

**COVID-19 Frequently Asked Questions (FAQs)
for State Medicaid and Children’s Health Insurance Program (CHIP) Agencies¹**

Emergency Preparedness and Response

Are states granted any flexibilities with regard to public notice, effective dates and the submission of state plan amendments (SPA) during the Public Health Emergency (PHE) period?

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

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

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

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

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

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

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

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

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

Eligibility and Enrollment Flexibilities

Basic Health Program

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

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

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

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

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

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

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

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

Flexibility to modify eligibility verification policies in BHP, including accepting self-attestation and/or extending the 90-day reasonable opportunity period, will vary depending on whether the

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state elected to follow the Medicaid or Exchange eligibility verification process. *See* 42 C.F.R. § 600.345.

States that elect to follow the Medicaid eligibility verification process may modify their verification policies to use attestation for eligibility factors, unless the statute requires other verification (such as for citizenship and immigration status); to accept attested information for an initial determination and enrollment, and conduct other verification processes post-enrollment; or to change their reasonable compatibility standard for verification of income. See more information in FAQ # II.F.1. (available here <https://www.medicaid.gov/state-resource-center/Downloads/covid-19-faqs.pdf>). Regarding citizenship and immigration status, electronic verification is available through the Social Security Administration and the Department of Homeland Security US Citizenship and Immigration Services Systematic Alien Verification for Entitlement (SAVE) program. For otherwise eligible individuals who attest to U.S. citizenship or a lawfully present immigration status, but whose U.S. citizenship or lawfully present immigration status cannot be verified electronically, a reasonable opportunity period is provided while the verification process is completed. At state option, a good faith extension may be available for non-citizens verifying their lawfully present immigration status under 42 C.F.R. § 600.345, cross referencing 42 C.F.R. § 435.956(b)(2)(ii)(B).

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

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

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

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

Presumptive Eligibility

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

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

Can states change their hospital PE performance standards?

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

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

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

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

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

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

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

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

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

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

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

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

If the individual is subsequently not enrolled in Medicaid beyond the PE period, either because the individual did not submit an application for Medicaid prior to the end of the month following the month in which the PE determination was made, or the individual submitted an application but was determined to be ineligible for Medicaid, and the state determines, based on a regular application, that the PE income determination by the hospital was too high, the state must adjust its payment to the institution for the coverage provided during the PE period. If the state determines that the hospital underestimated the individual’s income, the state may not adjust the payment to the institution, because such an adjustment would constitute a retroactive reduction in the individual’s medical assistance, which is not permitted. FAQ #B.8 of the Families First

Coronavirus Response Act – Increased FMAP FAQs found here

<https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf>

explains that individuals who have been determined presumptively eligible for Medicaid, but who are not later determined eligible based on a regular Medicaid application, are not subject to the requirements for continuous coverage described under section 6008 of the FFCRA.

Verification

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

States are generally able to begin furnishing Medicaid or CHIP benefits to many applicants based on self-attested information and then follow up with required verification following the individual's affirmative eligibility determination and enrollment, as described in more detail below. States may elect such "post-enrollment verification processes" for the duration of the PHE by using the disaster-related verification plan addendum discussed in FAQ # II.F.7., available at <https://www.medicaid.gov/state-resource-center/Downloads/covid-19-faqs.pdf>. States should be advised, however, that once an individual is enrolled for benefits in the state's Medicaid program, the state must continue to furnish benefits through the end of the month in which the public health emergency ends, even if the post-eligibility verification processes establishes that the individual does not meet all eligibility requirements—except for ineligibility due to residency—in order to claim the temporary FMAP increase available under section 6008(b)(3) of the FFCRA.

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

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

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

When are states required to conduct post enrollment verification?

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

For verification processes not required under the statute but adopted by the state in its verification plan (such as requiring proof of self-employment income), states also can elect to make a determination of eligibility based on attested information and complete these state verification processes post enrollment. See FAQ # II.F.7., available at <https://www.medicaid.gov/state-resource-center/Downloads/covid-19-faqs.pdf>, regarding documentation of state verification policies.

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

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

NEW FAQs – Released May 5, 2020

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

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

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

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

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

No. If a state enrolls an individual based on self-attested information under the special circumstances exception provided at 42 C.F.R. § 435.952(c)(3), due to the applicant's inability to provide documentation, no additional post-enrollment verification is required (as explained in FAQ # II.F.4, available at <https://www.medicaid.gov/state-resource-center/Downloads/covid-19-faqs.pdf>, states must document the reliance on attested information under 42 C.F.R. § 435.952(c)(3) in the individual's case record). At the beneficiary's next regular renewal, or following a change in circumstances, the state would verify eligibility in accordance with its usual processes, applying the special circumstances exception again only if the conditions warranted. As a state option, states also have flexibility to suspend or modify periodic data matching between initial application and regular renewals. To suspend periodic data matching

for the period of the emergency, states can submit a Medicaid Disaster Relief MAGI-Based Verification Plan Addendum for MAGI-based beneficiaries. For beneficiaries excepted from MAGI-based methodologies, states must clearly document any changes in the state's verification policies and procedures, and the period for which such changes will be in effect, for MAGI-excepted determinations. See FAQ # IL.F.7, available at <https://www.medicaid.gov/state-resource-center/Downloads/covid-19-faqs.pdf>, regarding documentation of state verification policy changes.

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

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

States may use the Medicaid and CHIP MAGI-Based Disaster Relief Verification Plan Addendum (<https://www.medicaid.gov/medicaid/eligibility/downloads/magi-based-verification-plan-addendum-template.docx>) to capture verification policy and procedure changes that the state is implementing only for the emergency period for both MAGI and MAGI-excepted populations. For MAGI-based verifications, states must submit the addendum (or a revised verification plan) to CMS for review. Any changes that a state intends to make to its non-MAGI-based verification policies must be documented in the state's internal policies and procedures, along with the period for which such changes will be in effect. States may include information about non-MAGI changes for an emergency period in the state's MAGI-based Disaster Relief Verification Plan Addendum in the "Other" section if the state chooses to do so.

Application, Enrollment, and Signatures

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

No. Regulations at 42 C.F.R. § 435.907 require that all applications must be signed under penalty of perjury by the applicant, an adult who is in the applicant's household or family, an authorized

representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant. States must accept electronic, including telephonically recorded, signatures and handwritten signatures. A record of the application signature must be stored in the individual's account. There is no flexibility to accept an application without the required signature. Without a signature, the application form is not considered a completed application for state processing.

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

Consistent with regulations at 42 C.F.R. §§ 435.907(f) and 457.330, all initial applications for Medicaid and CHIP must be signed under penalty of perjury. Individuals may receive help from others, including certified application assisters under 42 C.F.R. § 435.908, Exchange Navigators, or authorized representatives, to complete an application for Medicaid or CHIP. While these types of assisters typically provide in-person assistance with applications, CMS recognizes that such assistance may need to be provided by phone during the current public health emergency if offices or other locations are closed or otherwise to minimize in-person contact. If an assister or other individual is completing and submitting an online application on behalf of an applicant, based on information the applicant has provided by phone, for the period of the emergency and subject to state law, the applicant may designate that individual be an authorized representative with limited authority to sign and submit the application on behalf of the applicant. Due to the public health emergency posed by COVID-19 and the urgent need to avoid transmission of COVID-19, for the duration of the COVID-19 public health emergency, CMS will not enforce compliance with requirements at § 435.923(a)(1) that designation of an authorized representative must be signed by the applicant or enrollee, and submitted to the state agency, provided that applicants provide authorization for an assister or other individual to be their authorized representative orally, in writing, or both. A record of such authorization must be submitted by the authorized representative, along with the application. The agency must accept such authorization through any of the available modalities described at § 435.907(a) and must include the record in the applicant's account held by the state Medicaid agency. Assistors or other individuals acting as authorized representatives in these circumstances must also abide by confidentiality and conflict of interest requirements set out in regulation at 42 C.F.R. §§ 435.908(c) and 435.923(e), 45 C.F.R. §§ 155.210(d), 155.225(g)(2), 155.227, and 155.260, and the legal instrument establishing the assister's relationship with the Exchange or authorized representative's role with respect to the Exchange. We believe that this guidance is a statement of agency policy not subject to the notice and comment requirements of the Administrative Procedure Act (APA). 5 U.S.C. § 553(b)(A). For the same reasons explained above, in light of the PHE and the urgent importance of reducing the potential for transmission of COVID-19 through the authorization process, CMS additionally finds that, even if this guidance were subject to the public participation provisions of the APA, prior notice and comment for this guidance is impracticable, and there is good cause to issue this guidance without prior public comment and without a delayed effective date. 5 U.S.C. § 553(b)(B) & (d)(3).

As discussed above, assistors and other individuals serving as an authorized representative must obtain and record authorization from individuals to submit applications on behalf of the applicants they are helping. Options to do so can be found in the Federally Facilitated

Marketplace’s guidance for assisters on “How to Obtain a Consumer’s Authorization before Gaining Access to Personally Identifiable Information (PII)” linked here:

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

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

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

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

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

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

Eligibility

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

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

a group after that date) through the end of the month in which the public health emergency ends, even if the individual ceases to have earned income.

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

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

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

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

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

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

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

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

For the eligibility group described at section 1902(e)(3) of the Act and 42 C.F.R. § 435.225 (sometimes referred to as the “Katie Beckett” group), states may accept self-attestation of the individual's level-of-care need. However, for the eligibility groups described at sections

1902(a)(10)(A)(ii)(VI) and (XXII) of the Act, and, respectively, 42 C.F.R. §§ 435.217 and 435.219, states may not accept self-attestation of level-of-care need. The methods of the level-of-care determinations inherent to these groups are dictated by regulations outside the scope of Medicaid's eligibility regulations.

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

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

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

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

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

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

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

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

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

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

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

Can states modify their post-eligibility treatment-of-income (PETI) rules during the emergency period in a way that increases an institutionalized individual’s patient liability? For example, could a state reduce the personal needs allowance, impose a new reasonable limitation on incurred medical expenses, or reduce an existing home maintenance allowance deduction?

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

Coverage for American Indians and Alaska Natives

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

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

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

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

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

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

Benefit Flexibilities

Laboratories/COVID-19 Testing

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

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

Furthermore, CMS issued an interim final rule with comment period (IFC) on May 1, 2020, amending 42 C.F.R. § 440.30 to offer greater flexibility to states with respect to coverage of COVID-19 tests, in the effort to minimize transmission of COVID-19. During the COVID-19 PHE and any subsequent period of active surveillance (as defined in the IFC), Medicaid coverage is available for certain laboratory tests and X-ray services that do not meet the conditions specified in § 440.30(a) or (b), provided that certain conditions are met. Section 440.30(a) requires that Medicaid-covered laboratory and X-ray services be ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by state law, or ordered by a physician but provided by a referral laboratory. Section 440.30(b) specifies that Medicaid will cover laboratory and X-ray services only if provided in an office or similar facility other than a hospital outpatient department or clinic. Flexibility under the amendments in the IFC is available with respect to

testing to diagnose or detect SARS-CoV-2, antibodies to SARS-CoV-2, or COVID-19, and is available only if the deviation from the conditions specified in § 440.30(a) or (b) is intended to avoid transmission of COVID-19. Provided that this condition is met, the IFC permits states to cover COVID-19 tests conducted in non-office settings such as parking lots. Additionally, the IFC provides states with flexibility to cover laboratory processing of self-collected test systems that the FDA has authorized for home use, if available to diagnose or detect SARS-CoV-2, antibodies to SARS-CoV-2, or COVID-19, even if those self-collected tests would not otherwise meet the requirements in § 440.30(a) or (b), as long as the self-collection of the test is intended to avoid transmission of COVID-19. The IFC offers similar flexibilities for future PHEs resulting from an outbreak of communicable disease and any subsequent periods of active surveillance. The flexibilities available under the IFC will be effective retroactive to March 1, 2020.

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

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

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

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

Dental Coverage

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

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

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

Money Follows the Person (MFP) Program

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

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

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

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

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

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

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

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

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

you have any questions or need technical assistance related to MFP demonstration budget processes.

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

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

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

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

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

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

No, the qualified MFP community settings criteria is a statutory requirement for the MFP program and cannot be modified. Section 6071(b)(6) of the 2005 Deficit Reduction Act (DRA) defines an MFP qualified residence as: “(A) a home owned or leased by the individual or the

individual’s family member; (B) an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual’s family has domain and control; and (C) a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.” CMS will work with MFP grantees to explore other options and considerations to identify resources for increasing MFP qualified residence opportunities.

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

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

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

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

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

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

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

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

Home and Community-Based Services

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

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

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

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

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

States may seek section 1135 waiver authority to modify provisions of home and community-based services (HCBS) programs in accordance with the following parameters:

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

For section 1915(i) state plan HCBS programs, states similarly may request, under section 1135(b)(5) of the Act, to modify the deadline for conducting initial evaluations of eligibility

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required for the section 1915(i) state plan benefit at 42 C.F.R. § 441.715(d) and initial assessments of need to establish a care plan at 42 C.F.R. § 441.720(a). With this modification, these activities would not need to be completed before the start of care.

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

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

Cost-Sharing Flexibilities

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

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

Financing Flexibilities – Upper Payment Limits (UPL)

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

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

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

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

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

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

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

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

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

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

Financing Flexibilities – State Plan

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

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

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

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

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

States have considerable flexibility in establishing payment rates and methodologies for providers under the Medicaid state plan. Payments under the state plan must be consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are

available to the general population in the geographic area, as required under section 1902(a)(30)(A) of the Act. Unless there are limitations on provider payments otherwise specified in statute or regulation, states may make supplemental payments to providers under the Medicaid state plan. States have considerable flexibility in how these payments may be structured, but they must be consistent with section 1902(a)(30)(A) of the Act.

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

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

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

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

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

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

authority to increase provider payments back to the beginning of the PHE and after the public health emergency ends.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Managed Care Flexibilities

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

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

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methods for making retroactive adjustments to capitation rates may be extraordinarily difficult for states to implement at this time.

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

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

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

Information Technology

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

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

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

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

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

Telework

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

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

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

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

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

States that desire technical assistance with rapidly accelerating any of their telework capabilities may contact their Medicaid Enterprise State Systems Officer, who can help with obtaining any applicable authorization for funding and connecting states to other states that have already grappled with the policy, cultural and operations considerations associated with remote work. Reference also FAQ # VII.D.4., available at <https://www.medicaid.gov/state-resource-center/Downloads/covid-19-faqs.pdf>, which has additional information regarding issues involved with temporary office closures.

Data Reporting

Medicaid and CHIP Child and Adult Core Sets

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

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

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

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

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

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- If an alternate method is not feasible and prior year data are not available, please report to CMS that the state was unable to report the measure due to challenges with data collection as a result of the COVID-19 pandemic.

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

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

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

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

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

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

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

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

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

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Where preventive and elective services can be provided through telehealth, CMS encourages states to do so and to include those visits in their Core Sets data submissions where technical specifications allow for them (please refer to the [COVID-19 State Medicaid & CHIP Telehealth Toolkit](#) and FAQ # III.B.1., available at <https://www.medicaid.gov/state-resource-center/Downloads/covid-19-faqs.pdf>, regarding the delivery of telehealth services).

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

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

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

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

EPSDT/416 Reporting

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

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

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

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

No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services provided in the same manner or at the same rate that states pay for face-to-face services. A state plan amendment (SPA) would be necessary to implement any revisions to payment methodologies to account for telehealth costs (please refer to the [COVID-19 State Medicaid & CHIP Telehealth Toolkit](#) and for example, please refer to FAQ # III.B.1., available at <https://www.medicaid.gov/state-resource-center/Downloads/covid-19-faqs.pdf>, regarding the delivery of telehealth services).

How can states request technical assistance specific to EPSDT reporting?

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

Managed Care Quality Strategies & EORO Reporting

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

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

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

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

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

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

Annually, states are required to conduct an EQR, which consists of three mandatory EQR-related activities: Validation of Performance Measures, Validation of Performance Improvement Projects and a compliance review against elements found in 42 C.F.R. Part 438, subpart D.² Upon the completion of the EQR-related activities and EQR, an independent third party External Quality Review Organization (EQRO) must analyze the data and provide findings in an annual EQR technical report. This report is required to be submitted to CMS under Medicaid regulations at 42 C.F.R. § 438.364(c)(1) by April 30th of each year.

² The EQR-related activity for the validation against elements in 42 C.F.R. Part 438, subpart D is only required once every three years.

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

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

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

Statistical Enrollment Data System (SEDS) Reporting

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

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