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STATE OF CALIFORNIA
APPROVAL OF FEDERAL SECTION 1135 WAIVER REQUESTS

CMS Response: March 23, 2020

Temporarily suspend Medicaid fee-for-service prior authorization requirements. Section 1135(b)(1)(C) allows for a waiver or modification of pre-approval requirements, including prior authorization processes required under the State Plan for particular benefits.

Prior authorization and medical necessity processes in fee-for-service delivery systems are established, defined and administered at state/territory discretion and may vary depending on the benefit. See 42 C.F.R. §440.230(d). Under section 1135(b)(1)(C) of the Act, CMS is approving the State of California's request to waive or modify the state plan prior authorization requirements and processes for benefits administered through the fee-for-service delivery system.

Extend pre-existing authorizations for which a beneficiary has previously received prior authorization through the end of the public health emergency.

Prior authorization and medical necessity processes in fee-for-service delivery systems are established, defined and administered at state/territory discretion and may vary depending on the benefit. See 42 C.F.R. §440.230(d). The State of California may have indicated in its approved state plan specific requirements about prior authorization processes for benefits administered through the fee-for-service delivery system. We interpret prior authorization requirements to be a type of pre-approval requirement for which waiver and modification authority under section 1135(b)(1)(C) of the Act is available.

State Fair Hearing Requests and Appeal Timelines

California requested flexibility to temporarily delay scheduling of Medicaid fair hearings and issuing fair hearings decisions during the emergency period. CMS approves a waiver under section 1135 that allows enrollees to have more than 90 days, up to an additional 120 days for an eligibility or fee for service appeal to request a fair hearing. The timeframes in 42 C.F.R. §431.221(d) provides that states can choose a reasonable timeframe for individuals to request a fair hearing not to exceed 90 days for eligibility or fee-for-service issues.

CMS cannot waive parts of the Medicaid managed care regulations at 42 C.F.R. Part 438 Subpart F related to appeals of adverse benefit determinations which occur before Fair Hearings for managed care enrollees or parts of 42 C.F.R. Part 431, Subpart E. However, CMS is able to modify the federal timeframes associated with appeals and fair hearings. Therefore, CMS approves the following through the end of the public health emergency:

- Modification of the timeframe for managed care entities to resolve appeals under 42 C.F.R. §438.408(f)(1) before an enrollee may request a State fair hearing to no less than one day in accordance with the requirements specified below; this allows managed care enrollees to proceed almost immediately to a state fair hearing without having a managed care plan resolve the appeal first by permitting the state to modify

the timeline for managed care plans to resolve appeals to one day so the impacted appeals satisfy the exhaustion requirements.

The requirements of 42 C.F.R. §438.408(f)(1) establish that an enrollee may request a State fair hearing only after receiving a notice that the Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP) is upholding the adverse benefit determination but also permits, at 42 C.F.R. §438.408(c)(3) and (f)(l)(i) that an enrollee's appeal may be deemed denied and the appeal process of the managed care plan exhausted (such that the State fair hearing may be requested) if the managed care plan fails to meet the timing and notice requirements of 42 C.F.R. §438.408. Section 1135 of the Act allows CMS to authorize a modification to the timeframes for required activities under section 1135(b)(5) of the Act. CMS authorizes the state to modify the time line for managed care plans to resolve appeals to no less than one day. If the state uses this authority, it would mean that all appeals filed between March 1, 2020 and the end of the public health emergency are deemed to satisfy the exhaustion requirement in 42 C.F.R. §438.408(f)(1) after one day (or more if that is the timeline elected by the state) and allow enrollees to file an appeal to the state fair hearing level.

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

  In addition, CMS approves a modification of the timeframe, under 42 C.F.R. §438.408(f)(2), for managed care enrollees to exercise their appeal rights. Specifically, any managed care enrollees for whom the 120-day deadline described in 42 C.F.R. §438.408(f)(2) would have occurred between March 1, 2020 through the end of the public health emergency, are allowed up to an additional 120 days to request a State Fair Hearing.

Provider Enrollment

California currently has the authority to rely upon provider screening that is performed by other State Medicaid Agencies (SMAs) and/or Medicare. As a result, California is authorized to provisionally, temporarily enroll providers who are enrolled with another SMA or Medicare for the duration of the public health emergency.

Under current CMS policy, as explained in the Medicaid Provider Enrollment Compendium (PDF 586.81 KB) (7/24/18), at pg. 42, California may reimburse otherwise payable claims from out-of-state providers not enrolled in California Medicaid program if the following criteria are met:

The item or service is furnished by an institutional provider, individual practitioner, or pharmacy at an out-of-state/territory practice location– i.e., located outside the geographical boundaries of the reimbursing state/territory's Medicaid plan,

1. The National Provider Identifier (NPI) of the furnishing provider is represented on the claim,
2. The furnishing provider is enrolled and in an "approved" status in Medicare or in another state/territory's Medicaid plan,
3. The claim represents services furnished, and;

4. The claim represents either:
    a. A single instance of care furnished over a 180-day period, or
    b. Multiple instances of care furnished to a single participant, over a 180-day period

For claims for services provided to Medicaid participants enrolled with California Medicaid program, CMS will waive the fifth criterion listed above under section 1135(b)(1) of the Act. Therefore, for the duration of the public health emergency, California may reimburse out-of-state providers for multiple instances of care to multiple participants, so long as the other criteria listed above are met.

If a certified provider is enrolled in Medicare or with a state Medicaid program other than California, California may provisionally, temporarily enroll the out-of-state provider for the duration of the public health emergency in order to accommodate participants who were displaced by the emergency.

With respect to providers not already enrolled with another SMA or Medicare, CMS will waive the following screening requirements under 1135(b)(1) and (b)(2) of the Act, so the state may provisionally, temporarily enroll the providers for the duration of the public health emergency:

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

CMS is granting this waiver authority to allow California to enroll providers who are not currently enrolled with another SMA or Medicare so long as the state meets the following minimum requirements:

1. Must collect minimum data requirements in order to file and process claims, including, but not limited to NPI.
2. Must collect Social Security Number, Employer Identification Number, and Taxpayer Identification Number (SSN/EIN/TIN), as applicable, in order to perform the following screening requirements:
    a. OIG exclusion list
    b. State licensure – provider must be licensed, and legally authorized to practice or deliver the services for which they file claims, in at least one state/territory
3. California must also:
    a. Issue no new temporary provisional enrollments after the date that the emergency designation is lifted,
    b. Cease payment to providers who are temporarily enrolled within six months from the termination of the public health emergency, including any extensions, unless a provider has submitted an application that meets all requirements for Medicaid participation and that application was subsequently reviewed and approved by California before the end of the six

month period after the termination of the public health emergency, including any extensions, and

c. Allow a retroactive effective date for provisional temporary enrollments that is no earlier than March 1, 2020.

Under section 1135(b)(1)(B), CMS is also approving California's request to temporarily cease revalidation of providers who are located in California or are otherwise directly impacted by the emergency.

These provider enrollment emergency relief efforts also apply to the Children's Health Insurance Program (CHIP) to the extent applicable.

Provision of Services in Alternative Settings

CMS approves a waiver under section 1135(b)(1) of the Act to allow facilities, including NFs, intermediate care facilities for individuals with intellectual and developmental disabilities (ICF/IDDs), psychiatric residential treatment facilities (PRTFs), and hospital NFs, to be fully reimbursed for services rendered to an unlicensed facility (during an emergency evacuation or due to other need to relocate residents where the placing facility continues to render services) provided that the State makes a reasonable assessment that the facility meets minimum standards, consistent with reasonable expectations in the context of the current public health emergency, to ensure the health, safety and comfort of beneficiaries and staff. The placing facility would be responsible for determining how to reimburse the unlicensed facility. This arrangement would only be effective for the duration of the section 1135 waiver.

Duration of Approved Waivers

Unless otherwise specified above, the section 1135 waivers described herein are effective March 1, 2020 and will terminate upon termination of the public health emergency, including any extensions. In no case will any of these waivers extend past the last day of the public health emergency (or any extension thereof).

CURRENT BLANKET WAIVER:

The Trump Administration is taking aggressive actions and exercising regulatory flexibilities to help healthcare providers combat and contain the spread of 2019 Novel Coronavirus Disease (COVID19). In response to COVID-19, CMS is empowered to take proactive steps through 1135 waivers and rapidly expand the Administration's aggressive efforts against COVID-19. As a result, the following blanket waivers are available:

- **Skilled Nursing Facilities** CMS is waiving the requirement at Section 1812(f) of the Social Security Act for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of (SNF services without a qualifying hospital stay, for those people who need to be transferred as a result of the effect of a disaster or emergency. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. Second, CMS is waiving 42 CFR 483.20 to provides relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission.

- **Critical Access Hospitals** CMS is waiving the requirements that Critical Access Hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours.

- **Housing Acute Care Patients In Excluded Distinct Part Units** CMS is waiving requirements to allow acute care hospitals to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatient. The Inpatient Prospective Payment System (IPPS) hospital should bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to the disaster or emergency.

- **Durable Medical Equipment** Where Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) is lost, destroyed, irreparably damaged, or otherwise rendered unusable, contractors have the flexibility to waive replacements requirements such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable or unavailable as a result of the emergency.

- **Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital** CMS is waiving to allow acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of a disaster or emergency, need to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. The hospital should continue to bill for inpatient psychiatric services under the Inpatient Psychiatric Facility Prospective Payment System for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

- **Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital** CMS is waiving requirements to allow acute care hospitals with excluded distinct part inpatient Rehabilitation units that, as a result of a disaster or emergency, need to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the disaster or emergency. This waiver may be utilized where the hospital's acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

  CMS is waiving requirements to allow IRFs to exclude patients from the hospital's or unit's inpatient population for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF (commonly referred to as the "60 percent rule") if an IRF admits a patient solely to respond to the emergency and the patient's medical record properly identifies the patient as such. In addition, during the applicable waiver time period, we would also apply the exception to facilities not yet classified as IRFs, but that are attempting to obtain classification as an IRF.

- **Supporting Care for Patients in Long-Term Care Acute Hospitals (LTCH)s** Allows a long-term care hospital (LTCH) to exclude patient stays where an LTCH admits or discharges patients in order to meet the demands of

the emergency from the 25-day average length of stay requirement which allows these facilities to be paid as LTCHs.

- **Home Health Agencies** Provides relief to Home Health Agencies on the timeframes related to OASIS Transmission. Allows Medicare Administrative Contractors to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs) during emergencies.

- **Provider Locations** Temporarily waive requirements that out-of-state providers be licensed in the state where they are providing services when they are licensed in another state. This applies to Medicare and Medicaid.

- **Provider Enrollment**
    - Establish a toll-free hotline for non-certified Part B suppliers, physicians and nonphysician practitioners to enroll and receive temporary Medicare billing privileges
    - Waive the following screening requirements:
        - Application Fee - 42 C.F.R 424.514
        - Criminal background checks associated with FCBC - 42 C.F.R 424.518
        - Site visits - 42 C.F.R 424.517
    - Postpone all revalidation actions
    - Allow licensed providers to render services outside of their state of enrollment
    - Expedite any pending or new applications from providers

- **Medicare appeals in Fee for Service, MA and Part D**
    - Extension to file an appeal
    - Waive timeliness for requests for additional information to adjudicate the appeal;
    - Processing the appeal even with incomplete Appointment of Representation forms but communicating only to the beneficiary;
    - Process requests for appeal that don't meet the required elements using information that is available. Utilizing all flexibilities available in the appeal process as if good cause requirements are satisfied.

Medicaid and CHIP

When the President declares an emergency through the Stafford Act or National Emergency Act, and the Secretary declares a Public Health Emergency, the Secretary is authorized to waive certain Medicare, Medicaid and Children's Health Insurance Program (CHIP) authorities under Section 1135 of the Social Security Act. There is no specific form or format that is required to submit the request for a Section 1135 waiver, but the state should clearly state the scope of the issue and the impact. States and territories may submit a Section 1135 waiver request directly to Jackie Glaze, CMS Acting Director, Medicaid & CHIP Operations Group Center for Medicaid & CHIP Services by e-mail (Jackie.Glaze@cms.hhs.gov) or letter.

The following are examples of flexibilities that states and territories may seek through a Section 1135 waiver request:

Waive prior authorization requirements in fee -for-service programs
• Permits providers located out of state/territory to provide care to another state' s Medicaid enrollees impacted by the e mergency
• Temporarily suspend certain provider enrollment and revalidation requirements to increase access to care.

• Temporarily waive requirements that physicians and other health care professionals be licensed in the state in which they are providing ser vices, so long as they have an equivalent licensing in another state, and
• Temporarily suspend requirements for certain pre -admission and annual screenings for nursing home residents

• States and territories are encouraged to assess their needs and request these available flexibilities, which are more completely outlined in the Medicaid and CHIP Disaster Response Toolkit. For more information and to access the toolkit, visit: https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/index.html.

For questions please email: 1135waiver@cms.hhs.gov