

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

A. Emergency Preparedness and Response

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

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

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

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

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

Appendix K also provides states with opportunities to:

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

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

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

Please see attached link for instructions and template:

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

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

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

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

NEW

4. 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.

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.

B. Eligibility and Enrollment Flexibilities

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

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

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

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

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

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

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

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

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

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

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

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

Under the Medicaid state plan, states can also elect to extend coverage to certain additional

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

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

NEW

5. 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 Families First Coronavirus Response Act (FFCRA), Pub L. No. 116-127 (2020), 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 Question B.7. 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 modified adjusted gross income (MAGI) methodologies. See FAQ Question B.1. for additional information related to presumptive eligibility.

6. 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.

7. 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 Federal medical assistance percentage (FMAP) provided under section 6008(a) of the FFCRA, through the end of the month in which the public health emergency ends, pursuant to section 6008(b)(3) of the FFCRA, states may not terminate individuals enrolled for Medicaid benefits as of March 18, 2020, or determined eligible on or after that date. This includes continuing coverage for individuals who experience a change in circumstances that impacts eligibility or are determined eligible based on self-attestation for certain criteria, if the state has adopted post-enrollment verification of the criterion. Thus, if a state is able to process a change in circumstances prior to the end of the month in which the public health emergency ends, and determines that a beneficiary no longer meets all eligibility criteria for coverage, the state must postpone taking adverse action until after the end of the month in which the emergency ends in order to qualify for the temporary FMAP increase. See also Families First Coronavirus Response Act – Increased FMAP FAQ B.6, available at <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf>.

C. Benefit Flexibilities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEW

11. 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.

12. 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.

13. 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.

D. Cost-Sharing Flexibilities

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

emergency?

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

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

NEW

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

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

Even if a state does not suspend Medicaid and CHIP premiums, we note that in order to be eligible for the temporary FMAP increase under section 6008 of the Families First Coronavirus Response Act, states cannot disenroll Medicaid beneficiaries for failure to pay premiums. Section 6008(b)(2) of the FFCRA, as amended by section 3720 of the 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.

E. Financing Flexibilities

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

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

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

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

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

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

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

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

When requested by the state, FFP for IT systems can be provided in emergencies. The FFP request should include: (1) A brief description of the equipment and/or services to be acquired and an estimate of their costs; and (2) a brief description of the circumstances driving the state's

need and the harm that will be caused if the state does not immediately acquire the requested equipment and/or services. FFP approved under this authority would be available from the date the state actually acquires the equipment and services. Additional information regarding this process can be found at 45 C.F.R. § 95.624.

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

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

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

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

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

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

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

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

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

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

NEW

10. 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) home and community based services (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>.

11. 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.

12. How will CMS address Upper Payment Limits (UPL) 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.

13. 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.

14. 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.

15. 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.

16. 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.

17. 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.

18. 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.

19. 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.

20. 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.

21. 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.

22. 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.

23. 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.

24. 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.

25. 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.

F. Workforce Flexibilities

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

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

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

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

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

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

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

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

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

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

G. Miscellaneous

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

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

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

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

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

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

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

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

On February 6, 2020, CMS also gave Clinical Laboratory Improvement Amendments (CLIA)-certified laboratories information about how they can test for SARS-CoV-2. To read more about those efforts, visit: <https://www.cms.gov/medicareprovider-enrollment-and->

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

NEW

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.

H. Managed Care Flexibilities

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

The Trump Administration encourages states to take advantage of broad flexibility to deliver services via telehealth in Medicaid and CHIP to help prevent the spread of the Coronavirus as is discussed at <https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html> and <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/covid19/index.html>.

The available telehealth flexibility allows Medicaid beneficiaries to receive a wide range of healthcare services from their providers without having to travel to a health care facility so that they can limit risk of exposure and spread of the virus. In fee-for-service, states are not required to submit separate state plan amendments for coverage or reimbursement of telehealth services if they decide to reimburse for telehealth services in the same manner or at the same rate paid for face-to-face services. Medicaid guidelines require all providers to practice within the scope of their State Practice Act, and states may have laws and regulations that govern the scope of telemedicine coverage. In fee-for-service, a state plan amendment would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.

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

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

Regarding Medicaid managed care payment, under 42 C.F.R. §§438.3(c)(1)(ii) and 438.4, final capitation rates must be actuarially sound and based only upon services covered under the state plan or waiver authority and represent a payment amount adequate to allow the managed care organization (MCO), prepaid inpatient health plan (PIHP) or prepaid ambulatory health plan (PAHP) to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements. If a state determines a retroactive adjustment to capitation rates under one or more of its managed care contracts is necessary for costs eligible for reimbursement, such as telehealth-related infrastructure costs, retroactive adjustments must be

certified by an actuary in a revised rate certification and submitted as a contract amendment in accordance with 42 C.F.R. §438.7(c)(2). The rate certification must describe the rationale for the adjustment and the data, assumptions and methodologies used to develop the magnitude of the adjustment. For additional information about telemedicine, visit:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEW

6. 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.

7. 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.

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- **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.
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- **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.

8. 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.

9. 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.

10. 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.

11. 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>.

I. 1115 Demonstration Flexibilities

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

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

NEW

J. Fair Hearing Flexibilities

1. What flexibilities are available for Medicaid fair hearings?

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

- Suspend adverse actions for individuals for whom the state has completed a determination but either: (1) has not yet sent the notice; or (2) who the state believes likely did not receive the notice. This is consistent with 42 C.F.R. § 431.211, which requires the state to provide at least 10-days advance notice before taking adverse

action. See also Families First Coronavirus Response Act – Increased FMAP FAQ B.9 regarding the provision of continuous coverage during the emergency period as a condition for receiving the increased FMAP under that Act.

- Delay scheduling fair hearings and issuing fair hearing decisions under 42 C.F.R. § 431.244(f)(4)(i)(B), which allows states to delay taking final administrative action when there is an emergency beyond the state’s control. States should prioritize completing hearings that meet the standard for an expedited fair hearing under 42 C.F.R. § 431.224. States may offer to continue benefits to individuals who are requesting a fair hearing if the request comes later than the date of the action under 42 C.F.R. § 431.230.
- Hold fair hearings via video conferencing or telephone, provided states adhere to other fair hearing requirements (42 C.F.R. part 431, subpart E), including ensuring that the hearing system is accessible to persons who are limited English proficient and persons who have disabilities (see 42 C.F.R. §§ 431.205(e) and 435.905(b)).
- Reinstate services or eligibility if discontinued because the beneficiary’s whereabouts were unknown due to displacement, after the beneficiary’s whereabouts become known (if still eligible), consistent with 42 C.F.R. § 431.231(d).

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

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

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

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

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

NEW

K. Health Information Exchange Flexibilities

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 Medicaid Enterprise Systems (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 Medicaid Enterprise Systems (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.

NEW

L. COVID-19 T-MSIS Coding Guidance

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?

Last Updated April 2, 2020

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.

Additional Questions

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