UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

DEBORAH CARR, BRENDA MOORE, AND MARY ELLEN WILSON Plaintiffs, v. XAVIER BECERRA, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES Defendant.	Civil Action No. 3:22-cv-00988 August 3, 2022

PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND A PRELIMINARY INJUNCTION

As more fully set forth in the accompanying Memorandum of Law, Plaintiffs respectfully request that this Honorable Court grant a temporary restraining order, pursuant to Fed. R. Civ. P. 65(b), against the Defendant with respect to enforcement of his Interim Final Rule ("IFR") under Section 6008 of the Families First Coronavirus Response Act ("Coronavirus Response Act" or "FFCRA"), for plaintiffs Deborah Carr and Brenda Moore, and set down a hearing for Defendant to show cause why a broader preliminary injunction pursuant to Fed. R. Civ. P. 65(b) on behalf of all Plaintiffs should not immediately be granted in light of the Defendant's multiple and ongoing violations of the Administrative Procedures Act ("APA") in the issuance of the IFR and the irreparable harm it has caused and is continuing to cause, as also set forth in the accompanying memorandum.

In support thereof, Plaintiffs aver:

1. Under the Coronavirus Response Act, during the federally-declared public health emergency ("PHE") arising from the COVID-19 pandemic which has been in effect since January of 2020, state Medicaid agencies that accept enhanced federal Medicaid reimbursements are prohibited from terminating anyone from Medicaid, or from reducing their Medicaid benefits, if they were on such benefits on or after March 18, 2020 when the Coronavirus Response Act was passed, whether or not they appear to still be eligible for those benefits, and with only two statutory exceptions to this continuous enrollment requirement: the individual (1) moved out of state or (2) voluntarily asked to be removed from the rolls.

2. In exchange for agreeing to these protections designed to help particularly vulnerable individuals during the PHE, each state has been provided with an extra 6.2% in reimbursements for almost all of their Medicaid expenditures, including for the vast majority of Medicaid enrollees who would remain fully eligible for Medicaid regardless of the Coronavirus Response Act and the PHE.

3. Defendant, contemporaneous with the passage of the Coronavirus Response Act and repeated three times thereafter, issued a series of guidance documents to the public and all state Medicaid agencies making clear that the above two exceptions were the *only* exceptions and that any termination of Medicaid benefits during the PHE that did not fall under one of them would violate the Coronavirus Response Act.

4. Defendant also advised all state Medicaid agencies both contemporaneously with passage and on May 5, 2022 that any "***reduction*** *in medical assistance would be* ***inconsistent with the requirement at section 6008(b)(3) of the FFRCA*** 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." Center for Medicare and Medicaid Services

("CMS"), *COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies* 26 (May 5, 2020) (emphasis added).

5. Plaintiffs, all low-income disabled individuals residing in Connecticut, have been on full-benefit Medicaid on or after March 18, 2020, under the Connecticut Medicaid "expansion" program known as "HUSKY D."

6. These individuals were each accordingly kept on such benefits despite a determination by the Connecticut Department of Social Services ("DSS") that they had qualified for Medicare, which, but for the protections of the Coronavirus Response Act, would normally disqualify them from the HUSKY D program under federal law..

7. Thereafter, under a new IFR published by President Trump's Administration in the Federal Register on November 6, 2022, the Defendant purported to interpret a new-found "ambiguity" in the Coronavirus Response Act which allowed it to create from whole cloth several entirely new exceptions to the continuous enrollment requirements under the Coronavirus Response Act. 85 Fed. Reg. 71142, 71160.

8. The IFR newly authorized or required states to reduce or entirely eliminate Medicaid coverage for individuals who: (1) are eligible for Medicare and financial assistance to pay for out-of-pocket Medicare costs under a limited benefit Medicare Savings Program ("MSP"); (2) are deemed not "validly enrolled" at the time of the passage of the Coronavirus Response Act; or (3) are non-citizens otherwise losing Medicaid coverage because of being in the United States less than five years and no longer being pregnant or a child, 42 C.F.R § 433.400 (c)(2) and (d)(2).

9. The IFR was adopted without affording the public the prior notice and opportunity for comment normally required under the APA, without explaining the source of the new-found

statutory ambiguity it invoked to justify its abrupt about-face on the meaning of Section 6008(b)(3) of the Coronavirus Response Act, and without addressing how cutting people off of Medicaid under 42 C.F.R. § 433.400 was consistent with either the Coronavirus Response Act or the Medicaid Act, or why it was necessary to implement its new rule without adhering to prior notice and comment procedures.

10. Defendant later pronounced to all state Medicaid agencies that these newly created exceptions to the continuous enrollment requirements of the Coronavirus Response Act were not only authorized but mandated by the IFR.

11. Subsequently, each of the plaintiffs, along with at least 6,600 other low-income Connecticut Medicaid enrollees, was terminated from their full-scope Medicaid benefits by DSS upon orders from the Defendant that all such individuals must be terminated, despite the protections of the Coronavirus Response Act.

12. Because Medicare provides significantly fewer health benefits than Medicaid, and the Medicare Savings Programs are merely financial assistance programs that help with the costs of health services covered under Medicare and do not provide any coverage for services not covered by Medicare, each of the individuals cut off under this newly-created exception has lost, and continues to go without, HUSKY D coverage and thus vital health care services to which they are entitled under the Coronavirus Response Act.

13. In the case of two of the three plaintiffs, Deborah Carr and Brenda Moore, this has resulted in the termination of their coverage for extensive home care services that they require to address some or all of their activities of daily living, which they are unable to engage in due to severe disabilities related to chronic medical conditions, respectively, Freidrich's Ataxia and severe circulatory problems.

14. Without these services, Ms. Carr will be unable to dress, transfer from her wheelchair or out of bed, use the toilet, bathe and eat.

15. Similarly, absent these services, Ms. Moore will be unable to bathe, dress, transfer, clean herself after using the bathroom and prepare meals, and will be subject to harmful falls, as have happened in the past.

16. Additionally, without these crucial services, both of these two individuals are threatened with unnecessary institutionalization in a nursing facility during the COVID crisis, which has seen a shockingly high numbers of deaths in such facilities, particularly in Connecticut.

17. As of today, each of these individuals is receiving these vital health services on a temporary basis, Ms. Carr because she timely requested a hearing to challenge the termination and is receiving "aid pending" the decision on her appeal, and Ms. Moore because she was able to satisfy a one-time spenddown to qualify for a different full-benefit Medicaid program for a limited period that expires on August 31, 2022.

18. Ms. Carr will immediately be terminated from HUSKY D and thus access to all of her home care services if she loses her appeal challenging the legality of the IFR and asking that it be invalidated in her case, which DSS's counsel told the hearing officer at the hearing in her case she has no authority to do; that decision could be issued **at any time**.

19. Ms. Moore will immediately lose her full benefit Medicaid coverage on **August 31, 2022** when her one time eligibility under the spenddown process (under a different full-benefit Medicaid program) comes to a close, as she lacks the ability to incur the large amount of medical bills needed to satisfy another spenddown period.

20. Irreparable harm is readily established for all individuals cut off of full benefit Medicaid based on the IFR.

21. Plaintiffs are likely to succeed on the merits of their claims that the APA was violated both by the procedures followed by Defendant in adopting the IFR and by the issuance of a rule that contradicts the plain meaning of, and is therefore unauthorized under, the Coronavirus Response Act. Indeed, as shown in the accompanying memorandum, there is a "clear and substantial" likelihood of success on the merits of their claims warranting mandatory temporary and preliminary injunctive relief.

22. The balance of equities weighs in favor of Plaintiffs.

23. The granting of the requested temporary restraining order and preliminary injunction is in the public interest.

24. Plaintiffs have no adequate remedy at law.

25. In the case of Plaintiffs Carr and Moore, they will lose all of their home health care services, and thus be immediately subject to the risk of unnecessary institutionalization, sometime in the month of August.

26. A temporary mandatory restraining order is warranted to prevent further irreparable harm to these two Plaintiffs.

27. Plaintiffs, being low income and subject to severe harm if a TRO is not granted, are unable, and should be relieved of the duty, to post a security bond.

28. Plaintiffs have provided advance notice to the Defendant of this Motion.

29. This Motion is supported by the Memorandum of Law filed herewith; the Declarations of Plaintiffs Deborah Carr, Brenda Moore and Mary Ellen Wilson; the Declaration of Sheldon V. Toubman in Support of Plaintiffs' Motion for Temporary Restraining Order and Preliminary Injunction; and the exhibits attached thereto.

WHEREFORE, for the reasons set forth above and in the accompanying Memorandum and supporting exhibits, Plaintiffs respectfully request that the Court:

1. Immediately enter a temporary restraining order requiring Defendant to instruct the Connecticut Department of Social Services that it may not enforce 42 C.F.R. § 433.400(c)(2)(i)(B) under the Interim Final Rule with respect to plaintiffs Deborah Carr and Brenda Moore and that they must be kept on full-benefit Medicaid pending the hearing on plaintiffs' Motion for a Preliminary Injunction.
2. Schedule a date for an August hearing on plaintiffs' motion for a preliminary injunction.
3. Grant a preliminary injunction enjoining Defendant from enforcing 42 C.F.R. § 433.400 under his Interim Final Rule and requiring him to notify all states (1) that they may not apply any provisions of 42 C.F.R. § 433.400 under the IFR, and (2) that they must immediately reinstate anyone cut off of full benefit Medicaid since the implementation of the IFR based on any of the extra-statutory exceptions not contained in the Coronavirus Response Act itself (*i.e.*, for a reason other than voluntarily getting off of Medicaid or leaving the jurisdiction, including through death).

DATED: August 3, 2022

Respectfully Submitted,

SHELDON V. TOUBMAN
Fed Bar No. ct08533
Phone: (475)345-3169
E-mail: sheldon.toubman@disrightsct.org
DEBORAH A. DORFMAN (Application for Admission *Pro Hac Vice* pending)
CT Juris No. 442946
Phone: (860)469-4463
E-mail: deborah.dorfman@disrightsct.org
Disability Rights Connecticut
846 Wethersfield Avenue
Hartford, CT 06114

CAROL A. WONG (Application for Admission *Pro Hac Vice* pending)
DC Bar No. 1035086
Justice in Aging
1444 I Street, NW, Suite 1100
Washington, DC 20005
Phone: (202) 683-1995
E-mail: cwong@justiceinaging.org

REGAN BAILEY (Application for Admission *Pro Hac Vice* pending)
DC Bar No. 465677
Justice in Aging
1444 I Street, NW, Suite 1100
Washington, DC 20005
Phone: (202) 683-1990
E-mail: rbailey@justiceinaging.org

JANE PERKINS
NC Bar No. 9993
CA Bar No. 104784
Email: perkins@healthlaw.org
MIRIAM HEARD
NC Bar. No. 39747
Email: heard@healthlaw.org
(Applications for Admission *Pro Hac Vice* pending)
National Health Law Program
1512 E. Franklin St., Ste. 110
Chapel Hill, NC 27514
Phone: (984) 278-7661

HARVEY L. REITER
(Application for Admission *Pro Hac Vice* pending)
STINSON LLP
1775 Pennsylvania Avenue, N.W.
Suite 800
Washington, D.C. 2006
Email: harvey.reiter@stinson.com
Phone: (202)728-3016
Fax: (202)572-9968

PLAINTIFFS' COUNSEL

Certificate of Service

I hereby certify that on the above date a copy of the foregoing document was filed electronically and served by overnight delivery to anyone unable to accept electronic filing. Notice of this filing will be sent by email to all parties by operation of the Court's electronic filing system or by overnight delivery to anyone unable to accept electronic filing as indicated on the Notice of Electronic Filing. Parties may access this filing through the Court's CM/ECF System.

s/Sheldon V. Toubman
Sheldon V. Toubman

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

DEBORAH CARR, BRENDA MOORE, AND MARY ELLEN WILSON Plaintiffs, v. XAVIER BECERRA, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES Defendant.	Civil Action No. 3:22-cv-988 August 3, 2022

PLAINTIFFS' MEMORANDUM IN SUPPORT OF MOTION FOR A TEMPORARY RESTRAINING ORDER AND A PRELIMINARY INJUNCTION

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Other Authorities

PLAINTIFFS' MEMORANDUM IN SUPPORT OF MOTION FOR A TEMPORARY RESTRAINING ORDER AND A PRELIMINARY INJUNCTION

The Complaint challenges a final action by Defendant authorizing states to terminate individuals from full benefit Medicaid coverage during the COVID-19 pandemic while continuing to pay them significantly enhanced federal Medicaid payments. Plaintiffs allege this action is in direct conflict with the Families First Coronavirus Response Act ("Coronavirus Response Act" or "FFCRA"), which conditions the enhanced funding on the state refraining from terminating Medicaid coverage during the public health emergency ("PHE"). Plaintiffs file this memorandum in support of their motion for a preliminary injunction requiring Defendant to immediately notify all state Medicaid agencies that the portion of the Interim Final Rule ("IFR"), titled "Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency," *Temporary Increase in Federal Medicaid Funding,* 85 Fed. Reg. 71142, 71160 (Nov. 6, 2020), announcing this policy and promulgating 42 C.F.R § 433.400, cannot be applied and that the states must instead: (1) fully comply with the Coronavirus Response Act's requirements for continuous enrollment and (2) reinstate any individuals who have been cut off of full benefit Medicaid based on the IFR. They also file it in support of a motion for a Temporary Restraining Order ("TRO") with respect to two of the three Plaintiffs to compel an immediate order with respect to these individuals who face irreparable harm in the form of unnecessary institutionalization due to the impending termination of all of their essential home health services (in one case on August 31, 2022 and in the other case at any time).

Without an order from this Court, Plaintiffs will suffer immediate and irreparable harm. They will go without the full Medicaid benefit coverage to which they are entitled for as long as the PHE is in effect (currently extended to October 13, 2022). In addition, two of the Plaintiffs are immediately threatened with institutionalization if a TRO and preliminary injunction are not

granted because of the loss of Medicaid coverage of essential home health services to assist with activities of daily living. Monetary damages are not available after the fact and, even if they were, they could not undo the harm from forced institutionalization and the denial of timely access to needed medical care facing Plaintiffs.

I. APPLICABLE STANDARDS FOR DETERMINING TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION MOTIONS

The United States Supreme Court in *Winter v. Natural Resources Defense Council*, 555 U.S. 7 (2008), defined the standard for imposing a preliminary injunction. Parties seeking preliminary injunctions must demonstrate that: (1) they are likely to succeed on the merits, (2) they are likely to suffer irreparable harm, (3) the balance of hardships tips in their favor, and (4) the injunction is in the public interest. *Id*. at 20. In some cases, "Plaintiffs may be able to show that a preliminary injunction is warranted on the strength of these first two factors alone." *New York v. United States Dep't. of Homeland Sec*., 969 F. 3d 42, 87 (2d Cir. 2020) [1] In addition, "[w]here, as here, the government is a party to the suit, the final two factors merge." *Id. at* 58-59 (2d Cir. 2020).[2] "Any time the government is subject to a preliminary injunction, it necessarily suffers the injury of being prevented from enacting its preferred policy." *Id*. But absent other considerations, like the need to protect national security or "the need to correct a previous policy that had been deemed unlawful, *id*.—neither of which are at play in this case—this limited hardship would be outweighed by economic harms to movants, as well as the public interest in avoiding "[w]orse health outcomes." *Id*.

[1] *Citing Trump v. Deutsche Bank AG*, 943 F.3d 627, 636,640-41 (2d Cir. 2019), *rev'd on other grounds*, 140 S. Ct. 2019 (2020). As discussed below, given the strong likelihood of success on the merits and the clear irreparable harm to Plaintiffs, there is no reason not to consider the balance of equities and the public interest factors as well.
[2] *See also Nken v. Holder*, 556 U.S. 418, 435 (2009).

Finally, where a mandatory injunction versus government action is sought, there may be a requirement to demonstrate "clear and substantial" showing of likelihood of success. *Hartford Courant Co., LLC v. Carroll, 474 F. Supp. 3d 483, 494-95* (D. Conn. 2020), *citing N. Am. Soccer League, LLC v. United States Soccer Fed'n*, 883 F.3d 32, 37 (2d Cir. 2018).

As set forth below, Plaintiffs easily satisfy even the strictest of these likelihood of success on the merits tests. Irreparable harm is readily established for all individuals cut off of full benefit Medicaid based on the IFR, and the balance of hardships and the public interest strongly favor granting a preliminary injunction to ensure that Congress' unequivocal intentions are fulfilled during the ongoing PHE.

In the Second Circuit, the standard to prevail on a motion for a TRO is the same as for a preliminary injunction. *Natera Inc. v. Bio Reference Labs, Inc.*, No. 16 Civ. 9514, 2016 WL 7192106, at *2 (S.D.N.Y. Dec. 10, 2016) (collecting cases).

To obtain temporary and/or preliminary relief, the movant must show that: (1) they are likely to succeed on the merits; (2) irreparable harm will result if the injunction is not granted; (3) the balance of equities weighs in favor of the movants and (4) that the granting of the relief is in the public interest. *Basank v. Decker*, 449 F. Supp. 3d 205, 211 (S.D.N.Y. 2020) (TRO granted where detainees demonstrated imminent risk of irreparable harm as a result of their continued detention during the COVID-19 pandemic.). The movant "must show that the injury it will suffer is likely and imminent, not remote or speculative, and that such injury is not capable of being fully remedied by money damages." *NAACP v. Town of E. Haven*, 70 F.3d 219, 224 (2nd Cir. 1995). As with the standards for a preliminary injunction, the most important consideration when determining whether a TRO should be granted is whether the movant will suffer irreparable harm.

Basank, 494 F. Supp. 3d at 209, (*citing Faiveley Transport Malmo AB v. Wabtec Corp*, 559 F.3d. 110, 118 (2d Cir. 2009)(internal quotes, citations omitted).

Here, a temporary mandatory restraining order is warranted to prevent further irreparable harm to two of the Plaintiffs caused by Defendant's IFR, pending consideration of the preliminary injunction motion with its request for broader relief.

II. FACTUAL AND LEGAL BACKGROUND

A. Covid-19 Pandemic and Declared Public Health Emergency

On March 13, 2020, former President Donald Trump declared a national emergency due to the rapid spread of COVID-19 virus, a novel Coronavirus. 85 Fed. Reg. 15337, Pres. Proclamation, Mar. 13, 2020. On January 31, 2020, former Secretary of Health and Human Services ("HHS") Alex Azar declared a PHE retroactive to January 27, 2020. The PHE, which is approved in 90-day increments, *see* 42 U.S.C. § 247d(a)(2), has been repeatedly extended, most recently on July 15, 2022, assuring continuation of the PHE until at least October 13, 2022. Secretary Becerra, like his predecessor, also has assured states that there will be at least 60 days advance notice of the termination of the declared emergency. "Renewal of Determination that a Public Emergency Exists," July 15, 2022, *available at* https://aspr.hhs.gov/legal/PHE/Pages/covid19-15jul2022.aspx; *see also* Ltr. from Norris Cochran, Acting HHS Sec'y to State Governors, 1 (Jan. 22, 2021) available at https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf

While the end-date of the PHE is not at all certain, neither is it in sight. *The pandemic remains a global health emergency, the W.H.O. says*, New York Times, July 12, 2022, https://www.nytimes.com/2022/07/12/world/who-covid-health-emergency.html?smid=url-share . As of this filing, about 400 persons per day are still dying from COVID-19. *Coronavirus in the*

U.S.: Latest Map and Case Count, New York Times (last visited August 1, 2022), available at https://www.nytimes.com/interactive/2021/us/covid-cases.html .

Older individuals and those with weakened immune systems, including Plaintiffs, remain particularly vulnerable, and the Center for Disease Control and Prevention ("CDC") warns that the latest variants pose a continuing risk that may accelerate this fall. CDC, COVID 19, *People with Certain Medical Conditions*, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html (last visited July 14, 2022).

Similarly, people of color have experienced COVID-19 at disproportionate rates and have died at rates that greatly exceed their representation in the population. For example, Black people are 2.3 times more likely to get COVID-19 than white people, and 1.7 times more likely to die from it. CDC, *Risk for COVID-19 Infection, Hospitalization, and Death By Race/Ethnicity,* https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html (last visited July 14, 2022). In addition, people of color are disproportionately on Medicaid, largely due to disparate income levels compared with white Americans. In Connecticut, for example, 18.2 % of the Medicaid population identifies as Black or African-American, (Workbook: People Served (ct.gov), while only 12.7% of the state population overall is Black. U.S. Census Bureau QuickFacts: Connecticut.

B. Congress's Response to the PHE through the Coronavirus Response Act

On March 18, 2020, the Coronavirus Response Act was signed into law. Recognizing that states would face financial pressure as a result of the pandemic, the Coronavirus Response Act includes significant financial relief for state Medicaid programs by enhancing each state's Federal Medical Assistance Percentage ("FMAP") by 6.2 percent for nearly all Medicaid expenditures. Coronavirus Response Act §6008 (a). This has, for example, resulted in several hundred million dollars in additional federal Medicaid reimbursements to Connecticut since the passage of the

Coronavirus Response Act. Jennifer Sullivan, States to Get Enhanced Medicaid Funding Through 2021, Center on Budget and Policy Priorities, Feb.1, 2021, www.https:www.cbpp.org/blog/states-to-get-enhanced-medicaid-funding-through-2021 (last visited Aug. 2, 2022).

To be eligible for the enhanced FMAP, states must meet several conditions. These conditions, referred to as the "maintenance of effort" requirements, establish protections for Medicaid enrollees during the PHE. As relevant here, states must "provide that an individual who is enrolled for benefits under such plan (or waiver) as of" March 18, 2020, "or enrolls for benefits under such plan (or waiver) during" the PHE, "shall be treated as eligible for *such* benefits through the end of the month" in which the PHE ends. *Id.* § 6008(b)(3) (emphasis added).

There are only two specific statutory exemptions to the maintenance of effort provision requiring continued coverage of the same services: when "the individual requests a voluntary termination of eligibility or the individual ceases to be a resident of the State." *Id*. § 6008(b)(3). The Coronavirus Response Act is designed to balance the need for states to receive enhanced federal funding with the need to protect beneficiaries against state efforts to terminate or reduce Medicaid benefits during the PHE. The statute allows terminations or reductions only in those two narrow circumstances where continuation of benefits was deemed to be unreasonable. The Coronavirus Response Act gives Defendant no authority to create additional exceptions, much less to do so under rules adopted without prior notice and comment.

C. Initial Contemporaneous Interpretation by CMS Followed by Reversal

1. CMS's Spring 2020 Guidance

Contemporaneous with the enactment of the Coronavirus Response Act, CMS published several sub-regulatory documents containing FAQs to advise states of the requirements necessary to receive the enhanced funding offered under § 6008 of the Coronavirus Response Act. On March 24, 2020, CMS explained that pursuant to § 6008(b)(3):

> while states may increase the level of assistance provided to a beneficiary who experiences a change in circumstances, such as moving the individual to another eligibility group which provides additional benefits, states may not reduce benefits for any beneficiary enrolled in Medicaid on or after March 18, 2020, through the end of the month in which the emergency period ends, and still qualify for increased FMAP.

CMS *Families First Coronavirus Response Act – Increased FMAP FAQs*, 6 (Mar. 24, 2020), attached as Exh. 1 to Declaration of Sheldon V. Toubman in Support of Plaintiffs' Motion for Temporary Restraining Order and Preliminary Injunction ("Toubman Decl.")

On April 13, 2020, CMS again stated that states "may not reduce benefits for any beneficiary enrolled in Medicaid" during the public health emergency, including by moving them to a new eligibility group that provides fewer benefits. CMS, "Families First Coronavirus Response Act (FFCRA), Public Law No. 116-127; Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136 Frequently Asked Questions (FAQs)," 6 (Apr. 13, 2020), *available at* https://sss.usf.edu/covid19/resources/medicaid/Family%20First%20Coronavirus%20Response%20Act%20_%20Increased%20FMAP%20FAQs.pdf In that same April 13, 2020 statement, CMS repeatedly emphasized that, to satisfy § 6008(b)(3), states must continue providing individuals with the same amount, duration, and scope of services throughout the public health emergency, regardless of changes in individual circumstances:

> To be eligible for the enhanced FMAP authorized by the FFRCA, states may not reduce benefits for any beneficiary enrolled in Medicaid on or after March 18, 2020, through the end of the month in which the emergency period ends, and still qualify for increased FMAP. This means that states must continue to provide coverage to such beneficiaries in the eligibility group in which the beneficiary is enrolled if transitioning the beneficiary to another eligibility group would result in a reduction in benefits. If there is a separate eligibility group for which the individual is eligible and which provides the same amount, duration and scope of benefits, then a state may shift the individual to that group; *what is critical for ensuring eligibility for the temporary FMAP increase is that the same amount, duration and scope of medical assistance be maintained.*

Frequently Asked Questions (FAQs), 6 (Apr. 13, 2020) (emphasis added); *see also id.* (explaining that a state may not move an individual from one eligibility group to another, "unless the individual is eligible for a separate eligibility group which provides the same amount, duration and scope of benefits."); *id.* ("If . . . the individual is ineligible for another eligibility group which confers the same amount, duration and scope of benefits, the state must continue to furnish services available to beneficiaries enrolled in the adult group until the last day of the month in which the emergency period ends."); *id.* at 11 ("If . . . there is no other eligibility group for which the individual is eligible under the state plan or waiver that provides the same amount, duration and scope of benefits as those available to beneficiaries in the group under which the individual has been receiving coverage . . . state must continue to furnish the benefits available under such group in order to qualify for the temporary FMAP increase."); *id.* at 11 ("state must maintain, during the emergency period, an individual's eligibility for at least the same amount, duration, and scope of benefits as are covered for the group in which the individual is enrolled.").

On May 5, 2020, CMS confirmed for the third time that § 6008(b)(3) of the Coronavirus Response Act prohibits any **reduction** in the services or assistance provided to an individual:

> **Are states prohibited from increasing cost-sharing during the emergency period as a condition of receiving the FFRCA [Coronavirus Response Act] enhanced FMAP?**
>
> Yes. A state is not eligible for the temporary FMAP increase authorized by section 6008 of the FFRCA 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 FFRCA*** *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.

CMS, "COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies*,"* 26 (May 5, 2020) (emphasis added), attached as Exh. 2. to Toubman Decl. For good measure, CMS issued a fourth statement to the same effect in late June 2020. CMS, "COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies," 29-30 (June 30, 2020) (repeating guidance from May 5, 2020), attached as Exh. 3 to the Toubman Decl.

Connecticut's Medicaid agency reasonably responded to these clear and consistent pronouncements under the Coronavirus Response Act by assuring policy makers that no one on Medicaid would have their Medicaid benefits *reduced* during the PHE: it assured the members of the Medical Assistance Program Oversight Council that, "[f]or the duration of the PHE, DSS is not taking action on changes (e.g. change in family income, aging out of coverage) that would result in a change of eligibility group or termination of coverage." July 10, 2020 PowerPoint presentation, slide 10, *available at* 2906a2 (ct.gov).

2. Defendant's Interim Final Rule

In early November 2020, CMS reversed course and issued an IFR that included provisions significantly weakening the beneficiary protections Congress enacted in § 6008(b)(3) of the Coronavirus Response Act. *See* Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 85 Fed. Reg. 71142 (Nov. 6, 2020). The IFR newly authorized or required states to reduce or entirely eliminate Medicaid coverage for individuals who: (1) are eligible for financial assistance to pay for out-of-pocket Medicare costs under a Medicare Savings Program ("MSP"); (2) are deemed not "validly enrolled" at the time of the passage of the Coronavirus Response Act; or (3) are non-citizens otherwise losing Medicaid coverage because of being in the United States less than five years and no longer being pregnant or a child. 85 Fed. Reg. 71160; 42 C.F.R § 433.400(c)(2) and (d)(2).

The IFR was issued with no intervening change in CMS's public position or in the statutory language, nor any improvement in the COVID-19 pandemic itself. Rather, CMS claimed that its revised statutory interpretation was prompted by concerns of unidentified states (it does not say which states or how many) that its "existing interpretation of section 6008(b)(3) of the Coronavirus Response Act makes it challenging for them to manage their programs effectively and still qualify for the increased Federal financial participation." *Id.* at 71161.

The IFR was issued without the notice and comment procedures ordinarily required by the APA. CMS did ask for *post*-implementation comments on the IFR, 85 Fed. Reg. 71142. But while the overwhelming majority of the more than 260 comments received opposed the IFR provisions undermining the Coronavirus Response Act, the rule has remained in effect on an "interim" basis for nearly twenty-one months.

As relevant here, the IFR adds new subpart G, Temporary FMAP Increase During the Public Health Emergency for COVID–19, to 42 C.F.R. Part 433, including new § 433.400. The provisions in § 433.400 became "effective immediately upon display of this rule." 85 Fed. Reg. 71144.

Defendant's terse explanation for proceeding without notice and comment was that an IFR was "immediately necessary to ensure that states can determine eligibility and provide care and services during the [public health emergency] in a manner that is consistent with simplicity of administration and the best interests of beneficiaries and also claim the temporary funding increase." 85 Fed. Reg. 71181. It did not explain what harm, if any, had befallen states in the months they had operated without the IFR's provisions contradicting the Coronavirus Response Act. And the explanation that this was in the "best interests of the beneficiaries" made no sense because in fact it is completely *against* the best interests of Medicaid beneficiaries to cut them off

at all, let alone to do so under an immediately effective IFR. Defendant's explanation does not rise to the good cause required to bypass the statutorily-required prior notice and comment rule-making process.

No final rule has been issued by Defendant. His agency has not subsequently explained why it has yet to address any of the comments it invited or to issue a final rule.

After four previous times reiterating and reaffirming a contrary interpretation during the same calendar year, CMS's IFR announced, for the first time, that § 6008(b)(3) of the Coronavirus Response Act is "somewhat ambiguous" and that a new interpretation of the statute was needed to respond to unnamed states requesting unspecified "increased flexibility." *See* 85 Fed. Reg. 71160. Defendant provided no basis for his contention that cutting people off of necessary health benefits for which they have no other coverage, particularly during an ongoing PHE which may require prompt treatment for any infected individual, is "consistent with simplicity of administration," let alone in the "best interests of beneficiaries," as required under federal Medicaid law, 42 U.S.C § 1396a(a)(19).

The IFR permits states to continue receiving the enhanced FMAP, while authorizing and in some cases requiring them to reduce or eliminate coverage for Medicaid enrollees. CMS subsequently told the states that under the IFR they *must* conduct these terminations. CMS COVID-19 Medicaid & CHIP All State Call, 11-17-20, at pages 12-17, *available at* https://www.medicaid.gov/state-resource-center/downloads/allstatecall-20201117.pdf

CMS officials made clear the terminations under the IFR were in fact mandatory in response to a question from a Connecticut Medicaid official ("Krist[i]n [Dowty]"). CMS COVID-19 Medicaid & CHIP All State Call, 12-1-20, at pages 29-30, *available at* CMCS Medicaid and CHIP All State Calls - 2020 | Medicaid. This was followed by email correspondence between this

same Connecticut official and CMS in March 2021 in which CMS stated, on March 27, 2021: "Consistent with CMS regulation at 42 C.F.R. § 433.400(c)(2), Connecticut must transfer the individual described in this scenario from the adult group to the MSP-related group under which the individual is eligible. It is not optional for states." Email correspondence between Kristin Dowty and Marie DiMartino, CMS; attached as Exh. 4 to the Toubman Decl.

The IFR not only permits but, per the later CMS pronouncements, requires states to make "changes to beneficiary coverage, . . . including both changes affecting an individual beneficiary and approved changes to the state plan," or waiver "impacting multiple beneficiaries," without impacting "a state's ability to claim the temporary FMAP increase." 42 C.F.R. § 433.400(c)(3). According to the IFR preamble, this change permits states to "eliminate[e] an optional benefit from its state plan," such as dental benefits, and still claim the enhanced FMAP. 85 Fed. Reg. 71166.

Contrary to the Coronavirus Response Act, the IFR not only permits, but, per Defendant's pronouncements on how it intended to apply the IFR, requires states to transition Medicaid enrollees to different eligibility groups, even when this would result in a reduction in the amount, duration, or scope of services. 42 C.F.R. § 433.400(c)(2); 85 Fed. Reg. 71161. While the IFR retains some limitations on states' ability to move individuals between eligibility groups, *Id.* §§ 433.400(c)(2)(i)(A)-(B) (regarding individuals with minimum essential coverage under the Affordable Care Act); 42 C.F.R. § 433.400(c)(2)(ii) (regarding Medicaid coverage for COVID-19 testing and treatment), the limitations are quite narrow.

The IFR, as confirmed by CMS, requires states to move individuals from full-scope Medicaid to "coverage under a Medicare Savings Program [MSP] eligibility group," 42 C.F.R. § 433.400(c)(2)(i)(B). In doing so, the IFR conflates coverage standards in non-Medicaid regulations applicable only to market-based insurance in the Affordable Care Act, 26 U.S.C. §

5000A(a) and (f) with Medicaid, to justify eliminating Medicaid coverage, asserting that Medicare provides "essential coverage." *See* 85 Fed. Reg. 71165; 42 C.F.R §§ 433.400(b) and 433.400(c)(2)(i)(A) and (B). However, MSP eligibility provides payment only for Medicare costs and neither Medicare nor MSP provide the same full-scope Medicaid benefits previously received, such as vision and hearing exams, non-emergency medical transportation, hearing aids, dental services, personal care services, and long-term nursing facility services.

The IFR also requires states to terminate Medicaid coverage for certain immigrants. For "lawfully residing" children or pregnant women, who no longer meet the definition of "lawfully residing," "child," or "pregnant women," states "must limit coverage for such beneficiaries . . . to services necessary for treatment of an emergency medical condition." 42 C.F.R. § 433.400(d)(2).

The IFR added one further exemption from the statutory duty to maintain continuous coverage for individuals on Medicaid in March of 2020: an individual can be denied coverage if that individual is deemed not to have been "validly enrolled" in Medicaid in the first place. 42 C.F.R. § 433.400(b) and (c)(2). The statute, however, reflecting Congress' determination that keeping people of limited means on Medicaid benefits during the PHE, regardless of why they were on in the first place or changes that might otherwise affect eligibility, draws no distinction among enrolled individuals its protection applies to anyone "who is enrolled for benefits under such plan" mistakenly or otherwise (unless one of two statutory exceptions applies).

D. Response by States to Defendant's Interim Final Rule

Some states were initially reluctant to comply with the extra-statutory exceptions under the IFR. Nevertheless, CMS informed states through the All State calls and in specific written responses to states' inquiries that "it is not optional for states" to conduct the terminations. Transcript of December 1, 2020 All State Call, at pages 29-30; Transcript of March 9, 2021 All State Call, at page 13, *available at* CMCS Medicaid and CHIP All State Calls - 2021 | Medicaid;

see also March 11 and 27, 2021 email correspondence between CMS and Connecticut Medicaid official, attached as Exh. 4 to Toubman Decl. This was despite objections from some states that imposing these terminations, in the case of individuals who qualify for MSP, would cause significant harm to individuals with significant disabilities. *See, e.g.* January 4, 2021 comments to IFR by State of Vermont, available at Regulations.gov.

In Connecticut alone, at least 6,600 people were initially terminated from full-benefit Medicaid under the IFR solely because they qualified for an MSP program. Nationally, based on enrollment data, this led to the termination of Medicaid benefits for hundreds of thousands of Americans and legal permanent residents, which in many cases resulted in the termination of ongoing services essential to health or avoiding institutionalization, or even to maintaining life itself. Hundreds more have since lost protected benefits under the IFR just in Connecticut, because they have newly qualified for the lesser coverage of Medicare and related MSP programs. This does not include those terminated for some other basis contained in the IFR, such as because they have secured legal status in this country for less than five years and are no longer pregnant or under 21, or they are deemed not to have been validly enrolled for some reason.

E. The Medicaid Program

Title XIX of the Social Security Act establishes the medical assistance program known as Medicaid. *See id.* §§ 1396-1396w-5. The purpose of the Medicaid program is to enable each state, as far as practicable, "to furnish [] medical assistance" to individuals "whose income and resources are insufficient to meet the costs of necessary medical services" and to provide "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." *Id.* § 1396-1. The Medicaid program is implemented federally by HHS. Within HHS,

CMS is responsible for administration of the Medicaid program. States do not have to participate in Medicaid, but all do.

Each participating state must maintain a comprehensive state Medicaid plan for medical assistance that the Secretary has approved. *Id.* § 1396a. The state Medicaid plan must describe the state's Medicaid program and affirm its commitment to comply with the requirements imposed by the Medicaid Act and its implementing regulations. States are required under their state plans to administer their Medicaid programs in the "best interests of the recipients," as well as to do so "in a manner consistent with simplicity of administration." 42 U.S.C. § 1396a(a)(19).

States and the federal government share responsibility for funding Medicaid. Section 1396b requires the Secretary to pay each participating state the federal share of "the total amount expended . . . as medical assistance under the State plan." *Id*. §§ 1396b(a)(1), 1396d(b). The federal reimbursement rate is based on the state's relative per capita income and is called FMAP. In return for federal funding, participating states must pay the remaining portion of the costs of care and follow all federal requirements, including those regarding the scope of coverage and eligibility for the program. *Id.* §§ 1396-1, 1396b.

Using household income and other specific criteria, the Medicaid Act delineates who is eligible to receive Medicaid coverage. *Id*. §§ 1396a(a)(10)(A)(C). The Act contains required coverage groups and options for states to extend Medicaid to additional population groups. *Id*.

The mandatory population groups include: low-income children; parents and certain other caretaker relatives; pregnant women; the elderly, blind, or disabled; individuals under age 26 who were in foster care until age 18; and adults who are under age 65, are not eligible for Medicare, do not fall within another Medicaid eligibility category, and have household incomes below 133% of the federal poverty level (FPL) (this last group is often referred to as the "expansion population").

42 U.S.C. § 1396a(a)(10)(A)(i), (e)(14). The expansion population was initially included as a mandatory eligibility group. The decision in *National Federation of Independent Business v. Sebelius*, 567 U.S. 519, 588 (2012), however, barred HHS from terminating Medicaid funding to states choosing not to so extend Medicaid.

Generally, individuals must hold a qualified immigration status to be eligible for Medicaid coverage. *See* 8 U.S.C. § 1641(b). In addition, certain categories of qualified immigrants, such as Legal Permanent Residents, must hold that qualified status for five years before they are Medicaid eligible. *Id*. § 1613(a). Individuals without a qualified status, or who have not held their qualified status for the required five years, are eligible only for services to treat an emergency medical condition. *See* 42 U.S.C. § 1396b(v)(3).

Connecticut, like all states, also has the option to receive federal matching funds to cover certain immigrants who do not have a qualified status or who have a qualified status but have not held it for five years. Specifically, any state may provide Medicaid coverage to "lawfully residing" immigrants if they are pregnant or are children under age 21. *See* 42 U.S.C. § 1396b(v)(4)(A). CMS has defined "lawfully residing" to mean individuals who are "lawfully present" and meet the Medicaid state residency requirement. *See* CMS, Dear State Health Official Letter, 10-006 (July 1, 2020), https://www.medicaid.gov/federal-policy-guidance/downloads/SHO10006.pdf Coverage for pregnant people in this category extends through the 60-day period beginning on the last day of the pregnancy and for children until they turn 21. Connecticut has chosen this option. On July 26, 2022, Connecticut also received permission from CMS to extend post-partum coverage under Medicaid generally to twelve months instead of 60 days. CMS, HHS Approves 12-Month Extension of Postpartum Coverage in Connecticut, Massachusetts, and Kansas, July 12, 2022,

https://www.cms.gov/newsroom/press-releases/hhs-approves-12-month-extension-postpartum-coverage-connecticut-massachusetts-and-kansas.

States that participate in Medicaid must provide Medicaid beneficiaries with "medical assistance." The statute defines "medical assistance" to mean "payment of part or all of the cost of the following care and services or the care and services themselves, or both." 42 U.S.C. § 1396d. The "following care" includes a range of health care services that participating states either must cover or are permitted to cover, from physical therapy and hearing aids to long-term care at home and in nursing facilities. *Id.* § 1396d(a); 42 U.S.C. §§ 1396a(a)(10)(A). Non-emergency transportation to medical appointments also is a required Medicaid service. 42 U.S.C. § 1396u-7(a)(1)(F)(regarding so-called "benchmark" plans); 42 C.F.R. § 431.53.

There are many optional services, including prescription drugs, adult dental benefits, optometry services, prosthetic devices, and at-home personal care services. *See id.* §§ 1396(a)(10)(A), 1396(d)(a) (Medicaid Act listing 30 categories of medical assistance, only nine of which are mandatory). States must specify the amount, duration, and scope of services in the state plan, and services must also be "sufficient in amount, duration, and scope to reasonably achieve their purpose." 42 C.F.R. § 440.230.

In Connecticut, the full benefit Medicaid programs include coverage for extensive services in the form of personal care attendants. Under the optional Community First Choice program, personal care attendants are provided to individuals found by the State to meet a nursing facility level of care such that, without these services, they will be institutionalized.

F. Impact of Defendant's Interim Final Rule on Named Plaintiffs

1. Deborah Carr

Plaintiff Deborah Carr is a 63-year-old white woman who lives in her own home in New Haven, Connecticut. Declaration of Deborah Carr in Support of Plaintiffs' Motion for Temporary

Restraining Order and Preliminary Injunction ("Carr Decl.") ¶ 2. She has been on full-benefit Medicaid her entire life due to long term, chronic conditions. *Id*. ¶ 5. Ms. Carr needs daily assistance in her home due to her progressive neurological condition, Freidrich's Ataxia. *Id*. ¶¶ 3, 6. She needs help with dressing and bathing, in using the toilet, transferring from her wheelchair or out of bed, and with eating food. *Id*. ¶ 6. She has for years been receiving many hours per week of home health services paid for under the Medicaid program to help her with her activities of daily living and allow her to continue to live outside of an institutional setting. *Id*. ¶ 7.Ms. Carr has income of $1300/month; she cannot afford to pay for these services that cost several thousand dollars/month. *Id*. ¶¶ 4, 21.

Following issuance of the IFR and Defendant's declaration to all states that the IFR's newly created exceptions to maintenance of effort under the Coronavirus Response Act were mandatory, Connecticut terminated Plaintiff Carr's full benefit Medicaid under HUSKY D, based on that mandate, per a Feb. 15, 2022 notice. *Id*. ¶ 11. Ms. Carr timely challenged the termination of her Medicaid coverage through the administrative appeal process. *Id*. ¶ 17. During that appeal her personal care benefits of about 70 hours per week have continued pending the decision by the hearing officer**,** which could be issued at any time. *Id*. ¶ 20. If unsuccessful, she will be subject to repayment to the state of the cost of her care provided by the Medicaid program. 42 C.F.R. § 431.230(b). Once such a decision is issued, her continued benefits will cease and she will be forced to move to a nursing home. Carr Decl. ¶ 22.

2. Brenda Moore

Plaintiff Brenda Moore is a 57-year-old Black woman who lives in her own home with her adult son and three year-old grandchild in New Haven, Connecticut. Declaration of Brenda Moore in Support of Plaintiffs' Motion for Temporary Restraining Order and Preliminary Injunction ("Moore Decl.") ¶¶ 2-3. Ms. Moore's son works full time out of the house and is unavailable to

provide the daily care she requires. *Id*. ¶ 3. Ms. Moore has a severe vascular condition which has led to blood clots and required multiple surgeries which have been only partially successful. *Id*. ¶ 4. Due to her severe circulation issues, she requires daily assistance with bathing, dressing, transferring and toileting, and with meal preparation. *Id*. ¶ 5. She also has a significant risk of falling and has fallen several times. *Id*. ¶ 6. She is able to ambulate but only with a walker or cane. *Id*. Ms. Moore also has severe depression and Post-Traumatic Stress Disorder. *Id*. ¶7. Ms. Moore's entire income is $1402 in monthly Social Security Disability Insurance benefits, so she is unable to pay for the needed assistance herself. *Id*. ¶¶ 8, 17-18.

Ms. Moore had been receiving Medicaid-funded daily assistance from personal care attendants starting in July of 2020, due to her developing vascular condition which was causing falls and other symptoms. *Id*. ¶ 12. The personal care services paid for under the Medicaid program, currently totaling 39 hours per week, allow her to live outside of an institutional setting. *Id*. ¶ 13. Following issuance of the IFR and Defendant's declaration to all states that the IFR's newly created exceptions to maintenance of effort under the Coronavirus Response Act were mandatory, Connecticut terminated Ms. Moore's full benefit Medicaid under HUSKY D effective March 1, 2022, per a February 15, 2022 notice of termination, based on that mandate. *Id*. ¶ 14.

Ms. Moore has accrued extensive debt for services rendered during a period where her home health aide worked but was not paid, because of the termination of full-scope Medicaid (under HUSKY D), as required by Defendant under the IFR. *Id*., ¶17. She was able to meet Medicaid "spend down" for an alternative full-benefit Medicaid program, based on the application of this debt, which allowed her to continue coverage for a limited one-time six-month period ending on *August 31, 2022. Id*., ¶ 19. She will be unable to accrue such a large debt a second time,

so payment for her personal care attendant will abruptly end that day and she will be forced to move to a nursing facility. *Id*., ¶¶ 19-21, 30.

3. Mary Ellen Wilson

Plaintiff Wilson is a 62-year-old white woman who lives at home in Stamford, Connecticut. Declaration of Mary Ellen Wilson in Support of Plaintiff's Motion for Temporary Restraining Order and Preliminary Injunction ("Wilson Decl.") ¶ 2. She had seizures as a child and adult, surgery related to this, and has Multiple Sclerosis (MS) and dental complications related to decades of anti-seizure medication usage. *Id*. ¶¶ 3-4. Her income is $1391/ month. *Id*. ¶ 9. Ms. Wilson was terminated from full benefit Medicaid under the HUSKY D program also on the basis she is on Medicare and an MSP. *Id*. ¶¶ 13-14, 17-18. As a result, she has lost many benefits covered only by the Medicaid program. For example, dental work is not covered by Medicare, other than cleanings covered by her Medicare Advantage plan; dental coverage under Medicaid is far more comprehensive. *Id*. ¶ 19. She has paid for cabs to get to medical appointments even though Medicaid pays for this transportation. *Id*. ¶ 20. Multiple Sclerosis is a generally degenerative neurological disease, and so Ms. Wilson's course is uncertain and she could need additional services not covered under Medicare at any time (e.g., home care services, durable medical equipment not covered under Medicare, etc.). *Id*. ¶ 7.

Following issuance of the IFR and Defendant's clarification to all states that the IFR's newly created exceptions to maintenance of effort under the Coronavirus Response Act were mandatory, Connecticut terminated Ms. Wilson's full benefit Medicaid under HUSKY D, based on that mandate. *Id*. ¶¶ 14, 17-18. She appealed but lost her appeal based on § 433.400.

III. SECOND CIRCUIT STANDARDS FOR GRANTING A TEMPORARY RESTRAINING ORDER AND A PRELIMINARY INJUNCTION ARE ALL READILY MET.

A. Plaintiffs will Suffer Irreparable Harm Absent the Issuance of a TRO and PI.

"Irreparable harm is injury that is neither remote nor speculative, but actual and imminent and that cannot be remedied by an award of monetary damages." *New York v. United States Dep't of Homeland Sec*., 969 F.3d 42, 86 (2d Cir. 2020) quoting *New York ex rel. Schneiderman v. Actavis PLC*, 787 F.3d 638, 660 (2d Cir. 2015) (internal quotations marks omitted). "A showing of irreparable harm is 'the single most important prerequisite for the issuance of a preliminary injunction." *Faiveley Transport Malmo AB v. Wabtec Corp*., 559 F. 3d 110, 118 (2d Cir. 2009) *quoting Rodriguez v. DeBuono,* 175 F.3d 227, 233–234 (2d Cir. 1999).

Irreparable harm is readily satisfied whenever the termination of health benefits, which usually cannot be remedied with after-the-fact provision of care or damages, is involved. *See LaForest v. Former Clean Air Holding Co.*, 376 F. 3d 48, 55 (2d Cir. 2004)(loss of medical benefits leading to a substantial risk to health, financial hardship, and anxiety associated with uncertainty "comports with this Court's understanding of irreparable harm as harm shown to be non-compensable in terms of money damages")(internal quotation omitted). *Accord Commc'ns Workers of Am., Dist. One, AFL-CIO v. NYNEX Corp*., 898 F.2d 887, 891 (2d Cir.1990); *Whelan v. Colgan*, 602 F.2d 1060, 1062 (2d Cir.1979) ("the threatened termination of benefits such as medical coverage for workers and their families obviously raised the specter of irreparable injury"). And, in the Second Circuit, even the *risk* of loss of health benefits constitutes irreparable harm because of the severe anxiety induced:

> [T]here is Second Circuit and out-of-circuit appellate law holding that the mere threat of a loss of medical care, even if never realized, constitutes irreparable harm. Dr. Hernandez testified that particularly for elderly and demented patients, anxiety exacerbates symptoms of mental illness and worsens pain. Thus, even home care recipients who do receive aid pending their fair hearing are likely to suffer irreparable harm as a result of the threatened reduction in their care.

Strouchler v. Shah, 91 F.Supp.2d 504, 522 (S.D.N.Y. 2012), *citing LaForest,* 376 F. 3d at 55; *Whelan,* 602 F.2d at 1062. This is particularly true in the case of health insurance benefits under

Medicaid, which are made available only to individuals with limited incomes and thus an inability to purchase health care services out of pocket absent insurance coverage. Indeed, affirming a preliminary injunction where plaintiffs challenged the termination of Medicaid benefits to individuals who did not appear at scheduled administrative hearings and no follow-up notice was provided prior to the terminations, the Secord Circuit has noted that "[a] lack of medical services is exactly the sort of irreparable harm that preliminary injunctions are designed to address." *Fishman v. Paolucci*, 628 Fed. Appx. 797, 801 (2d Cir. 2015); *see also Beltran v. Myers*, 677 F.2d 1317, 1322 (9th Cir. 1982) (holding possibility that plaintiffs would be denied Medicaid benefits sufficient to establish irreparable harm).

In *Olson v. Wing*, 281 F. Supp. 2d 476 (E.D.N.Y. 2003), *aff'd by summary order*, 66 Fed. Appx. 275 (2d Cir. 2003), the court preliminarily enjoined New York from terminating individuals from Disaster Relief Medicaid ("DRM") made available after the 9-11 terrorist attack:

> A recipient of DRM who is denied benefits and is consequently unable to obtain medical services during the pendency of a fair hearing may suffer irreparable harm based on his or her inability to obtain potentially life-saving treatment and/or medications during that time period. The award of retroactive benefits cannot ameliorate the harm suffered if such a recipient should be forced by circumstances to forego treatment or medication.

Id. at 486. "The award of retroactive benefits cannot ameliorate the harm suffered if such recipient should be forced by circumstances to [forgo] treatment or medication" *Id*.

Here, all affected individuals have lost or will lose access to crucial health services when full-scope Medicaid was or is terminated and, at best, they are relegated to only what health insurance benefits are offered by Medicare and under the limited benefit MSPs, which only covers the cost-sharing for what is covered under Medicare (under the IFR, individuals deemed not to have been validly enrolled lose all of their coverage, while non-citizen children who lose coverage at 21 receive only emergency medical condition coverage). Those on an MSP have lost, or will

lose, access to dental services, eyeglasses, medical transportation, hearing aids and most home health services, as well as extensive durable medical equipment benefits, to name a few of the services denied to affected individuals. This was explained in comments to the IFR submitted by Justice in Aging and many other commentators. *See, e.g.*, IFR-Justice-in-Aging-comments-1-4-2021.pdf (justiceinaging.org). This is irreparable harm under the above precedents.

For two of Plaintiffs, Ms. Carr and Ms. Moore, the threatened harm is the serous likelihood of unnecessary institutionalization in a nursing facility. Risk of institutionalization is inherently irreparable harm for purposes of a preliminary injunction or temporary restraining order. *See M.R. v. Dreyfus*, 697 F.3d 706, 739 (9th Cir. 2012) (reversing denial of a preliminary injunction seeking to block decreases in state Medicaid expenditures for in home personal care services for disabled individuals and concluding the plaintiffs were likely to suffer irreparable injury due to "serious risk of institutionalization"); *A. H. R. v. Washington State Health Care Authority,* 469 F.Supp.3d 1018, 1046-47 (W.D. Wash. 2016), *K.W. ex rel. D.W. v. Armstrong*, 298 F.R.D. 479, 493 (D. Idaho 2014); *V.L. v. John A. Wagner*, 669 F.Supp.2d 1106, 1110, 1115, 1119-20, 1122 (N.D. Cal. 2009); *Crabtree v. Goetz,* 2008 WL 5330506, at *30 (M.D. Tenn. 2008). Those not threatened with imminent institutionalization still face irreparable harm. For example, Ms. Wilson suffers from a degenerative neuro-muscular disease, MS, that often results in the need for assistance with activities of daily living and, immediately, she is going without Medicaid-funded medical transportation to get to medical appointments.

In *Strouchler*, the district court granted a preliminary injunction against terminations of Medicaid-funded personal care assistance in the form of "split-shift care" to individuals who received such services, so that they are "able to continue living in their homes rather than in hospitals or other institutions." Among other things, the court found that, without these services,

"disabled elderly people have not been turned and repositioned as required by their doctors' orders and have spent nights lying in soiled diapers," putting them "at risk of developing bedsores and infections. *This loss of medical care in contravention of federal law, constitutes irreparable injury.*" *Strouchler, 891 F.Supp.2d* at 521-22 (emphasis added).

Plaintiffs Carr and Moore are similarly situated to the plaintiffs in *Strouchler:* They are receiving extensive weekly hours of home care services to address their needs for assistance with activities of daily living and thus avoid institutionalization– 39 hours per week for Moore and 70 per week for Carr. Ms. Carr needs assistance with all activities of daily living and Ms. Moore needs help with most of them. They are receiving these services only *temporarily*, Ms. Carr because she timely requested a hearing and is receiving aid pending the hearing decision, and Ms. Moore because she was able, for one six-month period only, to satisfy the substantial spenddown requirements in order to qualify for full benefit Medicaid under the lower-income eligibility level HUSKY C Medicaid program. Both also are eligible for the Connecticut Medicaid Personal Care Attendant Waiver program, for which a specific finding of likely institutionalization without the services requested is required. The only reason they have not been placed on that program, despite being cut off of full Medicaid benefits under HUSKY D (including home care services), is that this waiver program has a long waiting list of three to four years. The threat of institutionalization is unquestionably irreparable harm.

To complicate matters here, in Connecticut and elsewhere, there has been a devastatingly high rate of death among nursing facility residents due to infection with the Coronavirus, starting in the spring of 2020. While part of this is due to their vulnerability as generally being of advanced age and with one or more high-risk co-morbidities, it is also due to the inherent close quarters in such facilities and the movement of staff, who get exposed to the virus in their lives outside the

facility, from resident to resident. A shocking 37% of Connecticut's COVID-related deaths as of May 2022 were of nursing home residents (about 4100 of 11,000 deaths statewide). The cumulative and weekly death rates for nursing home residents in Connecticut are reported at https://data.ct.gov/stories/s/f8wz-xtcy. Accordingly, while unnecessary institutionalization is inherently irreparable harm, during the COVID-19 pandemic, it may also be a death sentence.

The imminency of this harm also is clear: Ms. Carr will *immediately* lose her 70 hours per week of home health services upon losing the pending administrative appeal to challenge that termination, and counsel for the Department of Social Services has argued in that case that its hearing officers have no authority to rule invalid a federal regulation as being in violation of a federal statute. In fact, at least two other DSS hearing officers have already rejected the argument, including the one who issued the decision in Ms. Wilson's appeal. *See* May 16, 2022 hearing decision attached to Wilson Declaration. Ms. Moore receives 39 hours of personal care attendant ("PCA") services per week not through the HUSKY D program from which she was terminated but through the HUSKY C full benefit program instead. She is only qualifying for that program through a one-time spenddown made possible by submitting thousands of dollars of unpaid bills for weeks of care provided by her PCA without compensation. This is not something we can expect the PCA to do a second time around after her six months of coverage under HUSKY C ends, especially given that Ms. Moore still owes her for the uncompensated services provided after the March 1, 2022 termination of her HUSKY D coverage. Her Medicaid benefits, including her daily PCA services, will therefore come to an abrupt halt at the end of this one-time six-month spenddown period, which is on *August 31, 2022*.

B. Plaintiffs are Likely to Succeed on the Merits.

Under *Winter*'s "likelihood of success" prong, "[a] plaintiff need not establish a 'certainty of success,' but must make a clear showing that he is likely to succeed at trial." *Di Biase v. SPX*

Corp., 872 F. 3d 224, 230 (4th Circ. 2017). In cases under the APA, there is no "trial," as such. Rather, "when a party seeks review of agency action under the APA [before a district court], the district judge sits as an appellate tribunal." *Am. Bioscience, Inc. v. Thompson*, 269 F.3d 1077, 1083 (D.C. Cir. 2001). This means that the court does not try factual allegations, but reviews "arguments about the legal conclusion to be drawn about the agency action." *Marshall County Health Care Auth. v. Shalala*, 988 F.2d 1221, 1226 (D.C.Cir.1993). Under the APA, "a reviewing court shall … hold unlawful and set aside agency action … found to be …not in accordance with law…[and] in excess of statutory… authority." 5 U.S.C. § 706(2)(A),(C). Thus, the question about likelihood of success turns, not on factual determinations, but, as in any APA appeal, on whether the agency acted arbitrarily or capriciously or contrary to law. HHS plainly acted contrary to law in two respects.

1. The Rule violates the APA's notice and comment requirement.

The APA requires agencies to offer the public an opportunity for notice and comment on a proposed rule *before* taking final agency action. Parties must be given "an opportunity to participate in the rulemaking through submission of written data, views, or arguments." 5 U.S.C. §§ 553(b) and (c). The only exceptions to the prior notice and comment provisions are: (1) where the agency issues "interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice," Section 553(b)(A) or "when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest," Section 553(b)(B).

The first exception is not invoked. Regarding the second exception, which HHS has invoked to justify acting without providing prior notice and opportunity for comment, "federal courts have consistently held that exceptions to notice-and-comment must be 'narrowly construed

and only reluctantly countenanced.' " *Biden v. Missouri*, 142 S. Ct. 647, 659 (2022), *citing Mack Trucks, Inc. v. EPA*, 682 F.3d 87, 93 (D.C. Cir. 2012) (*quoting Utility Solid Waste Activities Group v. EPA*, 236 F.3d 749, 754 (9th Cir. 2001)). The IFR fails to meet this stringent test under all three prongs of the second exception.

The "unnecessary prong of the exception ... 'is confined to those situations in which the administrative rule is a routine determination, insignificant in nature and impact, and inconsequential to the industry and to the public.'" *Utility Solid Waste Activities Grp. v. EPA*, 236 F.3d 749, 755 (D.C. Cir. 2001). *See also Pennsylvania v. Trump*, 281 F. Supp. 3d 553, 574 (E.D. Pa 2017). This IFR is certainly not routine. At least as characterized by HHS, the rule was adopted to address the society-disrupting COVID-19 public health emergency. 85 Fed. Reg. 71181. Moreover, the part of the IFR at issue was reversing the agency's repeated, contrary interpretations of the same wording of the same statute.

HHS fares no better under the "public interest" prong. The "public interest prong of the good cause exception 'connotes a situation in which the interest of the public would be *defeated* by any requirement of advance notice.'" *North Carolina Growers' Ass'n Inc. v. United Farm Workers*, 702 F.3d 755, 767 (4th Cir. 2012) (emphasis added). HHS does not even attempt to make such a claim, much less demonstrate facts that would support it. On the contrary, it merely bootstraps the Agency's valid reasons for its *January 2020* emergency rules at the start of the pandemic, when immediate action *was* needed in the public interest to address harm from the pandemic, and claims, without more, that those same justifications warrant immediate implementation of its new, far less protective interpretation of a statute it had been administering for months. 85 Fed. Reg. 71181. An agency cannot invoke a claim of needing to act quickly to address a public health emergency where, as here, its new interpretation does not address but rather

exacerbates that emergency by taking away health coverage just when it is needed the most because of the crisis. Such cynical, backward reliance upon the public health emergency must be rejected as any basis for acting quickly.

The "impractical" prong similarly requires a showing, wholly absent from the IFR, that "the due and required execution of the agency functions would be unavoidably prevented by its undertaking public rule-making proceedings." *Nat.'l Nutritional Foods Ass'n v. Kennedy*, 572 F.2d 377, 384-85 (2d Cir. 1978). Nothing in the Agency's terse "explanation" for eliminating notice and comment remotely satisfies this requirement either. To the contrary, the Agency's sole explanation for dispensing with notice and comment consisted of a single conclusory sentence: "This provision . . . is immediately necessary to ensure that states can determine eligibility and provide care and services during the PHE in a manner that is consistent with simplicity of administration and the best interests of beneficiaries and also claim the temporary funding increase." 85 Fed. Reg. 71181. HHS does not say *why* the changed interpretation was "immediately necessary." And its claim that some unidentified states found implementation of the agency's prior interpretation "challenging for them to manage their programs effectively," *Id.* at 71161, despite receiving hundreds of millions of dollars (and, in some cases, as of this point, billions of dollars) in extra federal reimbursements in exchange for doing so, is a far cry from a demonstration that the new rule was "immediately necessary" and that HHS could not wait a second longer to consider the comments it invited only on the very day the Rule went into effect.

And perhaps most telling is the failure by the Defendant, in trying to fall under the "impractical" prong, to even attempt to explain why authorizing or requiring states to cut off hundreds of thousands or perhaps millions of low income Medicaid enrollees nationwide from full-benefit Medicaid, and thus their necessary health care services, *during* the COVID crisis, and

still claim the temporary funding increase, would be "consistent with simplicity of administration and the best interests of beneficiaries." These two general policy goals of the Medicaid program, set forth at 42 U.S.C. § 1396a(a)(19), in fact are seriously *undermined* by this abrupt reversal without compliance with the APA's notice and comment provisions.

It is not in the interest of *any* Medicaid beneficiaries to be involuntarily cut off of most of their benefits during a public health emergency involving a debilitating, sometimes fatal, communicable disease which often requires extensive, expensive treatment for both acute symptoms and Long COVID. Individuals with chronic conditions are especially at high risk of severe disease or death. CMS itself recognized all of this in another part of the IFR preamble:

> Considering the impact on beneficiaries, our existing interpretation provided the strongest protections for beneficiary access to medically necessary care during the PHE. It ensured that beneficiaries remained enrolled in Medicaid and that no new coverage restrictions were imposed. Every Medicaid beneficiary who had access to MEC and to testing services and treatment for COVID–19 as of or after March 18, 2020 would continue to have access to these services under the existing interpretation. The enrollment {or alternative] interpretation would also protect beneficiary enrollment in Medicaid. At the same time, it would expand state flexibility to make cost-saving decisions that could reduce beneficiaries' coverage below what they had access to as of or after March 18, 2020. Under the enrollment interpretation, some beneficiaries would be transitioned from MEC to non-MEC coverage, which may not include testing services and treatment for COVID–19 pursuant to CMS's interpretation of FFCRA section 6008(b)(4). Ensuring access to testing and treatment, along with care for the chronic health conditions that place beneficiaries at higher risk for COVID–19, is important for fighting the pandemic.

85 Fed. Reg. 71163 (emphasis added).

And it is actually administratively simpler for a state Medicaid agency to summarily keep someone *on* Medicaid during the PHE than to go through the steps of checking to see if they are perhaps eligible under any other category of Medicaid (required in general under Medicaid law before cutting anyone off, *see* 42 C.F.R. § 435.930); if not, then cutting them off with proper written notices; and, where a hearing is requested based on these requirements, expending

significant resources to respond to and adjudicate those appeals (as is the case with two of the three plaintiffs). Accordingly, the new rule was not only not "immediately necessary," but it did not in any way serve the "need" cursorily identified as the rationale for acting so quickly.

2. The Rule violates the APA because it was ultra vires.

The IFR conflicts with the unambiguous provisions of Section 6008 of the Coronavirus Response Act. That Act conditions increased state Medicaid during the COVID-19 public health emergency on a state's agreement to abide by certain "maintenance of effort" conditions. These include the condition, relevant here, that a state "provide that an individual who is enrolled for benefits" in a state's Medicaid program during the public health emergency "shall be treated as eligible for *such* benefits [i.e., the benefits for which the person was enrolled] through the end of the month" in which the public health emergency ends. *See* Coronavirus Response Act § 6008(b)(3) (emphasis added). The Defendant himself made clear, shortly after the passage of the Act, that any "***reduction** in medical assistance would be **inconsistent with the requirement at section 6008(b)(3) of the FFRCA*** 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…." CMS, *COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies* 26 (May 5, 2020)(emphasis added), Toubman Declaration, Exh. A.

After four times previously stating that the Coronavirus Response Act bars a state from reducing an enrolled Medicaid recipient's benefits during the COVID emergency (or risk losing increased Medicaid funding), HHS's IFR declares that states can, and in some cases must, move those enrolled in Medicaid when the Act was enacted into other programs for which they would otherwise be eligible – even if that results in lesser medical benefits. 85 Fed. Reg. 71161.

HHS offers a newfound ambiguity in the Coronavirus Response Act as the basis for its flip flop, despite no intervening change in federal law or in the trajectory of the pandemic:

> The language in this section could also reasonably be interpreted to mean only that states must maintain the enrollment of beneficiaries who enrolled in the state's Medicaid program as of or after March 18, 2020, through the end of the month in which the PHE ends, but not the specific benefits package they were receiving at that time.
>
> ***
>
> Under this alternative interpretation, a state would be required to move a beneficiary who becomes eligible for another Medicaid eligibility group during the period in which section 6008(b)(3) of the FFCRA applies into that new group, no matter how limited the benefits package is for the new group.

IFR, 85 Fed. Reg. 71161. The agency later pronounced that this "alternative interpretation" in fact was *required* to be followed. Defendant's belated assertion that the statute is ambiguous is impossible to square with the plain language of the Act.

The FFCRA specifies that a state will not qualify for the 6.2% funding increase if it "fails to provide that an individual who is enrolled for *benefits* under such plan (i.e.,"the State plan of such State under title XIX of the Social Security Act" unless that individual is "treated as eligible for *such* benefits through the end of the month in which such emergency period ends unless the individual requests a voluntary termination of eligibility or the individual ceases to be a resident of the State."(emphasis added). These were the only two exceptions allowed in the statute. Congress provided no authority for Defendant to issue any regulations under this statute, let alone authority to create new exceptions to the central requirement of the statute.

By use of "such" to qualify benefits, the statute is unambiguous that the enrolled individual must continue to get the *same* benefits for which that individual was enrolled (absent one of the two exceptions being applicable). *See, e.g., American Standard, Inc. v. Crane Co*, 510 F.2d 1043, 1059 (2d Cir. 1974) ("such beneficial owner" refers back to the "*same* beneficial owner"). Where, as here, the statutory language admits of only one meaning, a contrary agency interpretation is not entitled to deference and the statute's unambiguous provisions govern. If the Congress "has

directly spoken to the precise question at issue," the court — and the agency — "must give effect to [its] unambiguously expressed intent." *Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. at 842-43 (1984) "[A]n agency's interpretation of a statute," therefore, "is not entitled to deference when it goes beyond the meaning that the statute can bear." *MCI Telecomms. Corp. v. Am. Tel. & Tel. Co.*, 512 U.S. 218, 229 (1994).

After the IFR was issued, CMS informed the states that the termination of individuals in this situation was *required*, under the "alternative interpretation" referenced in the preamble. Even if there were any ambiguity in the language, it plainly cannot mean that the state is "*required*" to move the beneficiary who might otherwise be eligible for a different Medicaid eligibility group to the new group "no matter how limited the benefits package is for the new group," 85 Fed. Reg. 71161, much less required to move the enrolled individual from full benefit Medicaid to a very limited program, MSP, which just provides cost-sharing and only for those services that the Medicare program covers. This follows from the *Chevron* principles: (1) that an agency's interpretation gets deference only where, using the normal tools of statutory construction, there is an actual ambiguity to resolve and (2) even where there is some slight ambiguity, the agency only gets the deference that the "ambiguity allows." *Smiley v. Citibank (South Dakota) NA*, 517 U.S. 735, 741 (1996).

Assuming an ambiguity broad enough to qualify for *Chevron* deference, where, as here, an agency has changed a previously consistently-held interpretation, it must acknowledge the change *and* both offer good reasons for its new interpretation and take reliance interests into account. *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009). If it "makes a sudden and unexplained change . . . or a change that does not take account of legitimate reliance on prior interpretation . . . its new interpretation may be 'arbitrary, capricious [or] and abuse of discretion.'" *Smiley,* 517

U.S. at 742. A failure to even acknowledge, much less take reliance interests into account, when changing a rule or policy is a type of arbitrary agency action. *FCC*, 556 U.S. at 515.

HHS Secretary Azar's post-election day IFR was certainly a "sudden and unexplained change." *Smiley,* 517 U.S. at 742. It was adopted without prior notice and opportunity for comment after the agency had four previous times in the immediately preceding months announced a directly opposite interpretation of the same statutory provision. And, while HHS has acknowledged its flip-flop,[3] it has failed either to offer good reasons for its new interpretation or to take the reliance interests of those affected by the change into account, be they states or the Medicaid beneficiaries. Its explanation for its about-face included no change in the underlying statute or the pandemic or any error it had discovered in its prior pronouncements.

If CMS had in any way considered reliance interests in light of the eight months both the Coronavirus Response Act and its original interpretation of it were in effect, it would have had to consider that all of the states accepted the enhanced funding on the premise that they would apply the strictest maintenance of effort requirements with only two exceptions, with the assurance of FMAP plus 6.2% for everyone on Medicaid, whether due to the Coronavirus Response Act maintenance of effort requirements or otherwise. When the IFR was issued, states were told that there were new exceptions but that, other than non-citizens who were formerly children or non-pregnant women, they were not *required* to cut-off these individuals and they acted accordingly. And then CMS flip-flopped again and the states were told, in later interpretations, that, per the IFR, they ***must*** cut off all of the individuals in the newly created exceptions. In assessing reliance on its earlier interpretation following the plain meaning of the statute, CMS would have to have

[3] 85 Fed. Reg. 71116.

considered the highly disruptive effects on states of undermining the clear requirements in the Coronavirus Response Act, as it initially reaffirmed.

But rather than even considering reliance, CMS claims that its revised statutory interpretation was prompted by the concerns of unidentified states (it does not say which states or how many) that its "existing interpretation of section 6008(b)(3) of the Coronavirus Response Act makes it challenging for them to manage their programs effectively and still qualify for the increased Federal financial participation." *Id*. at 71,161. The claim is dubious given the extra 6.2% FMAP each state is getting for almost all of its Medicaid expenditures, including the vast majority of individuals who would continue to be eligible for Medicaid even without the passage of the Coronavirus Response Act; in the case of Connecticut, this has already brought in hundreds of millions of dollars over and above what it would otherwise have received in regular Medicaid reimbursements since the onset of the PHE. Of course, even accepting that a few states might find compliance with a statute "challenging" does not make the provision ambiguous or provide a basis for a new statutory interpretation. Nor does it explain the agency's newfound claim that the statute is ambiguous.

At the same time, the assertion that the new immediately-effective rule was justified by what is in the "best interests of the beneficiaries" is patently wrong. As noted above, it is directly ***against*** the interests of any Medicaid beneficiaries to be involuntarily cut off of necessary health benefits during the public health crisis, as mandated by Defendant under the IFR. This confirms the arbitrariness of his new rule.

Finally, while more than a year and a half has passed since the "interim" final rule was passed, the agency has taken no action to finalize the rule, much less consider the comments urging the repeal of the portion of the rule promulgating 42 C.F.R § 433.400 as submitted by Justice in

Aging and over two hundred other commentators. Reasoned decision-making under the APA, however, requires the agency to "engage the arguments raised before it." *NorAm Gas Transmission Company v. F.E.R.C.*, 148 F.3d 1158, 1165 (D.C. Cir. 1998). By failing to address these comments the agency has compounded the arbitrariness of its actions. *See* Regulations.gov

Accordingly, not only have Plaintiffs established a likelihood of success on the merits, but they have established a *clear and substantial* likelihood of success on both their procedural and substantive APA claims, thus satisfying the higher standard for an award of mandatory preliminary relief, should that higher standard be deemed to be applicable for some of the relief sought by Plaintiffs, or to the TRO sought only for Plaintiffs Carr and Moore.

C. The Balance of Hardships Tips in Plaintiffs Favor and the Issuance of a TRO and Preliminary Injunction is in the Public Interest

As noted earlier, in cases involving the federal government, the balance of hardship and public interest tests for a preliminary injunction merge. *New York v. United States Dept. of Homeland Sec.*, 969 F. 3d 42, 58-59 (2d Cir. 2020). "Any time the government is subject to a preliminary injunction, it necessarily suffers the injury of being prevented from enacting its preferred policy." *Id*. But absent other considerations, like the need to protect national security or "the need to correct a previous policy that had been deemed unlawful,"– neither of which is applicable here – this limited hardship would be outweighed by economic harms to movants, as well as the public interest in avoiding "[w]orse health outcomes." *Id.* That is precisely this case.

The Government will suffer no material hardship from being unable to continue applying a policy at odds with the statute it is administering. Certainly, any minimal harm in delayed implementation of its preferred about-face IFR policy is far outweighed by the hardships for Plaintiffs, as discussed above in the irreparable harm section, the concerns of which are specifically identified as a priority goal of the Medicaid Act in requiring that the program be administered in

"the best interests of the recipients," 42 U.S.C. § 1396a(a)(19). And the public interest is served where, as here, Plaintiffs have demonstrated a high likelihood of success on the merits and that they would suffer irreparable harm if denied injunctive relief.

Absent relief from the Court, irreparable harm in the way of lack of access to health services will visit each of the Plaintiffs. In two cases, this likely means unnecessary institutionalization, but for all of them it means going without medical care that cannot be later ameliorated. The "hardship" for Defendant, on the other hand, is extremely minimal. While, for the final ruling on the merits, Plaintiffs seek to have the Court set aside the portion of the IFR promulgating 42 C.F.R. § 433.400, this is not necessary at the preliminary injunction stage. For purposes of preliminary relief, CMS need simply be required to immediately inform all states that the IFR may not be enforced and that states should instead: (1) follow the Coronavirus Response Act, as they did for several months after its passage, and (2) immediately reinstate all individuals cut off of full benefit Medicaid in reliance on the IFR. This can be done through simple written guidance of the kind which the agency routinely issues, and in fact issued under the Coronavirus Response Act and later under the IFR. While Defendant will be required to continue to pay its federal match for each dollar of health care provided to the individuals not cut off of, or reinstated on, full benefit Medicaid, that is not a hardship; it is what was *intended* by Congress because of the recognized serious circumstances facing anyone involuntarily cut of Medicaid during the public health crisis – which continues and is currently seeing a nationwide surge of infections due to the Omicron B.A5 variant – because of the likely inability to timely access all needed health care which may be necessary during, and possibly survive, COVID-19.

It should not be lost on anyone that the reason for the passage of the Coronavirus Response Act was, and continues to be, a grave concern with the impact of the virus on all Americans and

legal residents but particularly individuals with a high risk of serious disease or death. It was recognized that cutting off their access to basic medical services just when they might contract the virus was unwise and not in the public health interest of assuring individuals are timely treated for the virus. This was particularly true for low-income individuals, i.e., those who qualify for Medicaid, because they lack independent means to pay out of pocket for health services. It is for these reasons that Congress made the considered decision that it is better to err on the side of keeping individuals on full benefit Medicaid even if they may no longer be eligible for same, to ensure access to timely health care to address the disease during the public health emergency, for as long as it continues. And the Defendant has now extended the PHE ten times, in increments of 90 days each, from January 31, 2020, when it was originally declared, until at least October 13, 2022, because of the seriousness and ongoing nature of the pandemic.

In assessing the public interest, it also is reasonable to consider the impact on the states, which actually administer the program on the ground. In passing the FFCRA, Congress recognized that this would bring a significant cost to the states as well as the federal government, and it therefore included in the Act a generous increase in the federal match rate for almost all of a state's expenditures under Medicaid, to compensate for the minority of individuals who would be kept on despite apparent ineligibility. It also made the requirement of maintaining continuous coverage for individuals who were no longer eligible for Medicaid under normal rules optional; no state was required to accept the continuous enrollment requirement but rather they were rewarded with the 6.2% bump-up in federal reimbursements if they chose to do so. Lastly, Congress went beyond this to also recognize two (and only two) exceptions which would allow a state to terminate Medicaid coverage of some individuals while still receiving the optional 6.2% increase for all of its Medicaid expenditures: when a person voluntarily left the program or left the state entirely

(including through death). There was no hint in what Congress passed that it intended to allow the federal Medicaid agency to tack on *additional* exceptions for any reason, such as that some states might complain about the duty to keep individuals on despite receiving an additional several hundred million dollars for doing so. Congress considered all of this and expressly stopped at these two exceptions. Congress's assessment that this was well-balanced, adequate compensation was borne out by subsequent events: all states promptly accepted this increased reimbursement with the understanding — and repeated reminders — that, absent a statutory exception, all individuals needed to stay on the Medicaid program during the PHE.

The APA is designed to ensure considered decision-making by federal agencies in adopting regulations under a federal statute. Exceptions to its processes are reserved for true emergencies, which cannot even arguably be applied to the portions of the IFR which, rather than addressing an emergency, *removed* emergency protections for the individuals Congress specifically intended to protect under the Coronavirus Response Act. It was not for the Trump Administration to significantly undermine Congress' careful balancing in the public interest by inventing new exceptions and to cut individuals off of full benefit Medicaid while the PHE continues, especially when Congress was clear as to intentions on the face of the Coronavirus Response Act and it specifically declined to authorize *any* regulations from Defendant under it. And it was not for the Biden Administration to continue to enforce these lawless provisions as there was no authority for what its predecessor did in the IFR. The fact that the IFR was adopted without going through the regulatory process required by the APA, when there was no emergency of any kind compelling quick action to cut people *off* of Medicaid – versus keeping them on, which *is* an emergency –only confirms the lawlessness of the IFR and the appropriateness of now enjoining it in the public interest.

D. Plaintiffs Should Not Be Required to Post a Security Bond as a Condition of the TRO

Plaintiffs should not be required to post a security bond if a TRO and/or preliminary injunction is issued. Although courts may order a bond, they are not required to do so. *Gov't Employees Ins. Co. v. Wellmart Rx, Inc*., 435 F. Supp. 3d 443, 455-56 (E.D.N.Y. 2020) *appeal dismissed,* 20-225 (2d Cir. May 11, 2020)(citing *Pharm. Soc. of State of N.Y., Inc. v. N.Y. State Dept. of Soc. Svs*., 50 F.3d 1168, 1174 (2d Cir. 1995). Courts also regularly waive the bond requirement in cases "rais[ing] issues that seek relief involving the 'public interest' arising out of 'comprehensive federal health and welfare statutes.'" *Gov't Employees*, 435 F.Supp.3d at 456. Courts also regularly decline to require a plaintiff to post bond where the plaintiff is indigent and the harm to plaintiff significantly outweighs the harm to defendant. *Temple Univ. v. White*, 941 F.2d 201, 220 (3d Cir. 1991) (waiver of bond in case brought to enforce Medicaid rights). Here, Plaintiffs should not be required to post a security because they are indigent, raise federal health and welfare statutory claims, and any harm to Defendants resulting from the issuance of a temporary restraining and preliminary injunction order is sharply outweighed by the harm to Plaintiffs if such an injunction does not issue.

IV. SCOPE OF REQUESTED TRO AND PRELIMINARY INJUNCTIVE RELIEF

In their Complaint, Plaintiffs ask this Court to set aside the portion of the IFR promulgating 42 C.F.R § 433.400. But relief in a preliminary injunction may be more limited. Plaintiffs therefore request that the Court enter an order preliminarily enjoining Defendant from enforcing that portion of the IFR and requiring him to notify all states: (1) that they may not apply any provisions of 42 C.F.R § 433.400, and (2) that they must immediately reinstate anyone cut off of full benefit Medicaid since the implementation of the IFR based on any of the extra-statutory exceptions not contained in the FFCRA itself (i.e., for a reason other than voluntarily getting off of Medicaid or

leaving the jurisdiction, including through death). Reinstatement of individuals like plaintiffs wrongly terminated from full-benefit Medicaid in violation of federal law is entirely appropriate, given the irreparable harm being visited upon them if reinstatement is not granted. *See, e.g., Strouchler*, 891 F. Supp. at 507, 527 (granting preliminary injunction and instructing parties to confer on appropriate immediate relief for individuals who already lost their home care services under preliminarily enjoined policies). And while this type of relief is mandatory in nature, Plaintiffs here have established a clear and substantial likelihood of success on the merits, thus making such preliminary relief appropriate.

More immediately, Plaintiffs Carr and Moore require a TRO to order Defendant to immediately cease applying the IFR to them so that they will not lose their Medicaid-funded home care services, on which they constantly rely for activities of daily living and to avoid unnecessary institutionalization.

V. CONCLUSION

For the foregoing reasons, Plaintiffs' Motion for TRO and Preliminary Injunction should be granted.

DATED: August 3, 2022.

Respectfully, submitted,

SHELDON V. TOUBMAN
Fed Bar No. ct08533
Phone: (475)345-3169
E-mail: sheldon.toubman@disrightsct.org
DEBORAH A. DORFMAN (Application for Admission *Pro Hac Vice* forthcoming)
CT Juris No. 442946
Phone: (860)469-4463
E-mail: deborah.dorfman@disrightsct.org
Disability Rights Connecticut
846 Wethersfield Avenue
Hartford, CT 06114

CAROL A. WONG (Application for Admission *Pro Hac Vice* forthcoming)
DC Bar No. 1035086
Justice in Aging
1444 I Street, NW, Suite 1100
Washington, DC 20005
Phone: (202) 683-1995
E-mail: cwong@justiceinaging.org

REGAN BAILEY (Application for Admission *Pro Hac Vice* forthcoming)
DC Bar No. 465677
Justice in Aging
1444 I Street, NW, Suite 1100
Washington, DC 20005
Phone: (202) 683-1990
E-mail: rbailey@justiceinaging.org

JANE PERKINS
NC Bar No. 9993
CA Bar No. 104784
Email: perkins@healthlaw.org
MIRIAM HEARD
NC Bar. No. 39747
Email: heard@healthlaw.org
(Applications for Admission *Pro Hac Vice* forthcoming)
National Health Law Program
1512 E. Franklin St., Ste. 110
Chapel Hill, NC 27514
Phone: (984) 278-7661

HARVEY L. REITER
(Application for Admission *Pro Hac Vice* forthcoming)
STINSON LLP
1775 Pennsylvania Avenue, N.W.
Suite 800
Washington, D.C. 2006
Email: harvey.reiter@stinson.com
Phone: (202)728-3016
Fax: (202)572-9968

Counsel for Plaintiff

Certificate of Service

I hereby certify that on the above date a copy of the foregoing document was filed electronically and served by overnight delivery to anyone unable to accept electronic filing. Notice of this filing will be sent by email to all parties by operation of the Court's electronic filing system or by overnight delivery to anyone unable to accept electronic filing as indicated on the Notice of Electronic Filing. Parties may access this filing through the Court's CM/ECF System.

s/Sheldon V. Toubman
Sheldon V. Toubman

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

DEBORAH CARR, BRENDA MOORE, MARY ELLEN WILSON Plaintiffs, v. XAVIER BECERRA, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES Defendant.	)	Civil Action No. 3:22-cv-00988

Declaration of Deborah Carr

I, Deborah Carr, declare that:

1. I am over the age of 18, have personal knowledge of the matters stated herein and am competent to testify about these matters.
2. I am a resident of New Haven, Connecticut and I am a 63-year-old White woman.
3. I have Friedrich's Ataxia, a progressive neurological condition, scoliosis of the spine and severe hearing loss, and, related to my medical conditions, I also have an indwelling urinary catheter due to toileting difficulties.
4. My income consists of $1300 in monthly Social Security survivors' benefits based on my disability.
5. I have been on Medicaid for my entire life because of my long term, chronic conditions and the amount of my income.

6. I require assistance with almost all activities of daily living, including dressing, transferring from my wheelchair or out of bed, using the toilet, bathing and eating, due to my medical conditions.

7. I have for several years been receiving many hours per week of home health services paid for under Medicaid to help with all of my activities of daily living (ADL) and allow me to continue to live outside of an institution.

8. I reside with my friend, Donald Demmitt, but he cannot assist me with all of my ADL needs because he also is disabled and uses a wheelchair.

9. My income increased in the fall of 2021 (retroactive for over a year) due to qualifying for survivor's benefits on my deceased father's Social Security account.

10. Under the Medicaid program (HUSKY D), I was able to receive 42 hours per week of home care services.

11. I then received a notice dated February 15, 2022 (a copy of which is attached), stating that I was being cut off of HUSKY D effective February 28, 2022 because I had become eligible for Medicare (which occurred in December of 2021, as I had waited the two years for Medicare eligibility since my social security survivors' benefits (retroactively) started).

12. I was told in the February 15th notice that I could no longer have Medicaid under HUSKY D if I was on Medicare and I also qualified for the Medicare Savings Program.

13. I was told in this notice that I might qualify for Medicaid through HUSKY C and that I might be getting a separate notice about that possibility.

14. I was sent another notice of the same date, which was called a "spenddown welcome packet," stating that I had to incur $1746 in medical bills every six months to qualify for HUSKY C.

15. I was unable to incur this amount of medical bills to meet the HUSKY C spenddown because providers would not provide services to me without assurance of payment.

16. My social worker with the Department of Social Services ("DSS") advised me that the only way to get around this obstacle was to go to the hospital ER to produce a medical bill that I could then use to meet the spenddown, but I was unwilling to do this because it seemed wrong.

17. I timely appealed the HUSKY D termination notice dated February 15th through a request for a hearing dated February 22nd before the termination went into effect and I checked off that I wanted my benefits to continue pending the hearing and hearing decision.

18. Due to this termination of full Medicaid benefits under HUSKY D, I also applied for the Personal Care Attendant Medicaid home and community-based services waiver program in March of this year. This program has a higher income limit which would not require a spenddown and I was told that, under it, I would be able to access full Medicaid benefits, including home care services through Personal Care Attendants,

19. My DSS social worker told me that, though I met the criteria for being on the waiver because I needed a nursing home level of care, there is a waiting list of three to four years for this waiver program and that is why I had been denied coverage under it.

20. I am currently receiving 70 hours of home care services each week right, but this is temporary because I requested continued benefits pending the hearing decision in my appeal of the termination of HUSKY D. No decision has yet been issued in that appeal.

21. I cannot afford to pay on my own for the home care services I need, the cost of which is several thousand dollars every month.

22. I am terrified that if I lose these home care services paid for under Medicaid, I will be forced to move into a nursing home to survive since I need help with all of my activities of daily living.

23. I know other people who have gone to nursing homes with very bad outcomes.

24. I also am afraid of catching COVID-19 if I go to one of these places because I have heard that many people have died from that disease in nursing homes.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing declaration is true and correct.

Date: August 2, 2022

Deborah Carr

EXHIBIT 1

access health CT

HUSKY HEALTH CONNECTICUT

February 15, 2022

Person ID: 2569376
Application ID: 9782682

DEBORAH B CARR
66 Orange St Apt 301
New Haven Connecticut 06510

Dear DEBORAH B CARR ,

Your HUSKY Health coverage (HUSKY D) will end on February 28, 2022.

Under federal law, HUSKY D provides Medicaid coverage for income-eligible adults without dependent children who are between the ages of 19 and 64 and not enrolled in Medicare. Our records show that you receive Medicare. Ordinarily, we would have stopped your HUSKY D coverage as soon as you became eligible for Medicare. However, because of the COVID-19 pandemic, a change in federal rules allowed us to temporarily extend your HUSKY D coverage even after you enrolled in Medicare. Now, following the latest federal rules, we need to end your HUSKY D coverage because you are also enrolled in the Medicare Savings Program (MSP).[1] MSP is a Medicaid program that helps you with your Medicare costs, such as premiums.

Because you are enrolled in both Medicare and MSP, we can no longer extend your HUSKY D coverage. Your HUSKY D coverage will end on February 28, 2022. You will stay enrolled in MSP for as long as you continue to qualify. You can read more about MSP at the end of this notice.

Also, because you are enrolled in Medicare, you do not qualify to enroll in and buy a Qualified Health Plan through Access Health CT.[2]

How did we make this decision?

The Department of Social Services (DSS) and Access Health CT (AHCT) used information from your healthcare coverage applications. We may also have used information from government computer systems such as the Social Security Administration and the Internal Revenue Service. There are enclosures with this letter that will help you understand how we make our decisions.

For more information about HUSKY Health coverage, please review the “Different Types of HUSKY Health” enclosure. We will also check to see if you might be eligible for HUSKY C based on the information we have about you. HUSKY C is the state’s Medicaid program for individuals who are over age 65, disabled, or blind. If the information we have suggests you may be eligible for HUSKY C, we will send you a separate form to complete. You can also read more about HUSKY C at the end of this notice.

[1] 42 C.F.R. § 433.400(c)(2)(i)(B)
[2] 42 U.S.C. § 1395ss(d)(3)(A)

access health CT

HUSKY HEALTH CONNECTICUT

What should I do if I think you made a mistake?

You can appeal our decisions about your health coverage. For example, you can appeal if you think we made a mistake about your age or eligibility for Medicare

We have sent a "Hearing/Appeal Request Form" with this letter. This form explains your rights and the deadlines for asking for a hearing. For HUSKY Health decisions, the deadline is 60 days from the date of this letter.

If you want to keep your current HUSKY Health coverage while the appeal process is ongoing, your appeal request must be postmarked or received by DSS on or before the last day of coverage, or 10 days from the date of this letter, whichever is later. For decisions on whether you can buy a health plan through Access Health CT, you have 90 days from the date of the letter to request a hearing.

Sincerely,

The DSS HUSKY Health Program and Access Health CT

More about HUSKY C and long-term care programs

HUSKY C is the state's Medicaid program for individuals who are over age 65, disabled, or blind. If you need long-term care services and supports to help you remain in your home, or if you have a disability and continue to work, then HUSKY C might be for you. You can learn more about HUSKY C online at www.ct.gov/HUSKY.

What does having the Medicare Savings Program (MSP) mean for you?

- MSP will continue to provide assistance with cost-sharing for Medicare premiums, and, depending on the level you qualify for, may also provide assistance with your Medicare deductibles, coinsurance and other cost-sharing.
- You will continue to be eligible for Extra Help, which pays a portion of the Medicare Part D premium and lowers your cost-sharing for medications on that plan's list of covered medications.

Do you have questions about this notice or want help navigating your healthcare options?

For application assistance or questions about Medicare, MSP, or HUSKY Health programs, please **contact CHOICES at 1-800-994-9422** for free and unbiased assistance.

access health CT

HUSKY HEALTH CONNECTICUT

Reporting Changes

What changes do I need to report?	You must report any changes that might affect you or your household's health coverage within 30 days of the change. For example: ▸ You move. ▸ Household income changes. ▸ Household size changes. For example, you get married or divorced, become pregnant, or have a child. ▸ Someone's immigration status changes such as a visa expiring. ▸ Plans change on how you intend to file your taxes. ▸ Someone becomes qualified for other health coverage. To report any changes, you must contact Access Health CT either online or by phoning the call center.
How do I contact Access Health CT?	Contact Access Health CT if you need to report changes, apply for coverage, select a plan or program, or have any questions about this notice. Let us know if you need help applying for health care coverage or accessing your account. You can contact Access Health CT: ▸ **By going online** at www.accesshealthct.com, or ▸ **By calling** the Access Health CT Contact Center at: 1-855-805-4325. If you are deaf or hard of hearing call the TTY number: 1-855-789-2428. If you have a disability you may ask for and get a reasonable accommodation or special help from Access Health CT.
How do I report changes online?	If you want to report a change online, please follow the steps listed below: ▸ Log in to your Access Health CT account at: www.accesshealthct.com ▸ Click the "Report a Change/Renew Coverage" Quick Link from your account home screen. ▸ Review and confirm that each applicant's information is accurate. ▸ Report any changes necessary. ▸ Provide your electronic signature and SUBMIT. ▸ Select a program and complete the enrollment process.

Connecticut Department of Social Services
Making a Difference

access health CT

HUSKY HEALTH CONNECTICUT

Quick Guide to Access Health CT

Who should use Access Health CT?

Access Health CT is for people who don't have health coverage through a job, Medicare, or another source that provides qualifying coverage. Access Health CT is also for people looking for more affordable or better health coverage.

What types of coverage can I get through Access Health CT?

Access Health CT provides access to two types of health coverage:

- HUSKY Health is free or low-cost health coverage administered by the Department of Social Services (DSS).
- Health insurance plans also known as *Qualified Health Plans*.

How does Access Health CT determine the type of coverage for my family?

We first look at your information and based on this decide if you or anyone in your household qualifies for HUSKY Health. HUSKY Health is either completely free or has a low-cost monthly premium.

If you do not qualify for HUSKY then we will look to see if you can purchase a health insurance plan offered through our marketplace.

Most people who qualify for an insurance plan also qualify for a premium tax credit that lowers their monthly insurance bill. Some also save on out-of-pocket costs like deductibles and copayments.

What does Access Health CT consider when making its decision?

HUSKY Health and the health insurance plans have different rules. But both types of coverage consider factors such as whether you are a resident of Connecticut, your family size and relationships, how you might file your taxes, your citizenship or immigration status, and your income.

We also consider If you have other types of health coverage:

- **If you have job-based insurance:** You could still qualify for HUSKY Health if your income is low enough. But if you buy an insurance plan through Access Health CT you'll pay full price unless your employer's insurance doesn't meet certain standards.
- **If you have Medicare:** This can affect the type of HUSKY coverage you may be able to qualify for. You should not use Access Health CT insurance plans to supplement your Medicare, or use Access Health CT to buy a dental plan.

Connecticut Department of Social Services
Making a Difference

access health CT

HUSKY HEALTH CONNECTICUT

Different Types of HUSKY Health

What are the different types of HUSKY Health?	There are four types of HUSKY Health coverage: ▸ **HUSKY A** – Medicaid for children, parents, caretaker relatives and pregnant women. ▸ **HUSKY B** – Connecticut's Children's Health Insurance Program (CHIP) for children under 19 in families that are above the HUSKY A income limits. ▸ **HUSKY C** – Medicaid for the Elderly (65+), Blind or Disabled. It includes Long-Term Care Services such as Nursing Homes. ▸ **HUSKY D** – Medicaid for adults between the age of 19 and 64 who are not pregnant and who do not qualify for Medicare.
What types of HUSKY coverage can I get through Access Health CT?	The Access Health CT application is for HUSKY A, B and D coverage types. If you do not qualify for HUSKY then Access Health CT will look to see if you can purchase a health insurance plan offered through their marketplace. They will also tell you if you qualify for financial help with the cost of a health insurance plan.
Does Access Health CT support all types of HUSKY Health?	HUSKY C is not considered by the Access Health CT application because more information is needed. However, If we see reasons why you might qualify for HUSKY C we will contact you and request more information. See below for all the ways you can apply for HUSKY C.
How can I apply for HUSKY C?	There are several ways: ▸ Online at www.connect.ct.gov, or ▸ By visiting a Connecticut DSS office, or ▸ Using the special form that we will send you if you reported that you were disabled, 65 or older or receiving Medicare, or ▸ By filling in a comprehensive W1E application. You can use this to also apply for cash and food help (also known as TFA and SNAP). This form is available on the DSS website, at DSS offices and can be requested over the phone. If you have any questions about HUSKY C call the Department of Social Services (DSS) at 1-855-626-6632 or check out the DSS website at www.ctgov/dss.

Connecticut Department of Social Services
Making a Difference

access health CT

HUSKY HEALTH CONNECTICUT

Hearing/Appeal Request Form

IMPORTANT – Use this form only if you want a hearing.

Remember, before you ask for a hearing you may call Access Health CT for help in solving the problem.

You can call the Access Health CT Contact Center at 1-855-805-4325. If you are deaf or hard of hearing, the TTY number is 1-855-789-2428.

Appeal Rights and Deadlines	You have the right to a hearing if you disagree with any decision(s) we have made about your coverage. • For HUSKY Health decisions, you have 60 days from the date of this notice to request a hearing. **If you do not request a hearing within 60 days you may lose the right to a hearing.** • For all other decisions, you have 90 days from the date of this notice to request a hearing. **If you do not request a hearing within 90 days you may lose the right to a hearing**. • For assistance with the Appeals process, please contact the Office of the Healthcare Advocate: By Phone: 1-866-466-4446 By email: Healthcare.Advocate@ct.gov.
Where to Send this Form	Complete this Hearing/Appeal Request Form and submit: • **By mail** to Department of Social Services, Office of Legal Counsel, Regulations and Administrative Hearings, AHCT-DSS Hearings Unit, 55 Farmington Avenue, Hartford, CT 06105-3725 • **By email** to DSS-AHCT@ct.gov. • **By fax** to 860-424-4923. You can call (855) 306-8625 for questions and for help. If you are deaf or short of hearing call (800) 842-4524.
This Form is not for Every Issue	Do **NOT** use this form for: • Issues with your insurance company about premium payments. • Issues with health insurance and premium tax credit start dates. • Issues with your health insurance plan details. Contact Access Health CT or your insurance company, as most appropriate, to resolve these issues.

You may ask for an expedited (quicker) hearing if the regular decision deadlines put your life or health at serious risk or could seriously affect your ability to function. You or your health care provider must show us why you need an expedited hearing. If an expedited hearing is needed, we will make our hearing decision no more than three business days after we receive your request.

Connecticut Department of Social Services
Making a Difference

Person ID: 2569376

Application ID: 9782682

Step 1 Tell us about yourself

1. Name (*first middle last suffix*)

2. **Mailing** address		3. Apartment or Suite Number
4. City	5. State	6. ZIP code
7. Daytime phone number	8. Email address	

9. Will you need a translator at the hearing? ☐ Yes ☐ No. ***If yes,*** what language do you speak? _____

10. We usually hold hearings by telephone. You may also have a hearing by video conference from a DSS regional office. Please check how you want your hearing? ☐ By telephone ☐ By video conference at DSS

Step 2 Tell us what you wish to appeal

☐ I disagree with the decision to deny or end HUSKY Health (Medicaid or CHIP) coverage.

☐ I disagree with the decision about financial help with paying for my health insurance plan (includes decision to deny or end this help and decisions on the amount of help).

Financial assistance is for health insurance plans and can include premium tax credits and lower cost sharing such as co-pays and deductibles.

☐ I disagree with the denial to buy a health insurance plan.

☐ I disagree with the decision to deny Special Enrollment.

☐ Any other reason or if you want to give more details – ***please explain:***

☐ HUSKY Only: If you were getting HUSKY medical benefits and you ask for a hearing about the decision **any time before the change becomes effective,** your medical benefits will stay as they were until the Hearing Officer decides your case. **Please check this box if you want to keep your health care coverage** the way it was before the Access Health CT decision and until the Hearing Officer decides your case. **IF YOU CHOOSE TO KEEP YOUR COVERAGE UNTIL THE HEARING AND THE HEARING OFFICER DECIDES THAT WE WERE RIGHT, YOU MAY HAVE TO PAY BACK ANY MEDICAL ASSISTANCE YOU GOT WHILE YOU WERE WAITING FOR THE HEARING DECISION.**

Step 3 Read and sign this form

Is someone helping you with this appeal? (For example, this could be a friend, family member, an attorney, someone else)

☐ Yes ☐ No. ***If yes,*** please provide this person's contact information:

Name

Address

Phone	Email

Signature of applicant or authorized representative: **Date (*mm/dd/yyyy*):**

HUSKY HEALTH CONNECTICUT

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

DEBORAH CARR, BRENDA MOORE, MARY ELLEN WILSON Plaintiffs, v. XAVIER BECERRA, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES Defendant.	)	Civil Action No. 3:22-cv-00988

Declaration of Brenda Moore

I, Brenda Moore, declare that:

1. I am over the age of 18, have personal knowledge of the matters stated herein and am competent to testify about these matters.
2. I am a resident of New Haven, Connecticut and I am a 57 year old Black woman.
3. I live with an adult son who works outside of the house and is not able to provide help with my activities of daily living. I also live with my 3-year-old granddaughter for whom my son has custody.
4. I have a severe vascular condition which has led to blood clots and required multiple surgeries which have been only partially successful.
5. Due to my severe circulation issues, I require daily assistance with bathing, dressing, transferring and toileting, and also with meal preparation.
6. I am able to ambulate but only with a walker or cane. I have fallen several times in the last few months.

7. I also have severe depression and post-traumatic stress disorder.

8. My income is $1402 in monthly Social Security Disability Insurance ("SSDI") benefits.

9. I have been on full benefit Medicaid for many years.

10. I went on the HUSKY D Medicaid program about five years ago, around the time that my youngest child became an adult and therefore I was no longer eligible for the HUSKY A Medicaid program, and I had not yet been found to be disabled which would qualify me for the HUSKY C Medicaid program.

11. My income had been just Supplemental Security Income ("SSI") but in November of 2019, I became eligible for SSDI on my deceased husband's account, at which point my income increased to about $1300 per month, which was still within the income guidelines for HUSKY D.

12. Under HUSKY D, I had been receiving 39 hours of weekly assistance in the way of personal care assistance, starting in July of 2020, due to my developing vascular condition which was causing falls and other symptoms.

13. These services paid for under the Medicaid program, currently totaling 39 hours per week, allow me to live outside of an institutional setting.

14. DSS sent a notice to me dated February 15, 2022 stating that I was no longer eligible for HUSKY D effective February 28, 2022 (copy of notice attached to this declaration). The notice said that I qualified for the Medicare Savings Program.

15. The same notice also advised me that I might be eligible for HUSKY C.

16. I later received a notice from the Department of Social Services ("DSS") stating that I could qualify for full benefit Medicaid through spending down to the HUSKY C income limit, with a spenddown amount of $2766 every six months.

17. Since the termination of my HUSKY D benefits on March 1st, my wonderful aide continued providing services without any compensation from the Medicaid program, for five weeks. But as a result, I ended up owing her over $3700, based on the hourly rate Medicaid had been paying her.

18. I have no way to pay off this debt.

19. However, after going about three months without any assistance from Medicaid, I was able to get approval for HUSKY C under a spenddown period ending August 31, 2022, based on the amount of these medical bills, which exceeded my $2766 spenddown requirement for that program.

20. Proof of the medical expenditures was provided to DSS, which initially refused to accept them, but later they were accepted and used for this one-time spenddown period.

21. I cannot expect may aide to continue to provide uncompensated services to me after August 31st, especially since I still owe her for the period after my HUSKY D was terminated on March 1st.

22. Since I was cut off of Medicaid on March 1st, I applied for the PCA Medicaid waiver program, which has a much higher income limit and would cover the costs of my PCA needs, on or about April 21, 2022. I received a letter dated April 26th which said I was being denied benefits under this waiver.

23. During the period when I was cut off of Medicaid and my aide could no longer provide uncompensated care, I went without assistance with my activities of daily living, although my aide still did do daily safety checks on me.

24. Because of my great difficulty in getting out of bed on my own, I spent long times in bed in the morning after I woke, during this period.

25. Also during this period, I had not been able to clean myself after using the bathroom, as my aide had done before and is doing now.

26. Because I am not able to prepare meals myself, as my aide used to do for me, I subsisted during this period on cold food, which consisted of crackers and canned food which is supposed to be heated but which I ate cold.

27. On May 2nd, when my aide came by to do an uncompensated check on me, she found me on the floor, as I had fallen and was unable to get up on my own. It took me several weeks to recover from that fall, during which time I had a significant amount of pain. I also fell in the shower that month without my aide helping me there.

28. Since my entire income is $1402 in monthly SSDI benefits, I am unable to pay for the needed assistance myself, and still owe my aide for the several week period from March 1st when she provided assistance without Medicaid payment.

29. If I have no aide to help me after August 31, when Medicaid payment for these services will again stop, I am afraid I will have to go back to that awful experience when Medicaid stopped paying for all of my assistance in March, which means I will not be able to get out of bed, will go without being able to properly clean myself or safely take a shower, will have to eat only cold food, and will likely fall again.

30. Because of this potential for physical harm, I am afraid that without these services I will be forced to go into a nursing home to get needed assistance with activities of daily living.

31. I also have started going to a cardiologist because I was recently found, in late June 2022, to have had two small heart attacks, and I am scheduled for a stress test with this cardiologist on August 3, 2022.

32. I want to continue living in my own home and not in a nursing home where all of my independence will be taken away.

33. I also am afraid of contracting COVID-19 if I have to go to such a home because there has been so much of that disease in these places. This particularly worries me because of my new diagnosis of a heart condition.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing declaration is true and correct.

Date: August 2, 2022.

Brenda Moore

EXHIBIT 1

access health CT

HUSKY HEALTH CONNECTICUT

February 15, 2022

Person ID: 457308
Application ID: 9613622

Brenda R Moore
181 Plymouth St
New Haven Connecticut 06519

Dear Brenda R Moore ,

Your HUSKY Health coverage (HUSKY D) will end on February 28, 2022.

Under federal law, HUSKY D provides Medicaid coverage for income-eligible adults without dependent children who are between the ages of 19 and 64 and not enrolled in Medicare. Our records show that you receive Medicare. Ordinarily, we would have stopped your HUSKY D coverage as soon as you became eligible for Medicare. However, because of the COVID-19 pandemic, a change in federal rules allowed us to temporarily extend your HUSKY D coverage even after you enrolled in Medicare. Now, following the latest federal rules, we need to end your HUSKY D coverage because you are also enrolled in the Medicare Savings Program (MSP).[1] MSP is a Medicaid program that helps you with your Medicare costs, such as premiums.

Because you are enrolled in both Medicare and MSP, we can no longer extend your HUSKY D coverage. Your HUSKY D coverage will end on February 28, 2022. You will stay enrolled in MSP for as long as you continue to qualify. You can read more about MSP at the end of this notice.

Also, because you are enrolled in Medicare, you do not qualify to enroll in and buy a Qualified Health Plan through Access Health CT.[2]

How did we make this decision?

The Department of Social Services (DSS) and Access Health CT (AHCT) used information from your healthcare coverage applications. We may also have used information from government computer systems such as the Social Security Administration and the Internal Revenue Service. There are enclosures with this letter that will help you understand how we make our decisions.

For more information about HUSKY Health coverage, please review the “Different Types of HUSKY Health” enclosure. We will also check to see if you might be eligible for HUSKY C based on the information we have about you. HUSKY C is the state’s Medicaid program for individuals who are over age 65, disabled, or blind. If the information we have suggests you may be eligible for HUSKY C, we will send you a separate form to complete. You can also read more about HUSKY C at the end of this notice.

[1] 42 C.F.R. § 433.400(c)(2)(i)(B)
[2] 42 U.S.C. § 1395ss(d)(3)(A)

access health CT

HUSKY HEALTH CONNECTICUT

What should I do if I think you made a mistake?

You can appeal our decisions about your health coverage. For example, you can appeal if you think we made a mistake about your age or eligibility for Medicare

We have sent a "Hearing/Appeal Request Form" with this letter. This form explains your rights and the deadlines for asking for a hearing. For HUSKY Health decisions, the deadline is 60 days from the date of this letter.

If you want to keep your current HUSKY Health coverage while the appeal process is ongoing, your appeal request must be postmarked or received by DSS on or before the last day of coverage, or 10 days from the date of this letter, whichever is later. For decisions on whether you can buy a health plan through Access Health CT, you have 90 days from the date of the letter to request a hearing.

Sincerely,

The DSS HUSKY Health Program and Access Health CT

More about HUSKY C and long-term care programs

HUSKY C is the state's Medicaid program for individuals who are over age 65, disabled, or blind. If you need long-term care services and supports to help you remain in your home, or if you have a disability and continue to work, then HUSKY C might be for you. You can learn more about HUSKY C online at www.ct.gov/HUSKY.

What does having the Medicare Savings Program (MSP) mean for you?

- MSP will continue to provide assistance with cost-sharing for Medicare premiums, and, depending on the level you qualify for, may also provide assistance with your Medicare deductibles, coinsurance and other cost-sharing.
- You will continue to be eligible for Extra Help, which pays a portion of the Medicare Part D premium and lowers your cost-sharing for medications on that plan's list of covered medications.

Do you have questions about this notice or want help navigating your healthcare options?

For application assistance or questions about Medicare, MSP, or HUSKY Health programs, please **contact CHOICES at 1-800-994-9422** for free and unbiased assistance.

access health CT

HUSKY HEALTH CONNECTICUT

Reporting Changes

What changes do I need to report?	You must report any changes that might affect you or your household's health coverage within 30 days of the change. For example: ▸ You move. ▸ Household income changes. ▸ Household size changes. For example, you get married or divorced, become pregnant, or have a child. ▸ Someone's immigration status changes such as a visa expiring. ▸ Plans change on how you intend to file your taxes. ▸ Someone becomes qualified for other health coverage. To report any changes, you must contact Access Health CT either online or by phoning the call center.
How do I contact Access Health CT?	Contact Access Health CT if you need to report changes, apply for coverage, select a plan or program, or have any questions about this notice. Let us know if you need help applying for health care coverage or accessing your account. You can contact Access Health CT: ▸ **By going online** at www.accesshealthct.com, or ▸ **By calling** the Access Health CT Contact Center at: 1-855-805-4325. If you are deaf or hard of hearing call the TTY number: 1-855-789-2428. If you have a disability you may ask for and get a reasonable accommodation or special help from Access Health CT.
How do I report changes online?	If you want to report a change online, please follow the steps listed below: ▸ Log in to your Access Health CT account at: www.accesshealthct.com ▸ Click the "Report a Change/Renew Coverage" Quick Link from your account home screen. ▸ Review and confirm that each applicant's information is accurate. ▸ Report any changes necessary. ▸ Provide your electronic signature and SUBMIT. ▸ Select a program and complete the enrollment process.

Connecticut Department of Social Services
Making a Difference

access health CT

HUSKY HEALTH CONNECTICUT

Quick Guide to Access Health CT

Who should use Access Health CT?

Access Health CT is for people who don't have health coverage through a job, Medicare, or another source that provides qualifying coverage. Access Health CT is also for people looking for more affordable or better health coverage.

What types of coverage can I get through Access Health CT?

Access Health CT provides access to two types of health coverage:

- HUSKY Health is free or low-cost health coverage administered by the Department of Social Services (DSS).
- Health insurance plans also known as *Qualified Health Plans*.

How does Access Health CT determine the type of coverage for my family?

We first look at your information and based on this decide if you or anyone in your household qualifies for HUSKY Health. HUSKY Health is either completely free or has a low-cost monthly premium.

If you do not qualify for HUSKY then we will look to see if you can purchase a health insurance plan offered through our marketplace.

Most people who qualify for an insurance plan also qualify for a premium tax credit that lowers their monthly insurance bill. Some also save on out-of-pocket costs like deductibles and copayments.

What does Access Health CT consider when making its decision?

HUSKY Health and the health insurance plans have different rules. But both types of coverage consider factors such as whether you are a resident of Connecticut, your family size and relationships, how you might file your taxes, your citizenship or immigration status, and your income.

We also consider If you have other types of health coverage:

- **If you have job-based insurance:** You could still qualify for HUSKY Health if your income is low enough. But if you buy an insurance plan through Access Health CT you'll pay full price unless your employer's insurance doesn't meet certain standards.
- **If you have Medicare:** This can affect the type of HUSKY coverage you may be able to qualify for. You should not use Access Health CT insurance plans to supplement your Medicare, or use Access Health CT to buy a dental plan.

Connecticut Department of Social Services
Making a Difference

access health CT

HUSKY HEALTH CONNECTICUT

Different Types of HUSKY Health

What are the different types of HUSKY Health?	There are four types of HUSKY Health coverage: ▸ **HUSKY A** – Medicaid for children, parents, caretaker relatives and pregnant women. ▸ **HUSKY B** – Connecticut's Children's Health Insurance Program (CHIP) for children under 19 in families that are above the HUSKY A income limits. ▸ **HUSKY C** – Medicaid for the Elderly (65+), Blind or Disabled. It includes Long-Term Care Services such as Nursing Homes. ▸ **HUSKY D** – Medicaid for adults between the age of 19 and 64 who are not pregnant and who do not qualify for Medicare.
What types of HUSKY coverage can I get through Access Health CT?	The Access Health CT application is for HUSKY A, B and D coverage types. If you do not qualify for HUSKY then Access Health CT will look to see if you can purchase a health insurance plan offered through their marketplace. They will also tell you if you qualify for financial help with the cost of a health insurance plan.
Does Access Health CT support all types of HUSKY Health?	HUSKY C is not considered by the Access Health CT application because more information is needed. However, If we see reasons why you might qualify for HUSKY C we will contact you and request more information. See below for all the ways you can apply for HUSKY C.
How can I apply for HUSKY C?	There are several ways: ▸ Online at www.connect.ct.gov, or ▸ By visiting a Connecticut DSS office, or ▸ Using the special form that we will send you if you reported that you were disabled, 65 or older or receiving Medicare, or ▸ By filling in a comprehensive W1E application. You can use this to also apply for cash and food help (also known as TFA and SNAP). This form is available on the DSS website, at DSS offices and can be requested over the phone. If you have any questions about HUSKY C call the Department of Social Services (DSS) at 1-855-626-6632 or check out the DSS website at www.ctgov/dss.

Connecticut Department of Social Services
Making a Difference

access health CT

HUSKY HEALTH CONNECTICUT

Hearing/Appeal Request Form

IMPORTANT – Use this form only if you want a hearing.

Remember, before you ask for a hearing you may call Access Health CT for help in solving the problem.

You can call the Access Health CT Contact Center at 1-855-805-4325. If you are deaf or hard of hearing, the TTY number is 1-855-789-2428.

Appeal Rights and Deadlines	You have the right to a hearing if you disagree with any decision(s) we have made about your coverage. • For HUSKY Health decisions, you have 60 days from the date of this notice to request a hearing. **If you do not request a hearing within 60 days you may lose the right to a hearing.** • For all other decisions, you have 90 days from the date of this notice to request a hearing. **If you do not request a hearing within 90 days you may lose the right to a hearing**. • For assistance with the Appeals process, please contact the Office of the Healthcare Advocate: By Phone: 1-866-466-4446 By email: Healthcare.Advocate@ct.gov.
Where to Send this Form	Complete this Hearing/Appeal Request Form and submit: • **By mail** to Department of Social Services, Office of Legal Counsel, Regulations and Administrative Hearings, AHCT-DSS Hearings Unit, 55 Farmington Avenue, Hartford, CT 06105-3725 • **By email** to DSS-AHCT@ct.gov. • **By fax** to 860-424-4923. You can call (855) 306-8625 for questions and for help. If you are deaf or short of hearing call (800) 842-4524.
This Form is not for Every Issue	Do **NOT** use this form for: • Issues with your insurance company about premium payments. • Issues with health insurance and premium tax credit start dates. • Issues with your health insurance plan details. Contact Access Health CT or your insurance company, as most appropriate, to resolve these issues.

You may ask for an expedited (quicker) hearing if the regular decision deadlines put your life or health at serious risk or could seriously affect your ability to function. You or your health care provider must show us why you need an expedited hearing. If an expedited hearing is needed, we will make our hearing decision no more than three business days after we receive your request.

Connecticut Department of Social Services
Making a Difference

Person ID: 457308

Application ID: 9613622

Step 1 Tell us about yourself

1. Name (*first middle last suffix*)

2. **Mailing** address		3. Apartment or Suite Number
4. City	5. State	6. ZIP code
7. Daytime phone number	8. Email address	

9. Will you need a translator at the hearing? ☐ Yes ☐ No. ***If yes,*** what language do you speak? _____

10. We usually hold hearings by telephone. You may also have a hearing by video conference from a DSS regional office. Please check how you want your hearing? ☐ By telephone ☐ By video conference at DSS

Step 2 Tell us what you wish to appeal

☐ I disagree with the decision to deny or end HUSKY Health (Medicaid or CHIP) coverage.

☐ I disagree with the decision about financial help with paying for my health insurance plan (includes decision to deny or end this help and decisions on the amount of help).

Financial assistance is for health insurance plans and can include premium tax credits and lower cost sharing such as co-pays and deductibles.

☐ I disagree with the denial to buy a health insurance plan.

☐ I disagree with the decision to deny Special Enrollment.

☐ Any other reason or if you want to give more details – ***please explain:***

☐ HUSKY Only: If you were getting HUSKY medical benefits and you ask for a hearing about the decision **any time before the change becomes effective,** your medical benefits will stay as they were until the Hearing Officer decides your case. **Please check this box if you want to keep your health care coverage** the way it was before the Access Health CT decision and until the Hearing Officer decides your case. **IF YOU CHOOSE TO KEEP YOUR COVERAGE UNTIL THE HEARING AND THE HEARING OFFICER DECIDES THAT WE WERE RIGHT, YOU MAY HAVE TO PAY BACK ANY MEDICAL ASSISTANCE YOU GOT WHILE YOU WERE WAITING FOR THE HEARING DECISION.**

Step 3 Read and sign this form

Is someone helping you with this appeal? (For example, this could be a friend, family member, an attorney, someone else)

☐ Yes ☐ No. ***If yes,*** please provide this person's contact information:

Name

Address

Phone	Email

Signature of applicant or authorized representative: **Date (*mm/dd/yyyy*):**

HUSKY HEALTH CONNECTICUT

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

DEBORAH CARR, BRENDA MOORE, MARY ELLEN WILSON Plaintiffs, v. XAVIER BECERRA, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES Defendant.	)	Civil Action No. 3:22-cv-00988

Declaration of Mary Ellen Wilson

I, Mary Ellen Wilson, declare that:

1. I am over the age of 18, have personal knowledge of the matters stated herein and am competent to testify about these matters.
2. I am a resident of Stamford, Connecticut and I am a 62-year-old white woman.
3. As a child, I had seizures and these continued into adulthood, which sometimes brought convulsions.
4. When I was 40, I had surgery to help to reduce these seizures and I was then able to be weaned off of anti-seizure medications which had already caused significant dental problems, including the loss of some teeth.
5. I was diagnosed with Multiple Sclerosis ("MS") in my mid-50s.
6. My symptoms of MS include balance problems and difficulty in standing for any substantial period of time. I need to have regular physical therapy for this condition.

7. MS is generally a degenerative neurological disease, and so my course of this disease is uncertain. I need to be regularly monitored for new symptoms of MS, such as vision disorders and further balance problems.

8. I could need additional services to address this disease at any time, including hands on assistance and medical equipment to help with activities of daily living.

9. My income is $1391 per month in Social Security Disability Insurance benefits.

10. On May 1, 2014, I began receiving coverage under the HUSKY D Connecticut Medicaid program.

11. On November 1, 2018, I began receiving Medicare coverage from the federal government.

12. On or about February 1, 2021, I began receiving coverage under the Medicare Savings Program for some of my costs under the Medicare program.

13. I remained on the Medicaid HUSKY D program until I received a notice of action from the Connecticut Health Insurance Exchange, Access Health CT or "AHCT," stating that, effective February 28, 2022, I would be losing my HUSKY D coverage.

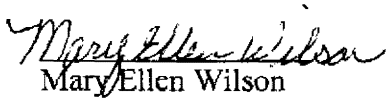
14. The notice dated February 10, 2020 stated that I was losing my benefits for the reason: "[B]ecause of the COVID-19 pandemic, a change in federal rules allowed us to temporarily extend your HUSKY D coverage even after you enrolled in Medicare. Now, following the latest federal rules, we need to end your HUSKY D coverage because you are also enrolled in the Medicare Savings Program."

15. After I received this notice, I appealed the decision and there was a telephone hearing on my appeal on March 24, 2022.

16. On May 16, 2022, a hearing decision was issued in my case (a copy is attached) in which the hearing officer upheld the termination of my HUSKY D coverage.
17. The hearing decision said that I was correctly kept on HUSKY D until February 28, 2022 because the Families First Coronavirus Response Act "required that states must maintain beneficiaries' same amount, duration and scope of benefits through the end of the last month of the Coronavirus public health emergency," this "applied unless the beneficiary moved to a different state, asked for their Medicaid coverage to be discontinued or passed away," and I was "active on [HUSKY D] coverage prior to March 18, 2020."
18. But the hearing decision also said that AHCT correctly discontinued my HUSKY D coverage on March 1, 2022 because I am a "recipient of the Medicare Savings Program and thus meet[ ] the Minimum Essential Coverage requirement as defined by regulation."
19. As a result, I have lost benefits covered only by the Medicaid program. For example, dental work, which I expect to continue to need related to my years of taking anti-seizure medications, is not covered by Medicare, other than cleanings covered by my Medicare Advantage plan.
20. I also have paid for cabs to get to medical appointments.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing declaration is true and correct.

Date: August 2, 2022



Mary Ellen Wilson

EXHIBIT 1

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06105-3725

May 16, 2022
SIGNATURE CONFIRMATION

CASE # 100091788
CLIENT# 003538677
REQUEST# 191218

NOTICE OF DECISION
PARTY

Maryellen Wilson
992 Summer Street
Apartment 3G
Stamford, CT 06905

PROCEDURAL BACKROUND

On February 10, 2022, the Health Insurance Exchange, Access Health CT ("AHCT") sent Maryellen Wilson (the "Appellant"), a Notice of Action ("NOA") discontinuing her Husky D Medicaid coverage, effective February 28, 2022.

On February 24, 2022, the Appellant requested an administrative hearing to contest the discontinuance of her Husky D Medicaid coverage.

On March 4, 2022, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for March 24, 2022.

On March 24, 2022, in accordance with sections 17b-60, 17b-61 and 4-176e to 4-189 inclusive, of the Connecticut General Statutes, OLCRAH held a telephonic administrative hearing. The following individuals participated in the hearing:

Appellant, Maryellen Wilson
Appellant's Attorney/Connecticut Legal Services, Jean Mills Aranha
AHCT Representative, Debra Henry
Hearing Officer, Joshua Couillard

STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT correctly discontinued the Appellant's Husky D Medicaid coverage, effective February 28, 2022.

FINDINGS OF FACT

1. The Appellant is 62-years-old [DOB: March 24, 1960]. (Appellant's Testimony)

2. On May 1, 2014, the Appellant began receiving Husky D Medicaid coverage. (Hearing Record)

3. On November 1, 2018, the Appellant qualified for, and began receiving, Medicare coverage. (Hearing Record, Appellant's Testimony, AHCT Representative's Testimony)

4. On February 1, 2021, the Appellant began receiving Q01 coverage through the Medicare Savings Program ("MSP"). (Appellant's Testimony, AHCT Representative's Testimony, Hearing Record)

5. AHCT kept the Appellant's Husky D Medicaid coverage active through February 28, 2022 due to the Families First Coronavirus Response Act ("FFCRA"), which required that states must maintain beneficiaries' same amount, duration and scope of benefits through the end of the last month of the Coronavirus public health emergency. The continuous coverage rule applied unless the beneficiary moved to a different state, asked for their Medicaid coverage to be discontinued or passed away. (Hearing Record)

6. On February 10, 2022, AHCT issued the Appellant a NOA which discontinued the Appellant's Husky D Medicaid coverage, effective February 28, 2022. The notice stated that, "Husky D provides Medicaid coverage for income-eligible adults without dependent children who are between the ages of 19 and 64 and not enrolled in Medicare." The notice further stated that, "because of the COVID-19 pandemic, a change in federal rules allowed us to temporarily extend your Husky D coverage even after you enrolled in Medicare. Now, following the latest federal rules, we need to end your Husky D coverage because you are also enrolled in the Medicare Savings Program." (Exhibit 1: Notice of Action)

7. The issuance of this decision is timely under Connecticut General Statutes 17b-61(a), which requires that a decision be issued within 90 days of the request for an administrative hearing. The hearing request was received on February 24, 2022; therefore, this decision is due no later than May 25, 2022.

CONCLUSIONS OF LAW

1. "*Acceptance of Federal Grants for Medical Assistance.* The Commissioner of Social Services is authorized to take advantage of the medical assistance programs provided in Title XIX, entitled "Grants to States for Medical Assistance Programs", contained in the Social Security Amendments of 1965 and may administer the same in accordance with the requirements provided therein, including the waiving, with respect to the amount paid for medical care, of provisions concerning recovery from beneficiaries or their estates, charges and recoveries against legally liable relatives, and liens against property of beneficiaries." Connecticut General Statutes ("Conn. Gen. Stat.") § 17b-260

2. "*Extension of Other Public Assistance Provisions*. All of the provisions of sections 17b-22, 17b-75 to 17b-77, inclusive, 17b-79 to 17b-83, inclusive, 17b-85 to 17b-103, inclusive, and 17b-600 to 17b-604, inclusive, are extended to the medical assistance program except such provisions as are inconsistent with federal law and regulations governing Title XIX of the Social Security Amendments of 1965 and sections 17b-260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, and 17b-357 to 17b-361, inclusive." Conn. Gen. Stat. § 17b-264

3. "*Options for Exchange Appeals*. Exchange eligibility appeals may be conducted by A State Exchange appeals entity, or an eligible entity described in paragraph (d) of this section that is designated by the Exchange, if the Exchange establishes an appeals process in accordance with the requirements of this subpart." Title 45 of the Code of Federal Regulations ("C.F.R.") § 155.505(c)(1)

4. "*Eligible Entities*. An appeals process established under this subpart must comply with § 155.110(a)." 45 C.F.R. § 155.505(d)

5. "*Eligible Contracting Entities*. The State may elect to authorize an Exchange established by the State to enter into an agreement with an eligible entity to carry out one or more responsibilities of the Exchange. Eligible entities are: (1) An entity: (i) Incorporated under, and subject to the laws of, one or more States; (ii) That has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and (iii) Is not a health insurance issuer or treated as a health insurance issuer under subsection (a) or (b) of section 52 of the Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or (2) The State Medicaid agency, or any other State agency that meets the qualifications of paragraph (a)(1) of this section." 45 C.F.R. § 155.110(a)

AHCT is the State of Connecticut's Health Insurance Exchange ("HIX") where consumers can enroll in affordable healthcare plans, including Husky D Medicaid.

6. "*Eligibility*. Effective January 1, 2014, the agency must provide Medicaid to individuals who: 1. Are age 19 or older and under age 65; 2. Are not pregnant; 3. Are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act; 4. Are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part; and 5. Have household income that is at or below 133 percent FPL for the applicable family size." 42 C.F.R. § 435.119(b)

7. "*Federal Medical Assistance Percentage ("FMAP")*. Computations. The FMAP is determined by the formula described in section 1905(b) of the Act... The formula provides for squaring both the State and national average per capita incomes; this procedure magnifies any difference between the State's income and the national average. Consequently, Federal matching to lower income States is increased, and Federal matching to higher income States is decreased, within the statutory 50-83 percent limits..." 42 C.F.R. § 433.10(b)

8. "*General Requirements*. Except as provided in paragraph (d) of this section, for all beneficiaries validly enrolled for benefits under the state plan, a waiver of such plan, or a demonstration project under section 1115(a) of the Act as of or after March 18, 2020, the state must maintain the beneficiary's enrollment as follows, through the end of the month in which the public health emergency for COVID-19 ends." 42 C.F.R. § 433.400 (c)(2)

   AHCT correctly granted the Appellant Husky D Medicaid coverage on May 1, 2014. AHCT also correctly maintained the Appellant's Husky D Medicaid coverage during the COVID-19 public health emergency as she was active on the coverage prior to March 18, 2020.

9. "*Definitions*. Minimum Essential Coverage ("MEC") has the meaning provided under section 5000A(f)(1) of the Internal Revenue Code and implementing regulations at 26 CFR 1.5000A-2 and includes minimum essential coverage determined by the Secretary under 26 CFR 1.5000A-2(f)." 42 C.F.R. § 433.400(b)

10. "*Minimum Essential Coverage*. In general, Minimum Essential Coverage means coverage under a government-sponsored program (described in paragraph (b) of this section), an eligible employer-sponsored plan (described in paragraph (c) of this section), a plan in the individual market (described in paragraph (d) of this section), a grandfathered health plan (described in paragraph (e) of this section), or other health benefits coverage (described in paragraph (f) of this section). Minimum essential coverage does not include coverage described in paragraph (g) of this section. All terms defined in this section apply for purposes of this section and § 1.5000A-1 and §§ 1.5000A-3 through 1.5000A-5." 26 C.F.R. § 1.5000A-2(a)

11. "*Definitions*. Medicare Savings Program means the coverage of Medicare premiums and cost sharing furnished to individuals described in, and determined

by the state to be eligible under, section 1902(a)(10)(E)(i), 1902(a)(10)(E)(iii), or 1902(a)(10)(E)(iv) of the Act." 42 C.F.R. § 433.400(b)

12. "For beneficiaries whose Medicaid coverage meets the definition of MEC in paragraph (b) of this section as of or after March 18, 2020, the state must continue to provide Medicaid coverage that meets the definition of MEC, except as provided in paragraph (c)(2)(i)(B) of this section." 42 C.F.R. § 433.400(c)(2)(i)(A)

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

AHCT correctly determined that the Appellant receives Medicare coverage. AHCT also correctly determined that the Appellant is enrolled in the Medicare Savings Program.

AHCT correctly determined that the Appellant meets the Minimum Essential Coverage requirement by being enrolled in the Medicare Savings Program.

AHCT correctly discontinued the Appellant's Husky D Medicaid coverage effective March 1, 2022, as she is a recipient of the Medicare Savings Program and thus meets the Minimum Essential Coverage requirement as defined by regulation.

DECISION

The Appellant's appeal is **DENIED**.

Joshua Couillard

Joshua Couillard
Fair Hearing Officer

CC: Becky Brown, AHCT
Mike Towers, AHCT
Debra Henry, AHCT

Modified Adjusted Gross Income (MAGI) Medicaid and Children's Health Insurance Program (CHIP) Right to Request Reconsideration

For denials or reductions of MAGI Medicaid and CHIP, the Appellant has the right to file a written reconsideration request within 15 days of the mailing date of the decision on the grounds there was an error of fact or law, new evidence has been discovered or other good cause exists. If the request for reconsideration is granted, the Appellant will be notified within 25 days of the request date. No response within 25 days means that the request for reconsideration has been denied. The right to request a reconsideration is based on §4-181a(a) of the Connecticut General Statutes.

Reconsideration requests should include specific grounds for the request: for example, indicate what error of fact or law, what new evidence, or what other good cause exists. Reconsideration requests should be sent to: Department of Social Services, Director, Office of Legal Counsel, Regulations, and Administrative Hearings, 55 Farmington Avenue, Hartford, CT 06105-3725.

Right to Appeal

For denials, terminations or reductions of MAGI Medicaid and CHIP eligibility, the Appellant has the right to appeal this decision to Superior Court within 45 days of the mailing of this decision, or 45 days after the agency denies a petition for reconsideration of this decision, provided that the petition for reconsideration was filed timely with the Department. The right to appeal is based on §4-183 of the Connecticut General Statutes. To appeal, a petition must be filed at Superior Court. A copy of the petition must be served upon the Office of the Attorney General, 165 Capitol Avenue, Hartford, CT 06106 or the Commissioner of the Department of Social Services, 55 Farmington Avenue, Hartford, CT 06105. A copy of the petition must also be served on all parties to the hearing.

The 45 day appeal period may be extended in certain instances if there is good cause. The extension request must be filed with the Commissioner of the Department of Social Services in writing no later than 90 days from the mailing of the decision. Good cause circumstances are evaluated by the Commissioner or his designee in accordance with §17b-61 of the Connecticut General Statutes. The Agency's decision to grant an extension is final and is not subject to review or appeal.

The appeal should be filed with the clerk of the Superior Court in the Judicial District of New Britain or the Judicial District in which the Appellant resides.

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

DEBORAH CARR, BRENDA MOORE, MARY ELLEN WILSON Plaintiffs, v. XAVIER BECERRA, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES Defendant.	Civil Action No. 3:22-cv-00988 August 3, 2022

DECLARATION OF SHELDON V. TOUBMAN IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND A PRELIMINARY INJUNCTION

I, SHELDON V. TOUBMAN, declare as follows:

1. I am one of the attorneys representing Plaintiffs in the above-captioned action. I am over the age of eighteen, have personal knowledge of the matters in this declaration and am competent to testify about them. I am submitting this Declaration in support of Plaintiffs' Motion for a Temporary Restraining Order and a Preliminary Injunction.

2. On August 3, 2022, Plaintiffs' Counsel notified the Defendant, by and through the United States Attorneys' Office for the District of Connecticut, that Plaintiffs were concurrently filing their Complaint and Plaintiffs' Motion for a Temporary Restraining Order and a Preliminary Injunction *via* a letter and a courtesy copy of the Complaint, the Motion and Memorandum and all supporting declarations and exhibits. Plaintiffs also are having the United States served with all of these and related documents consistent with the requirements of Fed. R. Civ. P. 4(i).

3. Attached hereto as Exhibit 1 is a true and correct copy of the Center for Medicare and Medicaid Services' (CMS) "Families First Coronavirus Response Act-Increased FMAP FAQs" (March 24, 2020).

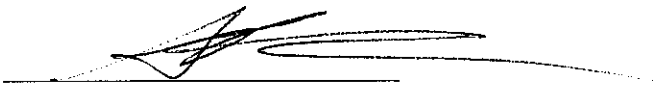
4. Attached hereto as Exhibit 2 is a true and correct copy of CMS's "COVID-19 Frequently Asked Questions (FAQ) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies" (May 5, 2020).

5. Attached hereto as Exhibit 3 is a true and correct copy of CMS's "COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies" (June 30, 2020).

6. Attached hereto as Exhibit 4 is a true and correct copy of email correspondence between Kristin Dowty, Department of Social Services, and Marie DiMartino, CMS, dated March 11 and 27, 2021, as forwarded to Peter Hadler, DSS, March 29, 2021.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

Dated: August 3, 2022 at Hartford, Connecticut.



Sheldon V. Toubman

EXHIBIT 1

Families First Coronavirus Response Act – Increased FMAP FAQs

On March 18, 2020, the President signed into law H.R. 6021, the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127). Section 6008 of the FFCRA provides a temporary 6.2 percentage point increase to each qualifying state and territory's [1] Federal Medical Assistance Percentage (FMAP) under section 1905(b) of the Social Security Act (the Act) effective beginning January 1, 2020 and extending through the last day of the calendar quarter in which the public health emergency declared by the Secretary of Health and Human Services for COVID-19[2], including any extensions, terminates.

A. General Questions

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

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

2. Does the 6.2 percentage point FMAP increase apply to all match rates used in determining how much Federal Financial Participation (FFP) states receive for Medicaid expenditures?

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

- Medicaid administrative expenditures, for which the matching rate is not defined in section 1905(b).
- Adult group expenditures matched at the "newly eligible" FMAP specified in section 1905(y) of the Act.
- Adult group expenditures matched at the "expansion state" FMAP specified in section 1905(z) of the Act.
- Expenditures for family planning services eligible for 90% match as specified in section 1903(a)(5).

---

[1] Unless specifically noted, each reference to a state or states in these FAQs includes a reference to the District of Columbia and the territories.

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

- Expenditures for services "received through" an IHS facility (including an IHS facility operated by an Indian tribe or tribal organization), as the 100% match rate for these services is not the same as the state-specific FMAP defined in the first sentence of section 1905(b) to which the 6.2 percentage point FMAP increase applies.
- Expenditures matched at 100% for individuals in Qualifying Individuals programs.
- Health home services under section 1945 of the Act when these are matched at 90% as specified in section 1945(c)(1). After the initial enhanced FMAP period for these services that is described in section 1945(c)(1), they will be matched at the state's regular FMAP, which might be subject to the 6.2 percentage point increase under section 6008(a).
- Community First Choice (CFC) 1915(k) service expenditures already eligible for a 6 percentage point in Federal match rate increase.
- Any other expenditures not matched at the FMAP determined for each state that is defined in the first sentence of section 1905(b).

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

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

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

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

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

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

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

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

5. For which period is the FMAP increase available?

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

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

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

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

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

8. Are states required to submit a State Plan Amendment (SPA) to be eligible for the 6.2 percentage point FMAP increase?

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

B. Requirements for States to Receive Increased FMAP

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

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

   a. Maintain eligibility standards, methodologies, or procedures that are no more restrictive than what the state had in place as of January 1, 2020 (maintenance of effort requirement).

   b. Not charge premiums that exceed those that were in place as of January 1, 2020

   c. Cover, without impositions of any cost sharing, testing, services and treatments—including vaccines, specialized equipment, and therapies—related to COVID-19.

   d. Not terminate individuals from Medicaid if such individuals were enrolled in the program as of the date of the beginning of the emergency period, or becomes enrolled during the emergency period, unless the individual voluntarily terminates eligibility or is no longer a resident of the state (continuous coverage requirement).

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

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

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

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

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

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

   Yes. States must cover, under the state plan (or waiver), testing services and treatments for COVID–19, including vaccines, specialized equipment, and therapies, for any quarter in which the temporary increased FMAP is claimed.

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

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

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

   Yes. In order to receive the temporary FMAP increase provided under section 6008 of the FFRCA, states must provide continuous coverage, through the end of the month in which the emergency period ends, to all Medicaid beneficiaries who were enrolled in Medicaid on or after March 18, 2020, regardless of any changes in circumstances or redeterminations at scheduled renewals that otherwise would result in termination. States may terminate coverage for individuals who request a voluntary termination of eligibility, or who are no longer considered to be residents of the state.

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

   To receive the increased FMAP, states may not terminate coverage for any beneficiary enrolled in Medicaid during the emergency period effective March 18, 2020, unless the beneficiary voluntarily requested to be disenrolled, or is no longer a resident of the state. States that want to qualify for the increased FMAP should make a good faith effort to identify and reinstate individuals whose coverage was terminated on or after the date of enactment for reasons other than a voluntary request for termination or ineligibility due to residency. At a minimum, states are expected to inform individuals whose coverage was terminated after March 18, 2020 of their continued eligibility and encourage them to contact the state to reenroll. Where feasible, states should automatically reinstate coverage for individuals terminated after March 18, 2020 and should suspend any terminations already scheduled to occur during the emergency period. Coverage should be reinstated back to the date of termination.

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

   Individuals who have been determined presumptively eligible for Medicaid have not received a determination of eligibility under the state plan, and are therefore not "enrolled" and subject to the requirements for continuous coverage described under section 6008 of the FFCRA.

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

Yes. Individuals who continue to receive services pending an appeal of a determination of ineligibility would be considered to be enrolled for benefits, if this was their status as of March 18, 2020 and therefore should not be terminated from enrollment until the end of the month when the emergency period ends.

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

No. States do not need to maintain coverage in CHIP in order to receive the temporary increase in the Medicaid federal medical assistance percentage (FMAP) provided under section 6008 of the FFRCA. However, the Maintenance of Effort (MOE) required under section 2105(d)(3) of the Social Security Act continues to apply.

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

The FFCRA does not prohibit a state from conducting regular Medicaid renewals and redeterminations or acting on reported or identified changes in circumstances. States may also continue to conduct periodic data matching between regular beneficiary renewals, consistent with states' verification plans. However, to receive the increased FMAP, states may not terminate coverage for any beneficiary enrolled in Medicaid on or after March 18, 2020, until the end of the month in which the emergency period ends, unless such individual is no longer a resident of the state or requests voluntary termination. This requirement to maintain continued coverage applies to beneficiaries who might otherwise have coverage terminated after a change in circumstances, including individuals who age out of a Medicaid eligibility group during the emergency period, who lose receipt of benefits that may affect their eligibility (e.g., SSI, foster care assistance payments), and whose whereabouts become unknown.

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

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

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

Yes. Individuals who are determined to be deceased are no longer residents of the state. States may terminate coverage for deceased individuals and remain eligible for receipt of the increased FMAP. States should communicate this clarification to their managed care plans.

C. Flow of Federal Funds and State Reporting

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

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

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

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

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

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

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

Medicaid expenditures reported by the state for the relevant quarter and recover any unexpended amounts or pay any additional amounts due to the state.

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

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

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

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

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

Consistent with existing practice, states have an opportunity at any time throughout each quarter to request additional funding from CMS as necessary to cover allowable Medicaid administrative and service costs, including those eligible for the 6.2 percentage point increased FMAP. Should any state need additional funds before the end of a quarter, they may request them through a supplemental request to the extent that the state and its expenditures qualify for the increased FMAP and have a permissible source of non-Federal share. CMS will evaluate such requests and issue any appropriate additional supplemental grant awards.

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

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

offer training to states as soon as possible on reporting budget estimates on the CMS-37 and quarterly expenditures on the Form CMS-64.

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

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

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

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

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

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

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

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

D. Requesting Increased FMAP

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

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

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

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

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

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

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

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

Section 6008(c) modifies section 1905(cc) of Act by providing that, to be eligible for the increased FMAP under section 6008(a) of the Families First Coronavirus Response Act, states must not require political subdivisions of the state to pay a greater portion of the non-federal share of expenditures required under section 1902(a)(2) of the Act or payments under

1923 of the Act than was required on March 11, 2020. CMS has already issued guidance about section 1905(cc) of the Act, including most recently through State Medicaid Director Letter #10-023 on November 9, 2010. States should refer to this guidance regarding requirements of section 1905(cc). Of note, for increased FMAP available under section 6008 of the Families First Coronavirus Response Act, the reference to ''December 31, 2009'' in section 1905(cc) of the Act shall be deemed to be a reference to ''March 11, 2020.''

EXHIBIT 2

Last Updated May 5, 2020

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

Table of Contents

I. Emergency Preparedness and Response

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

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

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

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

Appendix K also provides states with opportunities to:

- temporarily increase individual eligibility cost limits,
- modify service, scope, or coverage requirements,
- exceed service limitations,
- add services to the waiver,
- provide services in out-of-state settings, and/or

- permit payment for services rendered by family caregivers or legally responsible individuals.

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

Please see attached link for instructions and template: https://www.medicaid.gov/medicaid/home-community-based-services/downloads/1915c-appendix-k-instructions.pdf and https://www.medicaid.gov/medicaid/home-community-based-services/downloads/1915c-appendix-k-template.pdf

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

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

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

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

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

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

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

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

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

Yes. A state may request that CMS waive the requirement that a SPA be submitted no later than the last day of the same quarter as the requested effective date of the SPA, waive public notice requirements, and permit the state to modify the tribal consultation timeline, under section 1135 of the 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 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.

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

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

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

8. 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), Pub L. No. 116-127 (2020) may need to keep this group enrolled until the end of the month in which the PHE period ends in order to comply with the conditions in section 6008(b)(3) of that legislation. However, the limited coverage for which this group is eligible also terminates at the end of the PHE (per statute), so states do not need to provide this group with any coverage after the PHE ends, even if they keep members of this group enrolled in order to comply with section 6008(b)(3) of the FFCRA. States may elect the COVID-19 testing eligibility group by completing the appropriate section of the Medicaid disaster relief SPA template, which can be found here: https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/state-plan-flexibilities/index.html. The SPA is submitted to the relevant CMS SPA Mailbox for the state.

II. Eligibility and Enrollment

A. Application and Renewal Processing

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

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

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

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

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

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

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

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

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

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

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

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

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

States are required under regulations at 42 C.F.R. § 435.916(d) to promptly redetermine eligibility whenever they receive information about a change in circumstances that may impact eligibility. However, CMS recognizes that the impact of the COVID-19 public health emergency is impacting the ability of state agencies to process changes in circumstances in a timely manner, such that what is considered "prompt" under the current circumstances may be longer than what typically would be expected. States that are unable to promptly process changes in circumstances that may impact eligibility are advised to obtain CMS concurrence that the delay is warranted under the circumstances. States must document the delay in the beneficiary's case record. Alternatively, if a large number of cases are affected and the state can clearly define the cohort of cases for which it seeks CMS' concurrence, CMS will not enforce compliance with the requirement that states document the delay in each case record included in the cohort described. States do not need to make a formal request for CMS concurrence, but may notify via email to the CMS state lead.

Further, in order to qualify for the increased FMAP provided under section 6008(a) of the FFCRA, through the end of the month in which the public health emergency ends, pursuant to section 6008(b)(3) of the FFCRA, states may not terminate individuals enrolled for Medicaid benefits as of March 18, 2020, or determined eligible on or after that date. This includes

continuing coverage for individuals who experience a change in circumstances that impacts eligibility or are determined eligible based on self-attestation for certain criteria, if the state has adopted post-enrollment verification of the criterion. Thus, if a state is able to process a change in circumstances prior to the end of the month in which the public health emergency ends, and determines that a beneficiary no longer meets all eligibility criteria for coverage, the state must postpone taking adverse action until after the end of the month in which the emergency ends in order to qualify for the temporary FMAP increase. See also Families First Coronavirus Response Act – Increased FMAP FAQ B.6, available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf.

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

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

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

Consistent with regulations at 42 C.F.R. §§ 435.907(f) and 457.330, all initial applications for Medicaid and CHIP must be signed under penalty of perjury. Individuals may receive help from others, including certified application assisters under 42 C.F.R. § 435.908, Exchange Navigators, or authorized representatives, to complete an application for Medicaid or CHIP. While these types of assisters typically provide in-person assistance with applications, CMS recognizes that such assistance may need to be provided by phone during the current public health emergency if offices or other locations are closed or otherwise to minimize in-person contact. If an assister or other individual is completing and submitting an online application on behalf of an applicant, based on information the applicant has provided by phone, for the period of the emergency and subject to state law, the applicant may designate that individual be an authorized representative with limited authority to sign and submit the application on behalf of the applicant. Due to the public health emergency posed by COVID-19 and the urgent need to avoid transmission of COVID-19, for the duration of the COVID-19 public health emergency, CMS will not enforce compliance with requirements at § 435.923(a)(1) that designation of an authorized representative must be signed by the applicant or enrollee, and submitted to the state agency, provided that applicants provide authorization for an assister or other individual to be their authorized representative orally, in writing, or both. A record of such authorization must be submitted by the authorized representative, along with the application. The agency must accept such authorization through any of the available modalities described at § 435.907(a) and must be include the record in the applicant's account held by the state Medicaid agency. Assisters or other individuals acting as authorized representatives in these circumstances must also abide by confidentiality and

conflict of interest requirements set out in regulation at 42 C.F.R. §§ 435.908(c) and 435.923(e), 45 C.F.R. §§ 155.210(d), 155.225(g)(2), 155.227, and 155.260, and the legal instrument establishing the assister's relationship with the Exchange or authorized representative's role with respect to the Exchange. We believe that this guidance is a statement of agency policy not subject to the notice and comment requirements of the Administrative Procedure Act (APA). 5 U.S.C. § 553(b)(A). For the same reasons explained above, in light of the PHE and the urgent importance of reducing the potential for transmission of COVID-19 through the authorization process, CMS additionally finds that, even if this guidance were subject to the public participation provisions of the APA, prior notice and comment for this guidance is impracticable, and there is good cause to issue this guidance without prior public comment and without a delayed effective date. 5 U.S.C. § 553(b)(B) & (d)(3).

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

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

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

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

Yes. Per regulations at 42 C.F.R. § 435.1200(d)(4), assessment states have flexibility to accept findings from the FFE as final MAGI determinations and enroll individuals into coverage without additional verification if all eligibility criteria have been verified by the FFE. States will need to complete verification to determine eligibility for individuals for whom not all factors of eligibility have been verified by the FFE (i.e., the FFE has not resolved a discrepancy between

attested information and electronic data). No additional or express authority from CMS is needed.

B. Premiums and Cost-Sharing

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

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

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

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

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

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

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

3. 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.

C. Eligibility

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Fair Hearings

1. What flexibilities are available for Medicaid fair hearings?

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

- Suspend adverse actions for individuals for whom the state has completed a determination but either: (1) has not yet sent the notice; or (2) who the state believes likely did not receive the notice. This is consistent with 42 C.F.R. § 431.211, which requires the state to provide at least 10-days advance notice before taking adverse action. See also Families First Coronavirus Response Act – Increased FMAP FAQ B.9 regarding the provision of continuous coverage during the emergency period as a condition for receiving the increased FMAP under that Act.
- Delay scheduling fair hearings and issuing fair hearing decisions under 42 C.F.R. § 431.244(f)(4)(i)(B), which allows states to delay taking final administrative action when there is an emergency beyond the state's control. States should prioritize completing hearings that meet the standard for an expedited fair hearing under 42 C.F.R. § 431.224. States may offer to continue benefits to individuals who are requesting a fair hearing if the request comes later than the date of the action under 42 C.F.R. § 431.230.
- Hold fair hearings via video conferencing or telephone, provided states adhere to other fair hearing requirements (42 C.F.R. part 431, subpart E), including ensuring that the hearing system is accessible to persons who are limited English proficient and persons who have disabilities (see 42 C.F.R. §§ 431.205(e) and 435.905(b)).
- Reinstate services or eligibility if discontinued because the beneficiary's whereabouts were unknown due to displacement, after the beneficiary's whereabouts become known (if still eligible), consistent with 42 C.F.R. § 431.231(d).

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

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

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

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

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

E. *Presumptive Eligibility*

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

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

enrollment for presumptive eligibility qualified entities, 42 C.F.R. Part 433, Subpart C would apply.

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

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

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

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

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

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

States electing to apply the PETI rules to an individual during a presumptive eligibility period under 42 C.F.R. § 435.1110 must provide clear instructions to hospitals on the specific questions

the hospital must ask in making a reasonable estimate of the individual's total income and deductions.

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

5. Can states change their hospital PE performance standards?

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

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

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

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

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

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

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

F. Verification

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

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

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

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

Eligibility criteria that can be verified using attested information only. Consistent with regulations at 42 C.F.R. § 435.945(a), states have flexibility to accept self-attestation of the following eligibility criteria: age or date of birth, state residency, and household composition. Per

42 C.F.R. § 435.956(e), states must accept self-attestation of pregnancy, unless the state has information that is not reasonably compatible with the attestation. A state that currently requires additional verification for age, state residency or household composition can revise its verification procedures for the duration of the public health emergency. CMS has developed a disaster-related verification plan addendum which states can use for this purpose.

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

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

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

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

For verification processes not required under the statute but adopted by the state in its verification plan (such as requiring proof of self-employment income), states also can elect to make a determination of eligibility based on attested information and complete these state

verification processes post enrollment. See FAQ # II.F.7. regarding documentation of state verification policies.

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

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

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

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

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

Note that the requirement to accept self-attestation under 42 C.F.R. § 435.952(c)(3) does not mean that states can ignore discrepancies between attested information provided on an application or renewal form and a required electronic data match. Rather, the requirement means, in the unusual circumstances described, that (1) states must accept self-attestation of eligibility requirements for which there is no data source to support electronic verification; and (2) states

must accept a reasonable explanation attested by, or on behalf of, the individual explaining a discrepancy between attested information on the application or renewal and electronic data obtained by the agency. States must also document reliance on attested information under 42 C.F.R. § 435.952(c)(3) in the individual's case record.

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

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

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

States may not suspend use of their AVS under the state plan, which is required under sections 1902(a)(71) and 1940 of the Act. However, the statute does not require that states verify assets using their AVS prior to an initial determination. Instead, states may initially rely on self-attestation of assets and verify financial assets using their AVS post-enrollment in Medicaid. 42 CFR §435.945. Under regulations at 42 C.F.R. § 435.916(d), if a state obtains new asset information from the AVS post-enrollment that indicates an individual may not be eligible, the state must evaluate that information and redetermine eligibility as appropriate. However, we note that, pursuant to section 6008(b)(3) of the FFCRA, in order to be eligible for the temporary 6.2 percent FMAP increase under section 6008(a) of the FFCRA, states may not terminate an individual, once determined eligible, through the end of the month in which the public health emergency ends. This would include any individuals determined eligible for Medicaid based on self-attested asset information for whom verification using the state's AVS is done post-enrollment. See FAQ # II.A.4. for additional information on states' responsibility to redetermine eligibility whenever they receive information indicating a beneficiary may no longer satisfy the criteria for eligibility and for the implications of the FFCRA on this policy.

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

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

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

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

G. Basic Health Program

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

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

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

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

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

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

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

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

States that elect to follow the Medicaid eligibility verification process may modify their verification policies to use attestation for eligibility factors, unless the statute requires other verification (such as for citizenship and immigration status); to accept attested information for an initial determination and enrollment, and conduct other verification processes post-enrollment; or to change their reasonable compatibility standard for verification of income. See more information in FAQ # II.F.1. Regarding citizenship and immigration status, electronic

verification is available through the Social Security Administration and the Department of Homeland Security US Citizenship and Immigration Services Systematic Alien Verification for Entitlement (SAVE) program. For otherwise eligible individuals who attest to U.S. citizenship or a lawfully present immigration status, but whose U.S. citizenship or lawfully present immigration status cannot be verified electronically, a reasonable opportunity period is provided while the verification process is completed. At state option, a good faith extension may be available for non-citizens verifying their lawfully present immigration status under 42 C.F.R. § 600.345, cross referencing 42 C.F.R. § 435.956(b)(2)(ii)(B).

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

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

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

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

H. Coverage for American Indians and Alaska Natives

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

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

the COVID-19 public health emergency, the state may submit a Medicaid disaster relief SPA to make that change.

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

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

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

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

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

1. 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.

2. 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.

3. 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.

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

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

J. Miscellaneous

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

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

III. Benefits

A. COVID-19 Testing

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

Yes, tests for the detection of SARS-CoV-2 or diagnosis of COVID-19 are a mandatory laboratory service as described at 1905(a)(3) of the Act and 42 C.F.R. § 440.30. Section 6004(a) of the FFCRA added a new mandatory benefit in the Medicaid statute, at section 1905(a)(3)(B) of the Act, and this provision was amended by section 3717 of the 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.

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

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

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

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

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

B. Telehealth

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

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

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

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

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

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

Yes. For initiation of home health services, face-to-face encounters may occur using telehealth as described at 42 C.F.R. §440.70(f)(6). A physician, nurse practitioner or clinical nurse specialist, a certified nurse midwife, a physician assistant, or attending acute or post-acute physician for beneficiaries admitted to home health immediately after an acute or post-acute stay may perform the face-to-face encounter. The allowed non-physician practitioner must communicate the clinical findings of the face-to-face encounter to the ordering physician. Those clinical findings must be incorporated into the beneficiary's written or electronic medical record. Additionally, the ordering physician must document that the face-to-face encounter occurred within the required timeframes prior to the start of home health services and indicate the practitioner who conducted the encounter and the date of the encounter. A state plan amendment would only be necessary to revise existing state plan language that imposes telehealth parameters that would

restrict this practice. As is discussed above and at https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html, states are not required to submit separate state plan amendments for coverage or reimbursement of telehealth services if they decide to reimburse for telehealth services in the same manner or at the same rate paid for face-to-face services. A state plan amendment would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.

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

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

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

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

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

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

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

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

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

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

C. Home and Community Based Services

1. 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.

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

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

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

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

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

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

D. Pharmacy/Prescription Drugs

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

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

FFS / Supplies: States have flexibility to establish and manage prior authorization processes without CMS approval. Given that medically fragile children are subject to Early and Periodic

Screening, Diagnostic and Treatment (EPSDT) requirements, there should be no hard limits on services provided to these children. A SPA may be needed, depending on the state's goals.

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

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

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

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

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

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

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

There are currently no federal Medicaid rules that require beneficiaries to provide their signature in order to receive prescription drugs. Requirements for signatures are usually found in a state provider manual and are at the discretion of the state Medicaid program. Therefore, CMS encourages states to explore ways to ease state signature requirements in order to allow beneficiaries to access their medications during the public health emergency.

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

E. Money Follows the Person (MFP) Program

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

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

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

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

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

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

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

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

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

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

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

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

MFP programs may leverage MFP demonstration flexibility and resources to make temporary programmatic changes that are consistent with their states' and local communities' responses to COVID-19. MFP grantees should notify their MFP Project Officer as soon as possible if they

need to make programmatic changes, but states do not need to receive CMS approval before implementing programmatic changes to their MFP program's Operational Protocol if those changes are directly related to their response to COVID-19. These changes may include extending the 180-day period for transition coordination activities. Grantees should review the MFP letter to grantees and related budget forms provided to grantees in the April 8, 2020, grant note for more information on the flexibilities provided to MFP grantees related to COVID-19 and how to request budget approval for new activities related to COVID-19.

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

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

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

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

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

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

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

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

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

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

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

F. Miscellaneous

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

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

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

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

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

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

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

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

Section 6008(b) of the FFCRA establishes requirements that states must meet if they wish to qualify for the temporary 6.2% FMAP. These include providing coverage "under [the state] plan (or waiver), without the imposition of cost sharing for any testing services and treatments for COVID-19, including vaccines, specialized equipment, and therapies." CMS interprets this to mean that, to qualify for the temporary 6.2% FMAP increase, the state would have to provide

coverage for COVID-19 testing and treatment, without cost sharing, for beneficiaries receiving ABP coverage. Therefore, states operating ABPs that do not include the relevant services, without cost sharing in their programs must amend their ABPs in order to qualify for the enhanced FMAP. States may use the disaster SPA template, available at https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/state-plan-flexibilities/index.html, to make these changes for the period of the public health emergency.

IV. Financing

A. Administrative Claiming

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

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

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

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

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

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

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

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

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

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

B. Advance and Retainer Payments

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

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

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

States may increase Medicaid payment rates to offset losses to providers during the COVID-19 pandemic, if consistent with all applicable requirements, including section 1902(a)(30)(A) of the Act. FFP is not available under the Medicaid state plan to pay providers directly for the time when care is not provided to beneficiaries. However, on March 22, 2020, CMS released a template that states may use to request a section 1115 demonstration to combat the COVID-19

public health emergency, which allows states to request authority to make retainer payments to certain habilitation and personal care providers to maintain capacity during the emergency consistent with the limitations set forth in Appendix K. The template may be downloaded at this link: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-application-process/index.html.

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

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

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

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

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

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

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

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

FQHCs and RHCs generally may provide services outside the four walls of the clinic. If a state is concerned that something in its existing state plan might prevent that, CMS can work with the state to determine whether a state plan amendment might be necessary. If a state plan amendment

is necessary, CMS can work with the state to expedite processing it. We encourage states to maximize this flexibility during the emergency response to ensure necessary care is delivered within communities.

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

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

D. Payment Rates and Methodologies

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

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

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

States have flexibility to make reasonable adjustments to Medicaid payments to better align Medicaid payments with the increased cost of providing services to Medicaid beneficiaries during the PHE under the Medicaid state plan through base and supplemental payments. Such adjustments could include, but are not limited to, an increase resource utilization to account for the need for more personal protective equipment or other increased safety measures, but we would consider state's justification for increases in payment rates during the PHE. We recognize the uncertainty and challenges states and providers are facing and will work with them on their

proposals to increase Medicaid payments to help assure Medicaid patients have access to services. Payments must comport with all applicable requirements, including those under section 1902(a)(30)(A) of the Act.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-application-process/index.html.

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

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

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

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

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

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

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

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

As long as a service has been provided, CMS defers to states to determine whether an adjustment is warranted. In the case of patient quarantined away from a facility, states have the option to cover and pay for temporary absences under Medicaid reserve bed authority discussed at 42 C.F.R. 447.40. If such coverage is not currently provided for in the approved state plan, states would need to submit a SPA. If a quarantined Medicaid patient presents unique needs and resource demands, as indicated above, states could use the state plan process to adjust payment rates and/or methodologies to reflect the extra costs to provide services. On March 22, 2020, CMS released a Disaster Relief SPA template (https://www.medicaid.gov/state-resource-

center/disaster-response-toolkit/state-plan-flexibilities/index.html) that can be used by states for this purpose.

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

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

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

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

E. Upper Payment Limits

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

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

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

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

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

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

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

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

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

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

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

CMS UPL policy provides two general approaches to demonstrating compliance with the UPL ceiling. States can use a cost-based UPL approach to allow the UPL ceiling to fully recognize the provider's allowable costs of furnishing Medicaid services; therefore, an increase in allowable

facility costs can be accounted for in the cost-based UPL ceiling. If a payment-based UPL approach is used, states' demonstrations can make adjustments to the payment-based ceiling to the extent Medicare payment equivalents have increased.

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

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

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

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

F. Miscellaneous

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

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

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

The state Medicaid agency should notify CMS as soon as possible that it expects a delayed Form CMS-64 submission. Although federal regulations at 42 C.F.R. § 430.30(c)(1) require states to submit the form CMS-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program) to CMS not later than 30 days following the end of each quarter, in the event of a public health emergency that impacts a state's ability to do so, CMS will work with

impacted states to ensure the continued availability of FFP for allowable Medicaid services for the duration of the public health emergency. Additionally, CMS will provide technical assistance as necessary to assist the state with proper claiming of FFP and to ensure that funding provided is reconciled to actual incurred and allowable expenditures.

3. Will states continue to have secure access to the Medicaid Budget & Expenditure System (MBES)/State Children's Health Insurance Program Budget & Expenditure System (CBES) in the event that CMS buildings are closed?

Yes, CMS anticipates that states would have continued secure access to MBES/CBES, as it is a web-based application that is not dependent on whether CMS buildings are open.

V. Managed Care

A. Contracts and Rates

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

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

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

1. In-lieu of services (42 C.F.R. §438.3(e)(2) and 42 C.F.R. §457.1201(e)). Under these regulations, alternate services or services furnished in an alternative setting covered by a managed care plan or entity in lieu of state plan-covered services must be: (i) authorized by the state as being a medically appropriate and cost-effective substitute for the covered

service or setting under the state plan; (ii) authorized and identified in the managed care contract; and (iii) not required to be used by the enrollee in lieu of the state plan-covered service. In addition, there are specific rate development rules used when a managed care contract authorizes use of in-lieu of services.

2. Additional services, beyond those in the contract, voluntarily provided by managed care plans (commonly referred to as value-added services). No contract amendment is needed; however, *the cost of value-added services cannot be included when determining the capitation rates (per 42 C.F.R. §438.3(e)(1)(i) and 42 C.F.R. §457.1201(e)).*

Regarding Medicaid managed care payment, under 42 C.F.R. §§438.3(c)(1)(ii) and 438.4, final capitation rates must be actuarially sound and based only upon services covered under the state plan or waiver authority and represent a payment amount adequate to allow the managed care organization (MCO), prepaid inpatient health plan (PIHP) or prepaid ambulatory health plan (PAHP) to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements. If a state determines a retroactive adjustment to capitation rates under one or more of its managed care contracts is necessary for costs eligible for reimbursement, such as telehealth-related infrastructure costs, retroactive adjustments must be certified by an actuary in a revised rate certification and submitted as a contract amendment in accordance with 42 C.F.R. §438.7(c)(2). The rate certification must describe the rationale for the adjustment and the data, assumptions and methodologies used to develop the magnitude of the adjustment. For additional information about telemedicine, visit: https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html. For CHIP, rates must be based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles, as described in 42 C.F.R. §457.1203(a). States that update their CHIP capitation payments due to telehealth related costs would not need to submit a rate certification.

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

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

To the extent that health plans are responsible for providing laboratory services, they must cover the COVID-19 test. However, in the event the approved rates are not sufficient to cover the cost of these tests, states may wish to address through actuarially sound rate adjustments. States could amend their rates to include an adjustment for those costs, if such an adjustment is actuarially sound and the state determines that to be necessary, subject to compliance with

42 C.F.R. §§ 438.4 through 438.7 regarding rate development and amendment of capitation rates. States could also create a kick payment (consistent with actuarial soundness requirements) for managed care plans to cover the tests, which would require a contract amendment and rate certification.

States could also pay for the tests outside of the managed care capitation payment as a non-risk payment: either as a separate non-risk contract with its managed care plans (see the definition of "non-risk contract" at 42 C.F.R. §438.2[1] or as an amendment to its existing managed care plan contracts to include a non-risk payment. If a state chooses to amend its existing contracts to include a non-risk payment, the state would need to comply with upper payment limits outlined at 42 C.F.R. §447.362 consistent with the requirements for non-risk contracts. For CHIP, states could follow the same approach of paying for the tests outside of the managed care capitation payment as a non-risk payment.

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

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

3. Do states need to continue to submit preprints for state-directed payments?

Yes, states are required to submit preprints for state-directed payments. As noted above, any state-directed payment preprints related to COVID-19 should be submitted to CMCSManagedCareCOVID19@cms.hhs.gov. CMS is committed to expediting and prioritizing such reviews.

B. Quality Measurement

1. Could the COVID-19 pandemic have an impact on state level managed care plan performance and quality measurement efforts?

States use quality measurement in many aspects of their managed care contracts to govern payment to the plans as well as to providers. The COVID-19 pandemic has been disruptive to clinical practices: for example, individuals have generally been advised not to seek routine or preventive care unless medically necessary at this time. Moreover, public health recommendations around social distancing may lead to reluctance to conduct performance measurement and external quality review (EQR) activities that require visiting health care or health plan facilities. These recommendations have led some health plan accrediting organizations, such as National Committee for Quality Assurance (NCQA), to advise that states with mandatory Healthcare Effectiveness Data and Information Set (HEDIS) reporting requirements allow health plans to use 2019 HEDIS rates rather than 2020 HEDIS rates for certain measures. All of these factors can affect the actual performance of health plans on these

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

quality measures, as well as their ability to submit data to states on time. These factors can also limit the accuracy of that information and the ability for states to trend health plan performance rates over time.

2. Should states consider adjustments to their managed care contract quality measurement requirements to account for the changes in clinical practice resulting from the COVID-19 public health emergency?

CMS recognizes that the current COVID-19 pandemic is likely to affect clinical practices, and the timely and accurate reporting of quality data such that states may need or want to revise their contractual quality measurement requirements. Below are some of the common ways states implement and incentivize quality measurement in their managed care programs and issues to consider during this public health emergency.

- **Withholds**: Under 42 C.F.R. § 438.6(b)(3), states can implement a withhold, where a portion of a capitation rate is withheld from a managed care plan (MCO, PIHP, or PAHP) and a portion of or all of the withheld amount will be paid to the managed care plan for meeting targets specified in the contract. Withhold arrangements are frequently linked to quality performance measures or quality-based outcomes. CMS **strongly advises** states to work with their actuaries and their quality measurement staff to determine if any changes are needed to the data, assumptions and methodologies used to assess the ability to accurately trend the quality measurement data and to determine the portion of the withhold that is reasonably achievable. Should states believe a change or elimination of a contractual withhold arrangement is warranted due to the COVID-19 emergency, the state must submit a contract amendment and, depending on the nature of the change, a rate certification amendment.

- **Incentives:** Under 42 C.F.R. § 438.6(b)(2), states can implement an incentive arrangement, as long as total payment under the contract is not in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement. An incentive arrangement is an amount over and above the capitation rates the managed care plan was paid for meeting targets specified in the contract. Incentive payments are **in addition** to the actuarially sound capitation rates, so while changes in clinical protocols or access are likely to affect a plan's ability to earn the incentive payment, they do not affect the actuarial soundness of the underlying rates. States may elect to reexamine the specified targets for plans to earn the incentive payment; if a state chooses to do this, the state must submit a contract amendment and depending on the nature of the change, a rate certification amendment.

- **State-Directed Payments:** Under 42 C.F.R. § 438.6(c), states are prohibited from directing how a managed care plan pays its providers except for those payment methodologies that have been approved and reviewed by CMS to be in compliance with 42 C.F.R. § 438.6(c). For states that have approved directed payment proposals for this rating period that condition payment to providers upon performance on specific quality measures, states may want to reexamine these payment arrangements to determine if changes are necessary or desired in light of the COVID-19 emergency. If a state determines changes are necessary, states will

need to submit an amended directed payment preprint and, depending on the nature of the change(s), contract and rate certification amendments,.

- **General Contract Requirements and Penalties:** In addition to the examples provided above, states may have several other contract requirements related to plan performance or quality measures, such as quality assessment and performance improvement (QAPI) requirements. Some of these requirements may result in penalties imposed on the plan(s) for failing to meet a certain performance level. It is within state discretion to revise their contracts to remove or lessen such penalties; however, states will need to submit contract amendments to reflect any revisions. Depending on the nature of the change, a rate certification amendment may be needed if such changes are expected to have a material impact on the actuarially certified rates.

CMS is working to prioritize and expedite reviews of COVID-19 related managed care actions. All managed care actions (contract amendments, rate amendments, state-directed preprints) needed to respond to COVID-19 should be submitted as soon as possible to CMCSManagedCareCOVID19@cms.hhs.gov.

3. Are there additional considerations for External Quality Review-related (EQR-related) activities?

Some states contract with External Quality Review Organizations (EQROs) to conduct the EQR-related activities, while other states undertake these EQR-related activities themselves. Given the extenuating circumstances presented by COVID-19, health plans may find it challenging to submit accurate data to states and to do so on time. Health plans may also request that external quality review activities be limited if they would compromise the ability to maintain social distancing, such as encounter data validation or performance measurement validation that require onsite medical chart reviews. CMS encourages states to work with EQROs and health plans to rely as much as possible on quality data that can be submitted and validated electronically, consistent with the EQR protocols per 42 C.F.R. § 438.350(e) and 438.352, to enable quality activities to continue while minimizing the public health impacts of COVID-19. Where states determine that some accommodations may be appropriate, CMS recommends that states work with their quality measurement staff to determine the appropriate accommodations and to submit a contract amendment.

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

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

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

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

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

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

Annually, states are required to conduct an EQR, which consists of three mandatory EQR-related activities: Validation of Performance Measures, Validation of Performance Improvement Projects and a compliance review against elements found in 42 C.F.R. Part 438, subpart D.[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.

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

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

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

C. Miscellaneous

1. Can states allow managed care plans to permit 90-day supplies of medication at retail and mail-order pharmacies in situations where 90-day medication supplies are clinically

[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.

appropriate? Can states allow waivers of early refill requirements during public health emergencies?

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

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

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

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

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

4. Can states permit managed care organizations (MCOs) to expedite decisions of beneficiary functional eligibility for HCBS?

Federal regulations at 42 C.F.R. § 431.10(c)(2) require states to make functional beneficiary eligibility determinations for HCBS. As such, states can only delegate such determinations to another governmental entity. However, states could permit MCOs to conduct an assessment of eligibility and forward the assessment to states for final determination.

5. What flexibilities does a section 1135 waiver provide related to appeals of adverse benefit determination requirements in Medicaid managed care regulations at 42 C.F.R. Part 438?

Federal regulations at 42 C.F.R. Part 438 Subpart F establish appeals and grievance requirements for Medicaid managed care. Section 1135 of the Act does not provide authority to waive these requirements; however, CMS does have authority to modify timeframes for required activities during an emergency period under section 1135(b)(5) of the Act. For example: states can request a section 1135 waiver to modify timelines for managed care plans to resolve an appeal to no less than one day in order to permit earlier access to the state fair hearing level. If states use this authority, all appeals filed would allow managed care enrollees to quickly satisfy the exhaustion requirement in 42 C.F.R. § 438.408(f)(1) and proceed almost immediately to a state fair hearing. In addition, states can modify timeframes under 42 C.F.R. § 438.408(f)(2) requiring managed care enrollees to exercise their appeal rights within 120 days to allow more than 120 days to request a fair hearing during the authorized period of the immediate section 1135 waiver. In March 2020, CMS created a Medicaid & CHIP checklist for section 1135 waivers to assist states during public health emergencies, which is available here: https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/section-1135-waiver-flexibilities/index.html.

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

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

States that utilize risk mitigation mechanisms must describe such arrangements in their contract(s) and they must be developed in accordance with all requirements in 42 C.F.R. Part 438, including §§ 438.4 and 438.5, and generally accepted actuarial principles and practices. The rate certification and supporting documentation must also describe any risk mitigation and how it may affect the rates or the final net payments to the health plan(s) under the applicable contract as part of complying with § 438.7. States should follow the guidance in the Medicaid Managed

Care Rate Development Guide for documentation for risk-sharing mechanisms. See https://www.medicaid.gov/Medicaid/downloads/2019-2020-medicaid-rate-guide.pdf.

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

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

VI. Information Technology

A. Funding

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

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

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

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

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

B. Health Information Exchange

1. Can states request that FFP be provided through the process described in 45 C.F.R. § 95.624 (emergency funding requests) to connect non-pediatric Medicaid providers to Immunization Information Systems?

Medicaid providers who do not treat children are much less likely to have direct electronic health record (EHR) connections or EHR integration with immunization information systems, and tracking the administration of a vaccine in the adult population is more difficult due to this lack of public health connectivity. These connections are potentially eligible for enhanced funding under 42 CFR part 433, subpart C, and states should begin planning for eventual vaccination efforts accordingly. Please reach out to your Medicaid Enterprise Systems (MES) State Officer for information on submitting an FFP request under 45 C.F.R. § 95.624.

2. What is the Patient Unified Lookup System for Emergencies (PULSE) and how can states request that FFP be provided through the process described in 45 C.F.R. § 95.624 (emergency funding requests) to deploy PULSE resources to support COVID-19 response efforts?

The PULSE system provides first responders with information critical to patient care through a nimble, easy to understand system with access to patient health data (e.g., medications a patient is taking) and is designed to be deployed immediately to assist in emergency response. The first PULSE system was developed in California and has been used for wildfire response within the state. A COVID-19 iteration of PULSE (PULSE-COVID) supporting some immediate use cases is now available. PULSE-COVID focuses on collaboration with private sector partners and supports basic ad hoc searches over the national health information exchange networks. These searches could help medical response teams access critical patient information via direct connections to the electronic health records where their information is kept. The solution is hosted on a web platform to enable quick and easy deployment to multiple states. Depending upon resources available for the project, up to several states can be on-boarded to PULSE-COVID at once by the public/private partnership overseeing the effort. There is a range of capacity across the nation and immediate engagement would focus on areas with the capacity to implement PULSE-COVID in the near term. Please reach out to your MES State Officer for information on submitting an FFP request under 45 C.F.R. § 95.624.

3. How can states establish, implement, and enhance telehealth technologies through the process described in 45 C.F.R. § 95.624 (emergency funding requests) as part of the COVID-19 response effort and in support of their Medicaid provider and beneficiary populations?

CMS is available to provide technical assistance regarding approaches to rapidly scale telehealth technologies. If states are granted waivers under section 1135 for federal requirements related to provider location or provider enrollment (https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf), complementary technology investments may be appropriate. CMS advises states to leverage existing infrastructure and technology. States should discuss any patient-facing telehealth proposals with their MES State

Officer. Please reach out to your MES State Officer for information on submitting an FFP request under 45 C.F.R. § 95.624.

C. Transformed Medicaid Statistical Information System (T-MSIS)

1. How should COVID-19 related service codes be reported in the Transformed Medicaid Statistical Information System (T-MSIS)?

States should ensure that systems are coded to process the new codes and that providers have received updated billing guidance. States should report COVID-19 related procedure codes and diagnosis code information to T-MSIS as it is reported on the original claims form. Please contact your CMS Systems Officer with further questions. For information on COVID-19 testing HCPCS codes, please see CMS's February 13, 2020 public health news alert. For information on COVID-19 related diagnosis codes, please see the CDC's announcement regarding new diagnosis coding effective April 1, 2020.

2. How should telehealth-related services be reported in T-MSIS?

States should ensure that providers are educated on the correct submission of telehealth claims. States should report COVID-19 telehealth services to T-MSIS as they are billed on the claim form, identified through the procedure code and procedure code modifier fields. Please contact your CMS State Systems Officer with further questions. For general information on Medicaid telehealth, see Medicaid for Services Delivered Via Telehealth.

3. Will there be new federal reporting requirements in T-MSIS for the new COVID-19 testing optional Medicaid eligibility group?

To address the completeness and accuracy of T-MSIS reporting for states adopting the new COVID-19 testing optional Medicaid eligibility group, states should report the following two data elements in the Eligible file to document a beneficiary's enrollment in Medicaid as defined by the FFCRA: ELIGIBILITY-GROUP (ELG087) and RESTRICTED-BENEFITS-CODE (ELG097). An ELIGIBILITY-GROUP value of "76" should be reported for an uninsured individual eligible for COVID-19 testing. A RESTRICTED-BENEFITS-CODE value of "F" should be reported for an individual eligible for Medicaid but is only entitled to restricted benefits for medical assistance for COVID-19 diagnostic products and any visit described as a COVID–19 testing-related service for which payment may be made under the state plan. Additional information and comprehensive reporting guidance will be shared on the T-MSIS Coding Blog.

4. Will there be new federal reporting requirements in T-MSIS for reporting claims data for COVID-19 testing and testing-related visits for individuals enrolled in Medicaid and CHIP?

There are three data elements in the T-MSIS Claims files for state reporting of COVID-19 diagnostic products and testing-related services.

(1) In the CLAIM-HEADER-RECORD, a value of "17" should be reported in PROGRAM-TYPE for any COVID-19 diagnostic product or COVID–19 testing-related services as specified by the FFCRA;
(2) In the CLAIM-LINE-RECORD, a value of "136" should be reported in TYPE-OF-SERVICE, and a value of "107" should be reported in BENEFIT-TYPE for any COVID-19 diagnostic product as specified by the FFCRA;
(3) In the CLAIM-LINE-RECORD, a value of "137" should be reported in TYPE-OF-SERVICE, and a value of "108" should be reported in BENEFIT-TYPE for any COVID–19 testing-related services as specified by the FFCRA.
Additional information and comprehensive reporting guidance will be shared on the T-MSIS Coding Blog.

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

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

D. Telework

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

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

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

CMS welcomes states sharing best practices as they adopt more remote work capabilities, to inform other states and to help CMS support Medicaid agencies for this and future emergencies.

We do not expect to ask for any special reporting regarding eligibility determination processing by remote workers during the COVID-19 PHE.

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

States that desire technical assistance with rapidly accelerating any of their telework capabilities may contact their Medicaid Enterprise State Systems Officer, who can help with obtaining any applicable authorization for funding and connecting states to other states that have already grappled with the policy, cultural and operations considerations associated with remote work. Reference also FAQ # VII.D.4., which has additional information regarding issues involved with temporary office closures.

E. Miscellaneous

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

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

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

VII. Miscellaneous

A. Quality Reporting

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

While all Core Set reporting continues to be voluntary on the part of states, CMS encourages states that can collect and submit this information safely to continue doing so. To this end, however, CMS recommends temporarily suspending the types of measurement activities that could present a health risk to state employees or contractors, such as conducting on-site medical chart reviews. In addition, CMS expects that the COVID-19 pandemic could affect the accuracy of Core Set reporting in a number of ways. For example, state performance on preventive care

Core Set measures may decline, since individuals have generally been advised not to seek in-person routine or preventive care unless medically necessary at this time. Moreover, these services offered through telehealth may not be captured in the measure unless the measure specifications allow for telehealth. All of these factors can affect not only the ability of states to collect and submit Core Set data to CMS on time, but can also limit the accuracy of that information and the ability for CMS to trend state performance rates over time. To the extent those Core Set measures are also included in the Medicaid and CHIP Scorecard, state Scorecard performance and the ability to trend that information will also be affected.

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

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

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

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

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

The measure stewards (Human Services Research Institute (HSRI), National Association of State Directors of Developmental Disabilities Services (NASDDDS), and Advancing States (AD)) for

the National Core Indicator (NCI) surveys (NCI and NCI-AD) have "paused face-to-face surveying of any kind at this time." Additionally, NCI does not currently support phone or videoconference surveys.

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

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

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

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

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

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

Where preventive and elective services can be provided through telehealth, CMS encourages states to do so and to include those visits in their Core Sets data submissions where technical specifications allow for them (please refer to the COVID-19 State Medicaid & CHIP Telehealth Toolkit and FAQ # III.B.1, regarding the delivery of telehealth services).

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

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

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

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

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

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

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

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

No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services provided in the same manner or at the same rate that states pay for face-to-face services. A SPA would be necessary to implement any revisions to payment methodologies to account for telehealth costs (please refer to the COVID-19 State Medicaid & CHIP Telehealth Toolkit and for example, please refer to FAQ Section III.B.1. regarding the delivery of telehealth services).

10. How can states request technical assistance specific to EPSDT reporting?

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

B. Workforce Issues

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

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

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

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

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

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

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

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

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

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

C. 1115 Demonstrations

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

Yes, a state may submit a request to temporarily amend a demonstration in conjunction with the public health emergency. Demonstration special terms and conditions, as well as waivers and expenditure authorities, as applicable, may be authorized for a limited time, as needed. CMS will prioritize these requests for accelerated review.

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

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

3. Can an amendment request be retroactive?

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

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

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

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

Yes, in the context of this declared public health emergency, the state may be exempted from any of the normal public process requirements outlined in 42 C.F.R. § 431.408. Pursuant to 42 C.F.R. § 431.416(g), CMS has discretion to exempt the state from completing any aspect of the public notice process, including exemption from conducting any public notice, *when the State demonstrates to CMS the existence of unforeseen circumstances resulting from a natural disaster, public health emergency, or other sudden emergency that directly threatens human*

lives that warrant an exception to the normal public notice process. To address the question above, in lieu of in-person meetings, the state may hold meetings in any alternative format (webinar, telephonic, written submission) that permits submission of public input; including using two telephonic conferences in lieu of in-person public hearings.

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

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

D. Other

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

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

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

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

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

Medicaid program for the services provided to beneficiaries?

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

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

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

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

CMS's 12 local administrative contractors process and pay the fee-for-service Medicare claims for each of their respective jurisdictions. The contractors use a variety of methodologies to price new tests that will be paid at the local level, until a national price is established through CMS's

annual laboratory meeting process that includes the opportunity for public feedback. CMS is actively working with the contractors in this process and will provide information in separate guidance once it is available.

4. What should states do if they need to close Medicaid or CHIP state and local offices to applicants and beneficiaries during a disaster or emergency?

CMS recognizes that the COVID-19 public health emergency may impact states' normal operations, particularly in light of staff shortages and the recommendations that individuals socially distance themselves from others. As a result, we also acknowledge that this may limit states' ability to receive applications, reports of changes in circumstances, and renewal forms or provide assistance in-person.

While existing statute and regulation do not permit an exception to accepting information from applicants and beneficiaries through any of the required modalities (e.g., online, in person, via mail, and by phone), CMS recognizes that access to a particular modality may be temporarily limited due to an administrative or other emergency beyond the agency's control, including closure of public offices due to COVID-19. If an emergency impacts a state's ability to accept information from applicants or beneficiaries in person or through another modality, the state should make feasible adjustments to ensure that individuals still have the opportunity to apply. For example, if state and local offices are closed, a state could increase the capacity of other available modalities (e.g., by expanding call center capacity or placing additional out-stationed workers in specific locations), and ensure that individuals are informed of these other resources. Additionally, states should continue to ensure communication with applicants and beneficiaries are accessible to individuals with disabilities and those who are limited English proficient. CMS is available to assist states in identifying practical solutions when access to a particular modality may be limited due to the public health emergency.

Additionally, states may use contractors to perform certain Medicaid agency administrative functions, provided that the state exercises appropriate oversight consistent with federal regulations at 42 C.F.R. § 431.10. For example, states can use contractors to operate call centers, input data from paper applications into an eligibility system or serve as application assistors. For CHIP, states have broad flexibility to delegate functions to contractors as long as they maintain oversight.

Additional Questions

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

EXHIBIT 3

Last Updated June 30, 2020

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

Table of Contents

I. Emergency Preparedness and Response

1. What resources are available to assist states and territories in their response to COVID19?

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

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

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

Appendix K also provides states with opportunities to:

- temporarily increase individual eligibility cost limits,
- modify service, scope, or coverage requirements,

- exceed service limitations,
- add services to the waiver,
- provide services in out-of-state settings, and/or
- permit payment for services rendered by family caregivers or legally responsible individuals.

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

Please see attached link for instructions and template:
https://www.medicaid.gov/medicaid/home-community-based-services/downloads/1915cappendix-k-instructions.pdf and
https://www.medicaid.gov/medicaid/home-community-basedservices/downloads/1915c-appendix-k-template.pdf

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

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

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

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

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

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

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

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

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

Yes. A state may request that CMS waive the requirement that a SPA be submitted no later than the last day of the same quarter as the requested effective date of the SPA, waive public notice requirements, and permit the state to modify the tribal consultation timeline, under section 1135 of the 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 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-forstates/disaster-response-toolkit/state-plan-flexibilities/index.html.

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

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

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

8. 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), Pub L. No. 116-127 (2020) may need to keep this group enrolled until the end of the month in which the PHE period ends in order to comply with the conditions in section 6008(b)(3) of that legislation. However, the limited coverage for which this group is eligible also terminates at the end of the PHE (per statute), so states do not need to provide this group with any coverage after the PHE ends, even if they keep members of this group enrolled in order to comply with section 6008(b)(3) of the FFCRA. States may elect the COVID-19 testing eligibility group by completing the appropriate section of the Medicaid disaster relief SPA template, which can be found here: https://www.medicaid.gov/resources-

forstates/disaster-response-toolkit/state-plan-flexibilities/index.html. The SPA is submitted to the relevant CMS SPA Mailbox for the state.

II. Eligibility and Enrollment

A. Application and Renewal Processing

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

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

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

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

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

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

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

the exception in the beneficiary's case record, but also to obtain CMS concurrence that the exception is warranted under the circumstances.

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

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

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

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

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

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

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

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

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

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

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

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

Consistent with regulations at 42 C.F.R. §§ 435.907(f) and 457.330, all initial applications for Medicaid and CHIP must be signed under penalty of perjury. Individuals may receive help from others, including certified application assisters under 42 C.F.R. § 435.908, Exchange Navigators, or authorized representatives, to complete an application for Medicaid or CHIP. While these types of assisters typically provide in-person assistance with applications, CMS recognizes that such assistance may need to be provided by phone during the current public health emergency if offices or other locations are closed or otherwise to minimize in-person contact. If an assister or other individual is completing and submitting an online application on behalf of an applicant, based on information the applicant has provided by phone, for the period of the emergency and subject to state law, the applicant may designate that individual be an authorized representative

with limited authority to sign and submit the application on behalf of the applicant. Due to the public health emergency posed by COVID-19 and the urgent need to avoid transmission of COVID-19, for the duration of the COVID-19 public health emergency, CMS will not enforce compliance with requirements at § 435.923(a)(1) that designation of an authorized representative must be signed by the applicant or enrollee, and submitted to the state agency, provided that applicants provide authorization for an assister or other individual to be their authorized representative orally, in writing, or both. A record of such authorization must be submitted by the authorized representative, along with the application. The agency must accept such authorization through any of the available modalities described at § 435.907(a) and must be include the record in the applicant's account held by the state Medicaid agency. Assisters or other individuals acting as authorized representatives in these circumstances must also abide by confidentiality and conflict of interest requirements set out in regulation at 42 C.F.R. §§ 435.908(c) and 435.923(e), 45 C.F.R. §§ 155.210(d), 155.225(g)(2), 155.227, and 155.260, and the legal instrument establishing the assister's relationship with the Exchange or authorized representative's role with respect to the Exchange. We believe that this guidance is a statement of agency policy not subject to the notice and comment requirements of the Administrative Procedure Act (APA). 5 U.S.C. § 553(b)(A). For the same reasons explained above, in light of the PHE and the urgent importance of reducing the potential for transmission of COVID-19 through the authorization process, CMS additionally finds that, even if this guidance were subject to the public participation provisions of the APA, prior notice and comment for this guidance is impracticable, and there is good cause to issue this guidance without prior public comment and without a delayed effective date. 5 U.S.C. § 553(b)(B) & (d)(3).

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

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

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

individual to provide accurate responses to application questions and attest to their veracity and must abide by confidentiality and conflict of interest requirements.

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

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

B. Premiums and Cost-Sharing

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

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

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

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

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

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

as amended by section 3720 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, places additional restrictions on states' ability to increase premiums after January 1, 2020 in order to qualify for the temporary FMAP increase.

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

3. 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.

4. For states seeking to claim temporary increased FMAP, can states bill for premiums during the emergency period?

Yes. States may still charge premiums during the emergency period without violating section 6008(b)(2) of the FFCRA. However, a state may not terminate beneficiaries' eligibility or coverage due to unpaid premiums during the emergency period or terminate individuals' eligibility or coverage due to non-payment of premiums incurred during the PHE after the expiration of the emergency period. As discussed in Question F.22 of the FFCRA-CARES Act FAQs, available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-section6008-CARES-faqs.pdf, states seeking to claim temporary increased FMAP may not terminate individuals' eligibility or coverage for failure to pay those premiums.

Effective the month in which the emergency ends, a state may resume implementation of its premium policy under 42 C.F.R. § 447.55(b)(2), which allows for termination after 60 days of non-payment. While states cannot terminate beneficiaries' eligibility or coverage following the end of the PHE for unpaid premiums accumulated during the PHE, states can terminate beneficiaries for unpaid premiums incurred prior to the PHE. To implement this termination, states would not be able to count the PHE time period as part of the 60 days of non-payment and states would have to provide beneficiaries with advance written notice of the termination (see 42 C.F.R. §§ 435.917 and 431.206–.214) and provide fair hearing rights (see 42 CFR § 431.220(a)).

5. Does section 6008 of the FFCRA prohibit states from increasing premium amounts on any beneficiary even when his/her income increases during the public health emergency and his/her premiums are supposed to be charged on a sliding scale basis?

Yes. Section 6008(b)(2) of the FFCRA requires states to maintain premiums at the same or lower level as assessed on January 1, 2020 for any beneficiary.[1] If a beneficiary reports an

[1] Pursuant to section 6008(d) of the FFCRA, as added by section 3720 of the Coronavirus Aid, Relief, and Economic Security Act, P.L. 116-136, if a state imposed a premium higher than any in effect on January 1, 2020, during the

increase in income that would result in a higher premium after January 1, 2020, then assuming the individual still has an increase in income at the end of the public health emergency, the earliest date that a state could assess the increased premium would be the first day of the month following the end of the calendar quarter in which the public health emergency ends.

C. Eligibility

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

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

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

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

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

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

30-day period beginning on March 18, 2020, CMS will not find a state ineligible for the temporary FMAP increase on this basis.

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

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

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

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

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

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

We note that the Centers for Disease Control and Prevention (CDC) and United States Postal Service (USPS) guidance indicates that there is no evidence COVID-19 is spreading through US mail. See https://www.cdc.gov/coronavirus/2019-ncov/faq.html and https://about.usps.com/newsroom/statements/usps-statement-on-coronavirus.htm. Therefore, we do not believe it necessary or appropriate to discontinue mailing all hard copy documents to enrollees. However, states and managed care plans have several options that can reduce the number of hard copy documents that are mailed. For public documents such as provider directories and enrollee handbooks, 42 C.F.R. § 438.10(c)(6) provides the criteria for the provision of required materials in electronic form. For notice of adverse benefit determinations which contain protected health information and are critical to enrollees receiving services, managed care plans can offer enrollees the option to elect to receive such notices electronically. This option can be promoted by including an explanation of the option and a link in each written document or in an email or text specifically to advertise the option. Managed care plan staff

communicating with enrollees by phone can facilitate the use of this option by requesting email addresses from enrollees. The use of electronic communication is at the option of the enrollee and, consistent with 42 C.F.R. § 438.10(c)(6)(v), an enrollee must be informed that they may request information in paper form and without charge upon request. Additionally, all provisions of 42 C.F.R. § 438.10(d) apply to electronic communications.

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

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

D. Notice and Fair Hearings

1. What flexibilities are available for Medicaid fair hearings?

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

- Suspend adverse actions for individuals for whom the state has completed a determination but either: (1) has not yet sent the notice; or (2) who the state believes likely did not receive the notice. This is consistent with 42 C.F.R. § 431.211, which requires the state to provide at least 10-days advance notice before taking adverse action. See also Families First Coronavirus Response Act – Increased FMAP FAQ B.9 regarding the provision of continuous coverage during the emergency period as a condition for receiving the increased FMAP under that Act.
- Delay scheduling fair hearings and issuing fair hearing decisions under 42 C.F.R. § 431.244(f)(4)(i)(B), which allows states to delay taking final administrative action when there is an emergency beyond the state's control. States should prioritize completing hearings that meet the standard for an expedited fair hearing under 42 C.F.R. § 431.224. States may offer to continue benefits to individuals who are requesting a fair hearing if the request comes later than the date of the action under 42 C.F.R. § 431.230.

- Hold fair hearings via video conferencing or telephone, provided states adhere to other fair hearing requirements (42 C.F.R. part 431, subpart E), including ensuring that the hearing system is accessible to persons who are limited English proficient and persons who have disabilities (see 42 C.F.R. §§ 431.205(e) and 435.905(b)).
- Reinstate services or eligibility if discontinued because the beneficiary's whereabouts were unknown due to displacement, after the beneficiary's whereabouts become known (if still eligible), consistent with 42 C.F.R. § 431.231(d).

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

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

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

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

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

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

In FAQs issued on April 2, and republished in the "COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies" on May 5, we provided four flexibilities for fair hearings and adverse actions that can be utilized during the PHE and indicated that states should request concurrence if utilizing such flexibilities. We

are revising the information related to flexibilities for fair hearings below to clarify that states may implement two of these policies without a request for concurrence from CMS: 1) holding fair hearings via video conference or telephone; and 2) reinstating services or eligibility if discontinued because the beneficiary's whereabouts are unknown due to displacement, after the beneficiary's whereabouts become known. States may implement these policies consistent with current regulations without any additional authority (see Questions D.5. and D.6., below).

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

- Delay taking final administrative action, which could include scheduling fair hearings and issuing fair hearing decisions, due to an emergency beyond the state's control, consistent with 42 C.F.R. § 431.244(f)(4)(i)(B). States should prioritize completing hearings for individuals who meet the standard for an expedited fair hearing under 42 C.F.R. § 431.224.
- Suspend adverse actions for individuals for whom the state has completed a determination but either: (1) has not yet sent the notice; or (2) who the state believes likely did not receive the notice. This is consistent with 42 C.F.R. § 431.211, which requires the state to provide at least 10-days advance notice before taking an adverse action. We note that if the state is claiming the temporary FMAP increase under section 6008 of the FFCRA, the state will need to continue to provide coverage to beneficiaries receiving coverage as of or after March 18, 2020 through the end of the month in which the PHE ends, whether or not the state has sent an adverse action notice and/or the individual has received such notice. For additional information on continuing coverage, see FAQ II.I regarding Continuing Coverage under section 6008 of the Families First Coronavirus Response Act in the "COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies," published May 5, 2020.

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

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

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

address the effective communication needs of individuals with disabilities. States should maintain appropriate documentation regarding any policy and procedural changes to the state's fair hearing process in accordance with the state's policies.

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

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

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

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

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

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

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

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

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

E. *Presumptive Eligibility*

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

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

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

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

3. Must a state apply the transfer-of-assets rules to institutionalized individuals receiving coverage during a presumptive eligibility period following a determination of

presumptive eligibility made by a hospital in accordance with section 1902(a)(47)(B) of the Act and 42 C.F.R. § 435.1110((c)(2))?

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

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

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

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

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

5. Can states change their hospital PE performance standards?

Yes. States have flexibility under regulations at 42 C.F.R. § 435.1110(d) to establish statespecific 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-planflexibilities/index.html.

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

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

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

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

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

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

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

States may be able to help expedite provision of medical assistance to applicants who must meet a disability test through extension of hospital presumptive eligibility to populations excepted from modified adjusted gross income (MAGI) methodologies. See COVID-19 FAQs for State Medicaid and Children's Health Insurance Program (CHIP) Agencies, updated May 5, 2020, FAQ II.E., for additional information related to presumptive eligibility (PE). The requirements for continuous coverage under section 6008(b)(3) of the Families First Coronavirus Response Act do not apply to individuals receiving coverage during a presumptive eligibility period.

Coverage for individuals receiving coverage during a presumptive eligibility period ends for individuals who do not timely submit a full Medicaid application or who are determined not eligible based on submission of a full application. See COVID-19 FAQs on implementation of Section 6008 of the Families First Coronavirus Response Act, updated April 13, 2020, Question B.8, available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-section6008-faqs.pdf, for additional information on the requirements for continuous coverage for individuals in a presumptive eligibility period.

F. Verification

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

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

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

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

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

verification procedures for the duration of the public health emergency. CMS has developed a disaster-related verification plan addendum which states can use for this purpose.

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

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

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

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

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

Whenever a state has elected to conduct post enrollment verification, it must complete such processes as expeditiously as possible and within a reasonable timeframe following the initial determination of eligibility. CMS recognizes that due to workforce limitations and other operational challenges during the COVID-19 emergency, states may be unable to complete postenrollment 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-section6008-faqs.pdf).

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

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

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

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

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

electronic data obtained by the agency. States must also document reliance on attested information under 42 C.F.R. § 435.952(c)(3) in the individual's case record.

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

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

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

States may not suspend use of their AVS under the state plan, which is required under sections 1902(a)(71) and 1940 of the Act. However, the statute does not require that states verify assets using their AVS prior to an initial determination. Instead, states may initially rely on selfattestation of assets and verify financial assets using their AVS post-enrollment in Medicaid. 42 CFR §435.945. Under regulations at 42 C.F.R. § 435.916(d), if a state obtains new asset information from the AVS post-enrollment that indicates an individual may not be eligible, the state must evaluate that information and redetermine eligibility as appropriate. However, we note that, pursuant to section 6008(b)(3) of the FFCRA, in order to be eligible for the temporary 6.2 percent FMAP increase under section 6008(a) of the FFCRA, states may not terminate an individual, once determined eligible, through the end of the month in which the public health emergency ends. This would include any individuals determined eligible for Medicaid based on self-attested asset information for whom verification using the state's AVS is done postenrollment. See FAQ # II.A.4. for additional information on states' responsibility to redetermine eligibility whenever they receive information indicating a beneficiary may no longer satisfy the criteria for eligibility and for the implications of the FFCRA on this policy.

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

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

Consistent with § 435.945(j), states must document the verification policies and procedures used by the state to implement the verification provisions set forth in 42 C.F.R. §§435.940 through 435.956, including the data sources determined by the state to be useful for verifying eligibility, use of self-attestation, post-enrollment verification and reasonable compatibility standards, where appropriate. States also must submit their verification plan to CMS upon request. CMS has requested that all states submit, and update as necessary, their verification plans for MAGIbased 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 MAGIexcepted 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-verificationplan-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-MAGIbased verification policies must be documented in the state's internal policies and procedures, along with the period for which such changes will be in effect. States may include information about non-MAGI changes for an emergency period in the state's MAGI-based Disaster Relief Verification Plan Addendum in the "Other" section if the state chooses to do so.

G. Basic Health Program

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

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

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

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

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

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

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

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

States that elect to follow the Medicaid eligibility verification process may modify their verification policies to use attestation for eligibility factors, unless the statute requires other verification (such as for citizenship and immigration status); to accept attested information for an initial determination and enrollment, and conduct other verification processes post-enrollment;

or to change their reasonable compatibility standard for verification of income. See more information in FAQ # II.F.1. Regarding citizenship and immigration status, electronic verification is available through the Social Security Administration and the Department of Homeland Security US Citizenship and Immigration Services Systematic Alien Verification for Entitlement (SAVE) program. For otherwise eligible individuals who attest to U.S. citizenship or a lawfully present immigration status, but whose U.S. citizenship or lawfully present immigration status cannot be verified electronically, a reasonable opportunity period is provided while the verification process is completed. At state option, a good faith extension may be available for non-citizens verifying their lawfully present immigration status under 42 C.F.R. § 600.345, cross referencing 42 C.F.R. § 435.956(b)(2)(ii)(B).

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

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

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

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

H. Coverage for American Indians and Alaska Natives

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

Yes. Generally, per 42 C.F.R. § 435.403(i), a child's state of residency is the state where the child resides or the state of residency of her/his parent or caretaker. In the case of a student attending a boarding school, the state in which the school is located has the option under the regulations to consider students living at the school to be residents of the state. If a state chooses not to consider certain students living in the state as state residents, the state plan must indicate

that policy. If a state that considers students living in their state only for the purposes of attending school as not being a state resident wants to change its policy only for the duration of the COVID-19 public health emergency, the state may submit a Medicaid disaster relief SPA to make that change.

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

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

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

If an out-of-state provider declines to enroll in the home state's Medicaid program, the home state may still reimburse the out-of-state provider in accordance with the exception outlined in the *Medicaid Provider Enrollment Compendium* (1.5.1.C.2.), available at https://www.medicaid.gov/sites/default/files/2019-12/mpec-7242018.pdf. Additionally, a state may seek an 1135 waiver to pay a provider who is not enrolled in the state's Medicaid program. The 1135 waiver can be used to broaden the provider enrollment exception and waive the instances of care criteria outlined in the *Medicaid Provider Enrollment Compendium* for the duration of the public health emergency. Checklist and resources to request an 1135 waiver is available at: https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/section1135-waiver-flexibilities/index.html.

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

1. 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.

2. 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.

3. 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.

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

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

individual is eligible and is therefore inconsistent with the requirement at section 6008(b)(3) of the FFCRA.

J. Miscellaneous

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

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

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

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

K. Optional COVID-19 Testing Group

1. Is there an age criteria associated with the new COVID-19 optional eligibility group?

No, there is no age criteria for eligibility in the new optional COVID-19 testing group. Individuals of any age, including children under age 19, adults ages 19–65, and individuals over age 65, may receive coverage under this group as long as they meet the definition of "uninsured individual" in section 1902(ss) of the Act, citizenship or satisfactory immigration status requirements, and the state's residency requirements.

2. What steps are states required to take before terminating coverage for an individual in the optional COVID testing group? Are states required to provide advance notice of termination and fair hearing rights?

In general, most states will keep an individual enrolled in the COVID testing group until the last day of the month that the PHE ends in order to qualify for the 6.2 percentage point FMAP increase under section 6008 of FFCRA, unless one of the two exceptions provided for under subsection (b)(3) applies (i.e., the individual "requests a voluntary termination of eligibility" or "ceases to be a resident of the state"), or the beneficiary becomes eligible for another Medicaid eligibility group and moves to that other group. However, the authority for benefits available to the COVID testing group ends at the end of the PHE. Therefore, states may not claim FFP after the PHE ends for services provided to individuals who remain enrolled in the testing group after the PHE ends.

In accordance with regulations at 42 C.F.R. § 435.916(f), states generally must determine eligibility on all bases prior to determining a beneficiary ineligible and must provide advance notice at least 10 days prior to termination and fair hearing rights in accordance with 42 C.F.R. § 435.917, and 42 C.F.R. § 431.210 through § 431.214. States must also determine eligibility for other insurance affordability programs for an individual determined ineligible and transfer their account in accordance with 42 C.F.R. § 435.916(f). For beneficiaries disenrolled from the COVID-19 testing group on the last day of the PHE, or the last day of the month in which the PHE ends, there is not a right to a fair hearing to contest termination of coverage under that group, consistent with 42 C.F.R. § 431.220(b). However, such beneficiaries would have fair hearing rights if they submit an application for comprehensive coverage (i.e., using an application described in 42 C.F.R. 435.907) and are denied based on that application. States have the flexibility to satisfy the requirement to determine eligibility on other bases prior to terminating eligibility at the end of the PHE and to provide fair hearing rights related to termination of coverage under the COVID-19 testing group as follows: First, in providing the notice of eligibility at the time of initial enrollment, informing the individual of their eligibility under the COVID-19 testing group, the state would include information (1) that coverage of any testing or diagnostic services under the COVID-19 testing group will be terminated at the end of the PHE; (2) that the individual may be eligible for comprehensive Medicaid coverage; and (3) how to submit an application for comprehensive coverage. Second, in the advance notice required prior to termination at the end of the PHE, the state would again inform the individual how to apply for comprehensive Medicaid coverage. Beneficiaries who submit an application for comprehensive coverage and whose eligibility is subsequently denied based on the application for comprehensive coverage must be provided fair hearing rights if denied eligibility based on such application.

Individuals enrolled in the COVID-19 testing group who subsequently enroll in Marketplace coverage no longer meet the eligibility criteria for the COVID-19 testing group as they no longer meet the definition of "uninsured individual" in section 1902(ss) of the Act. Therefore, in order to meet the requirements under section 6008(b)(3) of the FFCRA, if it is determined that an individual may be potentially eligible for Marketplace coverage, the state must ensure that the individual is notified that submission of an application for and subsequent enrollment in Marketplace coverage constitutes the individual's voluntary request for termination of eligibility

from this COVID-19 testing group. If such an individual applies but is not found eligible for Marketplace coverage, the individual should not be considered to have requested termination of Medicaid eligibility.

CMS released additional information on how states may operationalize implementation of the COVID-19 testing group. That guidance is available at: https://www.medicaid.gov/stateresource-center/downloads/potential-state-flexibilities-guidance.pdf

III. Benefits

A. COVID-19 Testing

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

Yes, tests for the detection of SARS-CoV-2 or diagnosis of COVID-19 are a mandatory laboratory service as described at 1905(a)(3) of the Act and 42 C.F.R. § 440.30. Section 6004(a) of the FFCRA added a new mandatory benefit in the Medicaid statute, at section 1905(a)(3)(B) of the Act, and this provision was amended by section 3717 of the 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.

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

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

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

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

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

B. Telehealth

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

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

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

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

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

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

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

necessary to revise existing state plan language that imposes telehealth parameters that would restrict this practice. As is discussed above and at https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html, states are not required to submit separate state plan amendments for coverage or reimbursement of telehealth services if they decide to reimburse for telehealth services in the same manner or at the same rate paid for face-to-face services. A state plan amendment would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Office for Civil Rights in the Department of Health and Human Services is exercising enforcement discretion to waive potential penalties for Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security, and Breach Notification Rules violations against health care providers that in good faith provide patient care through remote communications technologies during the COVID-19 public health emergency. Additional guidance is available explaining how covered health care providers can use remote video communication products and offer telehealth to patients responsibly. See: https://www.hhs.gov/hipaa/for-professionals/special-topics/hipaa-covid19/index.html.

States may also refer to the guidance issued by the Office of Special Education Programs (OSEP) in the Department of Education for further information on the IDEA and other federal civil rights laws:

https://www2.ed.gov/about/offices/list/ocr/frontpage/faq/rr/policyguidance/Supple%20Fact%20Sheet%203.21.20%20FINAL.pdf. For other updates on the Department of Education website, see: https://www.ed.gov/coronavirus.

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

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

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

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

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

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

If the state establishes that a Medicaid-covered service can be delivered via telehealth, states may generally use existing state plan methodologies to cover and pay for the service when delivered via telehealth, or to reimburse additional costs that are incurred by the provider because of telehealth delivery. If the state plan contains restrictions that would prevent an otherwise covered service from being provided via telehealth, the state may use the Medicaid Disaster SPA template issued on March 22, 2020 to temporarily remove such restrictions during the period of the public health emergency. States can cover and reimburse for EIS that are Medicaid-covered services provided to a Medicaid-enrolled child by a qualified Medicaid provider. As explained previously in the CMS telehealth FAQs (Section III. Benefits, Item B. Telehealth, Question 1) updated May 5, 2020, states have broad flexibility to cover services provided via telehealth under Medicaid, and also have flexibility regarding the methods of

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

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

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

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

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

C. Home and Community Based Services

1. How can states provide 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.

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

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

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

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

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

For section 1915(k) Community First Choice programs, pursuant to section 1135(b)(5) of the Act, states may request a modification of the deadline for initial and annual level of care determinations required for the section 1915(k) state plan benefit, as described in 42 C.F.R. §

441.510(c). With this modification, the initial determination of level of care does not need to be completed before the start of services and the annual level of care determinations that exceeds the 12-month authorization period will remain in place and services will continue until the assessment can occur. A reassessment may be postponed for up to one year.

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

An Appendix K approval expires one year from the effective date or any earlier approved date elected by the state. However, end dates cannot extend beyond one year from the last day of the month in which the President signed the proclamation of a national emergency (March 31, 2021).
This FAQ has the effect of updating information in the table included in FAQ 7.

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

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

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

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

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

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

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

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

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

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

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

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

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

provide case management and/or that case management entities must temporarily provide direct services.

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

Yes. Pursuant to section 1135(b)(1)(C) of the Act, a state can request to waive provisions at 42 C.F.R. § 441.301(c)(2)(ix) for section 1915(c) waiver programs, 42 C.F.R. § 441.725(b)(9) for section 1915(i) HCBS state plan programs, and 42 C.F.R. § 441.540(b)(9) for section 1915(k) Community First Choice programs to permit documented verbal consent as an alternate to the regulatory requirement for a signature on the person-centered service plans from beneficiaries and all providers responsible for its implementation. This will facilitate rapid authorization of critically needed services and reduce the risk of transferring communicable diseases through the process of receiving signed documents.

D. Pharmacy/Prescription Drugs

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

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

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

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

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

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

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

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

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

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

There are currently no federal Medicaid rules that require beneficiaries to provide their signature in order to receive prescription drugs. Requirements for signatures are usually found in a state provider manual and are at the discretion of the state Medicaid program. Therefore, CMS encourages states to explore ways to ease state signature requirements in order to allow beneficiaries to access their medications during the public health emergency.

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

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

Yes. States must cover, under the state plan (or waiver), testing services and treatments for COVID–19, including vaccines, specialized equipment, and therapies, for any quarter in which the temporarily increased FMAP is claimed. For example, a state would have to cover any drug approved under an FDA Emergency Use Authorization (EUA) for COVID-19. In that regard, states must cover Remdesivir when used according to the EUA, which was issued on May 1, 2020. The FDA approved the use of this investigational drug for hospitalized COVID-19 patients with severe disease. While an unapproved drug, it would qualify for FFP as a prescribed

drug under 42 C.F.R. § 440.120. *See also* 42 C.F.R. § 447.522 that describes optional coverage of investigational drugs and other drugs not subject to rebate.

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

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

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

Thus, states may be able to cover and claim FFP for certain prescribed drugs when used for nonmedically accepted indications, as provided in 42 C.F.R. § 447.522. To the extent such a drug does not meet the definition of a covered outpatient drug, the state cannot claim rebates on these drugs under section 1927 of the Act. However, a State should assure that when these drugs are used for medically accepted indications as covered outpatient drugs that the state claims rebates, as appropriate.

E. Money Follows the Person (MFP) Program

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

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

We recommend that all states follow CDC recommendations and their own policies and procedures in order to reduce the risk of exposure and prevent the spread of the virus. We also recommend that states regularly monitor CMS's Current Emergencies webpage for responses to states' questions, information and guidance, and other updates on CMS's response to COVID19. 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/partnerresources/coronavirus-covid-19-partner-toolkit). Please visit these links and check back often for the most up-to-date information. Contact your MFP Project Officer if you have any questions or need technical assistance related to any state-specific challenges or issues.

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

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

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

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

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

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

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

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

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

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

As in section 1915(c) waiver programs, transition coordination can be covered as a component of case management services. States should follow the applicable rules and processes of those authorities if they are making changes to an HCBS program that operates under section 1915(c)

of the Act or another Medicaid authority, regardless of whether any of the service costs are funded under MFP. This includes any request to extend the time period for which transition coordination can be reimbursed prior to discharge from an institution. States should reach out to their CMS HCBS lead and request flexibility under Appendix K for the section 1915(c) waiver application if they need to request changes to a section 1915(c) waiver or have any questions about how to request approval under another HCBS authority. Information on Appendix K may be found on Medicaid.gov: https://www.medicaid.gov/state-resource-center/disaster-responsetoolkit/hcbs/appendix-k/index.html.

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

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

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

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

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

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

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

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

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

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

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

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

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

Yes. If CMS has approved a section 1135 waiver, a section 1915(c) Appendix K application, or a section 1115 demonstration modifying the delivery of home and community based services (HCBS) available to eligible MFP participants, these changes would apply to MFP participants transitioning from MFP qualified inpatient facilities and to MFP participants receiving HCBS in MFP qualified community residences. MFP demonstration requirements for eligibility,

furnishing of qualified HCBS services during the 365-day enrollment period, and assurance that the continuity of Medicaid covered HCBS is available to individuals after the 365-day period ends would remain unchanged. MFP programs should work with their respective state Medicaid agency partners to coordinate any changes to the delivery of HCBS that may affect MFP participants. MFP grantees should notify their MFP Project Officer as soon as possible of any changes to their MFP program's Operational Protocol.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

F. Miscellaneous

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

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

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

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

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

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

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

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

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

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

Yes, but only if CMS provides the state with time-limited waiver authority pursuant to section

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

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

Yes. A state may cover PPE for Medicaid beneficiaries if determined to be medically necessary under the home health medical supplies, equipment, and appliances benefit (42 C.F.R. 440.70(b)(3)). States may apply limits on amount, duration, and scope of benefits as long as the benefit is sufficient in amount, duration, and scope to meet the purpose of the benefit.

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

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

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

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

G. Non-Emergency Medical Transportation

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

A: No. There is no categorical waiver of provider enrollment requirements. CMS has provided guidance on how states may request and receive CMS approval for certain limited waivers concerning provider enrollment requirements, for example, to streamline enrollment requirements, waive certain conditions of participation, and waive state licensure requirements where the provider has an equivalent license in another state. See: https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/section-1135-waiverflexibilities/index.html. However, provider enrollment and screening are a condition of payment and as such cannot be waived by the agency. Furthermore, any abbreviated enrollment under an approved section 1135 waiver is temporary and must be either converted to a full enrollment (with the provider fully screened and appropriately licensed in the state), or deactivated within 6 months after the PHE is lifted.

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

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

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

No, but states have flexibility under the state plan to determine the least costly and most appropriate vehicle for the beneficiary. Specifically, the requirement to utilize the least costly and most appropriate ride is based on the requirements in section 1902(a)(30)(A) of the Act, which requires the state plan to provide for methods and procedures relating to utilization of and payment for care and services as necessary to guard against unnecessary utilization and assure that to payment is consistent with "efficiency, economy and quality of care[.]" When transportation is assured as an administrative activity under the plan, rather than as an optional medical service, the methods of administration with respect to transportation must be necessary for the "proper and efficient" operation of the plan, as specified in section 1902(a)(4) of the Act.

As specified in 42 C.F.R. § 431.53(a), the state must "ensure necessary transportation." Accordingly, states have the flexibility and the responsibility to determine when a Medicaidfunded ride is "necessary," which includes a determination whether the ride is the least costly and most appropriate mode of transportation available to meet the beneficiary's need. Thus, a state can make the determination that the least costly and most appropriate vehicle for a given transport is a non-emergency ambulance provider when no other appropriate form of transportation is available, including in circumstances where this would not be the least costly and most appropriate form of transportation if another appropriate form of transportation were available to the beneficiary. For example, if a beneficiary who has been diagnosed with COVID19 requires transportation to a dialysis facility or is ready for discharge from a hospital, in consideration of necessary infection control protocols in light of the patient's COVID-19 diagnosis, it could be appropriate for the state to authorize an ambulance to transport the beneficiary if the state determines that the ambulance is the least costly and most appropriate mode of transportation available to meet the beneficiary's need.

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

Yes, under limited circumstances for certain beneficiaries. The NEMT benefit requires states to assure that beneficiaries with no other transportation resources have access to Medicaid-covered medical services. Under section 1915(c) waiver and section 1915(i) state plan authority, the state can cover the delivery of meals to individuals served by those programs by adding home delivered meals as a service option and the NEMT providers can be included in the list of qualified providers (as indicated on page 53 of the "Application for a §1915(c) Home and Community-Based Waiver [Version 3.6, January 2019], Instructions, Technical Guide and Review Criteria" available at https://wms-mmdl.cms.gov/WMS/faces/portal.jsp). If there is an issue with paying one provider for the meals and the transportation provider for transporting them, the state can have two components to the rate with different rates for each component.

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

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

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

No, generally, the broker is prohibited from being a provider of transportation, as specified in the cited regulation. However, the current regulations in 42 C.F.R. § 440.170(a)(4)(ii)(B) allow four

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

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

1. What is the difference between the funds available to reimburse providers for COVID-19 testing and treatment services furnished to uninsured individuals through the Health Resources and Services Administration (HRSA) and the funds available through the Families First Coronavirus Response Act (FFCRA) to provide Medicaid coverage of COVID-19 testing services for uninsured individuals?

The new optional COVID-19 testing eligibility group, added by section 6004(a)(3) of the FFCRA at section 1902(a)(10)(A)(ii)(XXIII) of the Social Security Act, is similar to other optional eligibility groups under which states can elect to furnish a targeted set of benefits to eligible individuals. To reimburse providers for the covered services, a state must elect to adopt this group under its state plan. States that do so can then reimburse providers enrolled in their Medicaid program for in vitro diagnostic testing and other COVID-19 testing-related services furnished to individuals whom the agency has determined are eligible under the new group. For more information on the eligibility requirements for the optional COVID-19 testing eligibility group, covered benefits, the availability of hospital presumptive eligibility for the new group, and the availability of 100 percent FMAP for the testing services provided to individuals eligible under the optional COVID-19 testing eligibility group, see https://www.medicaid.gov/stateresource-center/downloads/covid-19-section-6008-CARES-faqs.pdf

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

1. Reimbursement for COVID-19 testing services. This component, authorized via the FFCRA and the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139) (PPPHCA), reimburses providers for conducting COVID-19 testing for

uninsured individuals. The FFCRA and the PPPHCA each appropriated funding for this purpose.

2. Reimbursement for COVID-19 treatment services. This component is authorized via the CARES Act and PPPHCA, which provide funds for hospitals and other health care providers, including those on the front lines of the COVID-19 response. A portion of this funding is being used to support healthcare-related expenses attributable to the treatment of uninsured individuals with COVID-19.

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

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

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

In most cases, providers can utilize the Medicaid Eligibility Verification System (MEVS) to verify if an individual is enrolled under Medicaid. This may include the new optional COVID19 testing eligibility group in states that have adopted this new group. If an individual is not enrolled in the Medicaid COVID-19 testing eligibility group and is otherwise uninsured at the time of services, a participating provider may file a claim with the HRSA-administered program for COVID-19 testing services furnished to the individual as long as the services provided meet the coverage and billing requirements established as part of the program.

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

Individuals with Medicaid coverage of COVID-19 testing and testing-related services are not eligible for coverage of testing and testing-related services through the COVID-19 Claims Reimbursement Program. To ensure appropriate billing, HRSA will coordinate benefits between the COVID-19 Claims Reimbursement Program and Medicaid, via HRSA's claims contractor, UnitedHealth Group (UHG). UHG will perform third party clearances at the initial receipt of a claim and conduct retrospective reviews periodically. If UHG has paid a claim for COVID-19

testing or testing-related services but determines that the individual to whom the services were furnished is eligible for and enrolled in Medicaid (including in the new optional COVID-19 testing group) with coverage effective dates that include the relevant date(s) of service, UHG will recover HRSA's claims payment(s) from the provider and will advise the provider to bill Medicaid, as primary payer. Providers may submit claims through the HRSA-administered program for COVID-19 treatment services provided to otherwise uninsured individuals who are enrolled in the new optional COVID-19 testing eligibility group but who do not have coverage for treatment services.

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

Yes, once an individual becomes Medicaid eligible, including Medicaid coverage received under the new optional COVID-19 testing group, the state must take steps to coordinate benefits with all identified liable third parties that pay primary to Medicaid, pursuant to generally applicable requirements for coordination of benefits/third party liability (COB/TPL). Examples of benefits/third parties subject to COB/TPL for health coverage include employer sponsored health plans, Medicare, and commercial/private insurers. If after Medicaid has paid, a liable third party is identified, the state must seek recovery of Medicaid payment(s). Pursuing payment of claims ensures Medicaid remains payer of last resort (see 42 C.F.R. § 433.139). Because Medicaid pays primary to the HRSA-administered COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured Program (COVID-19 Claims
Reimbursement Program), states are not responsible for initiating COB/TPL processes to identify payment from that HRSA-administered program. See Question 3 regarding COB between Medicaid and the COVID-19 Claims Reimbursement Program.

IV. Financing

A. Administrative Claiming

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

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

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

Increases in allowable and allocable state program administrative costs, resulting from COVID19 initiatives, would be recognized as part of the state's expenditures necessary for proper and efficient administration of the state plan. If revisions to the Public Assistance Cost Allocation Plans and other CMS-approved cost allocation plans and methodologies, including time study methodologies, are needed specifically to address the impact of COVID-19 public health emergency, the state should reach out to CMS, and we will work with the state to process necessary revisions expeditiously. We note that administrative costs resulting from COVID-19 initiatives are not eligible for the 6.2% FMAP increase authorized under the FFCRA.

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

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

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

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

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

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

B. Advance and Retainer Payments

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

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

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

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

3. What are the parameters for retainer payments authorized under section 1915(c) Home and Community-Based Services (HCBS) waivers, which may be used to maintain funding for providers not able to operate during the COVID-19 pandemic?

Retainer payments allow a provider to continue to bill for individuals who are enrolled in a program or who are receiving a HCBS service as specified in his/her person-centered service plan when circumstances prevent the individual from receiving the service. Therefore, retainer payment amounts are tied to amounts reflective of the services that would have been provided to enrolled members should the pandemic not have occurred. Self-quarantining activities during the COVID-19 pandemic, which may lead to the temporary closure of a program, are circumstances that may prevent individuals from receiving their HCBS services.

Retainer payments have been used historically under the section 1915(c) HCBS waivers since 2000. A July 2000 State Medicaid Director's letter, available at https://www.medicaid.gov/sites/default/files/Federal-Policy-

Guidance/downloads/smd072500b.pdf, announced specific parameters for the retainer payments, including that:

- Retainer payments are limited to providers of personal assistant services, and
- The length of time retainer payments could be used is the "lesser of 30 consecutive days or the number of days for which the state authorizes a payment for 'bed-hold' in nursing facilities.

The 2000 guidance did not place any restrictions on the number of time-limited periods (episodes) of retainer payments that could be authorized for a beneficiary. While retainer payments up to 30 days may be implemented within a section 1915(c) waiver application itself, consistent with prior disasters, states may authorize up to three 30-day episodes of retainer payments for an individual during the period of the disaster using the Appendix K. For all retainer payments, states will need to describe the methodology for determining the length of time retainer payments will be made available, and any limits on the number of episodes a state will fund (including specifying whether there will be a break in billing between episodes). CMS notes that the state can set the rate for retainer payments at a percentage below the full rate for the service.

CMS also notes that the references in the 2000 guidance to retainer payments being available for personal care services may also be viewed to incorporate the breadth of HCBS in which support for activities of daily living or instrumental activities of daily living occur. This would typically encompass most residential habilitation programs as well as many non-residential day programs providing services (because personal care is a component of the service).

CMS also clarifies that consecutive days are those days that are eligible for billing. As typical day habilitation services are rendered Monday through Friday, 30 consecutive billing days would encompass a 6-week period of time.

For states that are seeking to contractually require managed care plans to make retainer payments to providers where the authorized service is covered under the contract, states must seek approval under 42 CFR 438.6(c) for state directed payments. In order for states to seek approval under 42 CFR 438.6(c), the retainer payments must be authorized as part of the section 1915(c) HCBS waiver, section 1115(a) demonstration waiver for section 1915(c) HCBS services, or other Medicaid authority. Once the retainer payments are authorized under one of these authorities, a state directed payment preprint must also be submitted to effectuate the state directed retainer payments under a state's contract with its managed care plans. CMS published detailed guidance on this approach at: https://www.medicaid.gov/sites/default/files/FederalPolicy-Guidance/Downloads/cib051420.pdf.

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

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

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

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

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

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

could prevent the personal attendant from entering an individual's home or place of service receipt.

Section 1915(i)(1) of the Act permits states to include HCBS that are within the scope of services at section 1915(c)(4)(B) of the Act. Likewise, 42 CFR § 441.700 permits states to offer HCBS listed under 42 CFR § 440.182. As indicated in previous guidance, retainer payments are permissible within the scope of section 1915(c) waiver personal care and habilitation services that include a personal care component. Therefore, they are also within the scope of what would be permissible for a state using the same services in a section 1915(i) state plan benefit. As an example, where the individual is unable to attend a qualified program such as a day habilitation program authorized under section 1915(i) because of the closure of the program due to social distancing/self-isolating requirements, retainer payment may be made.

In terms of section 1915(k), 42 CFR § 441.520(a)(3) requires the inclusion of backup systems or mechanisms (backup systems) in all Community First Choice (CFC) programs. Backup systems, as defined in 42 CFR § 441.505, are used to ensure continuity of CFC services and supports, and retainer payments could be used to meet this requirement. The retainer payment could be used to retain the availability of an individual's personal attendant when an event removes an individual from his or her home or place of service receipt, or prevents a personal attendant from providing services in the home or place of service provision. Such payments are useful in preserving the availability of the attendant upon the return to typical service provision. This serves to ensure continuity of services and supports. For example, an individual may need to receive a few weeks of rehabilitative services in a skilled nursing facility. The individual plans to return home and wants to receive services from his personal attendant who has been providing services for the past several years. Under this circumstance, a retainer payment could be made to ensure the personal attendant will be available to provide services upon the individual's return to his home. Although retainer payments could be used as part of the backup system for individuals, the backup system must also address how individuals will receive needed services in the absence of their attendant.

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

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

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

If the state elects to make such payments, the applicable state plan must describe the circumstances under which such payments are authorized, and applicable limits on their

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Payment Rates and Methodologies

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

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

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

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

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

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

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

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

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

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

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

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

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

authority for the payment increase after the end of the PHE. In this way, states will have the authority to increase provider payments back to the beginning of the PHE and after the public health emergency ends.

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

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

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

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

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

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

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

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

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

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

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

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

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

States may increase Medicaid payment rates to offset losses to providers during the COVID-19 pandemic. However, FFP is not available under the Medicaid state plan to pay providers directly for the time when care is not provided to beneficiaries. On March 22, 2020, CMS issued a new section 1115 demonstration opportunity available to states under title XIX of the Act (Medicaid) (https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd200021115template.docx). The demonstration opportunity allows states to request expenditure authority to make retainer payments to certain habilitation and personal care providers to maintain capacity during the emergency. For example, adult day sites have closed in many states due to isolation orders, and may go out of business and not be available to provide necessary services and supports post-pandemic; the demonstration opportunity could allow interested states to evaluate the effects on beneficiaries and the Medicaid program of making retainer payments to mitigate a possible long-term reduction in provider capacity and access to services. More information about this demonstration opportunity is available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-applicationprocess/index.html.

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

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

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

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

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

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

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

17. Can states allow facilities to continue to receive full payment for a patient, even if there is a gap in treatment services, due to a client being quarantined or shortages in workforce for performing treatment activities (e.g., residential settings where the facility must still provide for the basic needs, but may not be able to meet the treatment requirements, such as 8 hours of treatment per day)?

As long as a service has been provided, CMS defers to states to determine whether an adjustment is warranted. In the case of patient quarantined away from a facility, states have the option to cover and pay for temporary absences under Medicaid reserve bed authority discussed at 42 C.F.R. 447.40. If such coverage is not currently provided for in the approved state plan, states would need to submit a SPA. If a quarantined Medicaid patient presents unique needs and resource demands, as indicated above, states could use the state plan process to adjust payment rates and/or methodologies to reflect the extra costs to provide services. On March 22, 2020, CMS released a Disaster Relief SPA template (https://www.medicaid.gov/state-resourcecenter/disaster-response-toolkit/state-plan-flexibilities/index.html) that can be used by states for this purpose.

18. How should states that receive section 1135 waivers to provide care in alternative settings appropriately pay for Medicaid services provided within those settings?

States that receive waivers to allow providers to offer care in alternative settings should pay the qualified Medicaid billing provider using the Medicaid state plan payment methodology that would otherwise be paid to the provider. The qualified billing provider is responsible for arranging for and providing care in the alternative setting, including making arrangements to pay for costs associated with the alternative setting.

19. Can states increase Medicaid payment rates to accommodate additional costs incurred by the qualified billing provider to arrange for care in an alternative setting?

Yes, states may increase Medicaid payment rates to factor in increased costs associated with arranging care in an alternative setting, such as higher costs associated with room and board. In accordance section 1902(a)(30)(A) of the Act, such increases must be consistent with efficiency and economy and care costs that would have otherwise been paid to the qualified billing provider may not be duplicated through the payment increase. For example, to the extent costs associated with room and board would have been paid to a hospital through a Medicaid payment methodology, increases in payments may only account for additional costs for room and board at the alternative setting.

20. Can a state increase provider payments to recognize higher costs of delivering care due to personal protective equipment?

Yes. States may increase Medicaid and CHIP service payment rates to recognize increases in costs associated with personal protective equipment (PPE) and we encourage states to review their payment structures to determine whether such increases are warranted and would increase access to care during the public health emergency. Consistent with section 1902(a)(30)(A) of the Act, States may set Medicaid payment rates consistent with efficiency and economy and have the option of increasing service rates to incorporate PPE costs or paying an add-on to a service rate for PPE costs in instances when such equipment is necessary to deliver care to a beneficiary. PPE is not a distinct benefit under the Medicaid or CHIP programs and, therefore, payments to providers are only available when PPE is used in the delivery of a Medicaid or CHIP service. We note that regulations at 42 C.F.R. 447.15 require the Medicaid agency to limit participation in the Medicaid program to providers who accept, as payment in full, the amount paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual. Based on this requirement, providers are prohibited from charging beneficiaries for the cost of PPE when delivering Medicaid services.

E. Upper Payment Limits

1. My state is concerned that increases in costs or payments related to the PHE may not have been contemplated in our upper payment limit (UPL) demonstration. How should we accommodate those changes?

If states have already submitted UPL demonstrations to CMS for state fiscal year 2020 and believe the UPL is understated because it does not include additional costs or payments, as applicable to the demonstration, related to the COVID-19 pandemic, states may submit UPL

demonstration adjustments for CMS review and approval. CMS realizes the cost and/or payment experience of providers may be vastly different than estimates projected from earlier periods not impacted by the pandemic. States believing an adjustment is warranted should inform CMS and we will work with them to modify their UPL demonstrations to include extra costs and/or payments, as applicable.

2. My state already makes supplemental payments under the state plan and has concerns that making these payments during the PHE might result in total payments that exceed the UPL demonstration(s) provided to CMS. Given the uncertainty around changes in costs and/or payments relevant to our UPL demonstration(s), how could we structure the Medicaid state plan supplemental payment methodology?

States should structure Medicaid state plan supplemental payments in a manner that is consistent with section 1902(a)(30)(A) of the Act. If a state is concerned that payments under the approved state plan could result in exceeding the UPL, please inform CMS and we will work with you to ensure that when the UPL demonstration for the affected period is submitted, that the UPL is properly calculated to reasonably recognize any increases in Medicare payments (in a paymentbased UPL) and increases in cost (in a cost-based UPL) in the demonstration.

3. My state makes supplemental payments under the Medicaid state plan up to the Medicaid upper payment limit. We anticipate that while inpatient hospitalizations will increase during the PHE, outpatient services may decrease, including certain particularly high-cost procedures, such as elective outpatient surgeries. What strategies might states employ to address these concerns?

CMS realizes the cost and/or payment experience of providers may be vastly different than estimates projected from earlier periods not impacted by the pandemic. States believing an adjustment is warranted should inform CMS and we will work with them to modify their UPL demonstrations to include extra costs and/or payments, as applicable. If a state is concerned that inpatient and/or outpatient supplemental payments under the approved state plan may exceed the applicable UPL, please inform CMS and we will work with you to ensure that the UPL is properly calculated and that all payments are accounted for in the demonstration.

4. Will CMS be including any increases to Medicare payment as a result of recently enacted legislation in any of the UPL demonstrations required by CMS?

Yes. CMS will consider any increases to Medicare payments during the PHE in any paymentbased UPL demonstrations for services provided during this period.

5. Do states need to submit UPL demonstrations as part of the Medicaid disaster relief SPA submission to support proposed payment increases which are limited only to the PHE period?

No. States are not required to submit UPL demonstrations as part of the Medicaid disaster relief

SPA submission supporting proposed payment increases that are only limited to the PHE period. However, approval of a Medicaid disaster relief SPA does not waive applicable UPLs, and all payments still must meet all applicable legal requirements. States should review the foregoing FAQ items regarding UPL demonstrations and adjustments to UPL demonstrations that already have been submitted. CMS is available to provide technical assistance to states regarding concerns that payment increases under a proposed Medicaid disaster relief SPA might result in total payments that exceed an applicable UPL.

6. How will CMS address UPLs when states increase rates for NFs? Will the NF UPL Demonstration Tools and Guidance change?

CMS UPL policy provides two general approaches to demonstrating compliance with the UPL ceiling. States can use a cost-based UPL approach to allow the UPL ceiling to fully recognize the provider's allowable costs of furnishing Medicaid services; therefore, an increase in allowable facility costs can be accounted for in the cost-based UPL ceiling. If a payment-based UPL approach is used, states' demonstrations can make adjustments to the payment-based ceiling to the extent Medicare payment equivalents have increased.

7. Given the COVID-19 emergency situation, are states still required to submit UPL demonstrations to CMS by June 30, 2020, or is there flexibility around that deadline, as there is for quarterly budget estimates (CMS-37) and expenditure reports (CMS-64)?

If states are unable to meet the annual UPL submission requirement as discussed in State Medicaid Director Letter 13-003 by the end of their state fiscal year, due to the COVID-19 emergency, please inform CMS and we will develop a state-specific compliance plan. Currently, CMS does not take immediate financial action against states based on a late UPL submissions.

8. Will CMS extend the deadline for states' Durable Medical Equipment (DME) UPL demonstration submissions as a result of COVID-19?

If states are unable to meet the DME UPL submission requirement due to the COVID-19 emergency, please inform CMS and we will develop a state-specific compliance plan. Currently, CMS does not take immediate financial action against states based on late UPL submissions.

F. Miscellaneous

1. What flexibilities are available in the event of a public health emergency impacting the availability of state Medicaid agency staff resulting in the state's inability to submit quarterly Medicaid budget estimates (Form CMS-37) 45 days before the beginning of the quarter, as required?

The state Medicaid agency should notify CMS as soon as possible that it expects a delayed Form CMS-37 submission. CMS will work with the state to ensure continued access to federal funds and uninterrupted Medicaid administrative activities and service delivery. If the state is unable to submit the form with enough time for CMS to review and process related grant awards, CMS

may use the state's most recent budget estimate submission (Form CMS-37) as the basis for issuing the quarterly grant award to ensure continued availability of FFP. Additionally, states have an opportunity at any time throughout each quarter to request additional funding from CMS as necessary to cover allowable Medicaid administrative and service costs.

2. What flexibilities are available in the event of a public health emergency impacting the availability of state Medicaid agency staff resulting in the state's inability to submit its quarterly Medicaid expenditure report (Form CMS-64) within 30 days after the end of the quarter, as required?

The state Medicaid agency should notify CMS as soon as possible that it expects a delayed Form CMS-64 submission. Although federal regulations at 42 C.F.R. § 430.30(c)(1) require states to submit the form CMS-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program) to CMS not later than 30 days following the end of each quarter, in the event of a public health emergency that impacts a state's ability to do so, CMS will work with impacted states to ensure the continued availability of FFP for allowable Medicaid services for the duration of the public health emergency. Additionally, CMS will provide technical assistance as necessary to assist the state with proper claiming of FFP and to ensure that funding provided is reconciled to actual incurred and allowable expenditures.

3. Will states continue to have secure access to the Medicaid Budget & Expenditure System (MBES)/State Children's Health Insurance Program Budget & Expenditure System (CBES) in the event that CMS buildings are closed?

Yes, CMS anticipates that states would have continued secure access to MBES/CBES, as it is a web-based application that is not dependent on whether CMS buildings are open.

4. Is CMS extending the due date for state plan rate year 2017 Medicaid DSH audits and reports required by section 1923 of the Act that are due to CMS on December 31, 2020?

No. CMS is not extending the audit and reporting submission deadline at this time, but CMS will continue to evaluate the situation. We recognize that some states and hospitals may experience challenges in completing audits and reporting timely during the public health emergency. We also recognize that hospitals might have limited resources to devote to working with states and auditors. States should follow the DSH audit and reporting timelines described in 42 C.F.R. § 455.304(b) and § 447.299(c), but may wish to take into consideration CMS' existing operational timeline for compliance enforcement. Specifically, if a state misses the annual audit and reporting deadline on December 31, 2020, CMS would begin deferring state claims for DSH expenditures reported on the CMS-64 beginning with the first quarter following the noncompliance; that is, beginning with the quarter ending March 31, 2021, consistent with the deferral timeframe specified in 42 C.F.R. § 447.299(e). Such deferrals would not occur until after March 31, 2021. This enforcement timeline effectively provides states extra time to submit their DSH audits and reporting before facing a deferral of federal funding.

V. Managed Care

A. Contracts and Rates

1. How can states implement or update Medicaid or CHIP managed care telehealth policies, including allowing remote monitoring and reimbursement of telehealth services at the in-person clinical services rate?

The Trump Administration encourages states to take advantage of broad flexibility to deliver services via telehealth in Medicaid and CHIP to help prevent the spread of the Coronavirus as is discussed at https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html and https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/covid19/index.html. The available telehealth flexibility allows Medicaid beneficiaries to receive a wide range of healthcare services from their providers without having to travel to a health care facility so that they can limit risk of exposure and spread of the virus. In fee-for-service, states are not required to submit separate state plan amendments for coverage or reimbursement of telehealth services if they decide to reimburse for telehealth services in the same manner or at the same rate paid for face-to-face services. Medicaid guidelines require all providers to practice within the scope of their State Practice Act, and states may have laws and regulations that govern the scope of telemedicine coverage. In fee-for-service, a state plan amendment would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.

If a benefit is covered under the state plan or Medicaid waiver (e.g., section 1915(b) or 1915(c)) or a state demonstration (e.g., section 1115), CMS encourages states to amend managed care contracts (if not already included in the contract) to extend the same telehealth flexibilities authorized under their state plan, waiver, or demonstration for services covered under the contract. Absent coverage under the state plan or otherwise authorized through a Medicaid waiver or demonstration, services furnished under telehealth through managed care could also be provided as:

1. In-lieu of services (42 C.F.R. §438.3(e)(2) and 42 C.F.R. §457.1201(e)). Under these regulations, alternate services or services furnished in an alternative setting covered by a managed care plan or entity in lieu of state plan-covered services must be: (i) authorized by the state as being a medically appropriate and cost-effective substitute for the covered service or setting under the state plan; (ii) authorized and identified in the managed care contract; and (iii) not required to be used by the enrollee in lieu of the state plan-covered service. In addition, there are specific rate development rules used when a managed care contract authorizes use of in-lieu of services.
2. Additional services, beyond those in the contract, voluntarily provided by managed care plans (commonly referred to as value-added services). No contract amendment is needed; however, *the cost of value-added services cannot be included when determining the capitation rates (per 42 C.F.R. §438.3(e)(1)(i) and 42 C.F.R. §457.1201(e)).*

Regarding Medicaid managed care payment, under 42 C.F.R. §§438.3(c)(1)(ii) and 438.4, final capitation rates must be actuarially sound and based only upon services covered under the state

plan or waiver authority and represent a payment amount adequate to allow the managed care organization (MCO), prepaid inpatient health plan (PIHP) or prepaid ambulatory health plan (PAHP) to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements. If a state determines a retroactive adjustment to capitation rates under one or more of its managed care contracts is necessary for costs eligible for reimbursement, such as telehealth-related infrastructure costs, retroactive adjustments must be certified by an actuary in a revised rate certification and submitted as a contract amendment in accordance with 42 C.F.R. §438.7(c)(2). The rate certification must describe the rationale for the adjustment and the data, assumptions and methodologies used to develop the magnitude of the adjustment. For additional information about telemedicine, visit: https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html. For CHIP, rates must be based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles, as described in 42 C.F.R. §457.1203(a). States that update their CHIP capitation payments due to telehealth related costs would not need to submit a rate certification.

2. In emergency circumstances where utilization and/or costs cannot be estimated, will CMS permit payment for testing as a non-risk payment outside a capitation payment?

There are multiple approaches under which states can permit payment for COVID-19 testing in managed care programs. To be considered a mandatory laboratory service as described at 1905(a)(3) of the Act and 42 C.F.R. § 440.30, the COVID-19 test must be ordered and provided by or under the direction of a physician or other licensed practitioner within the appropriate scope of practice as defined by the state, or ordered by a physician, but provided by referral laboratory. To meet this definition, the test must be provided in an office or similar facility other than a hospital outpatient department or clinic and furnished by a laboratory that meets Clinical Laboratory Improvement Amendments (CLIA) requirements at Part 493 of the Code of Federal Regulations. Tests that do not meet these criteria may still be covered under the optional diagnostic benefit described at 1905(a)(13) of the Act and 42 C.F.R. § 440.130(a).

To the extent that health plans are responsible for providing laboratory services, they must cover the COVID-19 test. However, in the event the approved rates are not sufficient to cover the cost of these tests, states may wish to address through actuarially sound rate adjustments. States could amend their rates to include an adjustment for those costs, if such an adjustment is actuarially sound and the state determines that to be necessary, subject to compliance with 42 C.F.R. §§ 438.4 through 438.7 regarding rate development and amendment of capitation rates. States could also create a kick payment (consistent with actuarial soundness requirements) for managed care plans to cover the tests, which would require a contract amendment and rate certification.

States could also pay for the tests outside of the managed care capitation payment as a nonrisk payment: either as a separate non-risk contract with its managed care plans (see the definition

of "non-risk contract" at 42 C.F.R. §438.2[2] or as an amendment to its existing managed care plan contracts to include a non-risk payment. If a state chooses to amend its existing contracts to include a non-risk payment, the state would need to comply with upper payment limits outlined at 42 C.F.R. §447.362 consistent with the requirements for non-risk contracts. For CHIP, states could follow the same approach of paying for the tests outside of the managed care capitation payment as a non-risk payment.

Additionally, states have the option to pay for the tests under their Medicaid/CHIP fee-forservice programs, and carve this benefit out of the managed care program and contracts.

In general, CMS advises that states review their managed care contracts and rates carefully to identify any existing flexibilities to determine whether managed care contract or rate amendments are needed.

3. Do states need to continue to submit preprints for state-directed payments?

Yes, states are required to submit preprints for state-directed payments. As noted above, any state-directed payment preprints related to COVID-19 should be submitted to CMCSManagedCareCOVID19@cms.hhs.gov. CMS is committed to expediting and prioritizing such reviews.

B. Quality Measurement

1. Could the COVID-19 pandemic have an impact on state level managed care plan performance and quality measurement efforts?

States use quality measurement in many aspects of their managed care contracts to govern payment to the plans as well as to providers. The COVID-19 pandemic has been disruptive to clinical practices: for example, individuals have generally been advised not to seek routine or preventive care unless medically necessary at this time. Moreover, public health recommendations around social distancing may lead to reluctance to conduct performance measurement and external quality review (EQR) activities that require visiting health care or health plan facilities. These recommendations have led some health plan accrediting organizations, such as National Committee for Quality Assurance (NCQA), to advise that states with mandatory Healthcare Effectiveness Data and Information Set (HEDIS) reporting requirements allow health plans to use 2019 HEDIS rates rather than 2020 HEDIS rates for certain measures. All of these factors can affect the actual performance of health plans on these quality measures, as well as their ability to submit data to states on time. These factors can also limit the accuracy of that information and the ability for states to trend health plan performance rates over time.

[2] An amendment to the existing contract that includes coverage of these testing services to exclude them from the risk-contract would be necessary.

2. Should states consider adjustments to their managed care contract quality measurement requirements to account for the changes in clinical practice resulting from the COVID-19 public health emergency?

CMS recognizes that the current COVID-19 pandemic is likely to affect clinical practices, and the timely and accurate reporting of quality data such that states may need or want to revise their contractual quality measurement requirements. Below are some of the common ways states implement and incentivize quality measurement in their managed care programs and issues to consider during this public health emergency.

- **Withholds**: Under 42 C.F.R. § 438.6(b)(3), states can implement a withhold, where a portion of a capitation rate is withheld from a managed care plan (MCO, PIHP, or PAHP) and a portion of or all of the withheld amount will be paid to the managed care plan for meeting targets specified in the contract. Withhold arrangements are frequently linked to quality performance measures or quality-based outcomes. CMS **strongly advises** states to work with their actuaries and their quality measurement staff to determine if any changes are needed to the data, assumptions and methodologies used to assess the ability to accurately trend the quality measurement data and to determine the portion of the withhold that is reasonably achievable. Should states believe a change or elimination of a contractual withhold arrangement is warranted due to the COVID-19 emergency, the state must submit a contract amendment and, depending on the nature of the change, a rate certification amendment.

- **Incentives:** Under 42 C.F.R. § 438.6(b)(2), states can implement an incentive arrangement, as long as total payment under the contract is not in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement. An incentive arrangement is an amount over and above the capitation rates the managed care plan was paid for meeting targets specified in the contract. Incentive payments are **in addition** to the actuarially sound capitation rates, so while changes in clinical protocols or access are likely to affect a plan's ability to earn the incentive payment, they do not affect the actuarial soundness of the underlying rates. States may elect to reexamine the specified targets for plans to earn the incentive payment; if a state chooses to do this, the state must submit a contract amendment and depending on the nature of the change, a rate certification amendment.

- **State-Directed Payments:** Under 42 C.F.R. § 438.6(c), states are prohibited from directing how a managed care plan pays its providers except for those payment methodologies that have been approved and reviewed by CMS to be in compliance with 42 C.F.R. § 438.6(c). For states that have approved directed payment proposals for this rating period that condition payment to providers upon performance on specific quality measures, states may want to reexamine these payment arrangements to determine if changes are necessary or desired in light of the COVID-19 emergency. If a state determines changes are necessary, states will need to submit an amended directed payment preprint and, depending on the nature of the change(s), contract and rate certification amendments,.

- **General Contract Requirements and Penalties:** In addition to the examples provided above, states may have several other contract requirements related to plan performance or quality measures, such as quality assessment and performance improvement (QAPI) requirements. Some of these requirements may result in penalties imposed on the plan(s) for failing to meet a certain performance level. It is within state discretion to revise their contracts to remove or lessen such penalties; however, states will need to submit contract amendments to reflect any revisions. Depending on the nature of the change, a rate certification amendment may be needed if such changes are expected to have a material impact on the actuarially certified rates.

CMS is working to prioritize and expedite reviews of COVID-19 related managed care actions. All managed care actions (contract amendments, rate amendments, state-directed preprints) needed to respond to COVID-19 should be submitted as soon as possible to CMCSManagedCareCOVID19@cms.hhs.gov.

3. Are there additional considerations for External Quality Review-related (EQR-related) activities?

Some states contract with External Quality Review Organizations (EQROs) to conduct the EQRrelated activities, while other states undertake these EQR-related activities themselves. Given the extenuating circumstances presented by COVID-19, health plans may find it challenging to submit accurate data to states and to do so on time. Health plans may also request that external quality review activities be limited if they would compromise the ability to maintain social distancing, such as encounter data validation or performance measurement validation that require onsite medical chart reviews. CMS encourages states to work with EQROs and health plans to rely as much as possible on quality data that can be submitted and validated electronically, consistent with the EQR protocols per 42 C.F.R. § 438.350(e) and 438.352, to enable quality activities to continue while minimizing the public health impacts of COVID-19. Where states determine that some accommodations may be appropriate, CMS recommends that states work with their quality measurement staff to determine the appropriate accommodations and to submit a contract amendment.

4. Will the current COVID-19 public health emergency impact timelines for states to submit Managed Care quality strategies to CMS for review?

Medicaid regulations at 42 C.F.R. § 438.340(c)(2) require that the state must review and update their quality strategy as needed, but no less than every three years. As such, there is no uniform timeline or required due date across all states. States due to submit an updated quality strategy during the current COVID-19 PHE should contact CMS through the Managed Care technical assistance mailbox at ManagedCareQualityTA@cms.hhs.gov if they need more time due to the COVID-19 PHE.

5. How will the public comment process and tribal consultation for quality strategy review be impacted?

Medicaid regulations at 42 C.F.R. § 438.340(c)(1) and (2) require that prior to finalizing the state's quality strategy, states must provide an opportunity for public comment and input as well as consulting with tribes in accordance with the State's tribal consultation policy.. The input from the public and tribes must be incorporated into the quality strategy, prior to submitting the draft to CMS for review and feedback.

States can hold this public comment and consultation process at any time as long as it occurs prior to submitting the state quality strategy to CMS. We understand that states may be concerned that holding this process during the COVID-19 pandemic would yield little stakeholder engagement and, in turn, have concerns that delaying the comment process will result in missed deadlines. However, public comment and tribal consultation are required. States should contact CMS through the Managed Care technical assistance mailbox at ManagedCareQualityTA@cms.hhs.gov if they have questions regarding the public comment and consultation process or need more time due to the COVID-19 PHE.

6. Will states receive an extension on the April 30th deadline for the submission of the annual External Quality Review (EQR) technical report?

Annually, states are required to conduct an EQR, which consists of three mandatory EQR-related activities: Validation of Performance Measures, Validation of Performance Improvement Projects and a compliance review against elements found in 42 C.F.R. Part 438, subpart D.[3] Upon the completion of the EQR-related activities and EQR, an independent third party External Quality Review Organization (EQRO) must analyze the data and provide findings in an annual EQR technical report. This report is required to be submitted to CMS under Medicaid regulations at 42 C.F.R. § 438.364(c)(1) by April 30th of each year.

States that need more time due to the COVID-19 PHE should contact CMS at ManagedCareQualityTA@cms.hhs.gov with any concerns about completing the EQR or EQRrelated activities, or submitting the annual EQR technical report by April 30, 2020.

7. How can states request technical assistance regarding managed care strategies and EQRO reporting?

Please email the managed care quality technical assistance mailbox at ManagedCareQualityTA@cms.hhs.gov.

C. Miscellaneous

1. Can states allow managed care plans to permit 90-day supplies of medication at retail and mail-order pharmacies in situations where 90-day medication supplies are clinically

[3] 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.

appropriate? Can states allow waivers of early refill requirements during public health emergencies?

States should review their state plans and managed care contracts to ensure they have no state restrictions in place. In general, states have flexibility to establish Medicaid and CHIP FFS prior authorization and drug utilization review processes that encompass extended day supplies and early refills for emergency situations without CMS approval. Some states may need to modify their state plans. Under CMS managed care regulations, the need for a contract amendment related to prior authorization, extended day supplies of medication, and early refills will be dependent upon the detail included in states' existing managed care contracts. If existing managed care contracts do not allow for 90-day supplies of medications or early refill requirements, states will need to submit a contract amendment. CMS will prioritize our review and approval of COVID-19 related state plan or contract amendments.

2. How can states and managed care plans educate beneficiaries on COVID-19, including CDC best practices for infection control and medical management, as well as provide COVID-19 information that can be shared with case managers and MCO disease management staff and partners?

We strongly encourage states and managed care plans to collaborate on communication of CDC best practices for infection control and medical management to their Medicaid enrollees. This information can be found at: https://www.coronavirus.gov. All relevant CDC guidance is also posted on the CMS website and new information will be shared with states as it becomes available. Current guidance is available at: https://www.cms.gov/About-CMS/AgencyInformation/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page. States and managed care plans may share relevant information with case and care managers. Managed care plans providing written documents to Medicaid and CHIP beneficiaries will need to comply with information requirement regulations at 42 C.F.R. §438.10 and 42 C.F.R. §457.1207. CMS notes that the materials provided by the CDC are compliant with the "Plain Language Act of 2010" (https://www.cdc.gov/other/plainwriting.html), which requires all federal agencies to write plainly when they communicate with the public. Therefore, for the purposes of 42 C.F.R. §438.10(c), CMS considers all CDC materials written in a manner and format that is easily understood and is readily accessible.

3. How can states collaborate with managed care plan partners and community-based organizations, including home-delivery services, to provide non-medical supports, such as meals and over the counter medications, to Medicaid and CHIP beneficiaries quarantined or self-quarantined in their homes?

As long as a benefit is covered under the state plan or waiver authority, states can add services to managed care contracts via a contract amendment. See FAQ # III.F.1. for information regarding adding benefits to state plans or waiver authorities. Managed care plans also have flexibility to voluntarily provide additional services beyond those in the contract, referred to as value-added services. No contract amendment is needed for value added services; however, the cost of such services cannot be included when determining the capitation rates.

4. Can states permit managed care organizations (MCOs) to expedite decisions of beneficiary functional eligibility for HCBS?

Federal regulations at 42 C.F.R. § 431.10(c)(2) require states to make functional beneficiary eligibility determinations for HCBS. As such, states can only delegate such determinations to another governmental entity. However, states could permit MCOs to conduct an assessment of eligibility and forward the assessment to states for final determination.

5. What flexibilities does a section 1135 waiver provide related to appeals of adverse benefit determination requirements in Medicaid managed care regulations at 42 C.F.R. Part 438?

Federal regulations at 42 C.F.R. Part 438 Subpart F establish appeals and grievance requirements for Medicaid managed care. Section 1135 of the Act does not provide authority to waive these requirements; however, CMS does have authority to modify timeframes for required activities during an emergency period under section 1135(b)(5) of the Act. For example: states can request a section 1135 waiver to modify timelines for managed care plans to resolve an appeal to no less than one day in order to permit earlier access to the state fair hearing level. If states use this authority, all appeals filed would allow managed care enrollees to quickly satisfy the exhaustion requirement in 42 C.F.R. § 438.408(f)(1) and proceed almost immediately to a state fair hearing. In addition, states can modify timeframes under 42 C.F.R. § 438.408(f)(2) requiring managed care enrollees to exercise their appeal rights within 120 days to allow more than 120 days to request a fair hearing during the authorized period of the immediate section 1135 waiver. In March 2020, CMS created a Medicaid & CHIP checklist for section 1135 waivers to assist states during public health emergencies, which is available here: https://www.medicaid.gov/resourcesfor-states/disaster-response-toolkit/section-1135-waiver-flexibilities/index.html.

6. Can states retroactively implement risk mitigation strategies (e.g. risk corridors) to mitigate risk in light of COVID-19?

CMS will consider, where appropriate, state requests to retroactively amend or implement risk mitigation strategies only for the purposes of responding to the COVID-19 pandemic. In the Notice of Proposed Rulemaking (NPRM); Medicaid Program: Medicaid and CHIP Managed Care (CMS-2408-P) published in November 2018, CMS proposed to prohibit states from implementing retroactive risk mitigation strategies. CMS continues to support the identification of all risk mitigation strategies in contracts prospectively. However, given that this NPRM has not been finalized, CMS recognizes that these are unique and unanticipated circumstances under which approving retroactive risk mitigation strategies may be appropriate given that other methods for making retroactive adjustments to capitation rates may be extraordinarily difficult for states to implement at this time.

States that utilize risk mitigation mechanisms must describe such arrangements in their contract(s) and they must be developed in accordance with all requirements in 42 C.F.R. Part

438, including §§ 438.4 and 438.5, and generally accepted actuarial principles and practices. The rate certification and supporting documentation must also describe any risk mitigation and how it may affect the rates or the final net payments to the health plan(s) under the applicable contract as part of complying with § 438.7. States should follow the guidance in the Medicaid Managed Care Rate Development Guide for documentation for risk-sharing mechanisms. See https://www.medicaid.gov/Medicaid/downloads/2019-2020-medicaid-rate-guide.pdf. States submitting requests to retroactively amend or implement risk mitigation strategies will need to submit both contract and rate amendments as soon as possible to CMCSManagedCareCOVID19@cms.hhs.gov. CMS is working to prioritize and expedite reviews of COVID-19 related managed care actions. To facilitate this, CMS recommends that states submit only managed care actions needed to respond to COVID-19 to this mailbox and use normal processes for other managed care actions.

CMS notes that retroactive risk mitigation strategies are one of a number of strategies that states can consider implementing in response to COVID-19; states may want to consider implementing one or more strategies to get funding out to providers more quickly. CMS is available to provide technical assistance as states explore different strategies.

VI. Information Technology

A. Funding

1. Do states need prior approval to acquire additional IT systems services and staffing?

Typically, CMS requires prior approval for most expenditures to receive enhanced FFP for state IT systems. However, when expenses are expected to fall below minimum thresholds, prior approval may not be required. The thresholds are:

1. For enhanced FFP: Approval of contracts and associated funding is not required in instances where the contract is not anticipated to exceed a total federal and state acquisition cost of $500,000.
2. For regular FFP: Approval of contracts and associated funding is not required in instances where the contract is not anticipated to exceed a total federal and state acquisition cost of $5,000,000.
3. For sole source contracts: Approval of contracts and associated funding is not required in instances where the contract is not anticipated to exceed a total federal and state acquisition cost of $1,000,000.

2. What flexibilities do states have to obtain additional funding to meet technology needs in response to COVID-19?

When requested by the state, FFP for IT systems can be provided in emergencies. The FFP request should include: (1) A brief description of the equipment and/or services to be acquired and an estimate of their costs; and (2) a brief description of the circumstances driving the state's need and the harm that will be caused if the state does not immediately acquire the requested

equipment and/or services. FFP approved under this authority would be available from the date the state actually acquires the equipment and services. Additional information regarding this process can be found at 45 C.F.R. § 95.624.

3. May states request enhanced Mechanized Claims Processing and Information Retrieval Systems FFP for costs associated with information technology that facilitates telework capabilities for state staff and/or contractors?

States may request enhanced Mechanized Claims Processing and Information Retrieval Systems FFP for information technology (IT) expenditures that support the design, development, and installation (DDI) or operations of mechanized claims processing and information retrieval systems that constitute the Medicaid Enterprise System (MES). That includes expenditures that support telework infrastructure so that state staff or contractors can continue MES DDI or operation remotely. CMS understands and strongly supports the central role that telework may play in a state's ability to develop, enhance, and operate the MES during the COVID-19 public health emergency, as well as to continue to improve and maintain the efficient operation of the MES thereafter.

States can request FFP under section 1903(a)(3)(A)(i) and (B) of the Act for state IT expenditures to enable telework for personnel who are engaged in the DDI or operation of the MES (including a subsystem or component thereof), so long as states meet all other applicable requirements for claiming FFP under those provisions of the Act. States cannot receive enhanced FFP under section 1903(a)(3)(A)(i) and (B) of the Act for their expenditures related to telework infrastructure for staff who are not engaged in the DDI or operation of an MES; instead, those expenditures might be eligible for the administrative FFP authorized by section 1903(a)(7) of the Act (which is 50%).

For example, states may request 90 percent mechanized claims processing and information retrieval systems FFP to procure and install hardware and to enhance and/or configure existing or new software, as necessary to support a remote workforce that is engaged in the DDI or operation of mechanized claims processing and information retrieval systems, as discussed above. Likewise, 75 percent mechanized claims processing and information retrieval systems FFP may be available thereafter to support the ongoing operations of that hardware and/or software, with respect to those staff.

Generally, states request enhanced FFP for the DDI or operations of mechanized claims processing and information retrieval systems through an Advance Planning Document, as described in 45 C.F.R. § 95.610. FFP to support these IT expenditures could also be requested through the emergency process described in 45 C.F.R. § 95.624, to rapidly expand teleworking capabilities during the COVID-19 public health emergency. States should consult with their MES State Officer for assistance.

4. Can the 100 percent FFP available for the new optional COVID-19 testing group be used for administrative costs related to systems development?

Yes. States that amend their state plans to cover the optional COVID-19 testing eligibility group under section 1902(a)(10)(A)(ii)(XXIII) of the Act can use the 100 percent FFP rate provided under section 6004(a)(3)(D) of the FFCRA for certain administrative expenditures, including systems development, described in section 1903(a)(7) of the Act that otherwise would be eligible for 50 percent FFP. To qualify for the 100 percent FFP, the state must demonstrate that the expenditures are attributable to administrative costs related to providing medical assistance to the COVID-19 testing eligibility group. This attribution must be performed in accordance with all applicable cost allocation requirements.

For example, a state could claim this 100 percent FFP for expenditures related to developing a portal for providers to submit claims for testing and testing-related services to individuals in this eligibility group. Similarly, a state could use this funding to support changes to their Presumptive Eligibility systems to adapt and expand that process to enroll individuals in the COVID-19 testing eligibility group.

Section 6004(a)(3)(D) of the FFCRA does not change the FFP rate or rules for mechanized claims processing and information retrieval systems under section 1903(a)(3) of the Act.

B. Health Information Exchange

1. Can states request that FFP be provided through the process described in 45 C.F.R. § 95.624 (emergency funding requests) to connect non-pediatric Medicaid providers to Immunization Information Systems?

Medicaid providers who do not treat children are much less likely to have direct electronic health record (EHR) connections or EHR integration with immunization information systems, and tracking the administration of a vaccine in the adult population is more difficult due to this lack of public health connectivity. These connections are potentially eligible for enhanced funding under 42 CFR part 433, subpart C, and states should begin planning for eventual vaccination efforts accordingly. Please reach out to your Medicaid Enterprise Systems (MES) State Officer for information on submitting an FFP request under 45 C.F.R. § 95.624.

2. What is the Patient Unified Lookup System for Emergencies (PULSE) and how can states request that FFP be provided through the process described in 45 C.F.R. § 95.624 (emergency funding requests) to deploy PULSE resources to support COVID-19 response efforts?

The PULSE system provides first responders with information critical to patient care through a nimble, easy to understand system with access to patient health data (e.g., medications a patient is taking) and is designed to be deployed immediately to assist in emergency response. The first PULSE system was developed in California and has been used for wildfire response within the state. A COVID-19 iteration of PULSE (PULSE-COVID) supporting some immediate use cases is now available. PULSE-COVID focuses on collaboration with private sector partners and supports basic ad hoc searches over the national health information exchange networks. These searches could help medical response teams access critical patient information via direct

connections to the electronic health records where their information is kept. The solution is hosted on a web platform to enable quick and easy deployment to multiple states. Depending upon resources available for the project, up to several states can be on-boarded to PULSECOVID at once by the public/private partnership overseeing the effort. There is a range of capacity across the nation and immediate engagement would focus on areas with the capacity to implement PULSE-COVID in the near term. Please reach out to your MES State Officer for information on submitting an FFP request under 45 C.F.R. § 95.624.

3. How can states establish, implement, and enhance telehealth technologies through the process described in 45 C.F.R. § 95.624 (emergency funding requests) as part of the COVID-19 response effort and in support of their Medicaid provider and beneficiary populations?

CMS is available to provide technical assistance regarding approaches to rapidly scale telehealth technologies. If states are granted waivers under section 1135 for federal requirements related to provider location or provider enrollment (https://www.cms.gov/files/document/covid19emergency-declaration-health-care-providers-fact-sheet.pdf), complementary technology investments may be appropriate. CMS advises states to leverage existing infrastructure and technology. States should discuss any patient-facing telehealth proposals with their MES State Officer. Please reach out to your MES State Officer for information on submitting an FFP request under 45 C.F.R. § 95.624.

C. Transformed Medicaid Statistical Information System (T-MSIS)

1. How should COVID-19 related service codes be reported in the Transformed Medicaid Statistical Information System (T-MSIS)?

States should ensure that systems are coded to process the new codes and that providers have received updated billing guidance. States should report COVID-19 related procedure codes and diagnosis code information to T-MSIS as it is reported on the original claims form. Please contact your CMS Systems Officer with further questions. For information on COVID-19 testing HCPCS codes, please see CMS's February 13, 2020 public health news alert. For information on COVID-19 related diagnosis codes, please see the CDC's announcement regarding new diagnosis coding effective April 1, 2020.

2. How should telehealth-related services be reported in T-MSIS?

States should ensure that providers are educated on the correct submission of telehealth claims. States should report COVID-19 telehealth services to T-MSIS as they are billed on the claim form, identified through the procedure code and procedure code modifier fields. Please contact your CMS State Systems Officer with further questions. For general information on Medicaid telehealth, see Medicaid for Services Delivered Via Telehealth.

3. Will there be new federal reporting requirements in T-MSIS for the new COVID-19 testing optional Medicaid eligibility group?

To address the completeness and accuracy of T-MSIS reporting for states adopting the new COVID-19 testing optional Medicaid eligibility group, states should report the following two data elements in the Eligible file to document a beneficiary's enrollment in Medicaid as defined by the FFCRA: ELIGIBILITY-GROUP (ELG087) and RESTRICTED-BENEFITS-CODE (ELG097). An ELIGIBILITY-GROUP value of "76" should be reported for an uninsured individual eligible for COVID-19 testing. A RESTRICTED-BENEFITS-CODE value of "F" should be reported for an individual eligible for Medicaid but is only entitled to restricted benefits for medical assistance for COVID-19 diagnostic products and any visit described as a COVID–19 testing-related service for which payment may be made under the state plan. Additional information and comprehensive reporting guidance will be shared on the T-MSIS Coding Blog.

4. Will there be new federal reporting requirements in T-MSIS for reporting claims data for COVID-19 testing and testing-related visits for individuals enrolled in Medicaid and CHIP?

There are three data elements in the T-MSIS Claims files for state reporting of COVID-19 diagnostic products and testing-related services.

(1) In the CLAIM-HEADER-RECORD, a value of "17" should be reported in PROGRAMTYPE for any COVID-19 diagnostic product or COVID–19 testing-related services as specified by the FFCRA;

(2) In the CLAIM-LINE-RECORD, a value of "136" should be reported in TYPE-OFSERVICE, and a value of "107" should be reported in BENEFIT-TYPE for any COVID-19 diagnostic product as specified by the FFCRA;

(3) In the CLAIM-LINE-RECORD, a value of "137" should be reported in TYPE-OF-SERVICE, and a value of "108" should be reported in BENEFIT-TYPE for any COVID–19 testing-related services as specified by the FFCRA.

Additional information and comprehensive reporting guidance will be shared on the T-MSIS Coding Blog.

5. Will compliance timelines for the 2020 T-MSIS Priority Item (TPI) Data Quality Assessments be adjusted due to the COVID-19 emergency?

Timely, accurate, and complete T-MSIS data submission continues to be a CMS priority and is critical to national analyses of Medicaid and CHIP services, activities, and expenditures during the current Public Health Emergency. States should continue to submit monthly T-MSIS data and continue, as much as possible, to work towards the recommended timelines for resolving TPIs. CMS will continue to measure and report on T-MSIS data quality issues, and to provide ongoing technical assistance to states. Generally, we do not expect to use State Data Quality Assessment results as the basis to initiate state compliance actions during or immediately following the COVID-19 PHE.

D. Telework

1. Does CMS have recommendations for IT systems, services, networks, and tools to rapidly transition Medicaid and CHIP operations to a virtual environment and expand use of telework?

CMS encourages states to adopt and accelerate their implementation of capabilities for their work force to telework. While we do not have specific recommendations for technologies and tools to support a virtual environment, many of the IT vendors can support telework in their existing implementations. Our primary suggestion is for states to work with their existing IT vendors (eligibility, MMIS, etc.) to assess and possibly expand their ability to support a remote work force. CMS recommends that states use remote work as a way to both maintain healthy social distancing practices and maintain processing of workloads to the maximum extent practical. We also encourage states wishing to accelerate additional telework capabilities to contact their Medicaid Enterprise State Systems Officer.

2. Does CMS anticipate requesting any special reporting from states on the number of Medicaid applications, renewals, and case changes that are processed via telework during the COVID-19 emergency?

CMS welcomes states sharing best practices as they adopt more remote work capabilities, to inform other states and to help CMS support Medicaid agencies for this and future emergencies. We do not expect to ask for any special reporting regarding eligibility determination processing by remote workers during the COVID-19 PHE.

3. Is CMS planning to provide any technical assistance to help states rapidly expand Medicaid/CHIP eligibility processing through telework?

States that desire technical assistance with rapidly accelerating any of their telework capabilities may contact their Medicaid Enterprise State Systems Officer, who can help with obtaining any applicable authorization for funding and connecting states to other states that have already grappled with the policy, cultural and operations considerations associated with remote work. Reference also FAQ # VII.D.4., which has additional information regarding issues involved with temporary office closures.

E. Miscellaneous

1. Will CMS issue waivers under section 1135(b) of the Act to the timely claims submission and processing requirements of 42 C.F.R. § 447.45(d)?

By regulation at 42 C.F.R. § 447.45(d), Medicaid agencies must require providers to submit all claims no later than 12 months from the date of service. The Medicaid agency must then pay 90 percent of all clean claims within 30 days of receipt and 99 percent of all clean claims within 90 days of receipt. Generally, the Medicaid agency must pay all other claims within 12 months of receipt, with certain exceptions.

CMS is not issuing waivers under section 1135(b) authority for timely claims processing or claims submission requirements. Maintaining timely and accurate processing, submission, adjudication and payment of provider claims for Medicaid and CHIP services continues to be important during this Public Health Emergency. However, if a state has more stringent requirements for claims submission and payment, those requirements may be relaxed, as long as they continue to meet the minimum requirements of 42 C.F.R. § 447.45(d). If a state encounters problems with the functionality of information technology systems supporting the submission, processing and/or payment of claims, please contact your MES State Officer.

VII. Miscellaneous

A. Quality Reporting

1. In what ways will the COVID-19 pandemic affect FFY 2020 reporting for the Medicaid and CHIP Child Core Set and Adult Core Set?

While all Core Set reporting continues to be voluntary on the part of states, CMS encourages states that can collect and submit this information safely to continue doing so. To this end, however, CMS recommends temporarily suspending the types of measurement activities that could present a health risk to state employees or contractors, such as conducting on-site medical chart reviews. In addition, CMS expects that the COVID-19 pandemic could affect the accuracy of Core Set reporting in a number of ways. For example, state performance on preventive care Core Set measures may decline, since individuals have generally been advised not to seek inperson routine or preventive care unless medically necessary at this time. Moreover, these services offered through telehealth may not be captured in the measure unless the measure specifications allow for telehealth. All of these factors can affect not only the ability of states to collect and submit Core Set data to CMS on time, but can also limit the accuracy of that information and the ability for CMS to trend state performance rates over time. To the extent those Core Set measures are also included in the Medicaid and CHIP Scorecard, state Scorecard performance and the ability to trend that information will also be affected.

2. How does CMS recommend states handle Core Set measures that require medical chart review—often referred to as "hybrid data collection methods"—due to the current public health emergency?

CMS recognizes that social distancing will make onsite medical chart reviews inadvisable during the COVID-19 pandemic. As such, hybrid measures that rely on such techniques will be particularly challenging during this time. While reporting of the Core Sets is voluntary, CMS encourages states that can collect information safely to continue reporting the measures they have reported in the past and to consider the following provisions for measures that include the hybrid method as an option. Doing so will enable CMS to fulfill its statutory obligation to report on the quality of healthcare in the Medicaid and CHIP programs while minimizing the adverse effects of the pandemic on quality reporting.

- CMS encourages states to review the quality and completeness of data collected using the hybrid method. If a state determines that it will not be able to report high-quality data for a measure using the hybrid method, CMS encourages the state to consider calculating the measure using the administrative method or electronic health records (EHRs), if applicable and permitted by the measure technical specification.
- When reporting hybrid measures to CMS for FFY2020, states should note if the FFY 2020 rate is worse than the FFY 2019 rate due to low chart retrieval and then indicate in MACPro whether the state would prefer to use the FFY 2019 rate instead, due to the COVID-19 pandemic. In this case, CMS encourages states to report both the FFY 2020 performance rate and the chart retrieval rate, if available, in MACPro.
- If an alternate method is not feasible and prior year data are not available, please report to CMS that the state was unable to report the measure due to challenges with data collection as a result of the COVID-19 pandemic.

3. How does CMS recommend states handle Experience of Care Surveys that require inperson interviewing?

CMS understands that current social distancing guidelines make in-person surveys inadvisable during this public health emergency. To the extent states can rely on other means of data collection such as electronic or telephonic methods, we encourage states to consider them so that quality measurement activities can continue while minimizing adverse public health impacts.

The measure stewards (Human Services Research Institute (HSRI), National Association of State Directors of Developmental Disabilities Services (NASDDDS), and Advancing States (AD)) for the National Core Indicator (NCI) surveys (NCI and NCI-AD) have "paused face-to-face surveying of any kind at this time." Additionally, NCI does not currently support phone or videoconference surveys.

The HCBS CAHPS Survey is currently voluntary for state reporting. We encourage states and managed care organizations to continue to collect and report on the HCBS CAHPS survey at their discretion. The survey can be conducted through telephone or in-person interviews. Please note that, due to the public health emergency, the Agency for Healthcare Research and Quality has extended the deadline for voluntary submission of HCBS CAHPS survey results to the HCBS CAHPS database from March 13, 2020, to October 31, 2020.

4. How will CMS account for the impact of the COVID-19 pandemic when trending data over time?

When publishing Core Set data for FFY 2020 and FFY 2021, CMS will carefully note how care delivery and data collection methods may have been affected by the current public health emergency and urge caution when trending the data and making interpretations about the data.

To this end, CMS encourages states to document changes in how the data were collected for FFY 2020 and FFY 2021 due to the COVID-19 pandemic. As discussed earlier regarding hybrid measures, for example, states should document whether they used an alternate method in

FY2020 than in FY2019 or would like CMS to consider using prior year data in public reporting. If chart review was conducted, states should document what percentage of charts were reviewed and how reviews were conducted (such as use of mail, fax, or online reviews).

5. How can states minimize the impact of the COVID-19 pandemic on quality measurement activities?

CMS encourages states to rely as much as possible on quality data that can be submitted and validated electronically to enable quality measurement and reporting activities to continue while minimizing the public health impacts of COVID-19.

Where preventive and elective services can be provided through telehealth, CMS encourages states to do so and to include those visits in their Core Sets data submissions where technical specifications allow for them (please refer to the COVID-19 State Medicaid & CHIP Telehealth Toolkit and FAQ # III.B.1, regarding the delivery of telehealth services).

6. Will the COVID-19 pandemic affect CMS's timeline for requesting states to submit their data on the Medicaid and CHIP Child and Adult Core Sets?

As in prior years, MACPro will be open between September and December 2020 for FFY 2020 Core Sets measure data. States that need more time due to the COVID-19 PHE should contact CMS at MACQualityTA@cms.hhs.gov.

7. How can states submit questions or request technical assistance specific to quality measurement activities?

Please email the quality measurement technical assistance mailbox at MACQualityTA@cms.hhs.gov

8. Will the current public health emergency impact CMS's timeline for requesting states to submit the Form CMS-416 which provides Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit data?

By statute, submissions of the Form CMS-416, which reflects the services delivered through the EPSDT benefit, were due to CMS on April 1st. States that need more time due to the COVID-19 PHE should contact CMS at EPSDT@cms.hhs.gov.

9. Can well-child screenings provided through telehealth be included in the Form CMS416, which provides a count of EPSDT services?

The American Academy of Pediatrics (AAP) issued guidance to address the delivery of wellchild screenings during the public health emergency, including the use of telehealth. To the extent it is clinically appropriate to conduct well-child screenings through telehealth and they

can be provided according to the state's periodicity schedule, these screenings can be included in the count of EPSDT services on the Form CMS-416.

No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services provided in the same manner or at the same rate that states pay for face-to-face services. A SPA would be necessary to implement any revisions to payment methodologies to account for telehealth costs (please refer to the COVID-19 State Medicaid & CHIP Telehealth Toolkit and for example, please refer to FAQ Section III.B.1. regarding the delivery of telehealth services).

10. How can states request technical assistance specific to EPSDT reporting?

Please email the EPSDT technical assistance mailbox at EPSDT@cms.hhs.gov.

B. Workforce Issues

1. What options are available if a state experiences a shortage of health care workers because of COVID-19?

To address provider shortages for individuals receiving 1915(c) waiver services, states can use Appendix K to expand provider qualifications (e.g., where a provider must be 21 years old, states could modify the age requirement to 18); add additional providers (including allowance of payment to family members and legally responsible relatives); add services, such as a live-in care giver; and temporarily adjust rates to entice more individuals into the workforce.

For state plan services, a SPA can increase the types of providers a state authorizes to deliver services. As always, states should be mindful of state-level requirements that might impact provider flexibility in delegation of authority.

Additionally, states have broad ability to cover telehealth through Medicaid, and no federal approval is needed for state Medicaid programs to reimburse for telehealth services in the same manner or at the same rate paid for face-to-face services, visits, or consultations. A SPA is necessary to accommodate any revisions to payment methodology to account for telehealth costs.

To address state staff shortages, the Appendix K process can also be utilized for case managers under 1915(c) to permit the use of telehealth or telephonic consultations in place of typical faceto-face requirements. Under 1915(i), existing regulatory flexibility at 42 C.F.R. § 441.720(a) permits use of telehealth in place of face-to-face assessments when certain conditions are met.

2. What precautions can states take to protect home health workers, personal care workers, and eligibility workers from contracting COVID-19?

CMS supports the CDC guidance on workforce protections; more information can be found on the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/community/index.html. CMS has

also issued relevant guidance at the following link: https://www.cms.gov/files/document/qso-2017-all.pdf. Any additional guidance will be posted to https://www.cms.gov/About-CMS/AgencyInformation/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page. Any additional guidance will be posted to https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page.

To account for increased costs in PPE for home care workers, a SPA or Appendix K for a 1915(c) waiver could be submitted to amend payment methodologies for impacted services.

3. What flexibility exists to allow states to utilize first responders (emergency medical technicians (EMTs), fire fighters, etc.) to administer testing for COVID-19?

Depending on the specificity in the existing Medicaid state plan, a SPA may be necessary to add first responders as testing providers. CMS notes that state laws may have implications for the scope of providers able to perform these activities. In addition, third party liability provisions apply for services covered across the Medicaid program, and states could utilize existing mechanisms to ensure compliance.

C. 1115 Demonstrations

1. Can a state temporarily amend a section 1115 demonstration in conjunction with the public health emergency?

Yes, a state may submit a request to temporarily amend a demonstration in conjunction with the public health emergency. Demonstration special terms and conditions, as well as waivers and expenditure authorities, as applicable, may be authorized for a limited time, as needed. CMS will prioritize these requests for accelerated review.

2. If a state submits a demonstration amendment, is full public notice required or does this situation meet the criteria for an exemption?

A state would not need to complete full public notice. To the extent a requirement for a public notice process otherwise would apply with respect to the amendment, a Secretary-declared public health emergency would meet the criteria for an exemption described in the transparency regulations at 42 C.F.R. § 431.416(g). The state would be required to submit an application that CMS would post to Medicaid.gov. Transparency regulations at 42 C.F.R. § 431.416(g) state that CMS may expedite approval of a demonstration if the following conditions are met: i) the state acted in good faith, and in a diligent, timely, and prudent manner; ii) the circumstances constitute an emergency and could not have been reasonably foreseen; and iii) delay would undermine or compromise the purpose of the demonstration and be contrary to the interests of beneficiaries. CMS expects that COVID-19 related requests generally would meet these criteria.

3. Can an amendment request be retroactive?

CMS can provide 1115 demonstration authority connected to a public health emergency retroactive to the effective date of the public health emergency. Secretary Azar issued a public health emergency regarding COVID-19 on January 31, 2020, which was effective January 27, 2020. Therefore, CMS can provide authority for such a request back to January 27, 2020, as needed.

4. Federal regulations at 42 C.F.R. § 431.420(c) require a public forum to allow comment on the progress of a state's section 1115 demonstration within six months of demonstration approval. Some state agencies have been directed to cancel in-person gatherings of constituency groups to prevent the spread of COVID-19. Does an alternate plan to host the forum as a webinar without an in-person audience, accepting comments via webinar and in writing, fulfill the 1115 demonstration requirements?

Yes, this alternate proposal would meet the public forum requirements for the section 1115 demonstration in the context of this declared public health emergency. States are reminded of their obligation to comply with applicable civil rights and other laws pertaining to accessibility, and should make these alternate public hearings as accessible as possible in the current environment. As another alternative, if a state would like to delay the post-award forum until a later time, CMS would also offer an extension of the deadline to meet this deliverable; a state interested in this option should contact the CMS-designated contact person for the demonstration to discuss the parameters of an extension.

5. Can alternative meeting formats fulfill the public hearing requirements at 42 C.F.R. § 431.408? For example, could two public meetings available only through telephonic and/or Web conference capabilities, without any in-person attendance, meet federal requirements?

Yes, in the context of this declared public health emergency, the state may be exempted from any of the normal public process requirements outlined in 42 C.F.R. § 431.408. Pursuant to 42 C.F.R. § 431.416(g), CMS has discretion to exempt the state from completing any aspect of the public notice process, including exemption from conducting any public notice, *when the State demonstrates to CMS the existence of unforeseen circumstances resulting from a natural disaster, public health emergency, or other sudden emergency that directly threatens human lives that warrant an exception to the normal public notice process*. To address the question above, in lieu of in-person meetings, the state may hold meetings in any alternative format (webinar, telephonic, written submission) that permits submission of public input; including using two telephonic conferences in lieu of in-person public hearings.

6. Can alternative meeting formats fulfill the medical care advisory committee participation requirements at 42 C.F.R. § 431.12? For example, could committee meetings available only through telephonic and/or Web conference capabilities, without any inperson attendance, meet federal requirements?

Yes, in lieu of in-person meetings, a state has discretion to hold meetings in any alternative format (webinar, telephonic, written submission) that provides committee members with the

opportunity to participate in policy development and program administration. States are reminded of their obligation to comply with applicable civil rights and other laws pertaining to accessibility, and should make these alternate meetings as accessible as possible in the current environment.

D. Other

1. What flexibilities will CMS provide states in the event that required deliverables cannot be submitted because of COVID-19 (i.e., SPA, waiver applications, renewals, or deliverables, etc.)?

CMS will monitor pending SPA submissions and 1915(c) waiver amendments and renewals and work closely with the state to ensure the appropriate approvals or temporary extensions are granted.

Regarding managed care reporting requirements, CMS is able to utilize enforcement discretion for managed care reporting requirements under 42 C.F.R. Part 438, with minimal exceptions (actuarial soundness, payments, and Medical Loss Ratio (MLR) requirements). The reporting requirements for MLR at 42 C.F.R. § 438.8(k) are determined by the state, as long as it is within 12 months of the end of the reporting year. CMS believes this provides states an ample window to meet MLR reporting requirements.

Regarding section 1115 demonstration deliverables or renewal requests (such as quarterly and annual monitoring or budget neutrality reports, evaluation designs, evaluation reports), states may e-mail their demonstration's CMS project officer requesting an extension to submit the deliverable/report or renewal application, along with an explanation of the rationale. As a general rule, if the state experiences challenges as a result of COVID-19, the state should notify CMS as soon as possible and CMS will work with the state to determine a reasonable timeline for compliance.

2. In the event of a public health emergency in which a healthcare facility experiences an acute critical staffing shortage, including a staffing shortage due to infectious disease, and temporarily utilizes federal health care workers (e.g., US Public Health Services Commissioned Corps Officers) in place of facility staff, may the facility continue to bill the Medicaid program for the services provided to beneficiaries?

Providers are generally prohibited from billing the Medicaid program and states may not receive FFP for practitioner services provided by federally employed health care workers. To the extent care provided by a federal employee supplants the costs of practitioner or non-practitioner services that are bundled into a rate that includes multiple service costs, the provider's payment would need to be allocated and the state's claim for FFP would need to be reduced to account for service costs associated with federally employed practitioners. For example, if a nursing facility is staffed in part by federally employed health care workers and is paid a per diem rate for Medicaid services, the state's claim of FFP for the per diem rate would need to be reduced for all care costs assumed for services provided by federal workers. In such instances, during a public

emergency, the state may continue to pay the nursing facility the full per diem rate and recoup funds from the provider once data is available to properly allocate service costs. Such an allocation may be conducted using cost data from a nursing facility's cost report or, if feasible, by reducing the per diem rates by cost factors associated with care costs assumed by the federal health care worker. The data used to allocate cost must be auditable and claimed FFP associated with the federally employed worker must be returned to CMS. CMS will work with state to ensure this process is conducted within an appropriate time frame following acceptance of federal assistance. In the interim, states may continue to pay providers in accordance with Medicaid state plan methodologies and CMS will work with the state on a case-by-case basis to ensure that a reasonable allocation method is developed in accordance with applicable cost allocation requirements.

3. What is CMS' coding guidance for laboratory testing of COVID-19 and what are the rates for testing?

CMS is working closely with the CDC to establish the appropriate coding practices related to COVID-19. CMS developed the first HCPCS code (U0001) to pay for claims and track testing for COVID-19. This code is used specifically for CDC testing laboratories to test patients for SARS-CoV-2. CMS has since added a second HCPCS billing code (U0002) which allows laboratories to bill for non-CDC lab tests for SARS-CoV-2/2019-nCoV (COVID-19). Medicare claims processing systems will be able to accept these codes starting on April 1, 2020, for dates of service on or after February 4, 2020. These codes serve to increase more testing and improve tracking. Because these HCPCS codes allow those labs conducting the tests to bill for the specific test instead of using an unspecified code, a descriptor is not required for Health Insurance Portability and Accountability Act (HIPAA) compliance.

On February 6, 2020, CMS also gave Clinical Laboratory Improvement Amendments (CLIA)certified laboratories information about how they can test for SARS-CoV-2. To read more about those efforts, visit: https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/notification-surveyorsauthorization-emergency-use-cdc-2019-novel-coronavirus-2019-ncov-real-time-rt.

CMS's 12 local administrative contractors process and pay the fee-for-service Medicare claims for each of their respective jurisdictions. The contractors use a variety of methodologies to price new tests that will be paid at the local level, until a national price is established through CMS's annual laboratory meeting process that includes the opportunity for public feedback. CMS is actively working with the contractors in this process and will provide information in separate guidance once it is available.

4. What should states do if they need to close Medicaid or CHIP state and local offices to applicants and beneficiaries during a disaster or emergency?

CMS recognizes that the COVID-19 public health emergency may impact states' normal operations, particularly in light of staff shortages and the recommendations that individuals socially distance themselves from others. As a result, we also acknowledge that this may limit

states' ability to receive applications, reports of changes in circumstances, and renewal forms or provide assistance in-person.

While existing statute and regulation do not permit an exception to accepting information from applicants and beneficiaries through any of the required modalities (e.g., online, in person, via mail, and by phone), CMS recognizes that access to a particular modality may be temporarily limited due to an administrative or other emergency beyond the agency's control, including closure of public offices due to COVID-19. If an emergency impacts a state's ability to accept information from applicants or beneficiaries in person or through another modality, the state should make feasible adjustments to ensure that individuals still have the opportunity to apply. For example, if state and local offices are closed, a state could increase the capacity of other available modalities (e.g., by expanding call center capacity or placing additional out-stationed workers in specific locations), and ensure that individuals are informed of these other resources. Additionally, states should continue to ensure communication with applicants and beneficiaries are accessible to individuals with disabilities and those who are limited English proficient. CMS is available to assist states in identifying practical solutions when access to a particular modality may be limited due to the public health emergency.

Additionally, states may use contractors to perform certain Medicaid agency administrative functions, provided that the state exercises appropriate oversight consistent with federal regulations at 42 C.F.R. § 431.10. For example, states can use contractors to operate call centers, input data from paper applications into an eligibility system or serve as application assistors. For CHIP, states have broad flexibility to delegate functions to contractors as long as they maintain oversight.

5. What is the CMS coding guidance for laboratory testing of COVID-19?

CMS works in coordination with the CDC to establish the appropriate coding practices related to COVID-19, and to date, four new HCPCS codes have been created for COVID-19 testing. HHS has previously shared ***Code U0001***: used specifically for CDC testing laboratories for CDC 2019 novel coronavirus (2019-NCOV) real-time RT-PCR diagnostic panel, and ***Code U0002***: for nonCDC lab tests for SARS-CoV-2/2019-nCoV (COVID-19). See more information in FAQ # VII.D.3, available here https://www.medicaid.gov/state-resource-center/Downloads/covid-19faqs.pdf.

Two new HCPCS codes have been established to identify clinical diagnostic laboratory tests for the detection of SARS-CoV-2 or the diagnosis of COVID-19 *that make use of high throughput technologies:*

- Code U0003 designates Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R. U0003 should identify tests that would otherwise be identified by CPT code 87635 but for being performed with these high throughput technologies.

- Code U0004 designates 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID19), for any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R. U0004 should be used for tests that would otherwise be identified by U0002 but for being performed with these high throughput technologies.

It is important to note that neither U0003 nor U0004 should be used for tests that detect COVID19 antibodies.

To ensure that Fee-For-Service claims and encounter data submitted to CMS as part of Transformed Medicaid Statistical Information System (T-MSIS) are accurate and complete, State Medicaid programs are encouraged to load the new codes (U0003 and U0004) into their systems and publish coding and billing guidance as soon as possible so that laboratories can submit claims timely. In addition, states with Medicaid managed care service delivery systems should communicate these codes to their managed care organizations.

Additional Questions

Please submit additional questions and requests to CMS' dedicated COVID-19 mailbox at MedicaidCOVID19@cms.hhs.gov.

EXHIBIT 4

Hadler, Peter B.

From: Dowty, Kristin
Sent: Monday, March 29, 2021 12:48 PM
To: Hadler, Peter B.
Subject: FW: MOE question [not-secure]

FYI

Kristin R. Dowty
Medical Program Administration Manager

CT Department of Social Services
Division of Program Oversight and Grant Administration
55 Farmington Avenue
Hartford, CT 06105
860.424.4805
kristin.dowty@ct.gov

From: DiMartino, Marie C.(CMS/CMCS) <Marie.DiMartino@cms.hhs.gov>
Sent: Saturday, March 27, 2021 9:24 AM
To: Dowty, Kristin <Kristin.Dowty@ct.gov>
Subject: RE: MOE question [not-secure]

Hi Kristin,

Consistent with CMS regulation at 42 C.F.R. §433.400(c)(2), Connecticut must transfer the individual described in this scenario from the adult group to the MSP-related group under which the individual is eligible. It is not optional for states.

Please let me know if the state has additional questions.

Thanks
Marie

From: Dowty, Kristin <Kristin.Dowty@ct.gov>
Sent: Thursday, March 11, 2021 12:59 PM
To: DiMartino, Marie C.(CMS/CMCS) <Marie.DiMartino@cms.hhs.gov>
Subject: MOE question [not-secure]
Importance: High

Hi Marie,

Would you kindly clarify this scenario for us?

If an individual ages out of the Medicaid expansion group but does not qualify for another full benefit Medicaid program but qualifies for MSP, are states required to discontinue enrollment in the expansion group (because MSP is considered MEC)? Or, it is permissible to discontinue but optional? Or not permissible to disenroll from the expansion group?

Thank you,
Kristin

Kristin R. Dowty
Medical Program Administration Manager

CT Department of Social Services
Division of Program Oversight and Grant Administration
55 Farmington Avenue
Hartford, CT 06105
860.424.4805
kristin.dowty@ct.gov

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF CONNECTICUT

DEBORAH CARR, BRENDA MOORE, MARY ELLEN WILSON, Plaintiffs v. XAVIER BECERRA, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, Defendant	Civil Action No. 3:22-cv-988

[PROPOSED] ORDER UPON PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND A PRELIMINARY INJUNCTION

Upon review of Plaintiffs' Motion for a Temporary Restraining Order and for a Preliminary Injunction, as more fully set forth in their accompanying Memorandum of Law, and upon finding that Plaintiffs have made a showing of a clear and substantial likelihood of success on the merits of their claims that the Defendant has violated Section 6008 of the Families First Coronavirus Response Act ("Coronavirus Response Act") and the Administrative Procedures Act in issuing 42 CF.R. Section 433.400 under his Interim Final Rule published on November 6, 2020; that Plaintiffs will be subject to ongoing and imminent irreparable harm without injunctive relief; and that the issuance of such relief is in the public interest and the balance of hardships supports such relief, the Court hereby **GRANTS** the requested Temporary Restraining Order as follows:

1. Defendant shall immediately instruct the Connecticut Department of Social Services that it may not enforce 42 C.F.R. Section 433.400 under the Interim Final Rule (IFR) with respect to plaintiffs Deborah Carr and Brenda Moore and that these two individuals must be kept on full-benefit Medicaid at least pending disposition of the hearing on plaintiffs' motion for a preliminary injunction.
2. A hearing is scheduled for August ____ , 2022 in Courtroom _____ on plaintiffs' motion for a preliminary injunction.
3. Defendant shall be required at said hearing to show cause why a preliminary injunction enjoining him from enforcing 42 C.F.R. Section 433.400 under the IFR and requiring him to notify all states (1) that they may not apply any provisions of 42 C.F.R. Section 433.400, and (2) that they must immediately reinstate anyone cut off of full benefit Medicaid since the implementation of the IFR based on any of the extra-statutory exceptions not contained in the Coronavirus Response Act itself (i.e., for a reason other than voluntarily getting off of Medicaid or leaving the jurisdiction, including through death), should not immediately be issued.

_____

Michael P. Shea, J.

Certificate of Service

I hereby certify that on August 3, 2022 a copy of the foregoing document was filed electronically and served by overnight delivery to anyone unable to accept electronic filing. Notice of this filing will be sent by email to all parties by operation of the Court's electronic filing system or by overnight delivery to anyone unable to accept electronic filing as indicated on the Notice of Electronic Filing. Parties may access this filing through the Court's CM/ECF System.

s/Sheldon V. Toubman
Sheldon V. Toubman