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

SHO# 20-004

RE: Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency

December 22, 2020

Dear State Health Official:

Introduction

Medicaid and the Children's Health Insurance Program (CHIP) play critical roles in helping states and territories respond to public health emergencies and disasters, including the outbreak of the Novel Coronavirus Disease 2019 (COVID-19). Over the course of the COVID-19 Public Health Emergency (PHE), state Medicaid, CHIP, and Basic Health Programs (BHP) adopted many flexibilities offered by the Centers for Medicare & Medicaid Services (CMS) to respond effectively to their local outbreaks, including changes to modify eligibility requirements and benefit packages, ensure access to home and community-based services (HCBS), and support health care providers by updating payment rates. In addition to adoption of these flexibilities, states made program changes to comply with the requirements of section 6008 of the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127) as amended by the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Pub. L. 116-136). The FFCRA provides states with a temporary 6.2 percentage point increase in the federal medical assistance percentage (FMAP) if they meet certain conditions, including a continuous enrollment requirement for most Medicaid beneficiaries who were enrolled in the program as of or after March 18, 2020.

Managing the continuing PHE remains a critical priority for CMS, including through our work to extend provider capacity and to prepare for the availability of a vaccine. The purpose of this letter is to provide guidance to states on planning for the eventual return to regular operations, including ending temporary authorities when the PHE concludes, making temporary changes permanent in certain circumstances, procedures for ending coverage and policies authorized under expiring FFCRA provisions, and addressing pending eligibility and enrollment actions that developed during the PHE.[1] CMS' expectations related to returning to normal eligibility and

[1] The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

enrollment operations are described in Section VI of this letter. States implemented an array of program and systems changes to best serve beneficiaries during the PHE, and this guidance will support states in planning for the eventual end of the PHE, ensuring that they are able to transition back to normal operations when the PHE ends efficiently and in such a way that minimizes burden for beneficiaries.

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I. Background

During a PHE or disaster, CMS can use various legal authorities to grant states' emergency flexibilities critical to ensuring a state's ability to respond to the crisis expeditiously and protect and serve the general public. On January 31, 2020, the Secretary of Health and Human Services (HHS) declared a PHE, effective as of January 27, 2020, for the entire United States to aid the nation's healthcare community in responding to COVID-19. On March 13, 2020, the President declared the ongoing COVID-19 pandemic of sufficient severity and magnitude to warrant an emergency declaration for all states, tribes, territories, and the District of Columbia pursuant to section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5207 (the "Stafford Act") with a retroactive effective date of March 1, 2020.

As part of CMS's ongoing efforts to assist states with addressing the COVID-19 PHE, CMS released new tools to speed states' access to emergency flexibilities and support state Medicaid, CHIP, and BHP agencies during the COVID-19 outbreak. CMS created and released four checklists to help states receive federal waivers and assist them in identifying other authorities in order to implement flexibilities in their Medicaid and/or CHIP programs more efficiently. These tools permit states to access emergency administrative relief, make temporary modifications to Medicaid eligibility and benefit requirements, relax rules to ensure that individuals with disabilities and older adults can be effectively served in their homes, modify payment rules to support health care providers affected by the PHE, and provide wider access to Medicaid-covered services furnished via telehealth. States have the option to request that many of these waivers, state plan amendments (SPAs), and other mechanisms be made effective retroactively, to as early as March 1, 2020, the effective date of the national emergency declared by the President. Many of the options and authorities available to states are described in Appendix A.

States are also able to take advantage of other flexibilities, including emergency information technology (IT) funding, CHIP Disaster Relief SPAs, BHP Blueprint revisions, verification process simplifications, and the flexibility that exists under current regulations related to the timeliness of eligibility determinations and taking final administrative action on fair hearings. As of December 17, 2020, CMS received nearly 700 submissions from states for waivers, SPAs, BHP Blueprint revisions, and other flexibilities, and CMS has approved more than 600 of these submissions. These approvals provide states the flexibility they need to make program changes to respond to the PHE.

Authority Effective and Termination Dates

Each temporary authority adopted by states to respond to the COVID-19 PHE is scheduled to automatically sunset upon termination of the PHE or another specified date. Effective and termination dates for the various authorities are provided in the table below. On October 2, 2020, the HHS Secretary renewed the COVID-19 PHE. The renewal took effect on October 23, 2020 and extends the PHE for another 90 days.[2]

Authority / Provision	Effective Date	Termination Date
Medicaid & CHIP 1135 Waivers	March 1, 2020	Expires at the end of PHE.
Appendix K of the 1915(c) HCBS Waiver Instructions and Technical Guidance	January 27, 2020 or any later date elected by state	For Appendix K submissions in response to the COVID-19 PHE, the termination date will be no later than six months after the expiration of the PHE.
Medicaid Disaster Relief SPA for the COVID-19 PHE	March 1, 2020 or any later date elected by state	Expires at the end of PHE or any earlier approved date elected by state.
CHIP Disaster Relief SPA (specific to COVID-19 PHE)	Start of state or federally declared emergency	Expires at the end of PHE or at state discretion before end of PHE.[3]
BHP Blueprint Revisions	March 1, 2020 or any later date elected by state	Expires no later than the end of PHE, unless a later date is requested and approved by CMS.
Medicaid and CHIP Disaster Relief MAGI-Based Verification Plan Addendum	Any date elected by state	Expires on a date selected by the state.
1115 Demonstration to Respond to the COVID-19 PHE	March 1, 2020 or any later date elected by state	Expires no later than 60 days after end of PHE.

[2] Declaration of 90 day extension of the COVID-19 Public Health Emergency (PHE) on October 2, 2020 https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-2Oct2020.aspx

[3] Some states have the authority to continue CHIP disaster flexibilities through the end of a state declared emergency. If you have questions about the duration of flexibilities, contact your CMS CHIP project officer.

Legislative Requirements Related to COVID-19

In addition to adoption of the flexibilities described above, states made program changes to comply with the requirements of section 6008 of the FFCRA, as amended by the CARES Act. Section 6008 of the FFCRA provides a temporary 6.2 percentage point increase to the FMAP under the first sentence of section 1905(b) of the Social Security Act (the Act) for states and territories that meet certain conditions, including that they 1) maintain eligibility standards, methodologies, or procedures that are no more restrictive than what the state had in place as of January 1, 2020; 2) do not charge premiums in excess of those in place on January 1, 2020;[4] 3) maintain Medicaid enrollment for certain beneficiaries through the end of the month in which the PHE ends; and 4) cover COVID-19 testing and treatment services (including vaccines, specialized equipment, and therapies) without cost sharing.[5] 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 PHE, including any extensions, ends. The continuous enrollment requirement in section 6008(b)(3) of the FFCRA prevents states seeking to claim the temporary FMAP increase from terminating eligibility for individuals enrolled as of or after March 18, 2020, through the end of the month in which the PHE ends, even if the individual no longer meets eligibility requirements, unless the person voluntarily disenrolls or is no longer a state resident. The requirements of section 6008 of the FFCRA do not apply to separate CHIPs or to the BHP.

Key Dates for Termination of Conditions for FFCRA FMAP Increase

Key termination dates for the requirements of section 6008(b) of the FFCRA are described below.

FFCRA Section 6008(b) Conditions for 6.2 Percentage Point Increase for FMAP	Termination Date
Maintenance of Effort (eligibility standards, methodologies, procedures) – Section 6008(b)(1) of FFCRA	Expires the first day of the month following the calendar quarter in which the PHE ends.
Premium Restrictions – Section 6008(b)(2) of FFCRA	Expires the first day of the month following the calendar quarter in which the PHE ends.
Continuous Enrollment – Section 6008(b)(3) of FFCRA	Expires the first day of the month following the month in which the PHE ends.
Coverage of, and Cost-sharing Exemption for, COVID-19-related Testing and Treatment – Section 6008(b)(4) of FFCRA	Expires the first day of the month following calendar quarter in which the PHE ends.

[4] Pursuant to section 6008(d) of the FFCRA, as added by section 3720 of the CARES Act, P.L. 116-136, a state is not ineligible for the temporary FMAP increase on the basis that it imposed a premium higher than any in effect on January 1, 2020, during the 30-day period beginning on March 18, 2020, if such premium was in effect on March 18, 2020.

[5] For additional information on the temporary FMAP increase and conditions for states and territories to qualify for it, see section 6008 of the FFCRA, Interim Final Rule with Comment (IFC) CMS-9912-IFC, "Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 85 FR 71142 (Nov. 6, 2020), and Medicaid and CHIP Frequently Asked Questions, available on Medicaid.gov.

All of the conditions described in section 6008(b) of the FFCRA extend beyond the end of the COVID-19 PHE, including (in some cases) through the end of the calendar quarter in which the PHE ends (if the state claims the temporary FMAP increase under FFCRA section 6008 in that quarter). However, Disaster Relief SPAs expire on the date the PHE expires (and could expire sooner). Therefore, states may need to amend their underlying state plans to ensure that they are able to meet the FFCRA section 6008(b) conditions for the entire period during which those conditions apply. For example, if a state provides for coverage and/or payment of services required under FFCRA section 6008(b)(4) under a Disaster Relief SPA, and wants to claim the FFCRA section 6008 temporary FMAP increase in the quarter in which the COVID-19 PHE ends, it may need another SPA in place to effectuate coverage and payment for those services through the end of the quarter in which the COVID-19 PHE ends. We note that some states have elected to apply certain provisions of section 6008 of FFCRA to their separate CHIP programs, such as covering COVID-19 related treatment without cost sharing, although it is not a requirement. If a state wishes to maintain this optional coverage in its separate CHIP beyond the end of the COVID-19 PHE and through the calendar quarter in which the PHE ends, the state should submit a CHIP SPA. CMS is available to provide technical assistance on these issues.

II. Resuming Normal Operations Before the End of the PHE and Continuing Temporary Authorities Beyond the PHE

CMS recognizes that the COVID-19 PHE is impacting each state differently and that local conditions influence the types and duration of emergency flexibilities necessary to ensure access to health care services and mitigate the spread of COVID-19. To ease the transition back to normal operations, CMS encourages states to inventory each flexibility it implemented to address the COVID-19 PHE to determine whether the flexibility should end prior to the end of the PHE, be maintained for the duration of the PHE, or be extended on a temporary or permanent basis after the PHE concludes, as allowable (to be determined on a case-by-case basis).

Resuming Normal Operations Before the End of the PHE

As local outbreak conditions evolve, states may no longer need to utilize all of the temporary authorities granted to them. CMS recommends states consider transitioning back to normal operations in a phased approach as individual flexibilities are no longer needed to address the COVID-19 PHE. For example, many states received concurrence from CMS that the PHE represents an emergency triggering an exception to meeting federal timeliness standards for processing Medicaid, CHIP, and BHP applications and redeterminations. However, states should begin processing these actions to the extent possible before the PHE ends to ensure they are able to comply with timeliness standards upon conclusion of the PHE. Additionally, some states received 1135 waiver authority for a 30-day delay of Pre-Admission Screening and Annual Resident Review (PASRR) Level I and Level II assessments. In recognition of the role PASRR plays in diverting unnecessary nursing facility stays or facilitating transitions out of nursing facilities for individuals with a mental illness or developmental disability, CMS encourages states to return to timely PASRR activities as quickly as possible. In addition, CMS reminds states that they continue to have independent obligations to comply with the Americans with Disabilities Act, Section 1557 of the Patient Protection and Affordable Care Act, and Section

504 of the Rehabilitation Act, including their requirements under *Olmstead v. L.C.,*[6] which remain in effect during this public health emergency. Technical assistance is available from the HHS Office for Civil Rights and the Department of Justice Civil Rights Division.

Extending Temporary Flexibilities Beyond the PHE

States may find that some flexibilities may be useful to extend on a temporary or permanent basis. For example, some states implemented temporary state plan changes to provide alternative payment and coverage for services furnished using telehealth. Other states allowed the temporary use of telehealth in their 1915(c) waivers, such as for personal care services that only require verbal cueing, using Appendix K. A state may choose to incorporate this service delivery modality into its post-PHE activities by amending their state plans or 1915(c) waivers, as described below. Additionally, a number of states received authority to pay COVID-19 laboratory testing services at 100 percent of Medicare rates, which differs from payment rates for other laboratory services in the state plan. Such states may elect to temporarily extend this payment policy beyond the end of the PHE by amending their state plan.

- *Extending SPA Authorities and BHP Blueprint Revisions:* States seeking to extend one or more Medicaid or CHIP state plan authorities or BHP Blueprint revisions approved to address the COVID-19 pandemic beyond the PHE must submit a SPA or Blueprint through the regular SPA or Blueprint revision process. States must comply with all regulatory and statutory requirements for submission of these regular SPAs and BHP Blueprint revisions, including 1) limitations on effective dates at 42 C.F.R. §430.20 for Medicaid SPAs, §457.65 for CHIP SPAs, and §600.125 for BHP Blueprint revisions; 2) tribal consultation requirements described in the state plan and at sections 1902(a)(73) and 2107(e)(1)(F) of the Act and §600.155; and 3) public notice requirements at §457.65(b) for CHIP SPAs[7] and §600.115(c) for BHP Blueprint revisions, where applicable. Additional information on extending Medicaid state plan authorities may be found at: https://www.medicaid.gov/state-resource-center/downloads/allstatecall-20200616.pdf. Details on extending CHIP state plan authorities may be found at: https://www.medicaid.gov/state-resource-center/downloads/allstatecall-20200623.pdf.

- *Updating Verification Processes:* States can extend or adopt new changes to their Medicaid and CHIP verification processes provided that the changes are consistent with federal statute and regulations at 42 C.F.R. §435.940 through §435.960 and §457.380. Any changes must be documented in the state's internal policies and procedures. States must also update and submit changes to verification plans for Modified Adjusted Gross Income (MAGI)-based populations to CMS, consistent with 42 C.F.R. §§435.945(j) and 457.380(j). For temporary changes, states may submit a revised verification plan addendum, which may be found at: https://www.medicaid.gov/medicaid/eligibility/downloads/magi-based-verification-

[6] Under title II of the ADA and the Supreme Court's *Olmstead v. L.C.* opinion, the unjustified isolation of individuals with disabilities constitutes unlawful discrimination. States are required to provide community-based treatment where such treatment would be appropriate, the affected person does not oppose such treatment, and the treatment can be reasonably accommodated. Further information on state obligations under Olmstead can be found at https://www.ada.gov/olmstead/q&a_olmstead.htm.
[7] We note that federal CHIP regulations in 42 CFR 457.65(b) only require public notice if the SPA eliminates or restricts eligibility or benefits. States should also follow any state laws related to public notice.

plan-addendum-template.docx. To notify CMS of indefinite changes to MAGI-based verification processes, states would submit a revised verification plan.

- *Extending Section 1915(c) Appendix K Flexibilities*: Termination of Appendix Ks for section 1915(c) waivers, unlike other authorities, is not typically tied to the end of the PHE declared by HHS, but instead to the end date specified in the Appendix K approvals. Many states' approved Appendix K authorities related to the COVID-19 PHE are currently set to terminate during the first quarter of 2021. States should routinely assess whether flexibilities will be needed beyond their specified termination date, and they may seek CMS approval to extend or modify their Appendix K flexibilities if necessary. If needed, states may submit an updated Appendix K application to extend or modify the end date. In recognition of the uncertainties associated with the period of time in which the COVID-19 PHE will be in effect, subsequent CMS approvals of state requests for new or extended Appendix K flexibilities will specify that the Appendix K flexibilities will terminate no later than six months after the expiration of the PHE. Although formal public notice is not required, states are strongly encouraged to keep 1915(c) waiver providers and participants up-to-date on changes that will be ending and the date those changes will end.

  Changes made through Appendix K that states would like to continue beyond the six-month post-PHE timeline must be submitted as an amendment to the state's 1915(c) waiver application via the Waiver Management System (WMS). These amendments must adhere to all policies and procedures detailed in the Version 3.6 1915(c) waiver application and accompanying instructions, technical guide, and review criteria.[8] Examples of common changes in Appendix Ks that may be approved in a standard 1915(c) waiver application include the use of telehealth for certain services, addition of home-delivered meals and other services, rate increases for waiver services, retainer payments up to 30 days, and increased ability to pay family caregivers. Please be advised that not all changes approvable through the Appendix K process may be included in the standard 1915(c) waiver application, including, but not limited to, the extension of timeframes for level of care re-evaluations, extensions of due dates for CMS-372s and evidentiary reports, and waiving of certain settings and conflict of interest requirements. In addition, changes approved using section 1135 waiver authority (e.g., extensions of person-centered service plan recertifications, verbal signatures for person centered service plans) generally may not be included as part of a standard 1915(c) waiver application. States are encouraged to consult with CMS if they have questions about what changes are permissible. Additional guidance on retaining temporary flexibilities is available at: https://www.medicaid.gov/state-resource-center/downloads/allstatecall-20200630.pdf.

[8] The 1915(c) waiver application and accompanying technical guidance is available for download on the WMS website.

III. Regulatory Requirements for Concluding Temporary Authorities

States will not need to take action to terminate temporary authorities that were approved with specified sunset dates; however, states will need to comply with relevant regulatory provisions when the transition back to regular operations results in, for example, terminations of coverage or a reduction of benefits. Some of these regulatory requirements are related to redetermining eligibility and assessing for coverage under another category or group prior to terminating coverage, provision of advance notice and fair hearing rights, and reporting. States must comply with these requirements when returning to regular operations after FFCRA provisions end, as well as when ending temporary flexibilities adopted during the PHE. Appendix B provides a snapshot of the regulatory requirements and the flexibilities subject to each requirement.

Conducting Renewals and Redeterminations

Once the PHE ends, states must take appropriate steps to redetermine eligibility and terminate coverage, as appropriate, for individuals who remained enrolled due to the maintenance of eligibility or continuous enrollment requirements in FFCRA, who gained or maintained coverage during the PHE through a temporary change in eligibility requirements, or whose redetermination was delayed due to circumstances described in 42 C.F.R. §435.912(e)(2), §457.340(d), or §600.320(b). Under the continuous enrollment requirement in the FFCRA, states seeking the temporary increase in FMAP under section 6008 of the FFCRA must treat beneficiaries whose enrollment in Medicaid would be terminated but for compliance with section 6008(b)(3) of the FFCRA as eligible for benefits and keep them enrolled through the end of the month in which the PHE ends.

As required at 42 C.F.R. §§435.916 and 457.343 (which generally incorporate the requirements of §435.916 into CHIP), states must renew eligibility for Medicaid and CHIP beneficiaries whose eligibility is determined using MAGI-based financial methodologies only once every 12 months. For Medicaid beneficiaries excepted from MAGI-based financial methodologies under 42 C.F.R. §435.603(j), states must renew such beneficiaries' eligibility at least once every 12 months in accordance with §435.916(b). For BHP, states must redetermine eligibility every 12 months in accordance with 42 C.F.R. §600.340. In addition, as described at 42 C.F.R. §435.916(d), §457.343, and §600.340(a), states must redetermine Medicaid, CHIP, and BHP eligibility between regular renewals when they have information about a change in a beneficiary's circumstances that may affect eligibility.

In accordance with 42 C.F.R. §§435.916(a)(2) and (b) and 457.343, states must redetermine eligibility without requiring information from the individual if able to do so based on reliable information in the individual's account or more current information available to the agency. If the state is not able to redetermine eligibility because the available information does not establish eligibility or is not recent or reliable, the state must request information from the beneficiary in accordance with 42 C.F.R. §§435.916(a)(3) and (b) and 457.343. For BHP, states have the option to follow the Medicaid redetermination policy described in 42 C.F.R. §435.916(a), or the Exchange policy described in 45 C.F.R. §155.335.

In addition, verification regulations at 42 C.F.R. §435.952 and §457.380(d) (which incorporate requirements of §435.952 into CHIP) require states to promptly evaluate information obtained or

received by the agency and prevents states from denying or terminating eligibility or reducing benefits on the basis of information received through electronic data sources unless the state reached out to the beneficiary, provided a reasonable opportunity for the beneficiary to respond and, as appropriate, provided advance notice and fair hearing (or in the case of CHIP, review) rights. For BHP, states have the option to follow the Medicaid verification policy described in 42 C.F.R. §435.952 or the Exchange policy described in 45 C.F.R. §155.315 and §155.320.

For Medicaid beneficiaries who are found to no longer be eligible for the group in which the individual receives coverage, states must consider all bases of eligibility prior to determining an individual is ineligible for Medicaid in accordance with 42 C.F.R. §435.916(f)(1). States must provide individuals determined ineligible for Medicaid on all bases with advance notice of termination and fair hearing rights in accordance with 42 C.F.R. §435.917 and 42 C.F.R. Part 431, Subpart E. For CHIP, under 42 C.F.R. §457.350, states must screen for eligibility in Medicaid and other insurance affordability programs prior to termination, and facilitate enrollment in Medicaid if found potentially eligible. States must provide individuals determined ineligible for CHIP timely notice of termination and review rights in accordance with 42 C.F.R. §457.340(e) and 42 C.F.R. §457.1180. States may refer to the CMCS Informational Bulletin, Medicaid and CHIP Renewal Requirements (Renewal CIB), which is available to assist states in meeting their obligations to make accurate and timely redeterminations of eligibility and resolve pending eligibility and enrollment actions.[9]

States are expected to follow the regulatory requirements described above when completing renewals and redeterminations after the end of the PHE. However, additional considerations may apply in determining what actions are needed in particular circumstances.

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

[9] CMCS Informational Bulletin, Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements, available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf.

- *Redeterminations for Individuals Not Required to be Continuously Enrolled*: States are not required to provide continuous enrollment for individuals enrolled in a separate CHIP or BHP during the PHE in order to comply with section 6008(b)(3) of the FFCRA, which does not apply to these programs. It also is important that states process CHIP and BHP renewals and redeterminations during the PHE in accordance with 42 C.F.R. §457.343 and §600.340 to the extent possible. As described in more detail below, some states have the authority in their CHIP state plans or BHP Blueprints to use an exception in meeting the timeliness standards for processing applications and redeterminations as a result of an administrative or other emergency beyond the agency's control. While the timeliness exception for processing applications and redeterminations acknowledges that a state may be unable to meet the time standards due to an emergency situation, this exception does not alleviate states of the obligation to process applications and redeterminations if the state is not prevented from doing so by the circumstances of the emergency or the emergency no longer exists. It also does not provide authority to extend beneficiary eligibility periods beyond what is necessary to use the exception.

- *Redeterminations Based on Changes in State Eligibility and Enrollment Policies:* Any time a state imposes a more restrictive income methodology for an eligibility group or ends coverage under an optional eligibility group, the agency must redetermine eligibility for all affected beneficiaries. Some temporary flexibilities adopted by states, such as adopting a less restrictive income methodology or establishing income and resource disregards for MAGI-excepted eligibility groups in a Medicaid Disaster Relief SPA, made some individuals temporarily eligible for Medicaid. Other temporary flexibilities, like the adoption of continuous eligibility, allowed individuals to maintain eligibility even if their circumstances changed. In addition, some states receiving the temporary FMAP percentage increase paused efforts to impose more restrictive eligibility standards, methodologies, or procedures in order to comply with the maintenance of effort requirement under section 6008(b)(1) of the FFCRA. When temporary eligibility changes and the maintenance of eligibility requirement sunset, agencies will need to redetermine financial eligibility for beneficiaries who gained or maintained eligibility as a result of these flexibilities or whose eligibility may be impacted with the adoption of a more restrictive eligibility standard, methodology, or procedure. These beneficiaries are considered to experience a change in circumstances that may affect eligibility when the authority sunsets or more restrictive methodology is adopted, and the agency must promptly act on such changes in accordance with 42 C.F.R. §435.916(d). The agency must provide the beneficiary an opportunity to provide information or other documentation to establish continued eligibility in accordance with 42 C.F.R. §435.916(f)(1).[10] The agency must provide the beneficiary with a reasonable period of time to provide such information or documentation in accordance with 42 C.F.R. §435.952(c) and must enable the beneficiary to respond to the agency's request online, by phone, by mail, or in person.[11] CMS encourages states to establish a reasonable period of time for all beneficiaries that is consistent with the requirement at 42 C.F.R.

[10] Per 42 C.F.R. §435.916(d)(1)(i) and 42 C.F.R §457.343, for renewals of Medicaid and CHIP beneficiaries whose financial eligibility is determined using MAGI-based financial methodologies, the agency must limit any requests for additional information from the individual to information relating to the eligibility criterion impacted by the change in circumstances.
[11] The required modes of submission are described at 42 C.F.R. §435.907(a).

§435.916(a)(3)(i)(B) to provide MAGI beneficiaries at least 30 days to return information at renewal. States may refer to Appendix A of the Renewal CIB for more information on processing changes in circumstances.[12]

- *Transitions of Coverage Between Coverage Programs at the end of the PHE:* Given that we anticipate a significant increase in the number of individuals disenrolled from Medicaid in states receiving the temporary FMAP percentage point increase once the continuous enrollment and maintenance of eligibility requirements under the FFCRA sunset, we also remind states and territories of their role in ensuring that individuals are able to smoothly transition to other insurance affordability programs, such as CHIP or enrollment in a Qualified Health Plan through the Marketplace, as appropriate, with minimal disruptions. When an individual is determined ineligible for Medicaid on all bases, states and territories must assess potential eligibility for other insurance affordability programs and transfer the individual's account in accordance with 42 C.F.R. §435.916(f)(2). The account must include all of the information collected and generated by the agency, regarding the individual's Medicaid eligibility.[13] Similar requirements exist in CHIP and BHP as outlined in 42 C.F.R. §457.350 and 42 C.F.R. §600.330(a), respectively, when a beneficiary is determined no longer eligible for coverage under those programs.

CMS understands that states may have a large volume of pending redeterminations that could not be completed during the PHE. States and territories will need a reasonable period of time to complete outstanding redeterminations and terminate coverage, as appropriate, when the PHE ends, the FFCRA maintenance of eligibility and continuous enrollment requirements expire, and any temporary eligibility authorities sunset. CMS outlines expectations related to completion of this work in Section VI of this letter.

Providing Advance Notice to Beneficiaries

Whenever the Medicaid or CHIP agency makes a decision affecting a beneficiary's eligibility or when a beneficiary is subject to a termination, reduction or change in benefits and/or services or an increase in beneficiary liability, the state generally must send a notice at least 10 days prior to the date of action (defined at 42 C.F.R §431.201 as "the intended date on which a termination, suspension, reduction, transfer or discharge becomes effective") of the agency's decision as well as the beneficiary's right to a Medicaid fair hearing as described at 42 C.F.R. §435.917 and 42 C.F.R. Part 431, Subpart E, or a CHIP review as described at 42 C.F.R. §457.340(e) and §§457.1120-1190.[14] BHP enrollees are also entitled to notice of any decision concerning eligibility as described in 42 C.F.R. §600.330(e) and must be provided notice of their appeals right in accordance with §600.335(a). When a Disaster Relief SPA that temporarily expands

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[12] CMCS Informational Bulletin, Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements, available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf.

[13] CMCS Informational Bulletin, Coordination of Eligibility and Enrollment between Medicaid, CHIP and the Federally Facilitated Marketplace (FFM or "Marketplace"), available at https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/cib072516.pdf.

[14] As noted previously in this letter, states have flexibility to satisfy the requirement to determine eligibility on other bases prior to terminating Medicaid eligibility and to provide fair hearing rights related to termination of coverage under the COVID-19 testing group.

eligibility or provides additional benefits or services, such as creating a more flexible residency policy or expanding monthly prescription limit, sunsets, the state also must provide beneficiaries with advance notice of this change when the redetermination results in a decision of termination, reduction, or suspension of eligibility, benefits, or services or an increase in beneficiary liability. Similarly, when a section 1135 waiver sunsets and a level of care determination or functional needs assessment is completed, the state must provide beneficiaries with advance notice of any changes resulting from the determination or assessment. Additionally, when FFCRA section 6008(b) conditions no longer apply to a state, such as when section 6008(b)(4) of the FFCRA expires at the end of the calendar quarter in which the PHE ends, states that complied with those conditions in order to claim the temporary FMAP increase under section 6008 of the FFCRA must provide beneficiaries advance notice of any eligibility, premium, coverage, or cost sharing policies that are ending because the state is no longer subject to FFCRA section 6008(b), unless the state chooses to extend these policies.

CMS recognizes that some states have been able to send notices during the PHE informing Medicaid beneficiaries determined ineligible that their enrollment will end after the month in which the PHE ends or, for other beneficiaries, as appropriate, that they will be subject to an increase in cost sharing or other adverse action after the PHE ends. For such Medicaid beneficiaries, states must send a second notice in advance of the adverse action, including applicable fair hearing rights, at the end of the PHE in order to satisfy the due process requirements codified in 42 C.F.R. Part 431, Subpart E. CMS outlines this obligation in more detail in Section IV of this letter

Providing Fair Hearing Rights

Typically a state Medicaid, CHIP, or BHP agency must provide an individual the opportunity to have a Medicaid fair hearing, CHIP review, or BHP appeal when an individual believes the state has taken an action erroneously, including suspensions, terminations, or reductions of eligibility or covered benefits or services, or when the state has denied the individual's claim for eligibility or for covered benefits or services (42 C.F.R. §431.220(a), §457.1120, §600.335). One exception is that states are not required to provide a Medicaid fair hearing, CHIP review, or BHP appeal when there is a change in law or policy, such as when the state makes a change to its state plan to eliminate an optional benefit (42 C.F.R. §431.220(b), §457.1130(c), §600.335(b)). While individuals would not be entitled to a fair hearing to appeal the end of eligibility or coverage of a benefit or service that was authorized only during the PHE (e.g., the extension of eligibility to non-residents temporarily residing in the state due to the PHE or addition of the personal care benefit) (see 42 C.F.R. §431.220(b), §457.1130(c), §600.335), a beneficiary always has the right to request a Medicaid fair hearing, CHIP review, or BHP appeal to contest that the decision was wrong on another basis under existing authority. For example, if a beneficiary was terminated for being over income once a temporary income disregard provided under a Medicaid Disaster SPA ended, but the individual experienced a significant loss of income and this information was not considered in the beneficiary's redetermination, the beneficiary could request a fair hearing based on the loss of income, if the individual believed he/she would be eligible for Medicaid.

Completing Required Reporting

Some of the temporary authorities granted to states have associated reporting requirements that need to be addressed. Other flexibilities affect existing reporting requirements, such as the CMS-64, and will need to be accounted for in regular reporting.

Many states used the Appendix K process to extend deadlines for annual HCBS waiver CMS 372(S) reports. If the state specified a due date for the report(s) in its Appendix K, a CMS analyst will contact the state 30 days prior to that date to offer an opportunity for the state to provide updates to CMS regarding any changes to its submission date(s). If the state did not specify a due date, a CMS analyst will follow-up at the conclusion of the PHE. CMS acknowledges that 1915(c) quality reporting and cost estimates may be significantly affected by the changes states made in their Appendix Ks or other authorities. For example, changes or delays in provider qualifications allowed during the pandemic may adversely affect the state's performance on quality measures that assess whether providers continuously meet required licensure or certification standards. Additionally, waiver cost estimates may be affected due to temporary services, service limit increases, and rate increases. CMS is available for technical assistance on how to address such issues.

Other reporting requirements include submission of annual upper payment limit (UPL) demonstrations, as discussed in State Medicaid Director Letter 13-003. If applicable, these UPL demonstrations would account for Medicaid state plan payment increases authorized by the Disaster Relief SPAs. States can work with CMS on other adjustments that may be needed to the UPL demonstrations as a result of the PHE.

IV. Other Requirements for Ending Specific Authorities

The COVID-19 outbreak affected states' routine processes as they responded to the public health crisis, and there are a number of instances where states modified their processes to adopt a certain flexibility or used a temporary exception. Requirements for ending such specific modifications are described below.

Terminating Coverage in the Optional Medicaid COVID-19 Testing Group

Authorization for the optional COVID-19 testing group established by the FFCRA expires at the end of the PHE. States seeking the temporary FMAP increase under the FFCRA must maintain enrollment for most beneficiaries enrolled as of or after March 18, 2020, through the end of the month in which the PHE ends, unless the individual voluntarily disenrolls or is no longer a state resident.[15] States may not claim federal financial participation (FFP) after the PHE ends for services provided to individuals who remain enrolled in the COVID-19 testing group after the PHE ends, however.

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[15] For additional information on the temporary FMAP increase and conditions for states and territories to qualify for it, see section 6008 of the FFCRA, Interim Final Rule with Comment (IFC) CMS-9912-IFC, "Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 85 FR 71142 (Nov. 6, 2020), and Medicaid and CHIP Frequently Asked Questions, available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf

Typically, in accordance with 42 C.F.R. §435.916(f), states must determine eligibility on all bases prior to determining a beneficiary ineligible and 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. As described in the Operationalizing Implementation of the Optional COVID-19 Testing (XXIII) Group: Potential State Flexibilities chart, available at https://www.medicaid.gov/state-resource-center/downloads/potential-state-flexibilities-guidance.pdf, and the COVID-19 Frequently Asked Questions document, available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf, states have the flexibility to satisfy the requirement to determine eligibility on other bases prior to terminating Medicaid eligibility for beneficiaries enrolled in the COVID-19 testing group. States electing this option would have provided notice at the time the initial eligibility notice is sent: (1) that coverage through 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 a Medicaid application for comprehensive coverage. As part of the final termination notice, states must again inform individuals who want to be considered for comprehensive coverage that they must submit a Medicaid application for comprehensive coverage and how to do so, as well as the circumstances when fair hearing rights would apply in accordance with 42 C.F.R. §431.210(d)(2). (*Please refer to Appendix B for more information on termination, notice and redetermination).*

Terminating Coverage for Individuals Determined Ineligible for Medicaid during the PHE

States receiving the temporary 6.2 percentage point FMAP increase under section 6008 of the FFCRA may not disenroll most Medicaid beneficiaries for whom the state could not verify eligibility or for whom the state could not determine that eligibility continues until the continuous enrollment requirement under section 6008(b)(3) of the FFCRA and 42 C.F.R. §433.400 expires.[16] There is the potential for a significant lapse in time to occur between when the state or territory determined the individual was no longer eligible for Medicaid during the PHE and when the state needs to send advance notice of termination, required under 42 C.F.R. §431.211, prior to terminating coverage for that individual after the PHE ends. States and territories receiving the temporary FMAP percentage point increase, as well as beneficiaries, could face increased administrative burden if the state must, prior to sending such advance notice, repeat post-enrollment verification procedures, redeterminations based on a change in circumstances, or renewals for beneficiaries found ineligible during the PHE, including beneficiaries whom the state determined no longer meet all eligibility requirements and beneficiaries who did not respond to a request for information needed to determine their eligibility.

States may avoid duplicative work associated with completing a second verification or redetermination and limit duplicative beneficiary requests for information for beneficiaries whom the state determined ineligible no more than 6 months prior to the date that the beneficiary's coverage is terminated. The process which states must follow to avoid having to

[16] For additional information on the temporary FMAP increase and conditions for states and territories to qualify for it, see section 6008 of the FFCRA, Interim Final Rule with Comment (IFC) CMS-9912-IFC, "Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 85 FR 71142 (Nov. 6, 2020), and Medicaid and CHIP Frequently Asked Questions, available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf

repeat post-enrollment verifications, redeterminations based on changes in circumstances, or renewals in such cases depends on whether the state determined that the beneficiary does not meet all eligibility requirements or the individual failed to respond to a request for information needed to determine eligibility.

- *Individuals determined ineligible*: The following steps are required for states to avoid repeating a renewal, redetermination, or verification for beneficiaries whom the state determined ineligible within 6 months of the month in which the state sends advance notice of termination following the end of the PHE. At the time of such determination of ineligibility, states must inform such beneficiaries: 1) of the eligibility determination; 2) their enrollment will end after the month in which the PHE ends; and 3) that they can and should report any changes in circumstances while they remain enrolled and that the state will redetermine their eligibility based on such changes. In addition, states and territories must provide a second notice prior to the actual date of termination that meets the requirements to provide a minimum 10-day advance notice of termination and fair hearing rights in accordance with 42 C.F.R. Part 431, Subpart E.

- *Individuals who fail to respond to a request for information:* States must allow beneficiaries to provide information or return necessary forms and/or documentation at least through the end of the month in which the PHE ends, regardless of when the request for information was sent. For beneficiaries who have not responded to a request for information sent within 6 months of the actual termination date after the PHE ends, the state does not need to attempt to repeat the verification or redetermination or to request the needed information following the end of the PHE, but may instead provide the required minimum 10-day advance notice of termination and fair hearing rights in accordance with 42 C.F.R. Part 431, Subpart E, prior to terminating coverage.

States must repeat any verification processes, redeterminations based on changes in circumstances, and renewals for individuals whom the state determined ineligible, or from whom the state had requested information needed to determine eligibility, more than 6 months prior to the date of termination. This will ensure that the state takes final action based on reliable information, consistent with 42 C.F.R. §435.916(a)(2) and (b).

Ending Temporary Verification Plan Changes

States must follow the verification policies and processes outlined in their MAGI-based verification plan, along with MAGI and non-MAGI verification policies documented in the state's internal policies and procedures, consistent with federal statute and regulations. Some states completed a Medicaid and CHIP Disaster Relief MAGI-Based Verification Plan Addendum to establish temporary changes to their verification policies, such as the use of post-enrollment verification. States that elected to enroll individuals based on self-attested information and verify eligibility post-enrollment (post-enrollment verification) during the PHE must access relevant data sources, consistent with their verification plan, and complete verifications of eligibility for all beneficiaries enrolled within a reasonable timeframe and prior to the beneficiary's renewal, even if the state discontinues use of post-enrollment verification after the PHE. In most cases, income will be the primary criterion of eligibility for states to verify. As temporary verification policies and processes change (or sunset), including but not

limited to the discontinuation of periodic data matching, states will need to have a plan in place to reinstate these processes.

Ending Flexibilities Granted via Regulatory Concurrence

Federal regulations at 42 C.F.R. §435.912(e)(2), §457.340(d), §600.320(b), and 42 C.F.R. §431.244(f)(4)(i)(B) provide states with an exception to meeting the timeliness standards for processing applications and redeterminations under Medicaid, CHIP, and BHP, as well as completing fair hearings and taking final administration action under 42 C.F.R. §431.244, caused by an administrative or other emergency beyond the agency's control. While the timeliness exception for processing applications and redeterminations acknowledges that a state may be unable to meet the time standards due to an emergency situation, this exception does not alleviate states of the obligation to process applications and redeterminations if the state is not prevented from doing so by the circumstances of the emergency or the emergency no longer exists. It also does not provide authority to extend beneficiary eligibility periods beyond what is necessary to use the exception.

Many states received an email providing CMS' concurrence that the PHE did represent an emergency triggering use of the timeliness exception in their Medicaid programs. Similar acknowledgement for CHIP and BHP came in the form of an approval of a CHIP Disaster Relief SPA or BHP Blueprint revision. These states should begin processing verifications, redeterminations and renewals to the extent possible during the PHE and will need to ensure they are able to comply with federal timeliness standards upon conclusion of the PHE.

- *Timely Processing of Applications and Redeterminations:* States that continue utilizing the regulatory exception in meeting timeliness standards at 42 C.F.R. §435.912(e)(2), §457.340(d), and §600.320(b) for processing applications, renewals, and changes in circumstances due to workforce shortages, increased workloads and other disruptions to their operations associated with the PHE must begin processing applications and redeterminations timely when the PHE ends. We remind states that, in accordance with 42 C.F.R. §435.912(c) and §457.340(d), states are required to make determinations of eligibility for MAGI and other non-disability applicants within 45 days. States must make Medicaid determinations of eligibility on the basis of disability for applicants within 90 days.[17] States must redetermine eligibility once every 12 months for MAGI beneficiaries and at least once every 12 months for non-MAGI beneficiaries in accordance with 42 C.F.R. §435.916 and §457.343, and must act promptly on changes in circumstances consistent with 42 C.F.R. §435.916(d) and §457.343. Section VI of this letter outlines expectations for states regarding the restoration of state eligibility and enrollment operations when the PHE ends as well as for conducting eligibility and enrollment processes to the extent possible during the PHE.

- *Fair Hearing Timeframes:* States utilizing the regulatory exception in meeting timeliness standards at 42 C.F.R. §431.244(f)(4)(i)(B) to allow the state to take more

[17] For more information on timely and accurate determinations of eligibility, see Medicaid and CHIP MAGI Application Processing: Ensuring Timely and Accurate Determinations of Eligibility, available at https://www.medicaid.gov/state-resource-center/downloads/mac-learning-collaboratives/timely-accurate-eligibility.pdf

than 90 days to take final administrative action on fair hearing requests due to an emergency beyond the state's control must ensure they begin processing fair hearing requests timely when the PHE ends. While some states may have been unable to hold in-person fair hearings during the PHE, states may modify certain fair hearing processes without need for additional state plan authority to avoid and reduce backlogs of fair hearings. States may hold hearings by telephone or video, as long as the state is providing access to the fair hearing process in accordance with 42 C.F.R. Part 431, Subpart E (including providing access to individuals with disabilities and those who are limited English proficient). Additionally, states may also resolve fair hearing requests through informal resolution processes without additional state plan authority. CMS is available to provide technical assistance to states related to fair hearing processes and specifically regarding meeting the expected regulatory timeframes after the public health emergency ends.

Ending Temporary 1915(c) Appendix K Flexibilities

Temporary changes approved in Appendix K submissions will automatically terminate when they reach the end date indicated by the state in Section K-1-F of the Appendix K template. All temporary changes must conclude and states must resume compliance with the language in their current, approved 1915(c) waiver upon termination of the Appendix K. Any extensions of waiver requirements included in the Appendix K must be concluded prior to the Appendix K's end date, with the exception of level of care recertification extensions.[18] For example, if a state allows a 90-day extension for new providers to complete background checks, then only those providers enrolled at least 90 days prior to the end date of the Appendix K would be eligible for the full 90 day extension. A provider enrolled 60 days prior to the end date of the Appendix K would only be eligible for a 60-day extension. If the state finds there is no longer need for any of the provisions of the Appendix K, the state can elect to end the entire Appendix K by amending the end date.

Ending Section 1135 Waivers

States received many different flexibilities through section 1135 waivers, which expire at the end of the PHE. Each state will need to evaluate the 1135 waivers they received to determine the types of actions that will be necessary as they sunset. Appendix C lists each 1135 waiver type and the actions needed. Such actions may include:

- *Informing Beneficiaries and Providers:* States will need to inform affected providers and beneficiaries when certain section 1135 waivers end. For example, states that received a waiver of the HCBS settings rule will need to inform beneficiaries residing in these settings that, pursuant to HCBS final regulation (CMS 2249-F/2296-F), they will be moved to a location or setting that complies with the HCBS settings rule in order to continue receiving Medicaid funding. States should work with impacted providers and

[18] Many states extended level of care recertifications for 12 months beyond the due date of the recertification. In doing so, the current level of care determination is considered valid for that individual for the entirety of the additional 12 month period, and the recertification is not due until 12 months after the original due date, regardless of the end date of the Appendix K. Please note that states cannot request extensions beyond 12 months for any given waiver participant.

beneficiaries to ensure a smooth transition. Upon termination of the PHE, FFP for services rendered at these facilities will no longer be available.

A number of states received flexibility under section 1135 waivers that allowed the beneficiary's representative to also furnish services to the beneficiary. As these types of waivers sunset, states will need to inform beneficiary representatives that they may no longer serve in the capacity of both a qualified provider and a representative or legally responsible individual. In addition, states will need to inform beneficiaries of this change and allow for choice of a new provider. For those states that received conflict of interest waivers, they will need to work with providers that were temporarily authorized to provide both case management and to render direct care HCBS to transition to providing only one of these services. This waiver applies to 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.

- *Revising Timeframes to Request a Fair Hearing:* CMS granted states flexibility through the end of the PHE, using section 1135 waiver authority, to allow applicants or beneficiaries more than 90 days to request a fair hearing.[19] These extended time periods for individuals to request fair hearings varied by state. Because individuals must be able to rely upon the amount of time in the notice of adverse action they received, even after the PHE ends, states need to honor these timeframes. However, for any new adverse actions conducted after the PHE period ends, the state may either revert back to the state's fair hearing request timeframe prior to the section 1135 flexibility or may modify its policy to provide an individual a longer reasonable time period (no longer than 90 days) to request a fair hearing, in accordance with federal regulations. (42 C.F.R. §431.221(d)).

- *Finalizing Provider Enrollments:* Due to anticipation of workforce shortages, many states utilized section 1135 waiver authority to delay revalidation of providers; to provisionally, temporarily, enroll providers who are enrolled with another Medicaid agency or Medicare; and/or to relax certain provider screening requirements for providers not already enrolled with another Medicaid agency or Medicare, including, but not limited to, payment of an application fee (42 C.F.R. §455.460) and fingerprint-based criminal background checks (42 C.F.R. §455.434). These providers were required to meet a minimum set of requirements, as reflected in the waiver approval language. Per the waiver approval, for the temporarily provisionally enrolled providers, states have up to six months from the end of the PHE (including any extensions) to cease payment to providers not fully screened and enrolled. In addition, *CMS will request an assurance from states that they have taken the necessary steps to complete the screening of provisional enrollments*.

  For states that have temporarily paused revalidation work per their 1135 waiver approval, revalidation work is expected to resume with the lift of the PHE. For those revalidation due dates that occurred during the PHE, the state may delay the revalidation due date by the amount of time the PHE is in place with an additional six months lead time to allow for

[19] Section 42 C.F.R. §431.221(d) requires states to choose a reasonable timeframe for individuals to request a fair hearing, not to exceed 90 days from the date the notice is mailed for eligibility or fee-for-service appeals.

notification to the provider of the new revalidation due date. The following example will illustrate the timeline assuming the PHE, which began on March 1, 2020, was lifted on November 1, 2020 (PHE in place for eight months). The provider's revalidation due date was March 2, 2020. Therefore, the state will move the provider's revalidation due date to May 2, 2021. In this example, the state has 14 months following the lift of the PHE to notify and revalidate this provider. However, this amount of time will continue to increase as long as the PHE remains in place. Also, for revalidations that are due within six months after the expiration of the PHE, states will be granted an additional six months to complete those revalidations.

- *Completing Level of Care Assessments:* Many states used section 1135 authority to delay initial level of care (LOC) determinations for participants in 1915(c) waivers, 1915(k) state plan programs, or initial functional needs assessments in 1915(i) and 1915(k) state plan programs. However, CMS waiver approvals did not specify the time period for the delay. CMS encourages states to complete these initial determinations via telehealth as resources permit during the PHE. Upon the PHE conclusion, states should complete all initial determinations delayed by the 1135 waiver within 90 days of the end of the PHE. After the PHE has ended, states must adhere to the requirement that new participants have their initial determinations completed prior to provision of any service.

Ending COVID-19 PHE Section 1115 Demonstrations

COVID-19 PHE Section 1115 demonstrations end no later than 60 days after the conclusion of the PHE. States must submit a final report, consistent with the special terms and conditions of the demonstration, one year after the demonstration ends. This report will consolidate all required monitoring and evaluation deliverables for the demonstration. As the COVID-19 PHE demonstrations contain authorities similar to the Disaster Relief SPAs and Appendix K authorities, states should follow the guidance for restoring regular operations in the same manner as recommended for the Disaster SPA and Appendix K authorities described earlier in this letter.

Requesting Formal Approval of Emergency IT Funding Requests

States can request emergency IT funding under 45 C.F.R. §95.624 whenever they face an "emergency situation" as defined in regulations at 45 C.F.R. §95.605; this authority is not aligned with the COVID-19 PHE. FFP approved under this authority is available from the date the state acquires the IT equipment and services for which emergency funding was requested. States with an approved emergency funding request must submit a formal request for approval which includes the information specified in 45 C.F.R. §95.611 to CMS within 90 days of the date of their requests for emergency IT funding. Additional information regarding this emergency IT funding process can be found at 45 C.F.R. §95.624.

V. Operational and Managed Care Considerations

In addition to complying with relevant regulatory requirements when terminating temporary authorities or changes made to comply with FFCRA provisions, states will need to take into account other operational considerations when transitioning back to regular operations, some of which are outlined below. Appendix D lists each temporary flexibility (eligibility and

enrollment flexibilities, SPAs, and waivers) and notes the operational considerations relevant to each one.

Notifying Providers

Changes which were approved through a Disaster Relief SPA, such as temporarily lifting a benefits limitation, allowing for a new covered service, or increasing provider payments, do not have a specific provider notification requirement; however, states should rely upon their usual processes for communicating such changes to the provider community. For example, depending on how states posted the temporary rate increases during the PHE, states may need to use the same means to inform providers of the payment rates that will be in effect upon the expiration of the PHE.

Updating IT Systems and Internal Processes

As each of the flexibilities afforded to states during the PHE sunsets, these changes will need to be reflected in the state's internal IT systems and processes. States will need to communicate policy changes internally to staff through updated materials and staff trainings and may need to communicate new processes externally, such as through website changes. States will need to make changes to their eligibility and enrollment systems to resume processes for terminating coverage of ineligible individuals; changes to their mechanized claims processing and information retrieval systems to remove coverage and payment for temporary services, and to revert to payment rates prior to any temporary increases; and changes to their pharmacy system to reinstate prior authorization requirements.

With respect to the COVID-19 testing group, states will need to take action to 1) disable or remove the COVID-19 testing group from relevant systems – Eligibility and Enrollment (E&E), Medicaid Management Information System (MMIS), Hospital Presumptive Eligibility (HPE), family planning; 2) conclude 100% FFP for systems funding related to the COVID-19 testing group; 3) establish claims edits for the COVID-19 testing group to prevent payment for services that occur after the end of the PHE; and 4) remove access to the simplified application (if applicable).

Ensuring Accurate Financial Reporting

States should ensure accurate and timely CMS-64 reporting of expenditures incurred during the PHE period by following federal guidance, including FAQs on the claiming of FFCRA's increased FMAP and Medicaid Budget & Expenditure System (MBES) instructions on the new optional COVID-19 uninsured testing group. Finally, for a state that implemented a temporary interim payment methodology through the Disaster Relief SPA, the state must complete the steps required by the SPA to reconcile interim payments to claims payment amounts; report any reconciliations timely and accurately on the CMS-64; and, where applicable, return the federal share of any overpayment to CMS.

Considerations for Managed Care

As previously described in CMS guidance, if a benefit, or other identified flexibility, is covered under a state plan, Medicaid waiver (such as section 1915(b) or 1915(c)), or a state demonstration (such as section 1115), CMS has encouraged states to amend their managed care contracts (if not already included in the contract) to extend the same flexibilities authorized under their state plan, waiver, or demonstration to the same services when covered under the managed care contract. While some states have chosen to align flexibilities with the contract rating period (for example, telehealth options for services already covered under the managed care contract), other states have chosen to extend flexibilities only for the duration of the PHE, to align with their current Disaster Relief SPA or waiver approvals.

As states analyze which flexibilities to make permanent and which flexibilities to end with the PHE, states should assess their managed care contracts to ensure consistency with their state plan, Medicaid waiver, or demonstration. States must also notify their managed care plans as needed of any changes that the state is considering using their usual processes for communicating managed care plan changes. This will ensure that managed care plans have adequate time to notify their network providers of any changes that affect the provider community. We remind states that under 42 C.F.R. §§ 438.3(c)(1)(ii) and 438.4, final capitation rates must be actuarially sound[20] and based only upon services covered under the state plan or waiver authority, and must 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.

Finally, some states have also considered adding permanent language to their managed care contracts to describe non-payment flexibilities (such as modifying prior authorization timeframes) and the terms under which such provisions of the contract would be invoked (such as during a PHE). As long as a state has the appropriate Medicaid authority in place, and the requirements in 42 C.F.R. Part 438[21] and the terms of their state plan, Medicaid waiver, or demonstration are met, CMS encourages states to consider this approach as a possible strategy to help mitigate administrative burden in future PHEs. We note that in some instances, this strategy may require states to condition such contract terms on a future federal approval of a Medicaid authority.

VI. Resuming Normal Eligibility and Enrollment Operations: Addressing Pending Eligibility and Enrollment Actions

States are facing a number of challenges due to the ongoing PHE that will leave many states and territories with large volumes of outstanding eligibility and enrollment actions when the PHE ends. States have faced stay-at-home orders, social-distancing recommendations, and transitions to telework, which impacted routine state operations. To accommodate workforce challenges and an influx of applications, states were excused from complying with the usual timeliness requirements for processing applications, changes in circumstances, and renewals, as permitted

[20] For CHIP, under 42 C.F.R. § 457.1203 rates must be developed using actuarially sound principals.
[21] For CHIP, under 42 C.F.R. Part 457 Subpart L.

under 42 C.F.R. §435.912(e)(2), §457.340(d), and §600.320(b). In addition, states receiving the temporary FMAP percentage increase may not terminate Medicaid coverage for most individuals found to no longer meet eligibility requirements until the end of the month in which the PHE ends. This will result in a backlog of cases, which may require a new redetermination and/or advance notice and termination of coverage, as appropriate, at the end of the PHE.

CMS expects states to take steps during the PHE to prioritize actions that ensure eligible individuals, particularly those with ongoing health care needs, are able to enroll and remain enrolled in coverage. CMS also expects states to initiate verifications of all eligibility criteria for individuals enrolled based on self-attested information, where additional verification is required under regulations and the state's verification plan (referred to as post-enrollment verifications in this letter), renewals, and redeterminations based on changes in circumstances during the PHE.

States will need to address pending eligibility and enrollment actions after the month in which the PHE ends in four key areas: processing applications received during the PHE, completing verifications for individuals enrolled based on self-attested information during the PHE, as applicable, acting on changes in circumstances experienced after a beneficiary's last determination, and completing renewals for beneficiaries whose eligibility period ended during the PHE. We refer in this letter to application, verification, redetermination, and renewal actions which are delayed due to the PHE together as COVID-related pending eligibility and enrollment actions. States are expected to use a risk-based approach outlined in this letter to expeditiously resume timely completion of all eligibility and enrollment actions.

CMS understands that states will not be able to immediately address the large number of pending COVID-related eligibility actions that continue to accumulate during the PHE. Accordingly, states may rely on the timeliness exception codified at 42 C.F.R. §435.912(e)(2), §457.340(d), and §600.320(b), to excuse continued delay in resolving pending applications for up to four months, and all other pending COVID-related eligibility and enrollment actions for up to six months, following the end of the month in which the PHE ends. CMS will not request that states document the use of the exception to meet these timelines in each case record as usually required under 42 C.F.R. §435.912(f), §457.340(d), and §600.320(b), since states will need to develop and document a plan to restore eligibility and enrollment operations. States do not need to request concurrence or authority from CMS to use the timeliness exception and avoid documenting the reason for delay in each beneficiary case record for purposes of complying with the timelines outlined in this letter.

The timelines for states to complete COVID-related pending eligibility and enrollment actions are described in more detail later in this section of this letter. The timelines provided, coupled with the other flexibilities and strategies available to states to address pending actions, will provide states a reasonable period to address the outstanding actions and resume timely compliance with federal requirements. States that do not meet the timelines outlined in this letter will be at increased audit risk and corrective action may be necessary.

Planning for Post-COVID Eligibility and Enrollment Operations

Develop a Post-COVID Eligibility and Enrollment Operational Plan. In order for states to achieve compliance within the timelines specified below after the end of the PHE, states will need to develop and document a comprehensive plan, which we refer to in this letter as a "post-COVID eligibility and enrollment operational plan." To the extent a state has pending CHIP and BHP cases when the PHE ends, states will need a post-COVID eligibility and enrollment operational plan for CHIP and BHP or incorporate CHIP and BHP in their Medicaid planning document. The post-COVID eligibility and enrollment operational plan is intended to help states think through how they will achieve compliance and the steps necessary to operationalize the plan.

States are expected to address in their plans how they will complete pending work delayed during the PHE and simultaneously process current cases that require action within the timelines specified in this letter. States will need to decide which flexibilities to retain (if permitted) and/or whether to adopt new flexibilities to streamline eligibility and enrollment processes in order to complete all pending COVID-related eligibility and enrollment actions within the timelines specified below. States will also need to plan for necessary system changes to reverse COVID-related flexibilities that expire at the end of the PHE.

CMS will release a Medicaid and Children's Health Insurance Program COVID-related Pending Eligibility and Enrollment Actions Resolution Planning Tool to assist states in their planning efforts. The tool serves as an example of the types of issues states may need to address in their planning efforts and also offers states the opportunity to address additional planning for other areas where states may expect an influx of work after the PHE ends, such as preparing for an increased workload of fair hearings. While CMS expects states to develop and document their operational plan to address applications, verifications, changes in circumstances, and renewals, states are not required to use the tool developed by CMS to document their plans and do not need to submit their post-COVID eligibility and enrollment operational plans or the planning tool, if used, to CMS for approval. States must make their plan available to CMS upon request or, as needed, for audit purposes. States that are not on track to achieve compliance within the timelines outlined in this letter should expect that CMS will request their post-COVID eligibility and enrollment operational plan. CMS is available to provide technical assistance to states and territories as they develop their plans.

Select a Risk-Based Approach to Address Pending Eligibility and Enrollment Actions. CMS expects states to adopt a risk-based approach that prioritizes pending eligibility and enrollment actions related to post-enrollment verifications, changes in circumstances, and renewals. A risk-based approach prioritizes actions for individuals who are most likely to be no longer eligible for coverage and minimizes the extent to which coverage is provided to individuals who no longer meet eligibility criteria. Even if a case is prioritized in a risk-based plan, states must still process all cases in accordance with 42 C.F.R. §435.916 and §435.940 through §435.960, including ensuring that eligibility is determined on all bases prior to making a determination of ineligibility. States and territories may select among four risk-based approaches to address the backlog of pending cases and must clearly describe and document the risk-based approach in the state's post-COVID eligibility and enrollment operational plan.

- *Population-based approach***:** States and territories may adopt a population-based approach that prioritizes completing outstanding eligibility and enrollment actions for individuals in groups who are most likely to be no longer eligible.

  Examples of populations CMS considers more likely to be no longer eligible when the PHE ends, and which states and territories may wish to prioritize include:

  - Individuals who became categorically ineligible for the group in which they are enrolled during the PHE (e.g., individuals who, during the PHE, exceeded the maximum age permitted for their eligibility group or individuals enrolled in the adult group who became eligible for Medicare.);
  - Individuals determined ineligible for Medicaid during the PHE, but not terminated in order to comply with the continuous enrollment requirement under the FFCRA in order to claim the temporary FMAP increase;
  - Individuals who gained eligibility due to states' use of a temporary eligibility flexibility;

  Populations whose eligibility tends to be stable, such as children, former foster youth, or individuals dually eligible for Medicaid and Medicare, are not among the types of populations CMS would expect states' to prioritize in a population-based approach.

- *Time-based approach:* States may adopt a time-based approach that prioritizes cases based on the length of time the action has been pending (age of action or aging reports), such that the state completes oldest pending actions first.

- *Hybrid approach:* States may adopt an approach that combines the population and time-based approaches. For example, a state may adopt a time-based approach prioritizing outstanding post-enrollment verifications and changes in circumstances and a population-based approach to prioritizing pending renewals. Alternatively, a state may adopt a population-based approach for the first wave of pending actions processed following the PHE and then switch to a time-based approach.

- *State-developed approach:* States may develop their own risk-based approach, which prioritizes actions for individuals who are most likely to be no longer eligible or for which there is a greater risk that ineligible individuals may remain enrolled longer. States will need to clearly define a state-developed approach in the state's post-COVID eligibility and enrollment operational plan.

Consider additional flexibilities. CMS recognizes states with large volumes of pending COVID-related eligibility and enrollment actions may want to consider in their planning efforts whether to continue flexibilities adopted during the PHE, or adopt other eligibility and enrollment strategies and flexibilities in order to meet the specified timelines. This may include strategies discussed in sections II and VII of this letter to minimize state workloads or streamline eligibility and enrollment processes for populations that tend to maintain eligibility for longer periods, such as adopting Express Lane Eligibility or Continuous Eligibility for children, or utilizing renewal processes required for MAGI beneficiaries for dually eligible beneficiaries. States also may need to submit SPAs or revisions to their verification plan in order to continue flexibilities adopted

during the PHE or to adopt such new strategies and flexibilities, which also should be documented in the state's post-COVID planning document.

Create efficiencies by combining actions. States can create efficiencies by aligning work on pending actions with an upcoming renewal and/or with a renewal or recertification conducted by another benefit program, such as Supplemental Nutrition Assistance Program (SNAP), if such renewal or recertification is due for completion in the 6-month timeframe. The following describe potential efficiencies identified by CMS. States should indicate if they are using any of these strategies in their post-COVID eligibility and enrollment operational plan.

- *Aligning pending verification and change in circumstances with renewals*: States may wait to conduct pending post-enrollment verification and act on changes in circumstances for beneficiaries whose renewal is due within 6 months after the month in which the PHE ends.

  This strategy cannot be used for beneficiaries whose next scheduled renewal is after this 6-month period, since that would result in unresolved pending COVID-related actions beyond the maximum time provided. This strategy may not be applied to outstanding verifications of citizenship or immigration status due to the statutory limit (90 days) on the reasonable opportunity period provided to verify citizenship and immigration status.

- *Aligning pending work with SNAP recertifications:* For beneficiaries also enrolled in SNAP, states with integrated eligibility systems may wait to act on a pending verification, change in circumstances, or renewal until the individual's SNAP recertification is processed as long as the SNAP recertification is scheduled for completion in time for the state to meet the maximum 6-month period to resolve all pending COVID-related eligibility and enrollment actions. This strategy may not only achieve greater efficiencies for stretched state resources, but can help states to align renewal dates for Medicaid and SNAP.

  This strategy cannot be used for beneficiaries whose next scheduled SNAP recertification is after the 6-month period provided to resolve all pending COVID-related eligibility and enrollment actions, nor may it be applied to outstanding verifications of citizenship or immigration status.

Processing Pending Eligibility and Enrollment Actions During the PHE

States are expected to make every effort to make timely determinations of eligibility for new applicants and to process changes in circumstances that may expand a beneficiary's coverage during the PHE. In order to meet the 6-month timeframe set forth in this letter for resolving all other pending COVID-related eligibility and enrollment actions, it also will be critical for states to begin processing pending post-enrollment verifications, changes in circumstances and overdue renewals to the extent possible now, before the PHE ends. The following sets forth CMS's expectations for states in addressing pending eligibility and enrollment actions during the PHE.

- *Applications*: States are expected to process applications as expeditiously as possible during the PHE, including disability-related applications or applications for other

vulnerable populations. This is critical to ensure that coverage is available to eligible individuals, particularly individuals with health conditions for whom delays in accessing coverage could have long-term consequences. For more information on making timely and accurate determinations of eligibility, states and territories may refer to the Medicaid and CHIP MAGI Application Processing: Ensuring Timely and Accurate Determinations of Eligibility resource.[22]

- *Verification of citizenship and immigration status:* States must send appropriate notice during the PHE to initiate a reasonable opportunity period for beneficiaries if the state was unable promptly to verify attested citizenship or satisfactory immigration status with the Social Security Agency or through the Systematic Alien Verification for Entitlements (SAVE) Program operated by the U.S. Department of Homeland Security. The reasonable opportunity period described at 42 C.F.R. §435.956(b), which must be provided to applicants attesting to U.S. citizenship or satisfactory immigration status to provide documentation of their status if electronic verification is not successful, does not begin until such notice is received.

- *Verifications based on available information*: States are expected to resume checking data sources to verify eligibility criteria for individuals enrolled based on self-attested information during the PHE. This will enable states to complete post-enrollment verification during the PHE for individuals whose attested information can be verified with reliable data sources, thereby minimizing the state's verification workload post-PHE.

- *Renewals based on available information*: States also are expected to initiate Medicaid, CHIP, and BHP renewals during the PHE based on electronic data and other information available to the state. This will enable states to complete some renewals for eligible individuals during the PHE and minimize renewal workload post-PHE.

CMS recognizes that it may not be feasible, due to the impact of the PHE on state operations, for some states to request additional information from individuals whose attested information is not verified by other data sources. CMS also recognizes that it may not always be efficient for states to request additional information from Medicaid beneficiaries to determine continued eligibility since states claiming the temporary FMAP increase may not terminate coverage for most Medicaid beneficiaries through the end of the month when the PHE ends. However, CMS encourages states to complete as many pending verifications, renewals, and redeterminations based on changes in circumstances as possible during the PHE even if adverse action may not be taken due to the protections afforded Medicaid beneficiaries under section 6008(b)(3) of the FFCRA if the state is claiming the temporary FMAP increase. As discussed in section IV of this letter, post-enrollment verifications, redeterminations following a change in circumstances, and renewals that, but for the requirement to maintain enrollment per section 6008(b)(3) of the FFCRA, would have resulted in termination (or other adverse action) and that are completed within 6 months of a beneficiary's actual termination date (or other adverse action) need not be

[22] CMS, Medicaid and CHIP MAGI Application Processing: Ensuring Timely and Accurate Determinations of Eligibility, available at https://www.medicaid.gov/state-resource-center/downloads/mac-learning-collaboratives/timely-accurate-eligibility.pdf

repeated, provided that advance notice of termination and fair hearing rights are provided in accordance with 42 C.F.R. part 431 subpart E.

We also note that states are not required to continue coverage during the PHE for enrollees in separate CHIPs and BHP in order to claim the temporary FMAP increase, and therefore states should complete pending verifications, redeterminations and renewals for enrollees in these programs during the PHE to the extent possible. This includes accessing available information, as well as sending pre-populated renewal forms to, or requesting other information from, CHIP and BHP enrollees. Completing pending actions in these programs during the PHE will free up resources for states to focus on pending Medicaid actions after the PHE ends.

Determining Eligibility Periods for Delayed Renewals

While states are expected to initiate and complete renewals based on available information during the PHE, CMS understands that some states temporarily delayed all renewals or are not able to complete renewals timely due to the impact of the PHE on state operations. In some cases, states delayed certain renewals to prevent inappropriate terminations of coverage that would have made the state ineligible to receive the temporary FMAP percentage increase. States that resume the renewal process after an extended delay may be determining eligibility for a large cohort of beneficiaries many months after the individual beneficiary's originally-scheduled renewal date. This has the potential to result in a large share of the state's beneficiaries scheduled for renewal in the same month in future years.

For beneficiaries scheduled for renewal during the PHE and whose eligibility is renewed without requiring additional information from the individual consistent with 42 C.F.R §435.916(a) (i.e. on an *ex parte* basis), states have the option to retain the beneficiary's initial eligibility period schedule, starting the day after the individual's originally-scheduled renewal date rather than based on the date that the state completes the redetermination and determines the individual to be eligible. This option may assist states maintain a manageable renewal schedule in future years. States should indicate in their post-COVID eligibility and enrollment operational plan how they are establishing new eligibility periods for renewals due during the PHE that are delayed and later resumed.

For example, a state that has delayed all renewals decides to resume the renewal process and base new eligibility periods on the date of the originally-scheduled renewal. The state initiates the renewal process on December 1, 2020, for a cohort of beneficiaries whose renewal was originally due by April 30, 2020. For beneficiaries in this cohort who the state is able to renew on an *ex parte* basis in December and are enrolled in a group whose eligibility is renewed once every 12 months, the new eligibility period begins May 1, 2020, and extends through April 30, 2021. If the state in this example provides whole month coverage and had instead based new eligibility periods on the date the renewal was completed, the new eligibility period would instead begin on January 1, 2021.

This option only applies to beneficiaries for whom the state is able to renew eligibility without requiring information from the individual. States do not have the option to determine when the eligibility period may begin for beneficiaries for whom the state must request additional information in order to complete the renewal. For renewals that require information from the

individual, states must establish the new eligibility following the date of renewal to ensure the renewal is based on reliable information and that requirements for the frequency of renewals are met, consistent with §435.916.

For example, consider the process for resuming renewals for a state that suspended regular processing of all renewals at the beginning of the PHE when that state ordinarily only terminates coverage for beneficiaries at the end of a month. The state decides to resume processing of all renewals during the PHE and initiates the renewal process on December 1, 2020, for a MAGI beneficiary whose renewal was originally due by April 30, 2020. The state is unable to determine continued eligibility based on the available information and sends the beneficiary a pre-populated renewal form. The beneficiary returns the form on January 15, 2021, and the state determines that the beneficiary remains eligible on January 29, 2021. The beneficiary's new eligibility period begins on February 1, 2021 and extends through January 31, 2022.

Timelines to Address Pending Eligibility and Enrollment Actions after the end of the PHE

The timelines set forth below reflect the amount of time that CMS has determined is reasonable for states to resolve pending COVID-related eligibility and enrollment actions related to applications, post-enrollment verifications, changes in circumstances, and renewals. To meet these timelines, it will be critical for states to process pending eligibility and enrollment actions in each of the focus areas described above to the extent possible during the PHE, and to have a plan to expeditiously complete the pending actions that remain immediately after the month in which the PHE ends and within the timeframes specified below.

- *Applications – 2, 3, and 4 month milestones:* Given that applications are received on a rolling basis, CMS anticipates most states will have some pending applications at the end of the PHE that were received during the PHE. While states should work as expeditiously as possible to process applications during the PHE, agencies may use a phased approach to complete eligibility determinations for pending applications received during the PHE. CMS expects states to have caught up on any applications pending at the end of the PHE and to have resumed making timely and accurate determinations of eligibility on new applications no later than four months after the month in which the PHE ends. CMS has established the following milestones to assist states in meeting this timeline:

    - **2 months:** Complete eligibility determinations for all pending MAGI and other non-disability related applications (e.g., individuals determined on the basis of being aged) received during the PHE.
    - **3 months:** Complete eligibility determinations for all pending disability-related applications received during the PHE.[23]
    - **4 months:** Resume timely processing of all applications.

[23] The Medicaid application processing time requirements at 42 C.F.R. §435.912(c) provide states and territories up to 90 days to make determinations of eligibility for applicants who apply for Medicaid on the basis of disability and 45 days to make determinations of eligibility for all other applicants. The milestones in this SHO letter are not intended to provide states and territories with less time to make determinations of eligibility than what is allowed under federal regulation.

CMS reminds states that an application is considered to be processed timely when the agency enrolls an eligible applicant or denies coverage for an individual the agency could not determine as eligible within the application time standards described at 42 C.F.R. §435.912(c) and §457.340(d).

CMS also reminds states of the requirement at 42 C.F.R. §435.912(g) and §457.340(d) that agencies may not use the application timeliness standards – or the timelines described in this letter – as a waiting period to delay determining eligibility or as a reason for denying eligibility because the state has not determined eligibility within the timeliness standards.

States are required to report performance indicator data, including application processing times, which CMS has begun publicly releasing as part of Medicaid and CHIP Scorecard 2.0.[24] CMS will use state application processing performance indicator data submitted prior to the PHE as the baseline against which to measure states' post-PHE performance in order to determine when corrective action may be necessary for states after the four month milestone is reached.

- *Verifications, Changes in Circumstances, and Renewals – 6 months*: As discussed, CMS expects states to use a risk-based approach to prioritize pending eligibility actions related to post-enrollment verification, changes in circumstances, and renewals. States are expected to complete the COVID-related actions pending in these areas, including termination of ineligible beneficiaries and those who do not provide requested information needed to determine eligibility, as appropriate, no later than 6-months after the month in which the PHE ends. In planning to meet this timeline, a few reminders are important to note:

    - **Changes in Circumstances:** Changes in circumstances experienced during the PHE include any changes that may impact eligibility, including changes that were anticipated or identified by the state, or reported to it. It also includes situations in which a redetermination is needed due the expiration of temporary eligibility flexibilities adopted by the state during the PHE (e.g., the expiration of an income or resource disregard applied during the PHE).

    - **Renewals:** CMS acknowledges that the need to process all renewals pending at the end of the PHE within 6 months may lead to an uneven distribution of renewals, concentrated in the months following the month in which the PHE ends, which could impact timely processing of renewals in future years. CMS is available to provide technical assistance to states and territories seeking to ensure renewals are distributed evenly over the course of a year to ensure a manageable and sustainable renewal workload in future years.

[24] Medicaid and CHIP Scorecard 2.0, State Administrative Accountability, Medicaid and CHIP Application Processing Times, available at https://www.medicaid.gov/state-overviews/scorecard/medicaid-magi-and-chip-application-processing-times/index.html

Monitoring State Progress and Corrective Action

CMS will monitor states' progress in achieving the timelines described in this letter. Under the authority in sections 1902(a)(6) and 1902(a)(75) of the Act and 42 C.F.R. §431.16, CMS will require states to submit data demonstrating state progress in completing outstanding eligibility and enrollment actions related to applications, verifications, changes in circumstances, and renewals post-PHE. States and territories will be required to submit baseline data to CMS when the PHE ends and to report data on a quarterly basis thereafter demonstrating state progress. States that do not meet the timelines specified in this letter may be required to report data more frequently. CMS will identify the data elements to be reported and provide a reporting template for states to use.

States will continue to be required to report performance indicator data, including application processing times, which CMS has begun publicly releasing as part of Medicaid and CHIP Scorecard 2.0.[25] CMS will use state application processing performance indicator data submitted prior to the PHE as the baseline against which to measure states' post-PHE performance in order to determine when corrective action may be necessary for states after four month milestone is reached.

Audits, Eligibility Errors and Corrective Action Plans

CMS will not consider eligibility and enrollment actions delayed due to the PHE as untimely for purposes of the Payment Error Rate Measurement (PERM) or Medicaid Eligibility Quality Control (MEQC) programs if such actions are completed within the timelines detailed in this letter. PERM and MEQC reviews will treat pending eligibility and enrollment actions that are not completed timely as detailed in this letter as an eligibility error or technical deficiency. Guidance on broader PERM and MEQC expectations will be provided separately to states. In addition, states and territories that do not resolve their pending COVID-related eligibility and enrollment actions within the timelines specified may be required to separately submit a corrective action plan to CMCS outlining strategies and a timeline to come into compliance with federal requirements.

VII. Strategies to Support Returning to Routine Operations

States may consider adopting a number of best practices and enrollment strategies to meet the requirements outlined in this letter and restore regular operations efficiently.

Best Practices for Restoring Operations Upon Conclusion of the PHE

- *Streamlining Notices - Combined Advance Notice of All Changes:* Prior to terminating many of the temporary changes enacted in response to the PHE, states must provide Medicaid beneficiaries with at least 10 days advance notice, in accordance with 42 C.F.R. §§431.206-214 and 435.917. States must provide CHIP enrollees with timely and

[25] Medicaid and CHIP Scorecard 2.0, State Administrative Accountability, Medicaid and CHIP Application Processing Times, available at https://www.medicaid.gov/state-overviews/scorecard/medicaid-magi-and-chip-application-processing-times/index.html

adequate written notice of any decision affecting eligibility in accordance with 42 C.F.R. §457.340(e). BHP enrollees must be provided written notice of an eligibility determination in accordance with 42 C.F.R. §600.330(e). These include any changes that may result in ineligibility, along with the termination or reduction of services that were temporarily added or increased during the public health emergency. States may issue a combined notice describing all changes occurring at the close of the PHE, including changes to eligibility, benefits, premiums and cost sharing. Such notice would also provide information about the circumstances in which the individual may have a right to a Medicaid fair hearing (42 C.F.R. §431.210(d)(2)), a CHIP review (42 C.F.R. §457.1180), or a BHP appeal (42 C.F.R. §600.335).

- *Ongoing Stakeholder Engagement:* Although formal public notice is not required to end the temporary changes elected in response to the PHE, states are strongly advised to engage with providers, beneficiaries and their families, tribes and tribal organizations, and other key stakeholders on an ongoing basis, to ensure they are well-informed of the specific changes that will be ending and the date they will end. This is especially critical for temporary services and service limit increases, provider qualifications, temporary rate increases, and retainer payments that the state made available only for the duration of the PHE. Methods states can use to keep their stakeholders informed of upcoming changes include communications from case managers, mailings of hardcopy materials, email blasts, and routine updates to Medicaid/CHIP Agency websites.

- *Incorporation of COVID-Derived Program Modifications*: States may wish to consider evaluating the effect of any temporary changes made to the Medicaid program during the PHE for promising practices that have fortified the state's ability to provide services in home and community-based settings. States are encouraged to submit 1915(c) waiver amendments or SPAs to facilitate this. (*See Section II for examples of modifications that may be continued.*)

Eligibility and Enrollment Strategies

States may wish to consider the adoption of one or more eligibility and enrollment strategies to facilitate efficient restoration of Medicaid and CHIP operations upon conclusion of the PHE, facilitate timely application and renewal processing, and assist states with staggering renewals to ensure future caseloads are manageable. Some strategies states may consider include:

- *Renewing Coverage When Processing Changes in Circumstances:* For certain individuals whom the agency determines continue to be eligible following a change in circumstances, states may begin a new 12-month renewal period if the agency has information available to it to verify eligibility with respect to all eligibility criteria without requiring any additional information from the beneficiary in accordance with 42 C.F.R. §§435.916(d)(1(ii) and 457.343. States may request, but not require, additional information from the beneficiary about other factors needed to start a new renewal period when the state is unable to verify all eligibility criteria based on information available to the agency. States may refer to the Renewal CIB, for more information on renewing

eligibility and processing changes in circumstances.[26] States do not need to submit a SPA for CMS approval to implement this option.

- *Facilitated Enrollment State Plan Option (with SNAP, Temporary Assistance for Needy Families (TANF), or other programs):* For some individuals receiving SNAP or other means-tested benefits, such as TANF, states may use a targeted enrollment strategy to rely on income determinations made by another program if the state is certain the individual would be income-eligible using MAGI-based methods. This option can be used at application, renewal, or both. States interested in this option may refer to the Policy Options for Using SNAP to Determine Medicaid Eligibility State Health Official letter for additional guidance. [27] To elect this option, states must submit a SPA.

- *12 Month Non-MAGI Renewals:* States that renew eligibility more frequently than once every 12 months for some or all of their non-MAGI beneficiaries may elect to renew eligibility only once every 12-months (or another specified timeframe). Extending the renewal timeframe may also simultaneously assist states address other state level priorities such as increasing access to home and community based services by reducing the frequency in which beneficiaries must respond to state requests. To elect this option, states must submit a SPA.

- *Adoption of MAGI Renewal Requirements for Non-MAGI Populations:* Under 42 C.F.R. §435.916(b) states may adopt renewal procedures required for MAGI beneficiaries under 42 C.F.R. §435.916(a)(3) for beneficiaries excepted from MAGI-based financial methodologies. This includes using a pre-populated renewal form for beneficiaries whose renewal cannot be completed using only information available to the state (sometimes referred to as an *ex parte* or administrative renewal) and providing a minimum of 30 days to respond. In addition, states may provide a reconsideration period for beneficiaries whose eligibility was terminated at renewal for failure to return their renewal form or other required information and who subsequently return their renewal form during the reconsideration period without requiring the submission of a new full application. States do not need to submit a SPA for CMS approval to implement these options.

- *Reconsideration Period for Changes in Circumstances:* States may offer a minimum 90-day reconsideration period consistent with the reconsideration period provided for MAGI beneficiaries at renewal under 42 C.F.R. §435.916(a)(3)(iii) and §457.343 for beneficiaries whose eligibility has been terminated for failure to respond to a request for information for a redetermination based on a change in circumstances, if the individual subsequently returns the information. Offering a reconsideration period allows states to determine an individual's eligibility without requiring the individual to fill out a new application to be determined eligible for benefits. The required information returned

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[26] CMCS Informational Bulletin, Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements, available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf.

[27] State Health Official Letter, Policy Options for Using SNAP to determine Medicaid Eligibility and an Update on Targeted Enrollment Strategies, available at https://www.medicaid.gov/federal-policy-guidance/downloads/SHO-15-001.pdf and CMCS Informational Bulletin, Extended Use of the Targeted Enrollment "SNAP Strategy" under Section 1902(e)(14)(A) of the Social Security Act, available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib071917.pdf.

within the reconsideration period serves as an application. This means that a determination or denial of eligibility must be made consistent with timeliness standards in 42 C.F.R. §435.912 and §457.340(d), as applicable. States would also need to ensure they collect any additional information from the individual that is not available to the state but required at application, such as a signature. States may refer to the Renewal CIB for more information on how to establish a new effective date of coverage and the provision of retroactive eligibility for individuals who return information during a reconsideration period and are determined eligible.[28] States do not need to submit a SPA for CMS approval to implement this option.

States may also wish to consider the adoption of one or more eligibility and enrollment strategies to streamline the enrollment and renewal process for populations that typically do not pose the greatest risk to program integrity and are populations that states are likely to not prioritize in their risk-based approach to restore eligibility and enrollment operations. Some population specific strategies states may consider include:

- *Streamlining Enrollment and Redeterminations for Children:* There are approximately 35.9 million children enrolled in Medicaid and CHIP. States have additional options to streamline the enrollment and redetermination process for children to promote continuity of coverage for children and ease administrative burden on states.

    - *Express Lane Eligibility:* Sections 1902(e)(13) and 2107(e)(1) of the Act permit states to rely on findings from an entity designated by the state to determine whether a child satisfies one or more factors of eligibility for Medicaid or CHIP. States may use this authority at application, renewal, or both. States interested in this option may refer to the CMS Express Lane Eligibility Option State Health Official letter for additional guidance.[29] To elect this option, states must submit a SPA.
    - *Continuous Eligibility for Children:* Under 42 C.F.R. §435.926 and §457.342, a state may provide up to 12-months of continuous eligibility in Medicaid and CHIP for children who are under age 19 or under a younger age specified by the agency. This option provides the state with the authority to not act on changes in circumstances for children (except turning 19, changes in state residency, death, or voluntary termination, and for children enrolled in CHIP, becoming eligible for Medicaid) during the continuous eligibility period. States implementing continuous eligibility in Medicaid must apply the policy to all individuals in mandatory and optional categorically needy groups under Section 1902(a)(10)(A) of the Act. To elect this option, states must submit a SPA.

- *Streamlining Application Processing and Renewals for Dually Eligible Beneficiaries:* There are approximately 12.2 million individuals enrolled in both Medicare and Medicaid, and these individuals are less likely to experience significant fluctuations in income that might lead to ineligibility at renewal. For this reason, states are encouraged to consider implementing a number of approaches that could streamline the redetermination process

[28] CMCS Informational Bulletin, Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements.
[29] State Health Official Letter, Express Lane Eligibility Option, available at https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/SHO10003.PDF

for dually eligible beneficiaries and help states manage eligibility workload.

- *Adoption of 12 Month Renewals:* States that renew the eligibility of dually eligible beneficiaries more frequently than once every 12-months may submit a SPA to adopt a 12-month renewal cycle.
- *Provision of Pre-Populated Renewal Forms and Reconsideration Period:* States can adopt certain streamlined renewal processes, which are required for MAGI-based beneficiaries, for dually eligible beneficiaries without the need to submit a SPA or seek approval from CMS. This includes use of a pre-populated renewal form for beneficiaries whose renewal cannot be completed on an *ex parte* basis and the provision of a 90 day reconsideration period for dually eligible beneficiaries terminated for failure to return their renewal form or other required information without the need for the individual to submit a new full application.
- *Maximize Use of Ex Parte Renewal Process:* States must attempt to conduct an *ex parte* renewal for all beneficiaries as required at 42 C.F.R. §435.916(a)(2) and (b). States can maximize use of the *ex parte* renewal processes by accepting information in the case record which the state determines is highly unlikely to change for dually eligible beneficiaries (such as income) as reliable information even if the state requires documentation of income not verified electronically from other beneficiaries. States do not need to submit a SPA or seek approval from CMS.
- *Modify Verification Policies:* States can accept self-attested information provided on the renewal form for which documentation is not expressly required, consistent with 42 C.F.R. §435.945, even if the state determines that documentation is needed from other beneficiaries. States only need to update their internal non-MAGI verification policy documents.
- *Align MSP and LIS eligibility criteria:* Low-income Medicare beneficiaries who meet certain income and asset limits qualify for the Part D Low-Income Subsidy (LIS), which provides assistance with Medicare Part D premiums and cost-sharing. Many of these beneficiaries also qualify for Medicaid coverage of their Medicare Parts A and B premiums and cost-sharing through the Medicare Savings Programs (MSPs). The Social Security Administration (SSA) assesses LIS eligibility for many applicants, and section 1144(c)(3) of the Act requires that SSA send LIS application information to states for the purposes of initiating an MSP application. Aligning MSP and LIS eligibility can help achieve substantial efficiencies in the enrollment process, both for applicants and Medicaid agencies. If a state uses the authority under section 1902(r)(2)(A) of the Act to align its MSP income and/or asset eligibility criteria and definitions with those of the LIS program, the state will have the option to consider LIS enrollees as meeting the eligibility criteria for MSP. States that align the eligibility criteria can use LIS "leads data" provided by the SSA to automate eligibility determinations without requiring a separate MSP application. This strategy reduces burden on both the applicant and the state by creating a streamlined process using the LIS "leads data" to enroll MSP eligible individuals.
- *Apply less restrictive income and/or resource criteria:* States can effectively raise the income and resources standards under the authority of section 1902(r)(2) of the Act, which generally permits state Medicaid agencies to disregard income and/or resources that are counted under non-MAGI financial eligibility methodologies.

States may use the authority of section 1902(r)(2) of the Act to eliminate any income or resource criteria for the MSP groups, thereby helping to streamline the verification process. If a state agency chooses to adopt new less restrictive income and resource methodologies, it must submit a SPA specifying the less restrictive methodologies that will be used.

VIII. Program Integrity Considerations

Program integrity is one area for states to consider when developing plans to return to regular operations when the PHE concludes. CMS will release guidance specific to COVID-19 program integrity issues, including beneficiary eligibility, to assist states as they analyze which flexibilities to seek to make permanent and which flexibilities to limit to cease after the duration of the COVID-19 PHE ends. This program integrity guidance will outline expectations for states to establish regular Medicaid program integrity operations post-PHE, taking into account new changes to state programs as a result of implementing COVID-19 flexibilities, as described above. Medicaid is a federal-state partnership, and collaboration is paramount to protecting the integrity of state Medicaid programs. CMS is committed to working with states to ensure adequate program integrity measures are in place post-PHE.

Closing

CMS remains committed to providing our state partners with the ongoing resources and technical assistance necessary to respond effectively to the COVID-19 outbreak and restore state operations upon the eventual conclusion of the current PHE. Please submit requests for technical assistance to your CMS State Lead.

Sincerely,

Anne Marie Costello
Acting Deputy Administrator and Director

Cc:

National Association of Medicaid Directors
National Academy for State Health Policy
National Governors Association
American Public Human Services Association
Association of State and Territorial Health Officials
Council of State Governments
National Conference of State Legislatures
Academy Health
National Association of State Alcohol and Drug Abuse Directors

APPENDIX A –Temporary Authorities Approved During the COVID-19 PHE

During a PHE or disaster, CMS can use various legal authorities to grant states' emergency flexibilities critical to ensuring a state's ability to respond to the crisis expeditiously. Many of the options and authorities available to states are described below.

Section 1135 Waivers

When the President declares a major disaster or an emergency under the Stafford Act or the National Emergencies Act, and the HHS Secretary declares a PHE, the Secretary is authorized by section 1135 of the Act to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act, to the extent the Secretary determines necessary to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs; and ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the emergency, may be reimbursed and exempted from sanctions for noncompliance. To respond to the COVID-19 outbreak, CMS has approved section 1135 waivers for all states and three territories with respect to various Medicaid and CHIP-specific requirements,[30] in addition to the Medicare-granted blanket 1135 waivers available to states and territories.[31] Examples of flexibilities available include the ability to temporarily suspend prior authorization requirements, provision of additional time for request for fair hearings and appeals, and relaxation of rules to enable faster enrollment of providers.

Section 1915(c) Appendix K Template

Appendix K is a stand-alone appendix of the 1915(c) HCBS Waiver Instructions and Technical Guidance that states may complete in emergency situations to accelerate amendment requests for approved 1915(c) HCBS waivers. It specifies actions that states can take under the existing section 1915(c) HCBS waiver authority in order to respond to an emergency.[32] Changes made through Appendix K are time-limited, tied specifically to individuals affected by the emergency, and may be applied retroactively by the state. Public notice requirements normally applicable under section 1915(c) waivers do not apply to amendments made through Appendix K because the changes are temporary and will not affect the Appendix K's underlying 1915(c) waiver when they end. Flexibilities available include addition of an electronic method of service delivery for certain services, allowing for service continuity without face-to-face interaction, addition of services to address additional needs of waiver recipients during the emergency, permitting retainer payments if the disaster necessitates the absence of an individual from a regularly scheduled program or service, allowing family members to serve as service providers,

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[30] During the COVID-19 outbreak, CMS pre-packaged relevant and commonly requested 1135 waivers into a checklist template to expedite states' ability to apply for and receive approval of the waivers. The checklist is available at https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/cms-1135-waivers/index.html.

[31] Information on Medicare-granted blanket 1135 waivers is available at: https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers.

[32] To support the specific types of flexibilities that states requested during the COVID-19 outbreak, CMS designed an Appendix K template addendum pre-populated with commonly requested and relevant program changes. The appendix is available at https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/hcbs/appendix-k/index.html.

temporarily adjusting rates to respond to the disaster, and temporary adjustments to process requirements to reduce administrative expectations until the end date specified in the Appendix K.

Medicaid Disaster Relief SPA Template

The Medicaid state plan is the document that describes the state's rules related to eligibility, benefits, payments and other key operational aspects of how states administer their Medicaid program. States have wide discretion within a broad federal framework to design their programs, and changes are processed through SPAs. During a disaster or emergency situation, states may wish to make temporary changes. To streamline and support this process, CMS developed a Medicaid Disaster Relief SPA template specific to the COVID-19 PHE that allows a state to submit one combined request for temporary changes states may wish to make in their programs.[33] The template addresses expanding temporary coverage to optional eligibility groups, adding specialized benefits, expanding access to Medicaid services furnished via telehealth by removing limitations that states may have in their program, and temporarily increasing or enhancing provider payment, among other temporary changes.

CHIP Disaster Relief SPAs

Similar to Medicaid, the CHIP state plan describes how the state administers its program and changes to the plan are processed through SPAs. States can submit CHIP SPAs that allow for temporary adjustments to beneficiary enrollment and eligibility redetermination policies during disaster events. The purpose is to implement provisions for temporary adjustments to enrollment and redetermination policies and cost sharing requirements for children in families living and/or working in Governor- or federally-declared disaster or emergency areas. The CHIP Disaster Relief SPA may be submitted in advance of, or in response to, a disaster or public health crisis.[34]

BHP Blueprints

The BHP Blueprint is a comprehensive written document submitted by the state to the Secretary for certification of a BHP. On May 8, 2020,[35] CMS issued an interim final rule with comment period (85 FR 27550, 27593) that included a policy permitting states operating BHPs to submit revised BHP Blueprints for temporary changes to their BHPs that could be effective retroactive to the first day the COVID-19 PHE.[36] States can use this flexibility during the COVID-19 PHE to implement temporary modifications and temporary significant changes that are directly tied to the COVID-19 PHE and would increase enrollee access to coverage.

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[33] The Medicaid Disaster Relief SPA template is available at: https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/state-plan-flexibilities/index.html.
[34] The CHIP Disaster Relief SPA is available at https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/state-plan-flexibilities/index.html
[35] 85 Fed. Reg. 27550, 27593, May 8, 2020, available at https://www.federalregister.gov/documents/2020/05/08/2020-09608/medicare-and-medicaid-programs-basic-health-program-and-exchanges-additional-policy-and-regulatory.
[36] See the Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program Interim Final Rule (85 FR 27550).

Medicaid and CHIP Disaster Relief MAGI-Based Verification Plan Addendum

States have discretion in establishing Medicaid and CHIP eligibility verification policies to implement federal requirements[37] and must develop and update a verification plan describing the state's income and eligibility verification policies and procedures.[38] States must submit their Medicaid and CHIP MAGI-based verification plans to CMS and must document any changes to non-MAGI verification practices in the state's internal policies and procedures. To streamline and support this process during an emergency, CMS developed a Medicaid and CHIP Disaster Relief MAGI-Based Verification Plan Addendum to allow states to submit temporary changes to state verification policies and procedures to CMS.[39] Such temporary changes may include suspending periodic data matches or electing to enroll individuals, where permissible, based on self-attested information and verify eligibility post-enrollment (post-enrollment verification).

Section 1115 Demonstration Opportunity

On March 22, 2020, CMS released State Medicaid Director Letter (SMDL) #20-002 outlining a new section 1115(a) demonstration opportunity to aid states with addressing the PHE.[40] The SMDL includes an application template that allows states to select waiver and expenditure authorities to streamline demonstration application requirements. With this template, states are able to request CMS approval of certain waivers as well as certain expenditure authorities to streamline enrollment into long-term care programs and provide access to HCBS for beneficiaries, as well as vary and target services based on population needs. States may request other flexibilities to deliver the most effective care to their beneficiaries in response to the COVID-19 PHE. Due to the extraordinary circumstances of this emergency, pursuant to 42 C.F.R. §431.416(g), CMS determined an exception to the normal state and federal public notice procedures is warranted and the Department is not requiring states to submit budget neutrality calculations. States are still required to track expenditures for approved demonstrations through standard CMS-64 reporting processes.

Emergency IT Funding

HHS will provide FFP at the applicable rates for state expenditures on automated data processing systems, including Medicaid mechanized claims processing and information retrieval systems, in certain circumstances during emergency situations, if the state submits a request pursuant to 45 C.F.R. §95.624. This authority is not limited to the period of the COVID-19 PHE declaration. To obtain emergency IT funding under this authority, states submit a request for FFP prior to the acquisition of any equipment or services. The request must be reflected in a record, and must include: a brief description of the equipment and/or services to be acquired as well as an estimate of their costs, a brief description of the circumstances driving the state's need to proceed prior to obtaining approval from the agency through the usual regulatory process, and a description of the harm that will be caused if the state does not immediately acquire the requested equipment

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[37] Set forth in requirements at 42 C.F.R. §435.940 through §435.956 and 42 C.F.R. §457.380.
[38] In accordance with requirements at 42 C.F.R. §435.945(j) and §457.380(j).
[39] https://www.medicaid.gov/medicaid/eligibility/downloads/magi-based-verification-plan-addendum-template.docx
[40] Information on the COVID-19 section 1115 demonstration opportunity is available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-application-process/index.html.

and/or services. This process is more streamlined than the advance planning document (APD) process by which states typically request funding approval.

For example, states could submit emergency IT funding requests to obtain FFP in their expenditures to expand the state's ability to support automated data processing systems via a remote work force (e.g., via telework), including to acquire state-owned laptops and other hardware and software. Emergency IT funding requests can also be submitted for IT infrastructure enhancements necessary to support the state's plan related to the COVID-19 PHE declaration, including claims processing, eligibility determinations, reporting, analytics, data collection, and applied research.

Within 14 days of receiving the state's emergency IT funding request, CMS will either approve or disapprove it. If CMS approves the request, the state must submit a formal request for approval through the usual APD process within 90 days of the date of the state's emergency IT funding request. If the state fails to submit a formal request for funding to CMS within 90 days of its emergency request, then the emergency IT funding will be disapproved retroactive to the date of the initial emergency request. Pursuant to 45 C.F.R. 95.623, a state may request reconsideration of disapproved IT funding, including if funding is disapproved because the state did not submit its formal funding request by the 90-day deadline, or if the state exercised a related contract without having received CMS prior approval. The usual APD approval process will govern CMS's formal approval of scope, timeline, and funding.

Action	Redetermine Eligibility	Provide Advance Notice to Beneficiaries
Modification of the deadline for re-evaluations of eligibility and reassessments of functional needs for 1915(i) state plan benefits		
Modifications of the deadline for initial assessments of functional need for 1915(k) state plan benefits		
Modification of the deadline for re- reassessments of functional needs and person-centered service plan for 1915(k) state plan benefits		
Modification of the deadline for conducting the assessments to make a determination that an individual requires 1915(j) self-directed Personal Assistance Services and supports and for the development of the service plan and budget. These activities do not need to be completed before the start of care.		
Modification of the deadline for annual review of the service plan required for the 1915(j) state plan benefit. The review can be postponed up for up to one year.		
Allowing legally responsible individuals to render personal care services		X
Temporary provision of HCBS in specified settings that have not been determined to meet HCBS settings criteria		X
Temporary provision of HCBS by entities also providing case management services under a temporary waiver of conflict of interest requirements		X
Waiver of the requirement to obtain beneficiary and provider written consent of new or amended HCBS person-centered service plans		
Modification of the deadline for a face-to-face encounter for 1905(a)(7) home health state plan services		
Allowing an individual's representative to render 1915(j) and/or 1915(k) services		X
Private Duty Nursing		
Allowing Private Duty Nursing (PDN) services to be delivered by a graduate registered nurse and/or graduate licensed practical nurse		X
Allowing PDN services to be directed by a nurse practitioner, clinical nurse specialist, and/or physician assistant		

Appendix C – Timeframes for Resolution of Section 1135 Waivers and Pending Eligibility and Enrollment Actions

As states end the temporary flexibilities authorized by section 1135 waivers and transition back to regular operations at the end of the PHE, they will need to complete certain required actions. Some actions must occur immediately at the conclusion of the PHE, or earlier if the flexibility expires prior to the end of the PHE. For example, a state that received a section 1135 waiver to temporarily suspend fee-for-service prior authorization requirements, would need to lift that suspension and reinstate the prior authorization requirements immediately at the conclusion of the PHE. For other flexibilities, CMS will use enforcement discretion to give states a reasonable period of time following the end of the PHE, in which to complete the action. For example a state that utilized the flexibility regarding timely processing of new applications will be expected to resume timely processing of all applications within 6 months of the conclusion of the PHE.

Table C-1 lists the actions necessary to resolve pending determinations of eligibility and enrollment. Table C-2 then lists each section 1135 waiver, along with the action required to end that waiver. For each action listed – related to both eligibility and enrollment and section 1135 waivers – the table specifies the time period within which the action is expected to be completed.

Maximum Timeframes for Completing Required Actions

Table C-1: Acting on Pending Eligibility and Enrollment Actions

Action	At conclusion of PHE or end of authority[1]	Within 2 months of PHE conclusion	Within 90 days / 3 months of PHE conclusion	Within 4 months of PHE conclusion	Within 6 months of PHE conclusion	Within 12 months of PHE conclusion
Verification						
Complete post-enrollment verification					X	
Application Processing						
Complete processing of MAGI and non-disability-related applications received during the PHE		X				
Complete processing of disability-based applications received during the PHE			X			
Resume timely processing of all applications				X		

Action	At conclusion of PHE or end of authority[1]	Within 2 months of PHE conclusion	Within 90 days / 3 months of PHE conclusion	Within 4 months of PHE conclusion	Within 6 months of PHE conclusion	Within 12 months of PHE conclusion
Changes in Circumstances						
Complete changes in circumstances reported, identified, or anticipated during the PHE and resume promptly acting on all changes in circumstances					X	
Renewals						
Complete any outstanding renewals and resume timely processing of all renewals					X	

Table C-2: Actions to End Section 1135 Waivers

Action	At conclusion of PHE or end of authority[1]	Within 2 months of PHE conclusion	Within 90 days / 3 months of PHE conclusion	Within 4 months of PHE conclusion	Within 6 months of PHE conclusion	Within 12 months of PHE conclusion
Authorizations						
Temporary suspension of fee-for-service prior authorization requirements – Lift the suspension	X					
Extension of pre-existing fee-for-service authorizations – End the extension	X					
30-day delay of Pre-Admission Screening and Annual Resident Review (PASRR) Level I and Level II assessments – Restore standard practices	X					

Action	At conclusion of PHE or end of authority[1]	Within 2 months of PHE conclusion	Within 90 days / 3 months of PHE conclusion	Within 4 months of PHE conclusion	Within 6 months of PHE conclusion	Within 12 months of PHE conclusion
Managed Care Service Authorizations and Appeals						
Extension of timelines for service authorization and appeal requirements for Medicaid managed care – Stop providing extensions	X					
Fair Hearings						
Extension of timelines for state fair hearing requests – Stop providing extensions	X					
Extension of the timeframe for the reinstatement of services and benefits for an individual who files a fair hearing request after the date of action – Stop providing extensions	X					
Provider Enrollment & Participation						
Waiver of certain provider enrollment requirements – Require completion of enrollment requirements – Complete revalidation of providers (the state may delay the revalidation due date by the amount of time the PHE is in place with an additional six months lead time to allow for notification to the provider of the new revalidation due date)					X	
Waiver of provider conditions allowing for provision of services in alternative settings – Discontinue	X					
Home and Community-Based Services						
Modification of the deadline for initial level of care determinations for 1915(k) state plan benefits and 1915(c) HCBS waivers – Complete initial level of care determinations			X			

Action	At conclusion of PHE or end of authority[1]	Within 2 months of PHE conclusion	Within 90 days / 3 months of PHE conclusion	Within 4 months of PHE conclusion	Within 6 months of PHE conclusion	Within 12 months of PHE conclusion
Modification of the deadline for level of care redeterminations for 1915(k) state plan benefits and 1915(c) HCBS waivers – Complete level of care redeterminations						X[3]
Modification of the deadline for initial evaluations of eligibility and assessments of functional needs for 1915(i) state plan benefits – Complete initial evaluations and assessments			X			
Modification of the deadline for re-evaluations of eligibility and reassessments of functional needs for 1915(i) state plan benefits – Complete re-evaluations and reassessments						X[3]
Modifications of the deadline for initial assessments of functional need for 1915(k) state plan benefits – Complete initial assessments			X			
Modification of the deadline for re- reassessments of functional needs and person-centered service plan for 1915(k) state plan benefits – Complete re-evaluations and service plans						X[3]
Modification of the deadline for conducting the initial assessments to make a determination that an individual requires 1915(j) self-directed Personal Assistance Services and Supports and for the development of the service plan and budget. – Complete initial assessment and service plan			X			
Modification of the deadline for annual review of the service plan required for the 1915(j) state plan benefit. – Complete re-evaluations						X[3]

Action	At conclusion of PHE or end of authority[1]	Within 2 months of PHE conclusion	Within 90 days / 3 months of PHE conclusion	Within 4 months of PHE conclusion	Within 6 months of PHE conclusion	Within 12 months of PHE conclusion
Allowing legally responsible individuals to render personal care services – Discontinue	X					
Temporary provision of HCBS in specified settings that have not been determined to meet HCBS settings criteria – Discontinue	X					
Temporary provision of HCBS by entities also providing case management services under a temporary waiver of conflict of interest requirements – Lift the waiver	X					
Waiver of the requirement to obtain beneficiary and provider written consent of new or amended HCBS person-centered service plan – Lift the waiver	X					
Modification of the deadline for a face-to-face encounter for 1905(a)(7) home health state plan services – Complete face-to-face encounter						X[3]
Allowing an individual's representative to render 1915(j) and/or 1915(k) services – Discontinue	X					
Private Duty Nursing						
Allowing Private Duty Nursing (PDN) services to be delivered by a graduate registered nurse and/or graduate licensed practical nurse – Discontinue	X					
Allowing PDN services to be directed by a nurse practitioner, clinical nurse specialist, and/or physician assistant – Discontinue	X					

Action	At conclusion of PHE or end of authority[1]	Within 2 months of PHE conclusion	Within 90 days / 3 months of PHE conclusion	Within 4 months of PHE conclusion	Within 6 months of PHE conclusion	Within 12 months of PHE conclusion
Clinic Facility Requirement						
Permitting the state and clinic to temporarily designate a clinic practitioner's location as part of the clinic facility so that clinic services may be provided via telehealth when neither the patient nor practitioner is physically onsite at the clinic – Discontinue	X					
Provision of clinic services within scope without the direction of a physician or dentist – Discontinue	X					
Psychiatric Services						
Provision of inpatient psychiatric services within scope for individuals under age 21 without the direction of a physician – Discontinue	X					
Targeted Case Management						
Modification of the deadline for conducting annual monitoring and follow-up activities for targeted case management – Complete annual monitoring and follow-up						X[3]

[1] A section 1135 waiver must be discontinued prior to the end of the PHE, or an earlier end date specified in the waiver, if it is no longer necessary to meet the purposes of section 1135(a) of the Social Security Act.

[3] Complete within 12 months of the due date.

Appendix D - Operational Actions Needed to End Temporary Authorities

In addition to complying with relevant regulatory requirements when terminating temporary authorities or changes made to comply with FFCRA provisions, states will also need to consider other operational implications as they transition back to regular operations. The tables below list each temporary flexibility (eligibility and enrollment flexibilities related to the FFCRA and regulatory concurrences, Disaster Relief SPA authorities, and section 1135 waivers) and note the operational considerations relevant to that flexibility. For example, as a state ends the temporary suspension of cost sharing authorized through a Medicaid or CHIP disaster SPA, the state will need to inform providers that they must begin collecting copays again, update their systems to require the collection of copays, reduce provider payments and state claiming by applicable cost sharing, and determine whether any revisions to their managed care contracts are needed to reinstate this policy.

Operational Activities to Consider as Temporary Authorities End

Table D-1: Acting on Pending Eligibility and Enrollment Actions

Action	Inform Providers	Update Systems and/or Processes	Ensure Accurate Financial Reporting	Assess Managed Care Implications
Continued coverage of ineligible beneficiaries who remained enrolled under 6008(b)(3) of the FFCRA		X	X	X
Exception to timely application processing		X		
Exception to promptly acting on changes in circumstances		X		
Exception to timely completion of renewals		X		
Temporary use of post-enrollment verification		X		

Table D-2: Ending SPA Authorities

Action	Inform Providers	Update Systems and/or Processes	Ensure Accurate Financial Reporting	Assess Managed Care Implications
Eligibility				
Election of the COVID-19 testing group	X	X	X	X
Adoption or modification of less restrictive methodologies		X	X	X
More flexible residency policies		X	X	X
Extension of the reasonable opportunity period		X	X	X

Action	Inform Providers	Update Systems and/or Processes	Ensure Accurate Financial Reporting	Assess Managed Care Implications
Enrollment				
Changes to presumptive eligibility (PE) or hospital presumptive eligibility (HPE)	X	X	X	
Extension of the renewal period for non-MAGI populations		X		
Adoption or modification of continuous eligibility for children		X		
Premiums and Cost Sharing				
Suspension of cost sharing	X	X	X	X
Suspension of premiums		X	X	x
Benefits				
Addition or expansion of benefits	X	X	X	X
Adoption of more flexible limitations or loosening of amount, duration, and scope	X	X	X	X
Addition or expansion of benefits in Alternative Benefit Plans	X	X	X	X
Revised utilization of telehealth	X	X	X	X
Pharmacy				
Changes to day/quantity supply (e.g., amount of medication dispensed at one time) for covered outpatient drugs	X	X	X	X
Changes to monthly prescription limit (e.g., number of prescriptions allowed per month.)	X	X	X	X
Changes to prior authorization requirements for medications on automatic renewal	X	X	X	X
Changes to preferred drug list	X	X	X	X
Adjustment of professional dispensing fees	X	X	X	X
Changes to coverage of investigational drugs	X	X	X	X
Payment				
Payment for additional benefits	X	X	X	X
Increased payment rates	X	X	X	X
Establishment of supplemental payments or interim payment methodology	X	X	X	X[41]

[41] In the context of Medicaid managed care, states should assess any managed care implications from the establishment of new state directed payments under 42 C.F.R. § 438.6(c) specifically related to the PHE. See our published guidance regarding this topic at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib051420.pdf and https://www.medicaid.gov/federal-policy-guidance/downloads/cib082420.pdf.

Action	Inform Providers	Update Systems and/or Processes	Ensure Accurate Financial Reporting	Assess Managed Care Implications
Post Eligibility Treatment of Income				
Modification or variance of the basic personal needs allowance for institutionalized individuals	X	X	X	X
CHIP-Specific Provisions				
Waiver of the waiting period		X	X	
Waiver of the premium lock-out period		X	X	
Suspension of premiums and cost sharing	X	X	X	X

Table D-3: Ending Section 1135 Waiver Authorities

Action	Inform Providers	Update Systems and/or Processes	Ensure Accurate Financial Reporting	Assess Managed Care Implications
Authorizations				
Temporary suspension of fee-for-service prior authorization requirements	X	X	X	
Extension of pre-existing fee-for-service prior authorizations	X	X	X	
Temporary suspension of Pre-Admission Screening and Annual Resident Review (PASRR) Level I and Level II assessments	X	X	X	X
Managed Care Service Authorizations and Appeals				X
Extension of timelines for service authorization and appeal requirements for Medicaid managed care	**X**	**X**	**X**	X
Fair Hearings				
Extension of timelines for state fair hearing requests	X	X		X
Extension of the timeframe for the reinstatement of services and benefits for an individual who files a fair hearing request after the date of action		X		X
Provider Enrollment & Participation				
Waiver of certain provider enrollment requirements	X	X	X	X
Waiver of provider conditions to allow for provision of services in alternative settings	X	X	X	X

Action	Inform Providers	Update Systems and/or Processes	Ensure Accurate Financial Reporting	Assess Managed Care Implications
Home and Community-Based Services				
Modification of the deadline for initial level of care determinations for 1915(k) state plan benefits and 1915(c) HCBS waivers	X	X	X	X
Modification of the deadline for level of care redeterminations for 1915(k) state plan benefits and 1915(c) HCBS waivers	X	X	X	X
Modification of the deadline for initial evaluations of eligibility and assessments of functional needs for 1915(i) state plan benefits	X	X	X	X
Modification of the deadline for re-evaluations of eligibility and reassessments of functional needs for 1915(i) state plan benefits	X	X	X	X
Modifications of the deadline for initial assessments of functional need for 1915(k) state plan benefits	X	X	X	X
Modification of the deadline for re-reassessments of functional needs and person-centered service plan for 1915(k) state plan benefits	X	X	X	X
Modification of the deadline for conducting the initial assessments to make a determination that an individual requires 1915(j) self-directed Personal Assistance Services and Supports and for the development of the service plan and budget.	X	X	X	X
Modification of the deadline for annual review of the service plan required for the 1915(j) state plan benefit.	X	X	X	X
Allowing legally responsible individuals to render personal care services	X	X	X	X
Temporary provision of HCBS in specified settings that have not been determined to meet HCBS settings criteria	X	X	X	X
Temporary provision of HCBS by entities also providing case management services under a temporary waiver of conflict of interest requirements	X	X	X	X
Waiver of the requirement to obtain beneficiary and provider written consent of new or amended HCBS person-centered service plans	X	X	X	X

Action	Inform Providers	Update Systems and/or Processes	Ensure Accurate Financial Reporting	Assess Managed Care Implications
Modification of the deadline for a face-to-face encounter for 1905(a)(7) home health state plan services	X	X	X	X
Allowing an individual's representative to render 1915(j) and/or 1915(k) services	X	X	X	X
Private Duty Nursing				
Allowing Private Duty Nursing (PDN) services to be delivered by a graduate registered nurse and/or graduate licensed practical nurse	X	X	X	X
Allowing PDN services to be directed by a nurse practitioner, clinical nurse specialist, and/or physician assistant	X	X	X	X
Clinic Facility Requirement				
Permitting the state and clinic to temporarily designate a clinic practitioner's location as part of the clinic facility so that clinic services may be provided via telehealth when neither the patient nor practitioner is physically onsite at the clinic	X	X	X	X
Provision of clinic services within scope without the direction of a physician or dentist	X	X	X	X
Psychiatric Services				
Provision of inpatient psychiatric services within scope for individuals under age 21 without the direction of a physician	X	X	X	X
Targeted Case Management				
Modification of the deadline for conducting annual monitoring and follow-up activities for targeted case management	X	X	X	X

Appendix E – State Eligibility and Enrollment Pending Action Timelines for Resolution