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

March 10, 2022

Stephen M. Groff
Director
Division of Medicaid and Medical Assistance
Department of Health and Social Services
1901 N. Dupont Highway
New Castle, DE 19720

Dear Mr. Groff:

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act) as amended (42 U.S.C. 1320b-5). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to 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 COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6:00 PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, upon termination of the public health emergency, including any extensions.

On May 13, 2021, CMS published State Medicaid Director Letter (SMDL) 21-003, *Implementation of American Rescue Plan Act of 2021 Section 9817: Additional Support for Medicaid Home and Community-Based Services During the COVID 19 Emergency*, which updated Medicaid retainer payment policy for HCBS providers during the COVID-19 Public Health Emergency (PHE) by permitting states to provide three additional 30-day episodes of retainer payments. In response to this new guidance, Delaware submitted an amendment request to provide three additional 30-day episodes of retainer payments to providers of day services using the rehabilitation services benefit as defined under section 1905(a) of the Act to maintain capacity during the emergency. After careful review and consideration, CMS is approving the

state's request and this authority is hereby authorized through 6 months after the end of the PHE (including any renewal of the PHE).

CMS has determined that this extension request is necessary to assist the state in delivering the most effective care to its beneficiaries in light of the COVID-19 PHE. The demonstration amendment is likely to assist in promoting the objectives of the Medicaid statute because it is expected to help the state furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID-19. Specifically, CMS is providing expenditure authority for the state to make retainer payments to providers of day services provided under the rehabilitative services benefit as defined under section 1905(a) of the Act to maintain capacity during the emergency, as limited by the guardrail language for retainer payments in Attachment K until 6 months after the end of the PHE.

In addition, in light of the unprecedented emergency circumstances associated with the COVID-19 pandemic and consistent with the President's declaration detailed above – and in consequence of the time-limited nature of this demonstration – CMS did not require the state to submit budget neutrality calculations for the demonstration amendment. In general, CMS has determined that the costs to the federal government are likely to have been otherwise incurred and allowable. Delaware will still be required to track demonstration expenditures and will be expected to evaluate the connection between those expenditures and the state's response to the PHE, as well as the cost-effectiveness of those expenditures. For similar reasons, and due to the highly limited scope of the changes under the amendment, CMS did not revise the Special Terms and Conditions (STCs).

In alignment with the requirements outlined in the state's COVID-19 section 1115 demonstration amendment approved on November 24, 2020, the state will continue conducting monitoring and evaluation pertinent to these amendments, including suitably incorporating this amendment into the demonstration's applicable monitoring and evaluation deliverables.

Approval of this demonstration amendment is subject to the limitations specified in the flexibilities listed in Attachment K and the previously approved expenditure authorities and STCs. The state may deviate from its Medicaid state plan requirements only to the extent that the requirements have been specifically identified as not applicable for the demonstration as specified in the list of approved authorities. This approval is conditioned upon continued compliance with the previously approved STCs, which set forth in detail the nature, character and extent of anticipated federal involvement in the project.

Your project officer is Mr. Thomas Long. Mr. Long is available to answer any questions concerning implementation of the state's section 1115(a) demonstration amendment and his contact information is as follows:

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We appreciate your state's commitment to addressing the significant challenges posed by the COVID-19 pandemic, and we look forward to our continued partnership on the Delaware Diamond State Health Plan section 1115(a) demonstration.

Sincerely,

Daniel Tsai
Deputy Administrator and Director

Enclosure

cc: Talbatha Myatt, State Monitoring Lead, Medicaid and CHIP Operations Group

Attachment K – Time-limited Expenditure Authority and Associated Requirements for State's Response to COVID-19 Public Health Emergency (PHE)

1. **Retainer payments.** Expenditure authority for the state to make retainer payments to providers of day services using the rehabilitative services benefit as defined under section 1905(a) of the Social Security Act to maintain capacity during the emergency.

   If the state is interested in utilizing retainer payments for multiple (up to three) episodes of up to 30 days per beneficiary, it will be expected to abide by the following guardrails:

   - Limit retainer payments to a reasonable amount and ensure their recoupment if other resources, once available, are used for the same purpose. In terms of setting a reasonable amount, a retainer payment cannot exceed the payment for the relevant service; the state may specify that a retainer payment will be made at a percentage of the current rate, or a state may specify retainer payments will not be made to a setting until attendance is below an identified percentage of the enrollment (e.g., 75 percent).
   - Collect an attestation from the provider acknowledging that retainer payments will be subject to recoupment if inappropriate billing or duplicate payments for services occurred (or in periods of disaster, duplicate uses of available funding streams), as identified in a state or federal audit or any other authorized third party review. Note that "duplicate uses of available funding streams" means using more than one funding stream for the same purpose.
   - Require an attestation from the provider that it will not lay off staff, and will maintain wages at existing levels.
   - Require an attestation from the provider that they had not received funding from any other sources, including but not limited to unemployment benefits and Small Business Administration loans, that would exceed their revenue for the last full quarter prior to the PHE, or that the retainer payments at the level provided by the state would not result in their revenue exceeding that of the quarter prior to the PHE. o If a provider had not already received revenues in excess of the pre-PHE level but receipt of the retainer payment in addition to those prior sources of funding results in the provider exceeding the pre-PHE level, any retainer payment amounts in excess would be recouped.
   - If a provider had already received revenues in excess of the pre-PHE level, retainer payments are not available.
   - If the state utilizes retainer payments for one period that is the lesser of 30 consecutive days or the number of nursing facility bed-hold days will have the option of requiring providers to comply with these guardrails.