DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

March 19, 2020

Jay Inslee
Governor
State of Washington
Office of the Governor
PO Box 40002
Olympia, WA 98504-0002

Re: Section 1135 Flexibilities Requested in March 15, 2020 Communication

Dear Governor Inslee:

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 *et seq*.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services waived or modified certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the 2019 Novel Coronavirus (previously referred to as 2019-nCoV, now as COVID-19) pandemic. These waivers and modifications take effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020.

Your letter sent to the Centers for Medicare & Medicaid Services (CMS) on March 15, 2020, detailed a number of federal Medicaid and Medicare requirements that pose issues or challenges for the health care delivery system in all counties in Washington and requested a waiver from those requirements. Attached, please find a response to your requests for waivers, pursuant to section 1135 of the Social Security Act, to address the challenges posed by COVID-19. This approval addressed those requests related to Medicaid. To streamline the section 1135 waiver request and approval process, the CMS has issued a number of blanket waivers for many Medicare provisions. These provisions do not require approval and therefore are not addressed in this letter. Please refer to the current blanket waiver issued by CMS that can be found at https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf. CMS is working on issuing new policies related to COVID-19 that will be responsive to many of your waiver requests related to Conditions of Participation. We will share the guidance with you once it is available.

CMS continues to work on the additional waiver requests that are not currently reflected in the attached approval. For those waiver requests that require approval under authority other than section 1135 including existing regulations, state plan, or section 1115, my staff will continue to work with your team to review and adjudicate as quickly as possible.

Please contact Jackie Glaze at (404) 387-0121 or by email at Jackie.Glaze@cms.hhs.gov if you have any questions or need additional information. We appreciate the efforts of you and your staff in responding to the needs of the residents of the State of Washington and the health care community.

Sincerely,

[redacted]

Calder Lynch
Deputy Administrator and Director

STATE OF WASHINGTON

FEDERAL SECTION 1135 WAIVER REQUESTS

CMS Response: March 19, 2020

Provider Participation

Washington currently has the authority to rely upon screening that is performed by other State Medicaid Agencies (SMAs) and/or Medicare. Washington is not required to create a temporary provisional enrollment for providers who are enrolled with another SMA or Medicare.

With respect to providers not already enrolled with another SMA or Medicare, CMS will waive the following screening requirements so the state may provisionally, temporarily, enroll the providers:

1. Payment of the application fee - 42 C.F.R §455.460
2. Criminal background checks associated with FCBC- 42 C.F.R §455.434
3. Site visits - 42 C.F.R §455.432
4. In-state/territory licensure requirements - 42 C.F.R §455.412

For those providers located out of state and from which Washington Medicaid participants seek care, enrollment is not necessary if the following criteria are met:

1. The item or service is furnished by an institutional provider, individual practitioner, or pharmacy at an out-of-state/territory practice location– i.e., located outside the geographical boundaries of the reimbursing state/territory's Medicaid plan,
2. The National Provider Identifier (NPI) of the furnishing provider is represented on the claim,
3. The furnishing provider is enrolled and in an "approved" status in Medicare or in another state/territory's Medicaid plan,
4. The claim represents services furnished, and;
5. The claim represents either:
    a. A single instance of care furnished over a 180-day period, or
    b. Multiple instances of care furnished to a single participant, over a 180-day period

If the Medicaid participant is enrolled with the Medicaid program, the final two criterions will be waived. Therefore, there is no limit to the instances of care furnished or to how many participants in a 180-day period.

In the instance that a certified provider is enrolled in Medicare or with a state Medicaid program other than Washington, Washington may perform an expedited enrollment, as described above, of an out-of-state facility in order to accommodate participants who were displaced by the emergency.

CMS is granting waiver authority to allow Washington to enroll providers who are not currently enrolled by meeting the following minimum requirements:

1. Must collect minimum data requirements in order to file claims and process, including, but not limited to NPI
2. Must collect Social Security Number, Employer Identification Number, and Taxpayer Identification Number (SSN/EIN/TIN) in order to perform the following screening requirements:
    a. OIG exclusion list
    b. State licensure – provider must be licensed, and legally authorized, in any state/territory to practice or deliver the services for which they intend to file claims
3. Washington may grant a provisional temporary enrollment that meets the following requirements:
    a. Must cease approving temporary provisional enrollments no later than the date that the emergency designation is lifted
    b. Must cease payment to providers who are temporarily enrolled within six months from the date that the emergency designation is lifted, unless a provider has submitted an application that meets all requirements for Medicaid participation and that application was subsequently reviewed and approved by Washington
    c. Washington must allow a retroactive effective date for provisional temporary enrollments that is no earlier than March 1, 2020.

Washington may temporarily cease revalidation of providers who are located in Washington or are otherwise directly impacted by the emergency. These provider enrollment emergency relief efforts also apply to the state's separate CHIP.

Waiver of Service Prior Authorization (PA) Requirements

Prior authorization and medical necessity processes in fee-for-service delivery systems are established, defined and administered at state/territory discretion and may vary depending on the benefit. The State of Washington may have indicated in their approved state plan specific requirements about prior authorization processes (42 C.F.R.§440.230(b)) for benefits administered through the fee-for-service delivery system. We interpret prior authorization requirements to be a type of pre-approval requirement for which waiver and modification authority under section 1135(b)(1)(C) of the Act is available. If prior authorization processes are outlined in detail in the State of Washington's state plan for particular benefits, CMS is using the flexibilities afforded under section 1135(b)(1)(C) of the Act that allow for waiver or modification of pre-approval requirements to permit services provided on or after March 1, 2020 through the termination of the emergency declaration for at least 90 days and up to 180 days (up to the last day of the emergency period under section 1135(e) of the Act), for beneficiaries with a permanent residence in a the geographic area of the public health emergency declared by the Secretary.

Waiver for Pre-Admission Screening and Annual Resident Review (PASRR) Level I Level II Assessments for 30-Days

Level 1 and Level 2 assessments can be waived for 30 days. All new admissions can be treated like exempted hospital discharges. After 30 days, new admissions with mental illness (MI) or intellectual disability (ID) should receive a Resident Review as soon as resources become available.

Additionally, please note that per 42 C.F.R.§483.106(b)(4), new preadmission Level 1 and Level 2 screens are not required for residents who are being transferred between nursing facilities (NF). If the NF is not certain whether a Level I had been conducted at the resident's evacuating facility, a Level I can be conducted by the admitting facility during the first few days of admission as part of intake and transfers with positive Level 1 screens would require a Resident Review.

The 7-9-day timeframe for Level 2 completion is an annual average for all preadmission screens, not individual assessments, and only applies to the preadmission screens (42 C.F.R. §483.112 (c)). There is no set timeframe for when a Resident Review must be completed but it should be conducted as resources become available.

Waiver to allow evacuating facilities to provide services in alternative settings, such as a temporary shelter when a provider's facility is inaccessible.

CMS approves the waiver to allow facilities including NFs, intermediate care facilities for individuals with intellectual and developmental disabilities (ICF/IDDs), psychiatric residential treatment facilities (PRTFs) and hospitals NFs to be fully reimbursed for services rendered during an emergency evacuation to an unlicensed facility (where the evacuation of facility continues to render services). The facility would be responsible for determining how to reimburse the unlicensed facility. This arrangement would only be effective for the duration of the section 1135 waiver. However, after the initial 30 days, CMS would require that the unlicensed facility either seek licensure or the evacuating facility would need to seek new placement for the individuals. The duration time for the section 1135 waiver will allow the state to accommodate these changes.

Specific to the state's request to waive relief from Drug Enforcement Administration (DEA) requirements around medications, CMS lacks authority to waive or not enforce DEA requirements. CMS will consult with DEA to determine if these requirements can be waived during the public health emergency.

State Fair Hearing Requests and Appeal Timelines

Washington requested flexibility to temporarily delay scheduling of Medicaid Fair Hearings and issuing Fair Hearing decisions during the emergency period. CMS cannot waive parts of 42 C.F.R.§438, Subpart F as they relate to appeals of adverse benefit determinations which occur before Fair Hearings for Medicaid managed care enrollees or parts of 42 C.F.R.§431, Subpart E. However, CMS is able to modify the timeframes associated with appeals and fair hearings. Therefore, CMS approves the following:

- Modification of the timeframe for managed care entities to resolve appeals under 42 C.F.R. §438.408(f)(1) before an enrollee may request a State fair hearing to zero days in accordance with the requirements specified below.

The requirements of 42 C.F.R. §438.408(f)(1) establish that an enrollee may request a State fair hearing only after receiving a notice that the Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PHIP) or Prepaid Ambulatory Health Plan (PAHP) is upholding the adverse benefit determination but also permits, at §438.408(c)(3) and (f)(l)(i) that an enrollee's appeal maybe deemed denied and the appeal process of the managed care plan exhausted (such that the State fair hearing may be requested) if the managed care plan fails to meet the timing and notice requirements of §438.408. Section 1135 of the Act allows CMS to authorize a modification to the timeframes for required activities under section 1135(b)(5). CMS authorizes the state to modify the time line for managed care plans to resolve appeals to zero days. If the state uses this authority, it would mean that all appeals filed between March 1, 2020 and June 29, 2020 are deemed to immediately satisfy the exhaustion requirement in 42 C.F.R. §438.408(f)(1) and allow enrollees to proceed directly to the state fair hearing.

Modification of the timeframe under 42 C.F.R.§438.408(f)(2) for enrollees to exercise their appeal rights to allow an additional 120 days to request a fair hearing when the initial 120th day deadline for an enrollee occurred during the authorized period of the immediate section 1135 waiver.

In addition, CMS approves a modification of timeframe, under 42 C.F.R.§438.408(f)(2), for managed care enrollees to exercise their appeal rights. Specifically, any managed care enrollees for who the 120 -ay deadline described in 42 C.F.R.§438.408(f)(2) would have occurred between March 1, 2020 through June 29, 2020, are allowed more than 120 days, and up to an additional 120 days to request a State Fair Hearing provided that they make the request no later than June 29, 2020.

- Modification of the timeframes in 42 C.F.R.§431.221(d) to allow beneficiaries to have more than 90 days to request a state fair hearing for eligibility or fee-for-service issues.

The following are flexibilities the state may utilize in operating their appeals and fair hearing process under authority of current regulations and state plan. The state 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. The state must document its policy in compliance with the state's record keeping practices.

Similarly, the state may delay scheduling fair hearings and issuing fair hearing decisions. Regulations at 42 C.F.R.§431.244(f)(4)(i)(B) allows the agency to delay taking final administrative action for state fair hearing decisions when there is an emergency beyond the agency's control. The agency must document the reason for delay in the beneficiary's record

and document the policy in compliance with the state's record keeping practices. If this flexibility is utilized, the state should prioritize completing hearings requested by beneficiaries who would be most impacted by the delay, specifically those who meet the standard for an expedited fair hearing under 42 C.F.R.§431.224. The state also 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.

Public Notice and Tribal Consultation

The State of Washington requested a waiver of public notice. Public notice for state plan amendments (SPAs) are required under 42 C.F.R 447.205 for changes in statewide methods and standards for setting Medicaid payment rates, 42 C.F.R. 447.57 for changes to premiums and cost sharing and 42 C.F.R. 440.386 for changes to Alternative Benefit Plans (ABPs). This is to ensure that the impacted public has reasonable opportunity to comment on such SPAs.

CMS recognizes that during this public health emergency, Washington must act expeditiously to protect and serve the general public. Therefore, for SPAs that only provide or increase beneficiary access to items and services related to COVID-19 (such as cost sharing waivers, payment rate increases, or amendments to ABPs adding services or providers) and would not be a restriction or limitation on payment or services or otherwise burden beneficiaries and providers, and that are temporary, with a specified sunset date related to COVID-19, CMS approves the state's request to waive public notice under section 1135(b)(1)(C) of the Act– to modify and waive preapproval requirements. We encourage the state to make all relevant information available to the public so they are aware of the changes. Similarly, the state has flexibility in modifying their tribal consultation timeframe, including shortening the number of days before submission or conducting consultation after submission of the SPA.