it does on CHIP service expenditures?

In general, yes. CHIP expenditures, including CHIP administrative expenditures, are matched at the EFMAP rate under section 2105(b) of the Act unless otherwise provided in the statute. As a reminder, CHIP administrative expenditures are included among other certain CHIP expenditures described at section 2105(a)(1)(D) of the Act (HSI, outreach, other child health assistance, and translation and interpretation) that are limited to 10 percent of the total amount of total computable expenditures reported for the fiscal year under section 2105(a) of the Act.

States have the option to claim Medicaid expansion CHIP administrative expenditures as Medicaid administrative expenditures. If the state elects to do so, these expenditures are matched at the Medicaid administrative match rate and are not eligible for the 6.2 percentage point FMAP increase.

14. Is the increased FMAP available for Medicaid DSH expenditures?

Yes, if the expenditures are matched at the 1905(b) FMAP and the state and the expenditures otherwise meet the qualifying requirements (the expenditures were incurred during the applicable time period, the state meets the requirements in section 6008(b) and (c) of the FFCRA).

15. The calculation of Medicaid DSH limits for Institutions for Mental Diseases (IMD) under section 1923(h) of the Act relies, in part, on the 1905(b) FMAP to determine the "applicable percentage" at section 1923(h)(2). Will CMS use the 1905(b) FMAP increased by 6.2 percentage points for this calculation? If so, what will the impact be?

Yes, we will use the section 1905(b) FMAP increased by 6.2 percentage points for each quarter that is subject to this increase to calculate the applicable percentage for each state under section 1923(h)(2) of the Act. As a result, some states will experience an increase to their Medicaid DSH limits for IMDs for FY 2020 and any subsequent FY that includes at least one quarter in which the 6.2 percentage point increase applies. Please note that this increase to some states' IMD limits does not affect states' overall DSH allotment amounts.

16. For which period is the FMAP increase available?

Section 6008(a) of the FFCRA states that the increased FMAP is available for each calendar quarter occurring during the public health emergency. As the public health emergency for COVID-19 was declared by the Secretary of Health and Human Services on January 31, 2020, the increased FMAP is available for qualifying expenditures that were incurred on or after January 1, 2020 and through the end of the quarter in which the public health emergency including any extensions, ends. At the time the public health emergency period for COVID-19 ends, CMS will inform states.

17. How do states know whether an otherwise qualifying expenditure falls within the period for which the increased FMAP is available?

States should follow existing federal requirements regarding the applicability of a particular match rate available for a given quarter. For purposes of determining which FMAP applies, expenditures are considered to be incurred based on when the state makes a payment to a provider, not based on the date of service. The quarter in which the state makes a payment is the quarter in which the expenditure will be considered to be incurred, and the FMAP applicable to that quarter is the appropriate FMAP for that claim.

18. Is the increased FMAP available for services provided under waivers and section 1115 demonstrations?

Yes, if the expenditures are matched at the FMAP defined in the first sentence of 1905(b) and the state and the expenditures otherwise meet the qualifying requirements in section 6008 of the FFCRA.

19. Are states required to submit a SPA to be eligible for the 6.2 percentage point FMAP increase?

No, states are not required to submit a SPA to be eligible for the FMAP increase. However, only expenditures matched at the FMAP defined in the first sentence of 1905(b) that are incurred by states that meet the qualifying requirements in section 6008 of the Families First Coronavirus Response Act are eligible for the increased FMAP.

20. CMS indicated that the 6.2 percentage point increase under section 6008 of the FFCRA applies to territories that meet eligibility requirements specified in that same section. If territories qualify for the increase, are these 6.2 percentage points added to the territory FMAPs specified at section 1905(ff) of the Act?

Yes. The 6.2 percentage point increase under the FFCRA is in addition to the existing FMAP increases under section 1905(ff) of the Act. For example, the FMAP for the quarter ending March 31, 2020, is 89.20% for American Samoa, Guam, the Northern Mariana Islands, and the Virgin Islands and 82.20% for Puerto Rico, if each territory qualifies for the temporary increase under section 6008 of the FFCRA.

Flow of Federal Funds and State Reporting

21. Will CMS be releasing funding all at once or through multiple grant awards?

We are prioritizing issuing grant awards to states for additional funding associated with the increased FMAP retroactive to January 1, 2020 first. The first set of grant awards will include increased funding for the period January 1, 2020 through March 31, 2020. We will then provide additional funds based upon state budget estimates for the April 1, 2020 through June 30, 2020. As with all Medicaid grant award funding, these funds will be reconciled against claimed and allowable expenditures when states file their quarterly CMS-64 expenditure reports.

22. When will CMS send the FFP associated with the increased FMAP to states?

We are currently processing grant awards to fund the increase match for the period beginning January 1, 2020 through March 31, 2020. We expect that states will receive the funds in their Payment Management System (PMS) account no later than Wednesday, March 25, 2020. We intend to issue funding for the increased match associated with the quarter beginning April 1, 2020 as close to April 1, 2020 as possible.

23. How did CMS calculate the amount of the grant awards associated with the increased FMAP?

CMS used budget estimates reported and certified by states on the Form CMS-37 in the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) for the quarter ending March 31, 2020 (Q2 FY 2020) to estimate the additional amount of federal funds that would be due states as a result of the 6.2 percentage point FMAP increase. The amount of the additional grant award that each state receives for Q2 FY 2020 will be equal to the difference between the estimated federal share recalculated for Q2 FY 2020 to include the FMAP 6.2 percentage point increase and the federal share previously reported and certified in MBES/CBES for Q2/FFY 2020 by the state for the Q2 FY 2020 budget submission.

We are working to modify MBES/CBES as soon as possible to reflect each state's increased FMAPs; however, in the meantime, we are providing additional funds to states in estimated amounts described above. Once MBES/CBES is reprogrammed to utilize the increased FMAPs, the system will automatically determine the correct amount of federal funds related to the increased FMAPs, and apply such FMAPs for the actual claimed expenditures that were incurred on or after January 1, 2020, and before the end of the emergency period. Per our standard Medicaid grant award reconciliation process, CMS will reconcile all amounts advanced to the state, including estimated amounts based on the increased FMAP, to actual Medicaid expenditures reported by the state for the relevant quarter and recover any unexpended amounts or pay any additional amounts due to the state.

24. The increased FMAP is available for expenditures incurred as early as January 1, 2020. Can states draw all funding associated with the increased FMAP as soon as they receive it?

If the state meets all applicable requirements and conditions established within section 6008 and other applicable existing federal requirements, it can draw funds associated with allowable Medicaid expenditures that have already been incurred and are eligible for the increased match. A state may not draw funds for expenditures it has not yet incurred, expenditures incurred prior to January 1, 2020, or expenditures that are not otherwise eligible for the increased FMAP.

25. Will grant awards issued relating to the increased FMAP be subject to adjustment or are they set amounts?

In calculating grant awards for the increased FMAP associated with the quarter ending March 31, 2020, we used estimated expenditures submitted and certified by states on the Form CMS-37. The final determination of allowability of expenditures eligible for the increased FMAP and any necessary reconciling grant awards will be determined after all the actual expenditures for the quarter have been submitted by the states and reviewed by CMS. At that time, final reconciling grant awards will be issued to reflect the amounts that the states are finally due based on federal requirements, including those specified in the FFCRA. Consistent with our existing practice and federal requirements, any overpayment or underpayment will factor into (be offset against or added to) the grant award for the following quarter.

26. What happens if a state determines that its spending will exceed its budget estimate? Will additional funding be available?

Consistent with existing practice, 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, including those eligible for the 6.2 percentage point increased FMAP. Should any state need additional funds before the end of a quarter, they may request them through a supplemental request to the extent that the state and its expenditures qualify for the increased FMAP and have a permissible source of non-Federal share. CMS will evaluate such requests and issue any appropriate additional supplemental grant awards.

27. How will CMS expect states to document and differentiate which expenditures they are claiming at the increased FMAP rate and expenditures matched at other rates?

Consistent with existing requirements, states must document expenditures to ensure a clear audit trail, including by isolating expenditures that are matched at increased FFP rates. We will be performing oversight to ensure that the state expenditures are allowable and accurate, including with respect to the matching rate claimed. We are currently working to modify the Form CMS-64 and Form CMS-37 in the MBES/CBES system to accommodate the changes from the FFCRA, including reporting of budget estimates and expenditures eligible for the increase FMAP. We intend to issue further guidance and offer training to states as soon as possible on reporting budget estimates on the CMS-37 and quarterly expenditures on the Form CMS-64.

28. Are there special reporting requirements for the Form CMS-64 or Form CMS-37 (i.e., separate lines or a separate report for the increased FMAP)?

We are currently working to modify the Form CMS-64 and Form CMS-37 in the MBES/CBES system to accommodate the changes from the Families First Coronavirus Response Act, including reporting of budget estimates and expenditures eligible for the increased FMAP. We intend to issue further guidance and offer training to states as soon as possible.

29. Will CMS expect states to document and differentiate which draws from its Payment Management System (PMS) account are applicable to the increased FMAP rate and which expenditures are matched at other rates? If so, how?

Consistent with existing requirements, states must document expenditures and draws to ensure a clear audit trail for use of federal funds. We expect states, on a quarterly basis, to provide CMS with a breakout of the total amount of PMS draws by quarter that are related to expenditure eligible for the increase FMAP and the total amount of PMS draws that were *not* for expenditures related to the increased FMAP. CMS expects states to provide this information as soon as possible at the end of every quarter. In line with our current processes, we will continue to reconcile states' PMS subaccounts with actual expenditures once states report them in MBES/CBES and CMS reviews the expenditures for accuracy and allowability. States' total draws in PMS are expected to equal the actual total expenditures reported for such quarter/fiscal year in MBES/CBES.

30. Does the increased FMAP only pertain to state expenditures or does it also pertain to collections and overpayments?

All states are responsible for reporting Medicaid collections and overpayments on the CMS-64. States must report overpayments and collections at the same match rate at which the expenditures were originally claimed, including when the original rate incorporated the 6.2 percentage point FMAP increase.

31. If a state recovers a provider payment that was originally claimed by the state with the 6.2 percentage point increased FMAP, should it return the FFP associated with the recovery at the increased FMAP?

Yes, recoveries of FFP must be returned at the same match rate at which they were originally claimed. Therefore, if a Medicaid expenditure was claimed using the increased FMAP, the federal share of any recoveries associated with that expenditure would have to be returned using the same increased FMAP.

Requesting Increased FMAP

32. To be eligible for the 6.2 percentage point FMAP increase, section 6008(c) of the Families First Coronavirus Response Act provides that states must not require political subdivisions of the state to pay a greater portion of the non-federal share of expenditures required under section 1902(a)(2) of the Act or payments under 1923 of the Act than was

required on March 11, 2020. Will CMS require states and territories to demonstrate compliance with this provision prior to receiving the increased FMAP?

While states are required to ensure compliance with this section, CMS will not require that states submit a demonstration of compliance prior to drawing FFP associated with the increased FMAP. Instead, CMS will require states to attest to compliance. If this attestation is determined to be incorrect such that the state does not satisfy the conditions under section 6008(c) of the FFCRA, then the state will be required to return the increased FFP for which it did not qualify to CMS.

33. Will CMS require that states attest to meeting the requirements of section 6008 of the Families First Coronavirus Response Act when drawing the FFP associated with the increased FMAP?

Yes. States must attest that they will assure compliance with the requirements in sections 6008(b) and (c) of the FFCRA. If this attestation is determined to be incorrect such that the state does not satisfy all applicable conditions under section 6008 of the FFCRA, then the state will be required to return the increased FFP for which it did not qualify to CMS.

34. How will states attest? What should states send in and to whom? Will CMS approve the attestation? May states draw funds before the attestation is approved? Must states attest before each draw down?

By drawing funds from the increased FMAP account in the PMS, each state is "attesting" that: it is eligible for the increased FMAP; the expenditures for which it is drawing funds are those for which the increased FMAP is applicable; and that the conditions under which the increased FMAP is available are met. The attestation includes specific agreement with enumerated requirements of sections 6008(b) and (c) of the FFCRA. To minimize the need for separate review, avoid state burden, and expedite providing funding to states, CMS has included these requirements as attestations in each grant award letter to the states. The grant award letter indicates that only after the state has assured itself that it meets all of the requirements under which the increased FMAP and associated funds were available, is it free to draw such funds. This process is referred to as a "passive attestation" under which each state did not need to send in a written confirmation that it met the requirements prior to receiving its funds; rather, by simply drawing down the funds the state was attesting that it had carefully considered all attestations and that it met those requirements. If this is determined to be incorrect such that the state does not satisfy all applicable conditions under section 6008 of the FFCRA, then the state will be required to return the increased FFP for which it did not qualify to CMS.

35. Does CMS intend to issue more specific guidance on the requirements relating to political subdivisions in section 6008(c)?

Section 6008(c) modifies section 1905(cc) of Act by providing that, to be eligible for the increased FMAP subdivisions of the state to pay a greater portion of the non-federal share of expenditures required under section 1902(a)(2) of the Act or payments under 1923 of the Act than was required on March 11, 2020. CMS has already issued guidance about section 1905(cc)

of the Act, including most recently through State Medicaid Director Letter #10-023 on November 9, 2010. States should refer to this guidance regarding requirements of section 1905(cc). Of note, for increased FMAP available under section 6008 of the Families First Coronavirus Response Act, the reference to ‘‘December 31, 2009’’ in section 1905(cc) of the Act shall be deemed to be a reference to ‘‘March 11, 2020.’’

36. If a state decides it will no longer comply with the requirements of section 6008(b) of the FFCRA that are necessary to be eligible for the temporary 6.2 percentage point FMAP increase, must it forfeit the FFP associated with increased FMAP retroactive to the start of the PHE or to the start of the quarter in which it no longer complied?

The state must comply with the requirements of section 6008(b) for each quarter in which FFP associated the temporary 6.2 percentage temporary point FMAP increase is claimed. If, during the PHE, a state decides to no longer comply with the 6008(b) requirements, FFP at the increased FMAP is no longer available for state expenditures effective the start of the quarter in which the state is no longer in compliance. However, states are able to receive FFP associated with the increased FMAP for expenditures incurred in prior quarters, if the state met the requirements of section 6008 (b) for that entire quarter.

37. Can a state claim prior period adjustments, including those relating to supplemental payments, at the FMAP temporarily increased by 6.2 percentage points under section 6008(a) of the FFCRA?

As indicated in Question IV.F.17, states should follow existing federal requirements regarding the applicability of a particular match rate available for a given quarter. The applicable FMAP is based on date of payment, not date of service, for current quarter original expenditures. The FMAP applicable to expenditures for all prior period adjustments should be the FMAP at which the original expenditure was claimed.

Because supplemental payments are adjustments to base payments originally made for the underlying services, supplemental payments are claimed as prior period adjustments to the original base payments. Accordingly, expenditures for supplemental payments are claimed at the same FMAP as the underlying original base payment expenditures, and in accordance with the timely claims filing requirement at 45 C.F.R. § 95.7, must be claimed within two years of the original base payment expenditures. We recognize that some states use the date of service to approximate the date of the base payment for the underlying services, as a practical means to determine the applicable FMAP when making supplemental payments. Such states should continue to do so. For example, if the state makes a lump sum supplemental payment in the quarter ending December 31, 2020 for services provided in the quarter ending March 31, 2020, the state should claim the supplemental payment as a prior period adjustment using the FMAP for the quarter ending March 31, 2020.

If a state has specific questions based on how it has traditionally claimed state plan lump sum supplemental payments, CMS will work with the state on a case-by-case basis to advise on how the increased FMAP under section 6008(a) of the FFCRA would apply.

G. Increased Federal Match Rate under Section 6004 of the FFCRA

1. Is there an increased federal match rate available for expenditures under section 6004 of the FFCRA for beneficiaries eligible under the new, optional group in section 1902(a)(10)(A)(ii)(XXIII) of the Act?

Yes, but only for expenditures associated with certain services and certain administrative activities. Section 6004(a)(3)(D) of the FFCRA specifies that the FMAP is 100 percent for expenditures for covered services provided to beneficiaries under the new optional eligibility group added at section 1902(a)(10)(A)(ii)(XXIII) of the Social Security Act. See Sections II and III in this FAQ document for more information on the covered benefits for this group. Additionally, 100 percent match is available for administrative costs related to providing for such services to such individuals under the state plan.

This 100 percent match rate does not apply to expenditures for medical services or administrative costs not described in the immediately preceding paragraph.

2. For which period is the 100 percent FMAP under section 6004(a)(3)(D) available for services?

As specified in section 6004(a)(3)(D) of the FFCRA, the 100 percent FMAP is available for expenditures based on the services provided to uninsured individuals as defined in section 1902(ss) of the Act who are eligible only on the basis of section 1902(a)(10)(A)(ii)(XXIII) of the Act. To the extent a state elects to cover the population and services under its state plan, and subject to other federal requirements, the 100 percent FMAP is applicable for the specified testing and testing-related services provided to beneficiaries determined eligible under section 1902(a)(10)(A)(ii)(XXIII) of the Act beginning with effective date of the approved state plan amendment adding coverage for this eligibility group and for the duration of the public health emergency period.

3. Are states required to obtain approval of a state plan amendment prior to claiming FFP at the 100 percent match rate under section 6004(a)(3)(D)?

Yes. Prior to claiming expenditures at the 100 percent match rate under section 6004(a)(3)(D) on the Form CMS-64, a state must have adopted the optional COVID-19 group in their approved Medicaid state plan (states should use the Medicaid Disaster SPA template to do so). States may request a retroactive effective date to adopt the optional COVID-19 group, as early as the effective date of the FFCRA, or March 18, 2020.

4. Will CMS require the state to update their cost allocation plan or administrative claiming plan to identify the administrative costs eligible for the 100 percent match under section 6004(a)(3)(D)?

No. CMS will not require states to update their public assistance cost allocation plans (PACAP) or Medicaid administrative claiming plans (MAC) in order to initiate claiming for COVID-19 related administrative costs associated with section 6004(a)(3)(D) of the FFCRA. However,

states should notify CMS of their intention to claim COVID-19 related administrative costs under this provision. CMS will work with states to ensure they are in compliance with federal claiming requirements associated with COVID-19-related administrative costs for the duration of the public health emergency. Due to the public health emergency posed by COVID-19 and the urgent need to make available to states the 100 percent match under the amendment to section 1905(b) of the Act made by section 6004(a)(3)(D) of the FFCRA, CMS is exercising its enforcement discretion to adopt a temporary policy of relaxed enforcement in connection with the PACAP requirements under 42 C.F.R. 433.34 and Subpart E of 45 CFR Part 95. We therefore believe that this guidance is a statement of agency policy not subject to the notice and comment requirements of the Administrative Procedure Act (APA). 5 U.S.C. § 553(b)(A). For the same reasons, CMS additionally finds that, even if this guidance were subject to the public participation provisions of the APA, prior notice and comment for this guidance is impracticable, and there is good cause to issue this guidance without prior public comment and without a delayed effective date. 5 U.S.C. § 553(b)(B) & (d)(3). As a result, states will be permitted to postpone updating their PACAP/MAC plans to reflect the addition of COVID-19 activities until after the cessation of the public health emergency.

5. Are there special expenditure reporting requirements for the Form CMS-64 (i.e., separate lines or a separate form report for expenditures relating to section 6004 of the FFCRA)?

We are currently working to modify the MBES/CBES system to accommodate the changes from the FFCRA and the CARES Act, including reporting of budget estimates and eligible expenditures relating to section 6004 of the FFCRA. We intend to issue further guidance and offer training to states as soon as possible.

6. Will CMS be issuing separate grant awards to states associated with COVID-19 testing under Medicaid and CHIP described under section 6004 of the FFCRA? What if a state determines that the Medicaid funding currently available in its PMS account isn't sufficient to cover its estimated expenditures for the rest of a particular quarter?

CMS does not intend to issue special grant awards to all states for funding associated with COVID-19 testing under Medicaid and CHIP described under section 6004 of the FFCRA.

Consistent with existing practice, states have an opportunity at any time throughout each quarter to request additional funding from CMS as necessary to cover expenditures for allowable Medicaid administrative and service costs, including expenditures resulting from amendments made by section 6004 of the FFCRA. Should any state need additional funds before the end of a quarter, they may request them through a supplemental grant award request to the extent that the state and its expenditures are allowable and the state has a permissible source of non-federal share. CMS will evaluate such requests and issue any appropriate additional supplemental grant awards.

7. Are there special requirements for claiming FFP at the 100 percent FMAP under section 6004 of the FFCRA when the legislatively-specified services for in vitro diagnostic products for detection of SARS-CoV-2 are delivered through managed care?

Medical assistance under the state plan now includes the COVID-19 testing benefit described in section 1905(a)(3)(B) of the Act. States should ensure that their managed care contracts adequately address the COVID-19 testing benefit described in section 1905(a)(3)(B) of the Act so that the managed care plan covers the testing benefit for individuals covered under the managed care contract. The 100 percent FMAP is available for only the COVID-19 testing and testing-related services provided to only beneficiaries enrolled in the new COVID-19 testing group (and for related administrative expenditures); the 100 percent match is not provided for COVID-19-related testing and diagnostic services provided to individuals covered under other Medicaid eligibility groups.

In order to provide coverage for the optional COVID-19 testing group under section 1902(a)(10)(A)(ii)(XXIII) of the Act, the State must ensure that the managed care contract provides for coverage of both the population and the COVID-19 test and testing-related services (see additional FAQs in Section II.K). The State should first review its contract with its managed care plans; depending on how covered populations are specified in the contract as being covered or eligible for coverage by the managed care plan, the State will need to amend the managed care contract to add coverage of the optional COVID-19 testing group and specify the scope of covered services available to that group.

To ensure proper claiming at the 100 percent FMAP available under section 6004 of the FFCRA when the state has included coverage of the optional COVID-19 testing group (i.e., coverage of the population for this specific benefit) in the managed care contract, states will need to isolate the managed care expenditures eligible for this increased match rate. Options include:

- Creating a kick payment (consistent with actuarial soundness requirements) for managed care plans for coverage of the test for the optional COVID-19 testing group, which would require both a contract and rate certification amendment. This option will require compliance with 42 C.F.R. §§ 438.4 through 438.7 regarding rate development and amendment of capitation rates.
- Paying for the tests for the optional COVID-19 testing group 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. 438.2) 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 for the non-risk payment, consistent with the requirements for non-risk contracts.

Note: CMS will process these contract amendments as expeditiously as possible and asks states to submit any COVID-19 related rate/contract amendments to our newly established mailbox at CMCSManagedCareCOVID19@cms.hhs.gov, including **COVID-19** in the subject line of the email and identifying the type of action(s) included.

H. Miscellaneous

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

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

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

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

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

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

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

No. CMS is not extending the audit and reporting submission deadline at this time, but CMS will continue to evaluate the situation. We recognize that some states and hospitals may experience challenges in completing audits and reporting timely during the public health emergency. We also recognize that hospitals might have limited resources to devote to working with states and auditors. States should follow the DSH audit and reporting timelines described in 42 C.F.R. §

455.304(b) and § 447.299(c), but may wish to take into consideration CMS' existing operational timeline for compliance enforcement. Specifically, if a state misses the annual audit and reporting deadline on December 31, 2020, CMS would begin deferring state claims for DSH expenditures reported on the CMS-64 beginning with the first quarter following the noncompliance; that is, beginning with the quarter ending March 31, 2021, consistent with the deferral timeframe specified in 42 C.F.R. § 447.299(e). Such deferrals would not occur until after March 31, 2021. This enforcement timeline effectively provides states extra time to submit their DSH audits and reporting before facing a deferral of federal funding.

5. Did the FFCRA or the CARES Act increase Medicaid disproportionate share hospital (DSH) allotments for states under section 1923 of the Act?

Not directly. However, section 3813 of the CARES Act eliminated $4 billion in Medicaid DSH allotment reductions applicable to FY 2020 that were scheduled to take effect on May 23, 2020, reduced the FY 2021 DSH allotment reductions from $8 billion to $4 billion, and delayed the start of FY 2021 DSH allotment reductions until December 1, 2020.

6. How should states and providers treat Provider Relief Fund revenue for purposes of Medicaid Disproportionate Share Hospital (DSH) payments?

Section 1923(g) of the Act limits DSH payments on a hospital-specific basis to each hospital's uncompensated care costs for inpatient and outpatient hospital services provided to Medicaid-eligible and uninsured individuals. Pursuant to 42 C.F.R. § 447.299(c), the hospital-specific DSH limit is calculated by reference to payments for inpatient and outpatient hospital services furnished to Medicaid beneficiaries "under the State plan" and "by Medicaid managed care organizations," 42 C.F.R. § 447.299(c)(6) through (c)(9), and payments "received by the hospital by or on behalf of individuals with no source of third party coverage," 42 C.F.R. § 447.299(c)(12).

Provider Relief Fund General and Targeted Distribution payments do not satisfy any of these regulatory provisions. Accordingly, Provider Relief Fund General and Targeted Distribution payments should not be included in the determination of total inpatient and outpatient hospital services payments for Medicaid beneficiaries.

However, when a provider receives reimbursement from either (1) the FFCRA Relief Fund for COVID-19 testing and testing-related services or (2) the Uninsured Relief Fund for COVID-19 care or treatment furnished to uninsured individuals,[16] the payment made is made "on behalf of" the individual with no other source of third party coverage for the service. Accordingly, when such payments are for inpatient and outpatient hospital services, they must be included in the determination of inpatient and outpatient hospital services revenue for the uninsured.

[16] Please see the terms and conditions applicable to each fund for additional relevant information. The FFCRA Relief Fund terms and conditions may be accessed at https://www.hhs.gov/sites/default/files/terms-and-conditions-ffcra-relief-fund.pdf and the CARES Act Uninsured Relief Fund terms and conditions may be accessed at https://www.hhs.gov/sites/default/files/terms-and-conditions-uninsured-relief-fund.pdf.

For more information, including permissible uses for General and Targeted Distribution payments for providers that have received Medicaid DSH payments, see https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/faqs/index.html.

7. How should states and providers treat Provider Relief Fund revenue for purposes of Medicaid fee-for-service (FFS) Upper Payment Limits (UPL)?

Provider Relief Fund payments will not impact a state's UPL demonstration, for either the calculation of Medicare payment-based ceiling or the accounting of the Medicaid payments subject to the ceiling. Specifically, states may not increase the UPL ceiling by counting all or a portion of these relief funds as Medicare FFS payments, since these payments are not made under Medicare payment principles in 42 C.F.R. Chapter IV, Subchapter B, *see* 42 C.F.R. §§ 447.272(b)(1), 447.321(b)(1). Furthermore, states will not count these relief funds as Medicaid FFS payments that are counted against the UPL, since the UPL is a limit on FFS Medicaid payments under the state plan. *See* 42 C.F.R. §§ 447.250 and 447.300.

8. How should states and providers treat Provider Relief Fund revenue for purposes of Medicaid cost reimbursement?

States and providers should continue to use ordinary cost reporting principles for Medicaid cost reimbursement. States and providers may modify cost reporting templates, consistent with all applicable cost reporting requirements, to allow documentation of additional health care related expenses that are attributable to coronavirus, for example, additional costs of personal protective equipment or isolation facilities. Further, when a state pays for Medicaid services using cost reimbursement, the provider is not required to offset Medicaid costs by Provider Relief Fund General and Targeted Distribution payments.

For information about the availability of Provider Relief Fund payments for Medicaid cost-reimbursed services, see https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/faqs/index.html.

9. How should states and providers treat Provider Relief Fund payments for purposes of health care related taxes under 42 C.F.R. § 433.68?

Providers should refer to their state's guidance on the determination of revenues subject to an applicable health care-related tax, and to their tax counsel. To the extent the state determines that a health care-related tax is imposed on certain revenue received by a provider from the Provider Relief Fund, then the state must include such tax proceeds in applying the indirect hold harmless test at 42 C.F.R. § 433.68(f)(3)(i)(A), which establishes an indirect guarantee safe harbor for health care-related taxes that produce revenue less than or equal to 6% of net patient service revenue for each permissible class of health care items or services.

V. Managed Care

A. Contracts and Rates

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

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

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

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

Regarding Medicaid managed care payment, under 42 C.F.R. §§438.3(c)(1)(ii) and 438.4, final capitation rates must be actuarially sound and based only upon services covered under the state plan or waiver authority and represent a payment amount adequate to allow the managed care

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

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

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

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

States could also pay for the tests outside of the managed care capitation payment as a non-risk payment: either as a separate non-risk contract with its managed care plans (see the definition of "non-risk contract" at 42 C.F.R. §438.2[17] 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

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

payment limits outlined at 42 C.F.R. §447.362 consistent with the requirements for non-risk contracts. For CHIP, states could follow the same approach of paying for the tests outside of the managed care capitation payment as a non-risk payment.

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

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

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

Yes, states are required to submit preprints for state-directed payments. As noted above, any state-directed payment preprints related to COVID-19 should be submitted to CMCSManagedCareCOVID19@cms.hhs.gov. CMS is committed to expediting and prioritizing such reviews.

4. What should states do to account for the effects of COVID-19 in Medicaid managed care rate development during rating periods impacted by the public health emergency?

CMS understands the significant level of uncertainty surrounding future COVID-19 and non-COVID-19 costs, and acknowledges that in some cases it may not be possible to prospectively project costs associated with the COVID-19 public health emergency in Medicaid managed care capitation rates with sufficient reliability or certainty until significantly more information is known about the impact of the virus on healthcare costs and utilization. Even as data for the initial periods of the public health emergency begins to emerge, CMS continues to recognize the significant level of uncertainty that exists around the future impacts of the public health emergency, including direct and indirect COVID-19 costs and savings such as new treatments and potential vaccines, deferred care, expanded coverage of telehealth, etc. CMS believes there are several strategies states can utilize to address this uncertainty in rate development, including utilization of a risk mitigation strategy (also known as a risk-sharing mechanism) and ceding COVID-19 related risk-based managed care plan costs back to the state and covering these costs in a non-risk payment outside the capitation payment. States could utilize one of these options or in combination.

5. Will CMS require states to implement a risk mitigation strategy with its Medicaid managed care plans to address the impact of COVID-19?

CMS requires implementation of a two-sided risk mitigation strategy when states implement new or revised state directed payments intended to mitigate the impacts of the public health emergency that are reviewed under the process outlined in the CIB published on May 14, 2020. However, while CMS will not generally require risk mitigation strategies to address the impact of COVID-19, CMS recommends that all states incorporate a two-sided risk mitigation strategy to address the uncertainty of COVID-19 related costs. States could implement a two-sided risk mitigation strategy alone, or in combination with contract modifications and revised rate certification as appropriate that cede COVID-19 related costs back to the state for the time

period, or within the applicable rating periods, impacted by the public health emergency. CMS assumes most states will implement a two-sided risk corridor as their risk mitigation strategy.

We note that CMS recently published the 2020 Medicaid managed care final rule, and this final rule included new requirements for state risk-sharing mechanisms. In accordance with our finalized rule at 42 C.F.R. § 438.6(b)(1), all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, must be documented in the contract and rate certification documents for the rating period prior to the start of the rating period, and must be developed in accordance with § 438.4, the rate development standards in § 438.5, and generally accepted actuarial principles and practices. Risk-sharing mechanisms may not be added or modified after the start of the rating period. This final rule is effective on December 14, 2020.

6. What factors should states consider when implementing a two-sided risk mitigation strategy with Medicaid managed care plans to address the impact of COVID-19?

CMS believes there are many factors a state should consider when designing and implementing a two-sided risk mitigation strategy with its Medicaid managed care plans (MCPs). First, CMS believes the addition of a two-sided risk mitigation strategy across all benefit costs will mitigate risk for the MCPs while not impacting beneficiaries' continuity of care. Additionally, CMS strongly recommends that states implement an adequately narrow and symmetrical risk corridor. This strategy will provide financial protection to the MCPs, while also providing some limit on financial risk for states and the federal government in the event benefit costs are significantly different from expected. CMS also recommends the risk mitigation strategy be implemented on all benefit costs (not just COVID-19 costs) as this option would be simpler to implement and would mitigate risk if non-COVID-19 costs differ significantly from projected. However, CMS understands that a two-sided risk mitigation strategy alone may not mitigate all potential risk, therefore, a state should consider, where appropriate, combining this option with an adjustment to the risk-based capitation rates and contract provision(s) ceding COVID-19 related risk-based MCP costs back to the state and covering these costs in a non-risk payment. Additionally, states may consider performing interim risk corridor calculations and making interim reconciliation payments based on emerging data, with final calculations and payments or reimbursements taking place at a later date once complete data are available and consistent with all applicable federal requirements. Finally, states must also ensure they adhere to all applicable federal requirements, including for risk mitigation strategies at 42 C.F.R. § 438.6(b). CMS reminds states that 42 C.F.R. § 438.6(b) requires, among other things, risk mitigation strategies be developed in accordance with 42 CFR §§ 438.4 and 438.5 and generally accepted actuarial principles and practices. The actuarial rate certification and supporting documentation must also describe any risk mitigation arrangement and how it may affect the rates or the final net payments to the managed care plan(s) under the contract as part of complying with 42 C.F.R. § 438.7.

The inclusion of a two-sided risk mitigation strategy that meets the above criteria will help to facilitate an expeditious review of states' rate certifications during rating periods impacted by the public health emergency. CMS provided an example of a narrow and symmetrical two-sided risk corridor as part of the CIB published on May 14, 2020 on managed care flexibilities in response to COVID-19.

We note that CMS recently published the 2020 Medicaid managed care final rule, and this final rule included new requirements for state risk-sharing mechanisms. In accordance with our finalized rule at 42 C.F.R. § 438.6(b)(1), all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, must be documented in the contract and rate certification documents for the rating period prior to the start of the rating period, and must be developed in accordance with § 438.4, the rate development standards in § 438.5, and generally accepted actuarial principles and practices. Risk-sharing mechanisms may not be added or modified after the start of the rating period. This final rule is effective on December 14, 2020.

7. How should states incorporate risk mitigation arrangements within Medicaid managed care contracts and rate development to address the impact of COVID-19?

In accordance with 42 C.F.R. § 438.6(b)(1), states should adequately describe the risk mitigation arrangements in their contract(s), including the methodology, process, and timeline for finalizing the results. States should submit the contract actions that incorporate a risk mitigation arrangement into the states' contracts with Medicaid managed care plans to CMS for review and approval in accordance with 42 C.F.R. § 438.3(a).

Additionally, the risk mitigation arrangements must also be developed in accordance with all applicable requirements in 42 C.F.R. Part 438, including 42 C.F.R. §§ 438.4 and 438.5, and generally accepted actuarial principles and practices. The actuarial rate certification and supporting documentation must describe any risk mitigation arrangement that may affect the rates or the final net payments to the managed care plan(s) under the applicable contract as part of complying with 42 C.F.R. § 438.7.

States seeking to add or amend an existing risk mitigation arrangement, including arrangements required as a result of a new or revised state directed payment to address the impacts of the public health emergency during a rating period already in effect, must submit both a contract amendment and a revised actuarial rate certification or addendum, in accordance with federal requirements. If there are no other material impacts on the capitation rates, the revised rate certification could be limited to incorporating the necessary documentation related to the risk mitigation strategy into the rate certification. Further details on CMS' documentation expectations for risk mitigation strategies in all rate certifications are outlined in Section I, item 4.C. of the most recent Medicaid Managed Care Rate Development Guide.

We note that CMS recently published the 2020 Medicaid managed care final rule, and this final rule included new requirements for state risk-sharing mechanisms. In accordance with our finalized rule at 42 C.F.R. § 438.6(b)(1), all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, must be documented in the contract and rate certification documents for the rating period prior to the start of the rating period, and must be developed in accordance with § 438.4, the rate development standards in § 438.5, and generally accepted actuarial principles and practices. Risk-sharing mechanisms may not be added or modified after the start of the rating period. This final rule is effective on December 14, 2020.

8. What factors should states consider when they seek to move COVID-19 related costs from a risk-based managed care plan to the state, using a non-risk payment outside a capitation payment?

CMS understands the significant level of uncertainty surrounding future COVID-19 costs. There may also be other non-COVID-19 related costs that may have a level of uncertainty due to utilization changes caused by COVID-19 (e.g., delays in elective care, etc.). In addition, CMS acknowledges that it is difficult to prospectively include costs associated with the COVID-19 public health emergency in the Medicaid managed care risk-based capitation rates until significantly more information is known about the impact of the virus on healthcare costs and utilization.

In light of this uncertainty, CMS recommends that states concerned about not being able to account for costs associated with COVID-19 in capitation rate development consider covering such costs on a non-risk basis. This option could be accomplished as either a separate non-risk contract with a prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP) (see the definition of "non-risk contract" at 42 C.F.R. § 438.2) or as an amendment to a state's existing risk-based managed care plan contracts to include a non-risk payment.

Under this approach, states could either cover (1) all COVID-19 service costs; or (2) all service costs for beneficiaries with a COVID-19 diagnosis on a non-risk basis. States that choose to amend their existing risk-based Medicaid MCP contracts should reimburse MCPs separately for these non-risk costs outside of the risk-based capitation rates. In addition, if a state is seeking to cover such costs on a non-risk basis, the state and its actuary will also need to determine if the rate certification adequately reflects services to be covered within the risk-based contract and that it excludes the services ceded to the state (i.e., to address any services and activities or plan functions previously included in capitation rate development that now need to be removed and paid on a non-risk basis). Contracts that contain non-risk elements must be clearly drafted to identify the specific services and costs that are paid by the State on a non-risk basis and must comply with applicable requirements in federal statute and regulation, including in 42 C.F.R. Part 438.

Covering such costs on a non-risk basis addresses the challenges of accounting for these costs in capitation rate development given the uncertainty and lack of data while mitigating the impact to the continuity of care for beneficiaries. CMS would also strongly recommend combining use of a non-risk contract or non-risk payment for certain costs, populations or benefits with a two-sided risk mitigation strategy on all risk-based benefit costs to reduce the risk to the state and federal government if remaining costs are significantly lower than projected.

However, states' ability to cover such costs on a non-risk basis will depend on being able to identify relevant costs and/or beneficiaries accurately in the existing MCP contract(s) to carve them out into a new contract or new contract provision. The state would need to amend their contracts with such MCPs to clearly define the benefits the MCPs must cover on a risk basis and the benefits (or populations) that are excluded from capitation rates and will be covered on a non-risk basis. For a state that chooses to amend existing contracts to include a non-risk payment or to enter into a non-risk contract, the state must comply with upper payment limits

outlined at 42 C.F.R. § 447.362 consistent with the requirements for non-risk contracts and separately identify administrative and medical assistance costs to comply with 42 C.F.R. § 438.812 as well as ensure administrative costs and activities associated with the benefits covered on a non-risk basis are also carved out of the risk-based capitation rates.

If a state is seeking to cover such costs on a non-risk basis during a rating period already in effect and has already submitted a rate certification to CMS, the state and its actuary will also need to determine if a rate amendment is necessary (i.e., to address any services and activities or plan functions previously included in capitation rate development that now need to be removed and paid on a non-risk basis). The state will need to work with their actuary to determine if the actuarially sound capitation rates need to be changed. States currently have the authority to make de minimis rate adjustments to their managed care capitation rates under 42 C.F.R. § 438.7(c)(3) if these adjustments result in an increase or decrease to the capitation rate per rate cell of up to 1.5 percent. If the expected effect on capitation rate development would have an increase or decrease of more than 1.5 percent per rate cell, the state will need to submit a rate amendment to address this change.

9. When can states utilize the de minimis rate adjustments in Medicaid managed care to address the impact of COVID-19?

In accordance with 42 C.F.R. § 438.7(c)(3), states have the authority to make de minimis rate adjustments to their actuarially sound Medicaid managed care capitation rates. This approach provides states the flexibility to make small programmatic changes while minimizing state administrative burden and upholding principles of actuarial soundness.

These de minimis adjustments may increase or decrease the most recently certified actuarially sound capitation rates per rate cell up to 1.5 percent within the rating period, and do not require the state to submit a revised rate certification. States should submit a contract amendment to effectuate any rate adjustment as the final capitation rates must be specifically identified in the managed care plan contracts in accordance with 42 C.F.R. § 438.3(c)(1). CMS also expects states to provide documentation of how this de minimis rate adjustment ensures compliance with 42 C.F.R. § 438.7(c)(3), including the percentage change of the rate adjustment per rate cell in comparison to the most recently certified actuarially sound capitation rates and an assurance that the state has not previously utilized this flexibility within the applicable rating period.

To implement capitation rate adjustments that result in an increase or decrease of more than 1.5 percent from the most recently certified capitation rates for any rate cell, states must submit a revised rate certification or rate amendment and contract amendment. The revised rate certification or rate amendment must address and account for all differences from the most recently certified rates.

10. What should states and their actuaries consider when setting Medicaid managed care capitation rates during rating periods that overlap the public health emergency, and what should be documented in the rate certification?

CMS expects that states and their actuaries consider applicable state specific, and other applicable national or regional, data that is available when the actuary develops actuarially sound capitation rates for rating periods that overlap the public health emergency. CMS expects that states and actuaries consider this data in order to make an informed decision on whether to include any adjustments for COVID-19 specific costs, or adjustments to other projected costs to reflect the indirect impacts of COVID-19 costs or savings, in rate development.

In accordance with 42 C.F.R. §§ 438.4 and 438.5 and generally accepted actuarial principles and practices, as states develop capitation rates for rating periods impacted by the public health emergency, CMS expects that states and their actuaries evaluate if rate development assumptions should be included that account for the direct and indirect impacts of COVID-19. States and their actuaries should evaluate all state specific, and other applicable national or regional, data that is available, including COVID-19 cases, Medicaid eligibility and enrollment changes, utilization implications, deferred caseload, etc. Even as data for the initial periods of the public health emergency begins to emerge, CMS continues to recognize the significant level of uncertainty that exists around the future impact of the COVID-19 pandemic, including direct and indirect costs and savings, such as new treatments and potential vaccines, deferred care, expanded coverage of telehealth, etc.

For rates developed at the beginning of the public health emergency, it may have been appropriate to continue monitoring the situation before making any specific adjustments to the rates. However, as states develop rates for their next rating period, CMS does not believe it is reasonable for capitation rates to be developed absent any evaluation and consideration for the COVID-19 public health emergency.

CMS' expectation is that the state's actuary describes within the rate certification the evaluation the state and its actuary conducted, and the rationale for the assumptions the state and its actuary did or did not include in rate development related to the COVID-19 public health emergency. This documentation expectation is consistent with Section I, Item 1.B.i and Item 2.B.iii of the most recent Medicaid Managed Care Rate Development Guide.

11. How will CMS consider the effects of COVID-19 in its actuarial review of Medicaid managed care rate development during rating periods impacted by the public health emergency?

Section 1903(m) of the Act and 42 C.F.R. § 438.4 require that Medicaid managed care capitation rates be actuarially sound, meaning that the capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract. In accordance with 42 C.F.R. §§ 438.4(b) and 438.7(a), states must submit all rate certifications to CMS and CMS reviews and, as appropriate, approves the capitation rates included in these rate certifications as actuarially sound. CMS will review and

approve actuarially sound capitation rates consistent with generally accepted actuarial practices and principles while acknowledging the significant uncertainty related to the COVID-19 public health emergency.

12. As CMS has delayed 2019 Medicare cost reporting due dates for hospitals, how does this impact states' base amount calculation for hospital pass-through payments for 2021 in Medicaid managed care?

As outlined in the fact sheet for CMS Flexibilities to Fight COVID-19 for hospitals, CMS is delaying the filing deadline of certain cost report due dates due to the COVID-19 outbreak. CMS is currently authorizing delay for the following fiscal year end (FYE) dates. CMS will delay the filing deadline of FYE 10/31/2019 cost reports due by March 31, 2020 and FYE 11/30/2019 cost reports due by April 30, 2020. The extended cost report due dates for these October and November FYEs will be June 30, 2020. CMS will also delay the filing deadline of the FYE 12/31/2019 cost reports due by May 31, 2020. The extended cost report due date for FYE 12/31/2019 will be July 31, 2020.

Hospital pass-through payments included in Medicaid managed care capitation rates are subject to a "lesser of" requirement of either a percentage of a base amount calculation or the historical payment amount as stipulated in 42 C.F.R. § 438.6(d)(1)(i). The base amount identifies the aggregate difference of a Medicare equivalent amount and the Medicaid paid amount for inpatient and outpatient hospital services utilized by eligible populations in managed care, and is calculated using data for the 12-month period immediately two years prior to the rating period as outlined in 42 C.F.R. § 438.6(d)(2)(i)-(ii).

As states' rating periods and data sources vary, CMS encourage states to reach out to CMS via the MMCratesetting@cms.hhs.gov mailbox if they have questions or concerns regarding the impact that the delay in these 2019 Medicare cost reports will have on the state's base amount calculation for hospital pass-through payments. As a general rule, consistent with 42 C.F.R. § 438.6(d)(2)(iv), CMS aims to ensure consistency between pass-through payments in Medicaid managed care with the upper payment limit requirements in 42 C.F.R. part 447.

13. When a state seeks to utilize a state directed payment to address the impacts of the public health emergency in Medicaid managed care, what are the requirements for a risk mitigation strategy?

States may direct Medicaid managed care plan expenditures to providers under certain circumstances. These payments can assist states in furthering the goals and priorities of their Medicaid programs, including a state's response to the COVID-19 public health emergency. As outlined in the CIB published on May 14, 2020, and described in the response to a related question in the Managed Care Contracts and Rates section, when a state submits a new or amended state directed payment proposal to address the public health emergency under the review process outlined in the CIB, a state is required to implement a two-sided risk mitigation strategy if a two-sided risk mitigation is not already currently in place. States must also ensure they adhere to all applicable federal requirements, including for risk mitigation strategies at 42 C.F.R. § 438.6(b).

When states direct payments to providers to specifically respond to the public health emergency, states may utilize the flexibilities outlined in the framework described in Section 3 of the May 14, 2020 CIB only if states also adhere to all standards outlined in this framework. However, if states are not seeking to utilize those flexibilities, states can utilize CMS' standard review process for state directed payments. Under CMS' standard review process, the flexibilities described in the May 14, 2020 CIB are not available, and states must complete the standard state directed payment preprint and comply with all of CMS' standard review requirements for state directed payments under 42 C.F.R.§ 438.6(c).

CMS notes that risk mitigation strategies are not required when the state submits a state directed payment tied to retainer payments authorized under section 1915(c)(4)(B) of the Act. CMS does not believe a risk mitigation strategy for retainer payments is required as these payments are specifically linked to the delivery of services specified in an individual's person-centered service plan, are made only when qualifying circumstances prevent an individual from receiving those services, and the underlying services are already included in the managed care contracts and rates.

We note that CMS recently published the 2020 Medicaid managed care final rule, and this final rule included new requirements for state risk-sharing mechanisms. In accordance with our finalized rule at 42 C.F.R. § 438.6(b)(1), all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, must be documented in the contract and rate certification documents for the rating period prior to the start of the rating period, and must be developed in accordance with § 438.4, the rate development standards in § 438.5, and generally accepted actuarial principles and practices. Risk-sharing mechanisms may not be added or modified after the start of the rating period. This final rule is effective on December 14, 2020.

14. Should the measurement period for a risk mitigation strategy implemented to mitigate the impact of the public health emergency in Medicaid managed care (either in the context of a state directed payment or not) align with the state's rating period or target a more specific timeframe?

CMS believes states in negotiation with their managed care plans are in the best position to determine a reasonable and appropriate measurement period for the risk mitigation strategy based on the unique circumstances of the public health emergency and its impact on the Medicaid beneficiaries enrolled in managed care in their states.

While CMS generally expects that most risk mitigation strategies would be implemented to align with the full duration of the state's 12-month rating period, it is possible that states (and their actuaries) may find it reasonable to implement a risk mitigation strategy for a period of time that does not align with the full duration of the rating period. For example, if a state implements a state directed payment to respond to COVID-19 in the last quarter of their state fiscal year, the state may find it reasonable to design the required risk mitigation strategy to align with the implementation of the state directed payment. If the state is approved under § 438.6(c) to continue that state directed payment into the next fiscal year, CMS believes it would also be reasonable for the state to maintain the risk mitigation strategy in the next contract rating period.

CMS believes that states in negotiation with their managed care plans are in the best position to determine the strategy that best provides protection to states and their plans during the public health emergency.

States must also ensure they adhere to all applicable federal requirements, including for risk mitigation strategies at 42 C.F.R. § 438.6(b). The rate certification should include documentation describing the state's risk mitigation strategy as outlined in Section I, item 4.C. of the most recent Medicaid Managed Care Rate Development Guide, and include the state's rationale for the measurement period utilized for the state's risk mitigation strategy if different from the state's 12-month rating period.

We note that CMS recently published the 2020 Medicaid managed care final rule, and this final rule included new requirements for state risk-sharing mechanisms. In accordance with our finalized rule at 42 C.F.R. § 438.6(b)(1), all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, must be documented in the contract and rate certification documents for the rating period prior to the start of the rating period, and must be developed in accordance with § 438.4, the rate development standards in § 438.5, and generally accepted actuarial principles and practices. Risk-sharing mechanisms may not be added or modified after the start of the rating period. This final rule is effective on December 14, 2020.

B. Quality Measurement

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

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

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

CMS recognizes that the current COVID-19 pandemic is likely to affect clinical practices, and the timely and accurate reporting of quality data such that states may need or want to revise their

contractual quality measurement requirements. Below are some of the common ways states implement and incentivize quality measurement in their managed care programs and issues to consider during this public health emergency.

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

- **Incentives:** Under 42 C.F.R. § 438.6(b)(2), states can implement an incentive arrangement, as long as total payment under the contract is not in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement. An incentive arrangement is an amount over and above the capitation rates the managed care plan was paid for meeting targets specified in the contract. Incentive payments are **in addition** to the actuarially sound capitation rates, so while changes in clinical protocols or access are likely to affect a plan's ability to earn the incentive payment, they do not affect the actuarial soundness of the underlying rates. States may elect to reexamine the specified targets for plans to earn the incentive payment; if a state chooses to do this, the state must submit a contract amendment and depending on the nature of the change, a rate certification amendment.

- **State-Directed Payments:** Under 42 C.F.R. § 438.6(c), states are prohibited from directing how a managed care plan pays its providers except for those payment methodologies that have been approved and reviewed by CMS to be in compliance with 42 C.F.R. § 438.6(c). For states that have approved directed payment proposals for this rating period that condition payment to providers upon performance on specific quality measures, states may want to reexamine these payment arrangements to determine if changes are necessary or desired in light of the COVID-19 emergency. If a state determines changes are necessary, states will need to submit an amended directed payment preprint and, depending on the nature of the change(s), contract and rate certification amendments.

- **General Contract Requirements and Penalties:** In addition to the examples provided above, states may have several other contract requirements related to plan performance or quality measures, such as quality assessment and performance improvement (QAPI) requirements. Some of these requirements may result in penalties imposed on the plan(s) for failing to meet a certain performance level. It is within state discretion to revise their contracts to remove or lessen such penalties; however, states will need to submit contract amendments to reflect any revisions. Depending on the nature of the change, a rate

certification amendment may be needed if such changes are expected to have a material impact on the actuarially certified rates.

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

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

Some states contract with External Quality Review Organizations (EQROs) to conduct the EQR-related activities, while other states undertake these EQR-related activities themselves. Given the extenuating circumstances presented by COVID-19, health plans may find it challenging to submit accurate data to states and to do so on time. Health plans may also request that external quality review activities be limited if they would compromise the ability to maintain social distancing, such as encounter data validation or performance measurement validation that require onsite medical chart reviews. CMS encourages states to work with EQROs and health plans to rely as much as possible on quality data that can be submitted and validated electronically, consistent with the EQR protocols per 42 C.F.R. § 438.350(e) and 438.352, to enable quality activities to continue while minimizing the public health impacts of COVID-19. Where states determine that some accommodations may be appropriate, CMS recommends that states work with their quality measurement staff to determine the appropriate accommodations and to submit a contract amendment.

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

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

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

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

States can hold this public comment and consultation process at any time as long as it occurs prior to submitting the state quality strategy to CMS. We understand that states may be

concerned that holding this process during the COVID-19 pandemic would yield little stakeholder engagement and, in turn, have concerns that delaying the comment process will result in missed deadlines. However, public comment and tribal consultation are required. States should contact CMS through the Managed Care technical assistance mailbox at ManagedCareQualityTA@cms.hhs.gov if they have questions regarding the public comment and consultation process or need more time due to the COVID-19 PHE.

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

Annually, states are required to conduct an EQR, which consists of three mandatory EQR-related activities: Validation of Performance Measures, Validation of Performance Improvement Projects and a compliance review against elements found in 42 C.F.R. Part 438, subpart D.[18] Upon the completion of the EQR-related activities and EQR, an independent third party External Quality Review Organization (EQRO) must analyze the data and provide findings in an annual EQR technical report. This report is required to be submitted to CMS under Medicaid regulations at 42 C.F.R. § 438.364(c)(1) by April 30th of each year.

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

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

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

C. Miscellaneous

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

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

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

requirements, states will need to submit a contract amendment. CMS will prioritize our review and approval of COVID-19 related state plan or contract amendments.

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

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

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

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

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

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

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

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

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

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

States that utilize risk mitigation mechanisms must describe such arrangements in their contract(s) and they must be developed in accordance with all requirements in 42 C.F.R. Part 438, including §§ 438.4 and 438.5, and generally accepted actuarial principles and practices. The rate certification and supporting documentation must also describe any risk mitigation and how it may affect the rates or the final net payments to the health plan(s) under the applicable contract as part of complying with § 438.7. States should follow the guidance in the Medicaid Managed Care Rate Development Guide for documentation for risk-sharing mechanisms. See https://www.medicaid.gov/Medicaid/downloads/2019-2020-medicaid-rate-guide.pdf.
States submitting requests to retroactively amend or implement risk mitigation strategies will need to submit both contract and rate amendments as soon as possible to CMCSManagedCareCOVID19@cms.hhs.gov. CMS is working to prioritize and expedite reviews of COVID-19 related managed care actions. To facilitate this, CMS recommends that states submit only managed care actions needed to respond to COVID-19 to this mailbox and use normal processes for other managed care actions.

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

VI. Information Technology

A. Funding

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

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

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

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

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

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

States may request enhanced Mechanized Claims Processing and Information Retrieval Systems FFP for information technology (IT) expenditures that support the design, development, and installation (DDI) or operations of mechanized claims processing and information retrieval systems that constitute the Medicaid Enterprise System (MES). That includes expenditures that support telework infrastructure so that state staff or contractors can continue MES DDI or

operation remotely. CMS understands and strongly supports the central role that telework may play in a state's ability to develop, enhance, and operate the MES during the COVID-19 public health emergency, as well as to continue to improve and maintain the efficient operation of the MES thereafter.

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

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

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

4. Can the 100 percent FFP available for the new optional COVID-19 testing group be used

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

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

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

B. Health Information Exchange

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

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

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

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

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

CMS is available to provide technical assistance regarding approaches to rapidly scale telehealth technologies. If states are granted waivers under section 1135 for federal requirements related to

provider location or provider enrollment (https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf), complementary technology investments may be appropriate. CMS advises states to leverage existing infrastructure and technology. States should discuss any patient-facing telehealth proposals with their MES State Officer. Please reach out to your MES State Officer for information on submitting an FFP request under 45 C.F.R. § 95.624.

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

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

States should ensure that systems are coded to process the new codes and that providers have received updated billing guidance. States should report COVID-19 related procedure codes and diagnosis code information to T-MSIS as it is reported on the original claims form. Please contact your CMS Systems Officer with further questions. For information on COVID-19 testing HCPCS codes, please see CMS's February 13, 2020 public health news alert. For information on COVID-19 related diagnosis codes, please see the CDC's announcement regarding new diagnosis coding effective April 1, 2020.

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

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

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

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

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

There are three data elements in the T-MSIS Claims files for state reporting of COVID-19 diagnostic products and testing-related services.
(1) In the CLAIM-HEADER-RECORD, a value of "17" should be reported in PROGRAM-TYPE for any COVID-19 diagnostic product or COVID–19 testing-related services as specified by the FFCRA;
(2) In the CLAIM-LINE-RECORD, a value of "136" should be reported in TYPE-OF-SERVICE, and a value of "107" should be reported in BENEFIT-TYPE for any COVID-19 diagnostic product as specified by the FFCRA;
(3) In the CLAIM-LINE-RECORD, a value of "137" should be reported in TYPE-OF-SERVICE, and a value of "108" should be reported in BENEFIT-TYPE for any COVID–19 testing-related services as specified by the FFCRA.
Additional information and comprehensive reporting guidance will be shared on the T-MSIS Coding Blog.

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

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

D. Telework

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

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

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

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

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

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

E. Miscellaneous

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

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

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

VII. Miscellaneous

A. Quality Reporting

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

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

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

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

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

- If an alternate method is not feasible and prior year data are not available, please report to CMS that the state was unable to report the measure due to challenges with data collection as a result of the COVID-19 pandemic.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Workforce Issues

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

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

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

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

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

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

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

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

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

Depending on the specificity in the existing Medicaid state plan, a SPA may be necessary to add first responders as testing providers. CMS notes that state laws may have implications for the scope of providers able to perform these activities. In addition, third party liability provisions

apply for services covered across the Medicaid program, and states could utilize existing mechanisms to ensure compliance.

C. 1115 Demonstrations

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

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

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

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

3. Can an amendment request be retroactive?

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

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

Yes, this alternate proposal would meet the public forum requirements for the section 1115 demonstration in the context of this declared public health emergency. States are reminded of their obligation to comply with applicable civil rights and other laws pertaining to accessibility, and should make these alternate public hearings as accessible as possible in the current

environment. As another alternative, if a state would like to delay the post-award forum until a later time, CMS would also offer an extension of the deadline to meet this deliverable; a state interested in this option should contact the CMS-designated contact person for the demonstration to discuss the parameters of an extension.

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

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

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

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

D. Other

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

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

Regarding managed care reporting requirements, CMS is able to utilize enforcement discretion for managed care reporting requirements under 42 C.F.R. Part 438, with minimal exceptions (actuarial soundness, payments, and Medical Loss Ratio (MLR) requirements). The reporting

requirements for MLR at 42 C.F.R. § 438.8(k) are determined by the state, as long as it is within 12 months of the end of the reporting year. CMS believes this provides states an ample window to meet MLR reporting requirements.

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

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

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

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

CMS is working closely with the CDC to establish the appropriate coding practices related to COVID-19. CMS developed the first HCPCS code (U0001) to pay for claims and track testing for COVID-19. This code is used specifically for CDC testing laboratories to test patients for SARS-CoV-2. CMS has since added a second HCPCS billing code (U0002) which allows

laboratories to bill for non-CDC lab tests for SARS-CoV-2/2019-nCoV (COVID-19). Medicare claims processing systems will be able to accept these codes starting on April 1, 2020, for dates of service on or after February 4, 2020. These codes serve to increase more testing and improve tracking. Because these HCPCS codes allow those labs conducting the tests to bill for the specific test instead of using an unspecified code, a descriptor is not required for Health Insurance Portability and Accountability Act (HIPAA) compliance.

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

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

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

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

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

Additionally, states may use contractors to perform certain Medicaid agency administrative functions, provided that the state exercises appropriate oversight consistent with federal

regulations at 42 C.F.R. § 431.10. For example, states can use contractors to operate call centers, input data from paper applications into an eligibility system or serve as application assistors. For CHIP, states have broad flexibility to delegate functions to contractors as long as they maintain oversight.

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

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

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.

Additional Questions

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