CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicaid and CHIP
MAC
Learning Collaboratives

Preparedness and Response Toolkit for State Medicaid and CHIP Agencies in the Event of a Public Health Emergency or Disaster

Center for Medicaid and CHIP Services (CMCS) Medicaid and CHIP Coverage Learning Collaborative

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Module 1: Toolkit Overview

I. Introduction

Medicaid and the Children's Health Insurance Program (CHIP) have played a critical role in helping states and territories respond to public health emergencies (PHEs) (e.g., Flint, Michigan lead contamination, H1N1 and the 2019 Novel Coronavirus (COVID-19) outbreak), human-made disasters, and natural disasters such as hurricanes (e.g., Hurricanes Katrina, Maria, Harvey and Irma), wildfires (e.g., California wildfires), and flooding (e.g., Hurricane Harvey floods in Texas).

To help Medicaid and CHIP agencies prepare for and respond to PHEs, disasters, and other emergencies, the Centers for Medicare & Medicaid Services (CMS) Medicaid and CHIP Coverage Learning Collaborative developed a Toolkit on the strategies available to support Medicaid and CHIP operations and beneficiaries. The Toolkit consists of three Modules:

- Module 1—This Module provides a review of the legal authorities that are available to effectuate various strategies, ranging from state plan amendments (SPAs) to obtaining a Social Security Act section 1135 waiver or modification, and provides a high-level summary of the types of Medicaid and CHIP strategies that can be deployed by states (including the District of Columbia and the territories, unless otherwise specified[1]). It is organized by operational area—eligibility and enrollment, benefits and cost sharing, and provider workforce and capacity—and provides examples of how the strategies have been used by other states. This Module is intended as an overview. For more details on available options and flexibilities, please see Module 2.
- Module 2—This Module is a companion inventory to Module 1. It lists the various strategies available to states and the action(s) needed to effectuate them. Based on interviews with federal officials and a review of federal statutes, regulations, and approved section 1135 waivers and section 1115 demonstrations, the CMS Coverage Learning Collaborative team compiled a detailed list of available strategies, some of which are available without needing approval from CMS. The inventory provides significantly more detail on available options than Module 1.
- Module 3—This Module is a strategic framework for Medicaid and CHIP agencies as they prepare to respond to a disaster or PHE. This step-by-step guide is intended to help states assess the situation, set priorities and design comprehensive disaster and PHE response efforts most appropriate for the specific emergency at hand.

Together, these three tools should serve as a comprehensive PHE and disaster preparedness and response Toolkit for states to have at their fingertips.

CMS strongly recommends that, in addition to reviewing these tools in advance of a PHE or disaster, Medicaid and CHIP agencies proactively develop preparedness and response operational protocols, and consider simulation exercises where appropriate, for contacting and coordinating with state agency personnel. We also recommend that Medicaid and CHIP agencies establish and maintain relationships

[1] Reference to states include the District of Columbia and the five US Territories unless otherwise specified.

with public health and human service agencies, as well as state and local emergency management agencies, given the critical role these entities play during a PHE or disaster.

In the event of a PHE or disaster, state Medicaid and CHIP agencies should reach out to their CMS state leads and the Director of the Medicaid and CHIP Operations Group, who will serve as the points of contact for the Center for Medicaid and CHIP Services (CMCS) for shepherding all state requests for flexibilities across CMS divisions.

II. Public Health Emergency and Disaster-Related Legal Authorities and Regulatory Exceptions

State Medicaid and CHIP agencies may want to make program changes as part of their emergency response. CMS can use existing flexibilities in statute and regulation that can be supplemented with emergency authority to provide state Medicaid and CHIP agencies with additional flexibilities in running their programs. Authorizing the use of these temporary flexibilities typically requires a state to request the use of a certain authority from CMS and CMS to approve its use.

If the President declares a state of emergency under the Stafford Act or the National Emergencies Act, and the Secretary of Health and Human Services also declares a PHE in the affected area, CMS is empowered to temporarily modify or waive certain Medicaid, CHIP, and Medicare requirements as determined necessary by the agency under section 1135 of the Social Security Act (the Act). Under section 1135, the Secretary may also waive certain HIPAA requirements insofar as they apply to Medicaid, CHIP, and Medicare.

State Medicaid and CHIP programs may request waivers and flexibilities from CMS through the following primary authorities:

- **Regulatory Exceptions:** There may be times when a state or territory is unable to meet certain federal requirements due to a PHE or disaster and may use an exception provided in regulations. For example, federal regulations at 42 CFR § 435.912(e)(2), provide an exception when a state or territory is unable to meet timeliness standards for processing applications, completing renewals, or acting on changes in circumstances due to an administrative or other emergency beyond the agency's control. Similarly, in a PHE or disaster, there are several fair hearing flexibilities states may utilize under current regulations, including an exception to general timeframes under 42 CFR § 431.244(f)(4)(i)(B) that permit a state to delay taking final administrative action, including scheduling fair hearings and issuing fair hearing decisions or conducting fair hearings via video conference or telephone.[2]

  When a state or territory uses a regulatory exception, it should document the reason for the delay in the applicant's or beneficiary's case record, and while not required under the regulations, states and territories are also advised to obtain CMS concurrence that their application of this exception is warranted under the circumstance. CMS concurrence is a mechanism to document the use of an

[2] Although regulatory exceptions are sometimes warranted, civil rights laws that prohibit discrimination on the basis of race, color, national origin, disability, age, sex (including sexual orientation, gender identity, and pregnancy) remain in effect during national emergencies.

exception in meeting certain federal requirements during circumstances beyond the agency's control in order to assist states in the event of a Payment Error Rate Measurement (PERM) program review or other audit.

- **Disaster Relief Verification Plan Addendum:** States or territories wishing to temporarily change their Medicaid and CHIP verification processes in response to a PHE, disaster, or other emergency must document those changes to the state's approved verification plan under 42 CFR § 435.945(j), and may do so through a Medicaid and CHIP Disaster Relief MAGI-Based Verification Plan Addendum. These provisions would go into effect immediately. States or territories must submit the addendum (or updated MAGI-Based Verification Plan Template) to CMS but prior CMS approval is not required. States and territories must also document non-MAGI-based changes but are not required to submit these changes to CMS for review.
- **Medicaid State Plan Amendment:** In response to a PHE or disaster, states or territories may wish to revise Medicaid eligibility, enrollment, benefit, payment methodology and other requirements in their state plans. The state plan must be amended to reflect material changes to the State Medicaid program via submission of a proposed state plan amendment (SPA); SPAs must be approved by CMS. In general, Medicaid SPAs can be retroactive to the first day of the quarter in which an approvable amendment was submitted to CMS. However, during a declared emergency or disaster under the National Emergencies Act or Stafford Act and a Public Health Emergency Declaration under Section 319 of the Public Health Service Act, section 1135 waiver authority may be used to permit state plan changes in response to the PHE or disaster to take effect earlier than the first day of the quarter in which the SPA was submitted (see below section on section 1135 waivers for more detail).

  There are some circumstances where a state or territory may leverage flexibilities already permissible under state plan authority and is not required to amend its state plan. Telehealth is one such example. No federal approval is needed for state Medicaid and CHIP programs to reimburse providers for services provided via telehealth in the same manner or at the same rate they pay for services provided face-to-face; a SPA would be needed only if the state or territory wants to change the current state plan payment rates or methodology.

  To streamline the SPA submission process when states and territories respond to particular emergency conditions, CMS may issue an Emergency Relief SPA template. For example, to implement time-limited changes during the COVID-19 PHE, states and territories can submit SPAs using the Medicaid COVID-19 Disaster Relief SPA template. The COVID-19 Disaster Relief SPA template (and accompanying instructions) bundle together multiple state plan authority changes that CMS anticipates states and territories might seek as they respond to the COVID-19 PHE. States and territories can use the template to submit a combined request for time-limited programmatic changes, including temporary coverage of optional eligibility groups or new benefits; streamlined enrollment procedures, including expanded use of presumptive eligibility authorities; temporary suspension of premiums and cost sharing; increased provider reimbursement rates; and other changes. The Disaster Relief SPA template and instruction can be accessed from the State Plan Flexibilities page.
- **CHIP Disaster Relief State Plan Amendments:** In advance of or in response to a PHE or disaster, states or territories may wish to document a list of CHIP eligibility, enrollment, and cost sharing provisions that will go into effect in the event of a PHE or disaster. States and territories that add this information in advance of a PHE or disaster may activate it by alerting CMS. States can submit a

CHIP SPA and request an effective date that can be retroactive to the first day of the state fiscal year in which an approvable amendment was submitted to CMS.

- **1915(c) HCBS Waiver Program Appendix K:** States and territories may submit an Appendix K amendment to the 1915(c) HCBS waiver program before or during PHEs or disasters to document necessary changes to waiver operations to address unique circumstances, service needs and supports experienced during and/or in the aftermath of the PHE or disaster. The Appendix K includes actions that states and territories can take under the existing section 1915(c) authority to temporarily amend the waiver to respond to a PHE or disaster. The provisions of an Appendix K amendment are effective on a temporary basis, can be approved retroactive to the start of the PHE or disaster and are typically effective for up to one year from the start date. The Appendix K template and instructions can be accessed from the Emergency Preparedness and Response for Home and Community Based (HCBS) 1915(c) Waivers page.
- **Section 1135 Waiver:** Under section 1135 of the Act, the Secretary has the authority to temporarily waive or modify certain Medicare, Medicaid, and CHIP requirements to ensure that sufficient health care items and services are available to meet the needs of enrollees in an area affected by a federally-declared PHE. The Secretary may invoke section 1135 waiver authority when a declaration of emergency or disaster under the National Emergencies Act or Stafford Act and a Public Health Emergency Declaration under Section 319 of the Public Health Service Act have been made. Section 1135 authority enables providers to furnish needed items and services in good faith during times of a PHE or disaster and to be reimbursed and exempted from sanctions (absent any determination of fraud or abuse). Section 1135 waivers typically end no later than the termination of the emergency period or 60 days from the date that the waiver or modification is first published. During the COVID-19 PHE, in addition to issuing section 1135 waivers on a case-by-case basis, HHS and CMS issued a number of nationwide Medicare "blanket" section 1135 waivers that apply broadly to any entity that meets the enumerated criteria. If there was not a blanket waiver in place, providers were able to request individual Medicare waivers using the CMS 1135 waiver portal. In May 2022, CMS updated the portal to both facilitate the submission of Medicaid 1135 waiver requests and help expedite the CMS approval process. State Medicaid Agencies may now use the CMS 1135 Waiver / Flexibility Request and Inquiry Form - CMS 1135 Form to request one or more pre-populated section 1135 Medicaid waivers and/or describe additional Medicaid flexibilities they are seeking for a particular PHE. Additional information and materials on how to submit a Medicaid 1135 waiver request can be found on CMS Emergency Preparedness site.
- **Section 1115 Demonstration:** Under section 1115 of the Act, the Secretary has broad, but not unlimited, authority to approve a state or territory's request to waive compliance with certain provisions of federal Medicaid law (under section 1115(a)(1)) and authorize federal matching for state expenditures not otherwise federally matchable by law (under section 1115(a)(2)). A demonstration may be granted for an "experimental, pilot or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of" the Medicaid program. To receive approval for a section 1115 demonstration, states and territories must submit a demonstration request and agree on Special Terms and Conditions. Special considerations have historically applied to section 1115 demonstrations during a federally-declared emergency or disaster, including:
  - States and territories have typically not been required to submit budget neutrality calculations;

- States and territories may be exempt from the normal public notice process in emergency situations provided they meet standards established in 42 CFR § 431.416(g); and
- Demonstrations can be retroactive to the date on which the Secretary declared a PHE.

To streamline the submission process for states and territories and to help states and territories respond to particular emergency conditions, CMS may issue a checklist/template application form for opportunities under section 1115 demonstrations. A template application outlines the most relevant and commonly requested flexibilities states and territories would seek during a PHE or disaster and also gives states and territories an opportunity to request additional flexibilities unique to their own needs. During the COVID-19 PHE, CMS issued a "COVID-19 Public Health Emergency Section 1115(a) Opportunity for States" State Medicaid Director Letter, which includes a Section 1115(a) Demonstration Application Template.

The Secretary of HHS has discretion with respect to approving demonstration projects and will evaluate state requests on a case-by-case basis. Generally, CMS encourages states to rely on other flexibilities – including those available under section 1135, the Medicaid or CHIP state plan, or as part of an HCBS Appendix K request – before requesting section 1115 authority.

III. Responding to Specific PHE- and Disaster-Related Problems

States and territories may leverage a variety of flexibilities and exceptions to Medicaid and CHIP requirements in the event of a PHE or disaster. In addition to exercising general administrative flexibilities, states and territories may modify their eligibility and enrollment processes; adapt benefits, cost sharing, and premiums policies; and modify requirements to bolster the provider workforce and capacity. The following section provides a high-level overview of the flexibilities that are available to states and territories. A detailed catalogue of the specific flexibilities, corresponding SPA or waiver authorities, and state examples is presented in the accompanying inventory, Module 2.

A. Bolstering Eligibility and Enrollment Processes

When a PHE or disaster occurs, a Medicaid or CHIP agency's capacity to process applications and make eligibility determinations may become compromised. During a PHE or disaster, Medicaid and CHIP agencies may be faced with the challenge of processing a high volume of eligibility determinations for individuals seeking health care. State Medicaid and CHIP eligibility workers may experience their own personal hardships impacting their ability to work. This reduction in workforce capacity may impact a state or territory's ability to process eligibility determinations and redeterminations in a timely fashion. In addition to these challenges, a natural or human-made disaster may place added burdens on the health care system. For example, loss of power and down phoned lines may disable eligibility and/or verification systems. Individuals experiencing a hurricane or flood may be displaced from their homes and may not have access to needed documents to verify their eligibility or be able to receive mail or other consumer notices. Finally, PHEs and disasters may make it impossible or inadvisable for beneficiaries to visit Medicaid/CHIP offices to apply for or renew coverage or request assistance in person. In recognition of these challenges, a number of strategies are available to support ongoing eligibility and enrollment during a PHE or disaster. States or territories may:

- Assess coverage options and increase eligibility levels on a temporary basis. Making such changes for specific populations or within specific geographic regions may require section 1115 demonstration authority, which is subject to CMS policy discretion.
- Consider Medicaid/CHIP enrollees who are evacuated from the state or territory as "temporarily absent" when assessing residency in order to maintain enrollment.
- Cover non-residents, or a state-defined subset of non-residents, such as individuals living in the state or territory temporarily due to a disaster circumstance in their home state or territory.
- Modify Medicaid/CHIP application and verification processes (e.g., develop simplified paper/electronic/telephonic applications, accept self-attestation of certain eligibility criteria, modify reasonable compatibility thresholds).
- Modify eligibility requirements for enrollment in 1915(c) HCBS waiver programs to serve additional individuals.
- Adopt presumptive eligibility for eligible populations.
- Use an exception in meeting application, change in circumstance, and renewal timeliness requirements during a PHE or disaster.
- Adopt continuous eligibility for children to provide for 12 months of continuous coverage.
- Adjust post-eligibility treatment of income to modify the basic personal needs allowance for institutionalized individuals.
- Request FFP for IT costs that facilitate teleworking by the state or territory's Medicaid or CHIP workforce during a pandemic or similar PHE.

Select State Examples

- After Hurricane Harvey flooded parts of **Texas** in 2017, the State submitted a **CHIP SPA** that allowed the State to maintain CHIP enrollees' access to services beyond the end of their redetermination periods.
- In response to the COVID-19 outbreak, **Maine** used a **Medicaid Disaster Relief SPA** to expand eligibility for the optional COVID-19 Testing Medicaid eligibility group and **Illinois** used a **Medicaid Disaster Relief SPA** to add presumptive eligibility for certain eligibility groups.

B. Ensuring Access to Needed Services: Benefits and Cost Sharing

The damage and disruption to infrastructure caused by large-scale PHEs and disasters often creates new health care needs for Medicaid and CHIP enrollees. Pandemics such as the COVID-19 outbreak may necessitate quarantine and may strain ongoing service provision to individuals with complex health needs living in the community. Poor access to clean drinking water is associated with increased health risks, as is living or working in damaged structures. Lack of electrical power can exacerbate chronic health conditions, particularly in tropical climates and particularly for the elderly and disabled. Further, enrollees may struggle to pay co-payments or premiums during a PHE or disaster. In recognition of these challenges, a number of strategies are available to support continued access to services during a PHE or disaster. States or territories may:

- Offer additional optional benefits not currently provided under the state plan or Alternative Benefit Plan.
- Suspend service prior authorization requirements in fee-for-service and amend the contract requirements in managed care.
- Extend fair hearing timelines for taking final administrative action, including scheduling fair hearings and issuing fair hearing decisions, and adapt processes to accommodate disaster-related barriers (e.g., conduct fair hearings telephonically instead of in-person).
- Add services to a 1915(c) waiver that are not expressly authorized in statute, so long as the state or territory can demonstrate that the service is necessary to assist a waiver participant to avoid institutionalization and maintain function in the community.
- Authorize coverage for services provided via telehealth and reimburse services at the same rate regardless of whether they are furnished in face-to-face encounters or via telehealth, or using a different payment methodology.
- Temporarily suspend co-payments for all Medicaid or CHIP beneficiaries.
- Exempt individuals subject to a PHE or disaster from payment of premiums using a hardship waiver or suspend premiums temporarily.
- Modify managed care restrictions (e.g., temporarily suspend out-of-network requirements for managed care enrollees).

Select State Examples

- In response to the COVID-19 outbreak, **Maine** used a **Medicaid Disaster Relief SPA** to modify state plan provisions regarding certain coronavirus-related benefits (including provisions related to lab tests, benefits delivered via telehealth, and pharmacy exceptions, such as allowing the use of brand name drug if a lower-cost generic is not available due to shortages), and **Washington** used a **Medicaid Disaster Relief SPA** to reimburse services provided via telehealth at the same rates that it reimburses for those services when provided during in-person encounters. **Iowa** used a **1915(c) Appendix K amendment** to add home-delivered meals, companion, and homemaker services to its 1915(c) waiver and **Nevada** used a **1915(c) Appendix K amendment** to allow for electronic signature of person-centered planning documents, including the support plan.

C. Bolstering the Provider Workforce & Capacity

Despite increased need, services can be difficult to access during a PHE or disaster. Provider facilities may be evacuated, damaged, or otherwise inaccessible. Health care provider staff may experience their own hardships or be incapacitated as a result of disease or injury, making them unavailable to provide care to enrollees and creating acute health care shortages. States and territories may leverage a number of strategies to ensure there are adequate providers to meet the demands of Medicaid and CHIP enrollees. States or territories may:

- Modify provider enrollment and participation requirements (e.g., temporarily waive provider screening requirements, temporarily delay the revalidation of providers who are located in-state or are otherwise directly impacted by a PHE or disaster, temporarily waive requirements that out-of-state providers be licensed in the state or territory).

- Temporarily increase payment rates to providers and/or make retainer payments (as allowed under Medicaid 1915(c) waiver Appendix K or, at CMS discretion, for other providers through section 1115 expenditure authority) to reimburse for an increased intensity of services as well as to ensure a sufficient provider pool and continuity of provider networks after the emergency conditions have resolved.
- Allow facilities to provide services in alternative settings, such as a temporary shelter, when a provider's facility is inaccessible.
- Permit the use of telehealth by a broad array of providers, including physicians, nurses, and care managers.
- Adjust reporting and oversight requirements and deadlines.
- Request FFP for IT enhancements so that state or territory systems can accommodate modified provider enrollment and participation standards during the PHE or disaster.

Select State Examples

- After emergencies were declared in **Florida** in response to Hurricane Irma and in **California** in response to 2017 wildfires, both states used **section 1135 waiver** authority to waive certain provider screening requirements, including payment of application fees, criminal background checks, site visits, and in-state licensure requirements, to enroll new Medicaid providers provisionally and temporarily.
- In the wake of the COVID-19 outbreak, **Oregon** used a **Medicaid Disaster Relief SPA** to allow certain home and community based services to be provided to individuals in inpatient settings and **Louisiana** used a **1915(c) Appendix K amendment** to temporarily permit payment for services rendered by family caregivers or legally responsible individuals. **California** used a **Medicaid Disaster Relief SPA** to identify Non-Emergency Medical Transportation CPT codes that are eligible to receive a time-limited supplemental payment and **Guam** used a **Medicaid Disaster Relief SPA** to increase payment rates for on-island inpatient hospital services. **Kentucky** and **North Dakota** used **1915(c) Appendix K amendments** to approve retainer payments for personal care and habilitation services that include a component of personal care and to establish that the amount of each payment will be determined on a service by service basis. **Washington used section 1115 demonstration** authority to make retainer payments to providers of personal care services and habilitation services under section 1915(k). **Michigan** used **section 1135 waiver** authority to temporarily enroll providers who are enrolled with another state Medicaid agency or Medicare for the duration of the PHE and **Washington, D.C.** used **section 1135 waiver** authority to authorize the provision of services in unlicensed facilities that meet minimum standards.

For more information about resources available to support states' and territories' response to the COVID-19 PHE, please see Appendix A.

Module 2: Inventory of Medicaid and CHIP Flexibilities and Authorities in the Event of a Public Health Emergency or Disaster

I. Overview

A. Introduction

This Module is a companion inventory to Module 1. It lists the various strategies available to states and territories and the action(s) needed to effectuate them. Based on interviews with federal officials and a review of federal statutes, regulations, and approved section 1135 waivers and section 1115 demonstrations, the CMS Coverage Learning Collaborative team compiled this detailed inventory of available strategies, some of which are available without needing approval from CMS. This inventory expands on the introduction provided in Module 1, and includes state examples, where relevant.

For more information about resources available to support states' and territories' response to the COVID-19 PHE, please see Appendix A.

Table A: General Administrative Flexibilities

Available flexibilities and exceptions	Relevant authorities and sources	Notes on implementation and necessary state action	Select state examples
A1. State Plan Amendment Effective Date			
Modification of requirement that a SPA must be submitted by the last day of a quarter in order to take effect in that quarter; if modification is approved, this permits states to have an earlier SPA effective date than would otherwise be permitted under CMS regulations.	42 CFR § 430.20 section 1135 waiver	Submit section 1135 waiver request. During the COVID-19 PHE, submit section 1135 waiver request together with Disaster Relief SPA. Should only be requested for SPAs that do **not** restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.	Colorado COVID-19 Section 1135 Waiver Approval Letter (3/26/20)
A2. Public Notice (CHIP included where relevant)			
Waive or modify public notice requirements associated with submission of certain SPAs.	42 CFR § 440.386 (Alternative Benefit Plan SPAs) 42 CFR § 447.57(c) (premiums and cost sharing) 42 CFR § 447.205 (methods and standards for setting rates) section 1135 waiver	Submit section 1135 waiver request. During the COVID-19 PHE, submit section 1135 request together with Disaster Relief SPA. Should only be requested for SPAs that do **not** restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.	Connecticut COVID-19 Section 1135 Waiver Approval Letter (3/27/20) Arizona COVID-19 Disaster Relief SPA TN-20-001 approved 4/1/20 (effective 3/1/20)
A3. Tribal Consultation			
Modify tribal consultation timelines specified in state plan.	section 1135 waiver SSA § 1902(a)(73)	Submit section 1135 waiver request. During the COVID-19 PHE, submit section 1135 request together with Disaster Relief SPA/CHIP Disaster Relief SPA. Should only be requested for SPAs that do **not** restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.	West Virginia COVID-19 Section 1135 Waiver Approval Letter (3/30/20) Kansas COVID-19 Disaster Relief SPA KS-20-0012 approved 5/11/20 (effective 3/1/2020)

Table B: Eligibility and Enrollment

Available flexibilities and exceptions	Relevant authorities and sources	Notes on implementation and necessary state action	Select state examples
B1. Eligibility and Enrollment (CHIP included where relevant)			
Eligibility Levels			
Expand eligibility for optional Medicaid eligibility groups (including age and disability-related poverty level group and adult expansion group).	SSA § 1902(a)(10)(A)(i)(VIII) (adult group) SSA § 1902(a)(10)(A)(ii) (most optional eligibility groups) SSA § 1902(a)(10)(C) (medically needy groups) SSA § 1902(a)(10)(F) (COBRA continuation coverage group) § 1902(e)(3) (group for children under age 19 with a disability)	Submit Eligibility SPA. For states adopting the adult group, also submit FMAP and Alternative Benefit Plan SPAs. During the COVID-19 PHE, submit Disaster Relief SPA. Through the COVID-specific Disaster Relief SPA template, states can elect to cover the new optional COVID-19 Testing group.	Maine COVID-19 Disaster Relief SPA TN-20-0020 approved 4/24/20 (effective 3/1/20) (covers new optional COVID-19 Testing group)
Expand eligibility to above 133% FPL (states that have not elected to cover the adult expansion group may elect this option for specified populations described in section 1905(a) of the Act, which they already cover up to 133% FPL or higher (e.g., pregnant women described at 1905(a)(iii)); expansion states may elect this option for all individuals or limit coverage to specified populations.	42 CFR § 435.218 (Provides for eligibility levels above 133% FPL for individuals under 65 with MAGI-based income). SSA § 1902(a)(10)(A)(ii)(XX) Can be targeted to one or more categorical populations in 1905(a)	Submit Eligibility SPA. During the COVID-19 PHE, submit Disaster Relief SPA.	District of Columbia SPA #15-0010 (effective 01/01/16)
Residency			
Consider beneficiaries evacuated from the state temporarily absent and maintain enrollment in their home state (for home state where disaster occurred or PHE exists).	42 CFR § 435.403(j)(3) (Requires that a state does not deny or terminate Medicaid eligibility because of temporary absence from the state) 42 CFR § 431.52 (Authorizes payment to providers for services provided out of state)	Check temporary absence policy in current state plan, and if not already in the state plan, submit eligibility SPA to articulate this policy. During the COVID-19 PHE, submit Disaster Relief SPA. This flexibility is available in CHIP without a SPA.	Washington COVID-19 Disaster Relief SPA TN-20-0014 approved 4/24/20 (effective 3/1/20)

Table B (*continued*)

Available flexibilities and exceptions	Relevant authorities and sources	Notes on implementation and necessary state action	Select state examples
Cover nonresidents, or a state-defined subset of nonresidents, such as individuals living in the state temporarily due to a disaster circumstance in their home state. (Option for state receiving evacuees).	42 CFR § 435.403 (Defines residency for individuals over the age of 21 as one who is living and intends to reside, without a fixed address in the state; or has entered the State with a job commitment or seeking employment)	Submit Eligibility SPA. During the COVID-19 PHE, submit Disaster Relief SPA.	Washington COVID-19 Disaster Relief SPA TN-20-0014 approved 4/24/20 (effective 3/1/20)
Income and Resource Tests			
Temporarily apply less restrictive income and resource disregards statewide for non-MAGI eligibility determinations (can apply to categorically needy or medically needy).	SSA § 1902(r)(2)	Submit Eligibility SPA. During the COVID-19 PHE, submit Disaster Relief SPA.	Illinois COVID-19 Disaster Relief SPA TN-20-0004 approved 4/24/20 (effective 3/1/20)
Institutional Eligibility			
States do not need to apply the transfer-of-asset rules against institutionalized individuals who are receiving services during a presumptive eligibility period and have not yet submitted a Medicaid application. Under section 1917(c)(1) of the Act, the transfer-of-asset rules are not implicated unless and until an individual has actually applied for medical assistance under the state plan.	SSA § 1902(a)(47)(B) 42 CFR 435.1110(c)(2)		

Table B (*continued*)

Available flexibilities and exceptions	Relevant authorities and sources	Notes on implementation and necessary state action	Select state examples
LTSS Eligibility			
Increase personal needs allowance (PNA) for selected eligibility groups or adopt a PNA variance for individuals with an identified greater need such that patient liability under post-eligibility treatment of income rules is lowered or eliminated, and institutionalized individuals are permitted to retain more or all of their available income. States would correspondingly increase their payments to medical institutions and to intermediate care facilities for individuals with intellectual disabilities for the medical assistance provided	SSA § 1902(a)(17) (Requires reasonable standards and comparability in determining eligibility and the amount of medical assistance)	Submit SPA to modify PNA amount or adopt a new PNA variance for eligibility groups other than individuals receiving waivered home- and community-based services (described at 42 C.F.R. §435.217). Submit 1915(c) waiver amendment for the latter individuals. During the COVID-19 PHE, submit Disaster Relief SPA (for all groups and individuals other than those described at §435.217) or Appendix K (for individuals receiving 1915(c) HCBS). During the COVID-19 PHE, submit Disaster Relief SPA.	
Modify or expand 1915(c) enrollee targeting criteria in order to serve additional individuals.	1915(c) waiver Appendix K	Submit Appendix K.	Colorado 1915(c) waiver Appendix K (combined) (effective 3/10/20)
Temporarily increase individual cost limits for 1915(c) enrollees.	1915(c) waiver Appendix K	Submit Appendix K.	Alaska 1915(c) waiver Appendix K (combined) (effective 3/11/20)
Increase the number of unduplicated 1915(c) enrollees (Factor C) (may be necessary to expand additional targeting criteria to serve more individuals or to increase the number of people entering, exiting and re-entering the waiver).	1915(c) waiver Appendix K	Submit Appendix K.	

Table B (*continued*)

Available flexibilities and exceptions	Relevant authorities and sources	Notes on implementation and necessary state action	Select state examples
B2. Eligibility Determination at Application (CHIP included where relevant)			
Develop a simplified paper MAGI application to support other enrollment strategies for use in affected areas	42 CFR § 435.907(b)(2), 42 CFR § 457.330 (Allows for use of alternative single, streamlined application)	Submit SPA to add an alternative single streamlined application for affected population. During the COVID-19 PHE, submit Disaster Relief SPA.	
Treat assessments from the Federally Facilitated Exchange (FFE) through the account transfer process as determinations during an emergency beyond the agency's control.	42 CFR § 435.1200 (Establishes authority to delegate determinations to the FFE) 42 CFR § 457.351 (applies 42 CFR § 435.1200(g) to CHIP)	Assessment states have flexibility to accept findings from the FFE as final MAGI determinations and enroll individuals into coverage without additional verification if all eligibility criteria have been verified by the FFE. States will need to complete verification to determine eligibility for individuals for whom not all factors of eligibility have been verified by the FFE (i.e., the FFE has not resolved a discrepancy between attested information and electronic data). Document policy in compliance with state's record keeping practices and seek concurrence from CMS. States seeking long-term changes should submit a single state agency SPA to delegate eligibility determination to the Exchange and update the FFM data collection tool to reflect the change to a determination state. For CHIP, states seeking long-term changes should submit an updated CS24.	
Adopt presumptive eligibility for eligible populations (MAGI only). States with an approved presumptive eligibility SPA may also add additional MAGI populations for which qualified entities may make presumptive eligibility determinations.	42 CFR § 435 Subpart L (Enables presumptive eligibility authority) 42 CFR § 457.355 (presumptive eligibility for children)	Submit Presumptive Eligibility SPA. During the COVID-19 PHE, submit Disaster Relief SPA. Submit CHIP CS28 to adopt presumptive eligibility. To make time-limited changes in CHIP, submit CHIP Disaster Relief SPA.	Illinois COVID-19 Disaster Relief SPA TN-20-0004 approved 4/24/20 (effective 3/1/20)

Table B (*continued*)

Available flexibilities and exceptions	Relevant authorities and sources	Notes on implementation and necessary state action	Select state examples
Establish the state as a presumptive eligibility qualified entity to presumptively enroll individuals based on preliminary information. Individuals who complete a full application would not be required to complete a new application for a full eligibility determination.	42 CFR § 435 Subpart L (Enables presumptive eligibility) 42 CFR § 457.355 (presumptive eligibility for children)	Submit Presumptive Eligibility SPA. During the COVID-19 PHE, submit Disaster Relief SPA. Submit CHIP CS28 to adopt presumptive eligibility. To make time-limited changes in CHIP, submit CHIP Disaster Relief SPA.	Illinois COVID-19 Disaster Relief SPA TN-20-0004 approved 4/24/20 (effective 3/1/20)
Add additional health care providers and/or community agencies to the state's list of qualified entities in an approved Presumptive Eligibility SPA eligible to presumptively enroll individuals based on preliminary information.	42 CFR § 435 Subpart L (Enables presumptive eligibility) 42 CFR § 457.355 (presumptive eligibility for children)	Submit Presumptive Eligibility SPA. During the COVID-19 PHE, submit Disaster Relief SPA. To make time-limited changes in CHIP, submit CHIP Disaster Relief SPA.	
Extend the availability of hospital presumptive eligibility to non-MAGI groups (including eligibility groups for individuals with disabilities) and/or to populations covered in a section 1115 demonstration.	42 CFR § 435 Subpart L (Enables presumptive eligibility authority)	Submit Hospital Presumptive Eligibility SPA. During the COVID-19 PHE, submit Disaster Relief SPA.	California COVID 19 Disaster Relief SPA TN -20-0024 approved 5/13/20 (effective 3/1/2020)
Use regulatory exception in meeting application processing timelines.	42 CFR § 435.912(e)(2) (Permits an exception to federal timeliness standards during an administrative or other emergency beyond the agency's control) 42 CFR § 435.912(f) (States must document the reason for the delay in each applicant case record) 42 CFR § 457.340(d) (Applies to CHIP the Medicaid timeliness exception during an administrative or other emergency beyond the agency's control)	Document reason for use of the exception in the applicant's case record. States are encouraged to seek concurrence from CMS that use of the exception is warranted under the circumstances and the timeframe for use of such exception, which must be tied to the emergency. States may do this by sending an informal email request to the CMS state lead for routing to the appropriate CMS staff. To make time-limited changes in CHIP, submit CHIP Disaster Relief SPA.	

Table B (*continued*)

Available flexibilities and exceptions	Relevant authorities and sources	Notes on implementation and necessary state action	Select state examples
CHIP-Specific			
Temporarily suspend waiting period policy for CHIP applicants and current enrollees who reside and/or work in a state or federally declared disaster area.	42 CFR §457.805 (The CHIP state plan must include a procedure to address substitution of coverage. A state may elect a waiting period as such procedure.)	Submit CHIP Disaster Relief SPA.	
B3. Redetermination and Change in Circumstances (CHIP included where relevant)			
Use regulatory exception in meeting timeliness standards.	42 CFR § 435.912(e)(2) (Permits an exception when states are unable to meet federal timeliness standards during an administrative or other emergency beyond the agency's control) 42 CFR § 435.912(f) (States must document the reason for the delay in each beneficiary case record) 42 CFR § 457.340(d) (Applies to CHIP the Medicaid timeliness exception during an administrative or other emergency beyond the agency's control)	Document the reason for the use of the exception in the beneficiary's case record. States are encouraged to seek concurrence from CMS that use of the exception is warranted under the circumstances, and the timeframe for use of such exception, which must be tied to the emergency. States may do this by sending an informal email request to the CMS state lead for routing to the appropriate CMS staff. To make time-limited changes in CHIP, submit CHIP Disaster Relief SPA.	
Use regulatory exception when unable to promptly act on changes in circumstances affecting eligibility.	42 CFR § 435.912(e)(2) (Permits an exception when states are unable to meet federal timeliness standards during an administrative or other emergency beyond the agency's control) 42 CFR § 435.912(f) (States must document the reason for the delay in each beneficiary case record) 42 CFR § 457.340(d) (Applies to CHIP the Medicaid timeliness exception during an administrative or other emergency beyond the agency's control)	Document reason for the use of the exception in promptly acting on any change in circumstances in the beneficiary's case record. States are encouraged to seek concurrence from CMS that use of the exception is warranted under the circumstances, and he timeframe for use of such exception, which must be tied to the emergency. States may do this by sending an informal email request to the CMS state lead for routing to the appropriate CMS staff. To make time-limited changes in CHIP, submit CHIP Disaster Relief SPA.	

Table B (*continued*)

Available flexibilities and exceptions	Relevant authorities and sources	Notes on implementation and necessary state action	Select state examples
Establish continuous eligibility for children for up to 12 months.	SSA § 1902(e)(12) 42 CFR § 435.926 42 CFR § 457.342 (applies Medicaid continuous eligibility policy to CHIP)	Submit SPA, or Disaster Relief SPA if available for a particular emergency, for children statewide. During the COVID-19 PHE, submit Disaster Relief SPA. To adopt continuous eligibility, generally in CHIP, submit a CS 27 SPA. To adopt continuous eligibility for a limited time during a PHE, submit a CHIP disaster SPA.	Rhode Island COVID-19 Disaster Relief SPA RI-20-0003 approved 4/8/20 (effective 3/1/20)
Extend redetermination period for non-MAGI eligibility determinations to 12 months (if state has elected to conduct more frequent renewals).	42 CFR § 435.916(b)	Submit SPA. During the COVID-19 PHE, submit Disaster Relief SPA.	
B4. Verification (CHIP included where relevant)			
Determine eligibility at application based on self-attestation of eligibility information and conduct post-enrollment verification within a reasonable timeframe, except where other processes are required by law (including for citizenship and immigration).	42 CFR § 435.945(a) (Authorizes the acceptance of self-attestation for eligibility verification, unless statute expressly requires documentation, e.g., for citizenship/immigration status) 42 CFR § 435.948 – income 42 CFR § 435.956 – examples, including residency 42 CFR § 457.380	Submit Medicaid and CHIP Disaster Relief MAGI-Based Verification Plan Addendum to make temporary changes to Verification Plan; update internal non-MAGI-based verification policies.	
Provide exception to use self-attestation in lieu of documentation to resolve inconsistency on case-by-case basis when documentation does not exist or is not reasonably available.	42 CFR § 435.952(c)(3) (Requires, on a case-by-case basis, that self-attestation be accepted when documentation is required to explain an inconsistency and the documentation does not exist or is not reasonably available to the individual during a natural disaster or other reason, unless statute expressly requires documentation) 42 CFR § 457.380 (Eligibility verification requirements).	Document use of exception in individual's case record.	

Table B (*continued*)

Available flexibilities and exceptions	Relevant authorities and sources	Notes on implementation and necessary state action	Select state examples
Modify reasonable compatibility standard for inconsistencies in income when the self-attested income is at or below, and the income obtained electronically is above the applicable income standard.	42 CFR § 435.952(c)(2)(1) 42 CFR § 457.380 (Eligibility verification requirements)	Submit Medicaid and CHIP Disaster Relief MAGI-Based Verification Plan Addendum to CMS to make temporary changes to Verification Plan; update internal non-MAGI-based verification policies.	
If state requires submission of paper documentation to resolve inconsistency, allow individuals to provide a reasonable explanation of inconsistencies in lieu of requiring paper documentation.	42 CFR § 435.952(c)(2)(i) 42 CFR § 457.380 (Eligibility verification requirements)	Submit Medicaid and CHIP Disaster Relief MAGI-Based Verification Plan Addendum to make temporary changes to Verification Plan; update internal non-MAGI-based verification policies.	
Allow for extensions to the reasonable opportunity period to provide documentation of satisfactory immigration status verification.	42 CFR § 435.956(b)(2)(B) (Allows state to extend reasonable opportunity period for individuals in a satisfactory immigration status if individual is making good faith effort to obtain documents or state needs more time to verify eligibility) 42 CFR § 457.380	Check if state has elected to extend reasonable opportunity period in current state plan; can elect by submitting SPA During the COVID-19 PHE, submit Medicaid Disaster Relief SPA. To make time-limited changes in CHIP, submit CHIP Disaster Relief SPA.	

Table B (*continued*)

Available flexibilities and exceptions	Relevant authorities and sources	Notes on implementation and necessary state action	Select state examples
Allow for self-attestation of resources for individuals whose financial institutions are unable to provide verification of resources due to disaster.	42 CFR § 435.945(a) (Authorizes the acceptance of self-attestation for eligibility verification, unless statute expressly requires documentation, e.g., for citizenship/immigration status). For financial assets, states may initially rely on self-attestation of assets and verify financial assets using their AVS post-enrollment in Medicaid. Under regulations at 42 C.F.R. § 435.916(d), if a state obtains new asset information from the AVS post-enrollment that indicates an individual may not be eligible, the state must evaluate that information and redetermine eligibility as appropriate. For other types of resources, not found in the AVS, states may rely upon self-attestation exclusively without further post eligibility verification.	Document policy in compliance with state's non-MAGI verification plan and seek concurrence from CMS.	
Allow for self-attestation of incurred medical expenses (needed to meet spend-down for purposes of medically needy eligibility).	42 CFR § 435.945(a) (Authorizes the acceptance of self-attestation for eligibility verification, except for citizenship/immigration status)	Document policy in compliance with state's non-MAGI verification plan.	
Temporarily suspend periodic data checks of unemployment, SWICA, TALX, or other data as applicable.	42 CFR § 435.948(a) (Usefulness of electronic data sources) 42 CFR § 457.380 (Establishes state authority to adopt eligibility standards for CHIP program)	Submit Medicaid and CHIP Disaster Relief MAGI-Based Verification Plan Addendum to make temporary changes to Verification Plan; update internal non-MAGI-based verification policies	

Table C: Beneficiary Cost Sharing and Premiums

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
Medicaid (CHIP included where relevant)			
Modify or suspend imposition of co-payments applied under state plan.	SSA § 1902(a)(17) (Requires reasonable financial standards and methods and comparability in determining eligibility) SSA § 1902(a)(14) (Requires cost sharing to be imposed only as provided under SSA 1916 and 1916A) 42 CFR § 447.52 (general cost sharing) 42 CFR § 447.53 (cost sharing for drugs) 42 CFR § 447.54 (cost sharing for non-emergency use of emergency department) 42 CFR § 457.515(c) (Provides states with authority to define the group or groups of individuals subject to cost sharing and the amount of charges imposed) (Note: If the state imposes co-payments under section 1115 authority, changes to a state's section 1115 demonstration may be needed to suspend co-payments.)	Amend cost sharing SPA if suspending co-payments statewide. During the COVID-19 PHE, submit Disaster Relief SPA. States may not eliminate or modify co-payments based on disease or diagnosis, unless specifically authorized by statute. To make time-limited changes in CHIP, submit a CHIP Disaster Relief SPA.	Alabama COVID-19 Disaster Relief SPA AL-20-0004 approved 4/6/20 (effective 3/1/2020) Texas CHIP SPA TX-17-0043 (8/31/17)
Suspend payment of premiums.	42 CFR § 447.55 (Allows states to impose premiums upon one or more specified eligibility groups and/or categorical populations of individuals) 42 CFR § 457.510 (Provides states with authority to define the group or groups of individuals subject to premiums and/or enrollment fees and the amount of charges imposed) (Note: If the state imposes premiums under section 1115 authority, changes to a state's section 1115 demonstration may be needed to suspend premiums.)	During the COVID-19 PHE, submit Disaster Relief SPA. Use a hardship exemption if state wants to suspend premiums for only individuals facing disaster or PHE. To make time-limited changes in CHIP, submit a CHIP Disaster Relief SPA.	Alaska COVID-19 Disaster Relief SPA AK-20-0003 approved 5/7/20 (effective 3/1/2020)

Table C (*continued*)

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
Hardship exemption for individuals subject to a disaster or PHE from payment of premiums.	42 CFR § 447.55(b)(4) (Allows for premiums to be waived where the agency determines payments will create an undue hardship for the individual or family) 42 CFR § 457.510 (Provides states with authority to define the group or groups of individuals subject to premiums and/or enrollment fees and the amount of charges imposed)	Check state plan to determine if state has this policy articulated; if not, submit (disaster) SPA to implement this policy. Document reason for not requiring premium payment in enrollee's case record. To make time-limited changes in CHIP, submit a CHIP Disaster Relief SPA.	Minnesota COVID-19 Disaster Relief SPA MN-20-0002 approved 4/6/20 (effective 3/1/2020)
CHIP-Specific			
Temporarily suspend or delay collection of enrollment fees for families approved for coverage or renewal.	42 CFR § 457.510 (Provides states with authority to define the group or groups of individuals subject to premiums and/or enrollment fees and the amount of charges imposed)	Suspension of enrollment fees applies to families determined eligible, but whose enrollment is pending payment of fee. To make time-limited changes in CHIP, submit a CHIP Disaster Relief SPA.	Texas CHIP SPA TX-17-0043 (8/31/17)
Temporarily suspend application of premiums (and/or waive premium balances or premium lock-out policies) or extend premium submission deadlines for enrollees who meet certain income and other eligibility requirements.	42 CFR § 457.510 (Provides states with authority to define the group or groups of individuals subject to premiums and/or enrollment fees and the amount of charges imposed)	To make time-limited changes in CHIP, submit a CHIP Disaster Relief SPA.	

Table D: Benefits[3]

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
D1. Medicaid			
Offer additional optional benefits not currently provided under the state plan or Alternative Benefit Plan.	SSA § 1902 SSA § 1905 SSA § 1937	Submit state plan amendment for the traditional state plan or an Alternative Benefit Plan. During the COVID-19 PHE, submit Disaster Relief SPA.	
Change amount, duration ,or scope of mandatory or optional benefits.	SSA § 1902 SSA § 1905 Section 1115 authority might be needed to make certain changes to the amount, duration, or scope of benefits if those changes would apply only to certain populations or only in certain parts of a state.	Submit amended state plan or Alternative Benefit Plan, if applicable. During the COVID-19 PHE, submit Disaster Relief SPA.	
Provide nursing facility care to evacuees in the host state if their institutional stay is less than 30 days and the individual has established Medicaid eligibility in their home state.	section 1135 waiver	Submit section 1135 waiver request.	
D2. LTSS Benefits (1915(c), 1915(i), 1915(k))			
Modify 1915(c) service, scope or coverage.	1915(c) waiver Appendix K	Submit Appendix K.	Connecticut 1915(c) waiver Appendix K (combined) (effective 3/16/20)

[3] See Table H for flexibility and exceptions related to telehealth and other information technology mediums.

Table D (*continued*)

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
Add or expand services to a 1915(c) waiver to address the emergency situation that are necessary to assist a waiver participant to avoid institutionalization and live in the community.	1915(c) waiver Appendix K	Appendix K includes a list of example supplemental support services that may be provided under an emergency (for example, emergency counseling, heightened case management to address emergency needs, emergency medical supplies and equipment, self-directed goods and services, transportation) Submit Appendix K.	Connecticut 1915(c) waiver Appendix K (combined) (effective 3/16/20)
Modify service limitations or requirements for amount and duration of services.	1915(c) waiver Appendix K	Submit Appendix K.	Hawaii 1915(c) waiver HI.0013.R07.04 Appendix K (effective 3/1/20)
Modify the person-centered service plan development process and individual(s) responsible for person-centered service plan development for 1915(c) enrollees.	1915(c) waiver Appendix K	Modifications should include emergency specific risk assessment and mitigation techniques (e.g., permitting telephonic assessments, adjusting minimum qualifications of persons doing assessments). Submit Appendix K.	Pennsylvania 1915(c) waiver PA.00354.R04.05 Appendix K (effective 3/11/20) Nevada 1915(c) waiver Appendix K (combined) (effective 1/27/20)
Temporarily waive written consent requirement and permit documented verbal consent on person-centered service plans from beneficiaries and all providers responsible for its implementation. Applies to 1915(c), 1915(i), and 1915(k) programs.	42 CFR § 441.301(c)(2)(ix) 42 CFR § 441.725(b)(9) 42 CFR § 441.540(b)(9) section 1135 waiver	Submit section 1135 waiver request.	

Table D (*continued*)

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
Institute or expand opportunities for self-direction for 1915(c) enrollees, or expand decision making authority.	1915(c) waiver Appendix K	Submit Appendix K.	Kentucky 1915(c) waiver Appendix K (combined) (effective 3/6/20) Iowa 1915(c) Appendix K (combined) (effective 1/27/20)
Temporarily expand allowable, in-state 1915(c) waiver service settings.	1915(c) waiver Appendix K	Submit Appendix K.	Hawaii 1915(c) waiver HI.0013.R07.04 Appendix K (effective 3/1/20)
Temporarily allow 1915(c), 1915(i), 1915(k) services to be provided in alternative settings that have not been determined to meet HCBS criteria.	section 1135 waiver	Submit section 1135 waiver request. This waiver applies to settings that have been added since the March 17, 2014, effective date of the HCBS final regulation (CMS 2249-F/2296-F), to which the HCBS settings criteria currently applies, to accommodate circumstances in which an individual requires relocation to an alternative setting to ensure the continuation of needed home and community-based services during a disaster and/or emergency.	
Temporarily provide 1915(c) waiver services in out of state settings.	1915(c) waiver Appendix K	Submit Appendix K.	Connecticut 1915(c) waiver Appendix K (combined) (effective 3/16/20)
Temporarily permit payment for 1915(c) waiver services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver.	1915(c) waiver Appendix K	Submit Appendix K.	New Mexico 1915(c) waiver Appendix K (combined) (effective 1/27/20) Louisiana 1915(c) waiver Appendix K (combined) (effective 1/27/20)

Table D (*continued*)

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
Temporarily modify provider qualifications to allow family members of 1915(c) enrollees or legally responsible individuals to provide waiver services prior to background checks and training for 90 days.	1915(c) waiver Appendix K	Submit Appendix K that could, for example, permit online training for certain qualifications typically available through an on-site curriculum like CPR or basic first aid to reduce choking risk.	Colorado 1915(c) waiver Appendix K added relatives, spouses, and legally responsible persons to the provider qualifications for Personal Care in five of their waivers
Temporarily permit payment for 1905(a) personal care services rendered by legally responsible individuals provided the state makes a reasonable assessment that the caregiver is capable of rendering such services.	section 1135 waiver	Submit section 1135 waiver request.	
Allow for payment for home and community-based services in an acute care hospital for beneficiaries receiving HCBS under sections 1915(c), (i), (j), (k) or under section 1115 demonstrations.	1915(c) waiver Appendix K Section 1902(h) as amended by Section 3715 of CARES Act, applicable to 1915(c) waivers, 1915(i) and (k) state plan options.	Submit Appendix K. Submit waiver or SPA.	Wyoming 1915(c) waiver Appendix K (combined) (effective 1/27/20)
Allow for payment for services for purposes of supporting 1915(c) enrollees during short term institutional stay.	1915(c) waiver Appendix K	Submit Appendix K.	
Include retainer payments to providers of services that include personal care assistance when a 1915(c) enrollee is hospitalized or absent from their home for a period of no more than three episodes of 30 days.	1915(c) waiver Appendix K	Available for personal care and habilitation services that include personal care as a component of the service. Submit Appendix K.	Kentucky 1915(c) waiver Appendix K (combined) (effective 3/6/20).

Table D (*continued*)

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
D3. Authorizations			
Medicaid and CHIP Authorizations			
Temporarily suspend Medicaid fee-for-service prior authorization requirements.	42 CFR §440.230	During the COVID-19 PHE, submit Disaster Relief SPA, if necessary based on state plan language. For CHIP, states do not describe their prior authorization policies in the state plan. Thus, no SPA or 1135 authority is needed to modify prior authorization requirements as long as they meet the requirements of 42 CFR §457.495.	
Require fee-for-service providers to extend prior authorizations through the termination of the emergency declaration.	42 CFR §440.230	During the COVID-19 PHE, submit Disaster Relief SPA.	
Modify prior authorization requirements for services provided under EPSDT.	SSA § 1905(r)	States may establish limits on services provided under EPSDT only if they can be exceeded based on medical necessity. Depending on state approach to services provided under EPSDT, states may establish and manage prior authorization processes for these services without CMS approval. However, in other cases a SPA may be required. For separate CHIPs that offer EPSDT benefits, states follow the Medicaid process. For other programs, the CHIP state plan does not include prior authorization policies. Thus, no SPA or 1135 authority is needed to modify prior authorization requirements as long as they meet the requirements of 42 CFR §457.495.	

Table D (*continued*)

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
LTSS Authorizations and Face-to-Face Requirements (1915(c), 1915(i), 1915(k))			
Temporarily suspend face-to-face requirements in home and community-based service programs.	42 CFR §440.70(f)(6) SPA for state plan LTSS/HCBS 1915(c) waiver Appendix K	State plan amendments would only be needed to revise existing state plan language that imposes telehealth parameters that would restrict this practice Submit Appendix K.	Connecticut 1915(c) waiver Appendix K (combined) (effective 3/16/20)
Temporarily suspend pre-admission screening and annual resident review (PASRR) Level and Level II Assessments for 30 days.	section 1135 waiver	Submit section 1135 waiver request.	Alabama COVID-19 Section 1135 Waiver Approval Letter (3/23/20)
Temporarily suspend or modify 1915(c) prior authorization requirements.	1915(c) waiver Appendix K	Submit Appendix K.	
Extend medical necessity or level of care authorizations for 1915(c) recipients.	1915(c) waiver Appendix K	Extensions cannot exceed 12 months beyond initial reevaluation deadline. Submit Appendix K.	Pennsylvania 1915(c) waiver Appendix K (PA.0147) (effective 3/11/20)
Temporarily modify process for conducting medical necessity or level of care evaluations and re-evaluations for 1915(c) recipients (e.g., permit evaluations to be conducted telephonically).	1915(c) waiver Appendix K (*See following rows for more extensive flexibilities available across HCBS authorities using section 1135 waiver authority.)*	Submit Appendix K.	Rhode Island 1915(c) waiver Appendix K (combined) (effective 2/27/20)
Delay initial level of care assessment for 1915(c) beneficiaries after the individual begins receiving services; annual re-evaluation and reassessment may be extended by up to one year.	42 CFR § 441.302(c) section 1135 waiver	Submit section 1135 waiver request.	

Table D (*continued*)

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
Delay initial assessments to determine level of care for 1915(k) beneficiaries needing LTSS until after the individual begins receiving services; annual level of care redetermination may be extended for up to one year.	42 CFR § 441.510(c) section 1135 waiver	Submit section 1135 waiver request.	
Delay initial evaluations and assessments for 1915(i) beneficiaries until after the individual begins receiving services; annual re-evaluation and reassessment may be extended by up to one year.	42 CFR § 441.715 42 CFR § 441.720 section 1135 waiver	Submit section 1135 waiver request.	
Temporarily authorize reimbursement for HCBS services provided by an entity that also provides case management services and/or is responsible for the development of the person-centered service plan, notwithstanding conflict of interest requirements. Applies to 1915(c), 1915(i), and 1915(k) programs.	42 CFR § 441.301(c)(1)(vi) 42 CFR § 441.555(c) 42 CFR § 441.730(b) section 1135 waiver	Submit section 1135 waiver request.	
Extend minimum data set authorizations for nursing facility and SNF residents.	section 1135 waiver	Submit section 1135 waiver request.	
Temporarily allow home health agencies to perform certifications, initial assessments and determine patients' homebound status remotely or by record review.	section 1135 waiver	Submit section 1135 waiver request.	
Permit MCOs to conduct an assessment of functional eligibility and forward the assessment to the state for final determination.	42 CFR 431.10(c)(2) (requiring states to make functional beneficiary eligibility determinations for HCBS)	State policy change.	

Table D (*continued*)

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
Prescription Drugs			
Temporarily suspend or increase limits on prescription drug fills and refills and dispensing signature requirements	SSA § 1927 (Does not limit the amount of prescription drugs that can be dispensed)	Submit amended state plan (if existing fill or refill limits require modification). During the PHE, submit Disaster Relief SPA.	Minnesota COVID-19 Disaster Relief SPA TN-20-0002 approved 4/2/20 (effective 3/1/20)
Temporarily make exceptions to the published Preferred Drug List (for use in the case of drug shortages)	SSA § 1927	Submit amended state plan. During the PHE, submit Disaster Relief SPA.	Arkansas COVID-19 Disaster Relief SPA AR-20-0015 approved 4/29/20 (effective 3/1/2020)
Modify prior authorization requirements for prescription drugs.	SSA § 1927(d)	States have flexibility to establish and manage prior authorization process without CMS approval. States with prior authorization as part of their state plan can submit Disaster Relief SPA to change those requirements.	Montana COVID-19 Disaster Relief SPA MT-20-0024 approved 5/8/20 (effective 3/1/20)

Table E: Adverse Actions and Fair Hearings

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
Medicaid and CHIP			
Suspend adverse actions for individuals in the disaster area for whom the state has completed a determination but either: (1) has not yet sent notice due to exigent circumstances related to the disaster (e.g., due to inability to deliver mail); or (2) who state believes likely did not receive notice.	42 CFR § 431.211 (Requires the state to provide at least 10 days advance notice before taking an adverse action)	When the state has a widespread cohort of cases to which this policy applies, document policy in compliance with state's record keeping practices and seek concurrence from CMS. This policy would likely be necessary in a very small set of cases for which the state had not sent required notice at the time of the disaster. During the COVID-19 PHE, if the state is claiming the temporary FMAP increase under section 6008 of the Families First Coronavirus Response Act, the state will need to continue to provide coverage to beneficiaries receiving coverage as of or after March 18, 2020 through the end of the month in which the PHE ends, whether or not the state has sent an adverse action notice and/or the individual has received such notice.	

Table E (*continued*)

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
Delay scheduling of fair hearings, issuing fair hearing decisions and taking final administrative action when there is an administrative or other emergency beyond the agency's control. For CHIP, delay scheduling reviews and issuing review decisions.	42 CFR § 431.244(f)(4)(i)(B) (Allows the agency to take final administrative action outside of timeline set in regulation when there is an administrative or other emergency beyond the agency's control). 42 CFR § 457.1160, 457.1170	Document reason for delay in enrollee's case record. Document policy in compliance with state's record keeping practices and seek concurrence from CMS. States should prioritize completing hearings for individuals who meet the standard for an expedited fair hearing under 42 CFR 431.224. States must offer to continue benefits to individuals who are requesting a fair hearing if the request comes before the date of the action under 42 C.F.R. § 431.230 and may reinstate benefits if the individual requests a fair hearing no later than 10 days after the date of the action under 42 CFR 431.231(a) (see additional flexibility below re: 431.231(a)). For CHIP, 42 CFR § 457.1160 requires reviews of eligibility and enrollment matters to be completed in a reasonable amount of time, and reviews of health services matters to be completed in accordance with the medical needs of the patient. States should prioritize completing hearings for individuals who meet the standard for an expedited fair hearing under 42 CFR 457.1160(b)(2). If states include more specific timeframes in their state plan, they may extend the time through a CHIP disaster relief SPA.	

Table E (*continued*)

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
Reinstate services for a beneficiary who requests a fair hearing more than 10 days after the date of action.	42 CFR § 431.231(a) (The agency may reinstate services if a beneficiary requests a hearing not more than 10 days after the date of action). section 1135 waiver	Submit 1135 request. Under the extended timeframe, states may reinstate services and benefits for beneficiaries who request a fair hearing more than 10 days after the date of action, but not to exceed the time permitted under the state plan or an approved section 1135 waiver for beneficiaries to request a fair hearing. The state should reinstate the individual's services and benefits as quickly as practicable.	Texas COVID-19 Section 1135 Waiver (11/25/20)
Hold fair hearings or CHIP reviews via videoconferencing or telephone, provided states adhere to other fair hearing requirements, including ensuring that the hearing system is accessible to persons who are limited English proficient and persons who have disabilities (see 42 C.F.R. §§ 431.205(e) and 435.905(b).	42 CFR § part 431, subpart E 42 CFR § part 457, subpart K	Document policy in compliance with state's record keeping practices.	
Allow enrollees to have more than 120 (if a managed care appeal) or more than 90 days (eligibility or fee-for-service appeal) to request a state fair hearing.	42 CFR § 438.408(f)(2) (Requires enrollees to request a state fair hearing no later than 120 days from the date of a managed care plan notice of resolution), 42 CFR § 431.221(d) (requires the state to permit an individual to request a state fair hearing for a reasonable time period not to exceed 90 days) section 1135 waiver 42 CFR §457.1260 (Applies Medicaid managed care appeals processes to CHIP). CHIP regulations do not specify a time period that states must give to enrollees to submit a review request.	Submit section 1135 waiver request.	Kansas COVID-19 Section 1135 Waiver Approval Letter (3/25/20)

Table F: Managed Care

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
F1. Prior Authorizations			
Temporarily suspend prior authorization requirements.	42 CFR § 438.210(b)(d) (Requires managed care contracts to specify the prior authorization requirements between the State and the managed care plan.) 42 CFR §457.1230(d) (applies 42 CFR § 438.210 to CHIP)	Amend managed care plan contract, depending on level of detail in existing managed care contract. Authority can be used to allow early prescription refills and/or extended length of refills; telehealth visits; out-of-network/state services; and continuing home health visits, dialysis services and supplies, home oxygen services, medications related to supporting immune function, and other critical services.	
Require managed care plans to extend prior authorizations through the termination of the emergency declaration.	42 CFR § 438.210(b) 42 CFR § 457.1230(d) (applies 42 CFR § 438.210 to CHIP)	Amend managed care plan contract.	
Require managed care plans to expedite processing of new prior authorizations and allow flexibility in documentation (e.g., physician signatures).	42 CFR § 438.210(d) (Provides for authorization decisions that are within state-established timeframes; the regulation does not prohibit states from requiring authorization decisions that are more expeditious than the timeframes provided in the regulation) 42 CFR § 438.210(b) (Provides that for the processing of requests for initial and continuing authorizations of services, the contract must require managed care plans to have in place, and follow, written policies and procedures, and that managed care plans have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions) 42 CFR § 457.1230 (applies 42 CFR § 438.210 to CHIP)	Amend managed care plan contract.	

Table F (*continued*)

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
F2. Provider Network			
Temporarily suspend out-of-network requirements for managed care enrollees.	42 CFR § 438.206(b)(4) (Requires the provision of access to services when the provider network is unable to provide necessary services covered under the contract to a specific enrollee) 42 CFR § 457.1230 (applies 42 CFR § 438.206 to CHIP)	Amend managed care plan contract.	
F3. Care Management Initial Screening			
Provide managed care plans flexibility with the timeframe of conducting an initial care management screening of each enrollee's needs if they've demonstrated "a best effort" to reach out to the enrollee.	42 CFR § 438.208(b)(3) (Requires plans to make a best effort to conduct an initial screening within 90 days) 42 CFR § 457.1230(d) (applies 42 CFR § 438.208 to CHIP)	Document reason for delay in enrollee's case record.	
F4. Appeals			
Allows enrollees to proceed almost immediately to a state fair hearing without having a managed care plan resolve the appeals; state would modify the timeline for managed care plans to resolve appeals to one day so that the impacted appeals satisfy the exhaustion requirement.	42 CFR § 438.402(c)(1)(i)(A), 42 CFR § 438.408(c)(3), and 42 § CFR 408(f)(1)(i) (Deemed exhaustion of appeals processes) section 1135 waiver	Submit section 1135 waiver request.	Delaware COVID-19 Section 1135 Waiver Approval Letter (3/27/20)
F5. Quality Measurement Requirements			
Adjust managed care contract quality measurement requirements to account for changes in clinical practice resulting from a PHE.	42 CFR § 438.6(b)(3) (withholds) 42 CFR § 438.6(b)(2) (incentives) 42 CFR § 438.6(c) (state-directed payments)	Submit a contract amendment and, depending on the nature of the change, a rate certification amendment.	

Table G: Provider Enrollment and Participation

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
Medicaid and CHIP[a]			
Temporarily waive payment of application fee to temporarily enroll a provider.	42 CFR § 455.460 (Requires state to collect application fee prior to enrolling provider) section 1135 waiver	Submit section 1135 waiver request.	Hawaii COVID-19 Section 1135 Waiver Approval Letter (3/26/20)
Temporarily waive criminal background checks to temporarily enroll a provider	42 CFR § 455.434 (Requires providers to consent to criminal background checks for provider enrollment) 42 CFR § 455.450(c)(2) (Requires criminal background checks to screen providers designated as high categorical risk) section 1135 waiver	Submit section 1135 waiver request.	Indiana COVID-19 Section 1135 Waiver Approval Letter (3/25/20)
Temporarily waive site visits to temporarily enroll a provider.	42 CFR § 455.432 (Requires state to conduct a pre- and post-enrollment site visit of providers who are designated as 'moderate" or "high" categorical risks) 42 CFR § 455.450(b)(2) (Requires site visit to screen providers designated as moderate categorical risk) 42 CFR § 455.450(c)(1) (Incorporates screening requirements for providers of limited or moderate categorical risk (including site visits) for providers of high categorical risk) section 1135 waiver	Submit section 1135 waiver request.	Kentucky COVID-19 Section 1135 Waiver Approval Letter (3/25/20)
Temporarily increase types of providers a state authorizes to deliver services (changes must be in compliance with state-level requirements impacting provider flexibility in delegation of authority).		Appendix K (for 1915(c) waiver services). Submit SPA (for state plan services). Change in state policy also may be required.	Arkansas allowed Qualified Behavioral Health Paraprofessionals employed by Outpatient Behavioral Health Service Agencies to provide Supportive Living services.

Table G (*continued*)

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
Temporarily waive requirement that physicians and other health care professionals be licensed in the state in which they are providing services, so long as they have equivalent licensing in another state. Permit providers located out of state/territory to provide care to a disaster state's Medicaid enrollee.	42 CFR § 455.412 (Requires state to have method for verifying that any provider purporting to be licensed in accordance with the laws of any state is licensed by such state) 42 CFR § 455.450(a)(2) (Requires license verifications in states other than where the provider is enrolling) section 1135 waiver	The following conditions must be met: the service was provided outside the geographical boundaries of the state/territory's Medicaid plan; the NPI is presented on the claim; the furnishing provider is enrolled and in an approved status in Medicare or in another state/territory's Medicaid program; the claim represents services furnished; and the claim is a single instance of care over a 180-day period or multiple instances of care to a single participant over a 180-day period. For purposes of reimbursement only. State law governs whether a non-federal provider is authorized to provide services in the state without state licensure. Providers must not be affirmatively excluded from practice in the state or in any state that is included in the emergency area. Submit section 1135 waiver request.	Arizona COVID-19 Section 1135 Waiver Approval Letter (3/23/20) Michigan COVID-19 Section 1135 Waiver Approval Letter (4/6/20) New Mexico COVID-19 Section 1135 Waiver Approval Letter (3/23/20)
Streamline provider enrollment requirements when enrolling providers.	42 CFR § 455, subpart E (Provide screening and enrollment requirements) section 1135 waiver	Submit section 1135 waiver request.	Florida COVID-19 Section 1135 Waiver Approval Letter (3/16/20)
Postpone revalidation of providers who are located in state or otherwise directly impacted by the disaster.	42 CFR § 455.414 (Requires revalidation of the enrollment of providers at least every 5 years) section 1135 waiver	Submit section 1135 waiver request.	Massachusetts COVID-19 Section 1135 Waiver Approval Letter (3/26/20)

Table G (*continued*)

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
Provide payments to facilities for providing services in alternative settings, including an unlicensed facility or temporary facility, if the provider's licensed facility has been evacuated, compromised, is inadequate to meet the demand as determined by the state of facility or is necessary to protect the health and safety of other patients.	section 1135 waiver	*Examples*: Allow nursing facilities to be reimbursed for services rendered in a temporary shelter; allow reimbursement for dialysis provided to patients with kidney failure in an alternate setting; allow providers to be reimbursed for services rendered in a temporary facility set up due to an evacuation to an unlicensed facility or to meet surge demand for hospital beds. Submit section 1135 waiver request.	Louisiana COVID-19 Section 1135 Waiver Approval Letter (3/23/20) District of Columbia COVID-19 Section 1135 Waiver Approval Letter (4/3/20)
Flexibility in requirements under Patient Self Determination Act.	42 CFR § 489.102 section 1135 waiver	Submit section 1135 waiver request.	
Waive sanctions relating to limitations on physician referral.	SSA § 1877(g) section 1135 waiver	Submit request to waive sanctions.	
1915(c) Waiver			
Temporarily modify 1915(c) waiver provider types, provider qualifications, and licensure or other requirements for settings where waiver services are furnished.	1915(c) waiver Appendix K	Submit Appendix K. *Example*: Identify minimally acceptable provider qualifications and provider types to ensure 1915(c) enrollees receive waiver services by providers operating at the top of their scope of practice.	Arkansas allowed Qualified Behavioral Health Paraprofessionals employed by Outpatient Behavioral Health Service Agencies to provide Supportive Living services.
Waive weekly processing of timesheets by fiscal intermediaries or other onerous documentation when a provider is unable to come into the office.	1915(c) waiver Appendix K	Submit Appendix K.	New Mexico 1915(c) waiver Appendix K (combined) (effective 1/27/20)

Table G (*continued*)

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
CHIP			
Provide payments to facilities not certified to participate in CHIP if they provide services to CHIP enrollees	section 1135 waiver	Submit section 1135 waiver request.	

[a] The requirements in 42 CFR § 455 subpart E apply to both Medicaid and CHIP.

Table H: Telehealth

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
Medicaid and CHIP			
Extend coverage of services provided via telehealth beyond that described in state plan (if state has language in state plan noting each benefit for which telehealth is available).		Submit SPA or amend Alternative Benefit Plan. To make time-limited changes during Presidential and Secretarial emergency declarations, submit Disaster Relief SPA. No CHIP SPA is needed to cover or pay for services provided via telehealth. The CHIP state plan does not specify a method of delivering benefits.	Minnesota State Plan Amendment 20-0004 (4/20/20)
Extend payment methodologies for in-person services to services provided via telehealth.		Change in state policy. No federal approval is needed for state Medicaid programs to reimburse providers for services provided via telehealth in the same manner or at the same rate that states pay services provided in face-to-face encounters. A SPA would be necessary to change state plan payment methodologies that describe payments specifically for services delivered via telehealth, or to remove any restrictions on the services that can be delivered via telehealth or providers that can use telehealth. No CHIP SPA is needed to cover or pay for services provided via telehealth. The CHIP state plan does not specify a method of delivering benefits.	Alaska Division of Health Care Services Guidance for Coverage during the COVID-19 PHE (3/01/22)

Table H (*continued*)

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
Expand the telehealth technologies that can be used for services provided via telehealth to include services delivered via live video, "store and forward" method (e.g., sending picture or video), telephone, and secure messaging.		Change in state policy. Submit SPA or amend Alternative Benefit Plan. During the COVID-19 PHE, submit Disaster Relief SPA.	Colorado State Plan Amendment 20-0019 (9/4/20)
Establish a patient's home or any place the patient is located as an eligible originating site.	A section 1135 waiver may be necessary to do this for clinic services, 42 CFR 440.90	Change in state policy. Submit section 1135 waiver request for clinic services.	New Hampshire Department of Health and Human Services COVID-19 Telehealth Fact Sheet (3/18/20)
Temporarily modify provider types who can remotely monitor and treat patients.		Change in state policy.	Georgia Department of Community Health COVID-19 Provider Informational Notice (3/26/20)
Temporarily modify licensure or other requirements for providers who can remotely monitor and treat patients.		Change in state policy.	Idaho State Board of Medicine COVID-19 Response Protocol 1 (3/18/20)
Temporarily suspend requirement for "telepresenters" or other providers (e.g., originating site providers) to be physically present with a patient during a telehealth visit.		Change in state policy.	
Temporarily suspend any pre-telemedicine visit requirements (e.g., prior authorization, referral, and in-person evaluation/established patient relationship requirements).		Change in state policy.	North Carolina Medicaid Special Bulletin COVID-19 #9 (3/20/20)

Table H (*continued*)

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
Conduct remote PASRR evaluations.		Unless state has a specific requirement that PASRR Level 2 evaluations be conducted in a face-to-face interview, there is no need to amend language in state plan.	Illinois Department of Healthcare and Family Services COVID-19 Provider Informational Notice (3/20/20)
Reimburse FQHCs and RHCs for services provided via telehealth (including via telephone).		Submit SPA and consult with CMS if it is determined that the state's approved state plan excludes FQHC/RHC services from being provided via a telehealth delivery system, or from being provided telephonically. CMS can work with the state to expedite processing of SPA. FFP is available for services provided via telephone by FQHCs or RHCs. No CHIP SPA is needed to cover or pay for services provided via telehealth. The CHIP state plan does not specify a method of delivering benefits.	Arizona Health Care Cost Containment System FAQs Regarding COVID-19 (4/1/20)
LTSS			
Temporarily suspend face-to-face requirements in home and community-based service programs.	42 CFR §440.70(f)(6) SPA for state plan LTSS/HCBS 1915(c) waiver Appendix K	State plan amendment only needed to revise existing language that imposes telehealth parameters that would restrict this practice Submit Appendix K to utilize telehealth (remote communications/monitoring) options in place of face-to-face.	Connecticut 1915(c) waiver Appendix K (combined) (effective 3/16/20)

Table H (*continued*)

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
Temporarily modify process for conducting medical necessity or level of care evaluations and re-evaluations for 1915(c) recipients (e.g., permit evaluations to be conducted telephonically).	1915(c) waiver Appendix K	Submit Appendix K. As an alternative, states may submit a section 1135 waiver to postpone LOC initial and re-determinations in 1915(c) and (k), and the corresponding assessments in (i) during the PHE period.	Montana 1915(c) waiver Appendix K (combined) (effective 1/27/20)
Temporarily allow home health agencies to perform certifications, initial assessments remotely or by record review.	section 1135 waiver	Submit section 1135 waiver request.	
Modify the person-centered service plan development process and individual(s) responsible for person-centered service plan development.	1915(c) waiver Appendix K section 1135 waiver	Modifications should include emergency specific risk assessment and mitigation techniques (e.g., permitting telephonic assessments, adjusting minimum qualifications of persons doing assessments). Submit Appendix K for 1915(c). As an alternative, states may submit a section 1135 waiver to adopt similar flexibilities for 1915(i), and 1915(k) services during the PHE period.	Pennsylvania 1915(c) waiver PA.00354.R04.05 Appendix K (effective 3/11/20)
Modify 1915(c) service, scope or coverage.	1915(c) waiver Appendix K	Submit Appendix K. Example: states can allow case management or personal care services that require only verbal cueing and/or instruction to be done via telephone or other information technology medium.	Connecticut 1915(c) waiver Appendix K (combined) (effective 3/16/20)
Managed Care			
Include all benefits that Medicaid FFS will cover when provided via telehealth in managed care contracts (if not already included in the contract).		Amend managed care contracts.	

Table H (*continued*)

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
Financing			
Receive FFP under an expedited process for technology investments to implement section 1135 waivers related to provider location or enrollment	45 CFR § 95.624 COVID-19 FAQs for State Medicaid and Children's Health Insurance Program (CHIP) Agencies	State must send request to CMS that includes the following: (1) brief description of the equipment and/or services to be acquired and an estimate of their costs; and (2) brief description of the circumstances driving the state's need to proceed prior to obtaining CMS approval for the FFP, and (3) the harm that will be caused if the state does not immediately acquire the requested equipment and/or services. Note: States are not required to use the emergency process to obtain FFP for technology in an emergency. This emergency process provides an expedited process for obtaining FFP in advance of following the usual prior approval requirements in 45 CFR § 95.611. Once emergency approval is received, the state then has 90 days to submit a formal request through regular Advance Planning Document (APD) processes.	

Table I: Medicaid Finance and Reimbursement

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
I1. General Requirements			
Temporarily suspend requirement that state pays a percentage of clean claims within 30 days and 90 days of receipt.	42 CFR § 447.45(e)	Submit to CMS proposed revised deadlines and timetables for claims processing, and an explanation of how the circumstances prevent the state from meeting the ordinarily applicable claims processing timeframes despite good faith efforts.	
Temporarily increase payment rates for specific covered services with temporary change to rate methodology.	SSA § 1902(a)(30)(A)	During the COVID-19 PHE, submit Disaster Relief SPA. *Example*: Can be used to account for increased costs in personal protective equipment (PPE) for providers or to make acuity-based payments to providers serving individuals in community or institutional settings.	COVID-19 FAQs for State Medicaid and Children's Health Insurance Program (CHIP) Agencies
Develop interim payment methodology to make periodic interim payments to providers (i.e., based on the provider's prior claims payment experience) for services furnished that are subject to final reconciliation.	SSA § 1902(a)(30)(A)	During the COVID-19 PHE, submit Disaster Relief SPA.	
Cover and pay for temporary absences under Medicaid reserve bed authority.	42 CFR § 447.40	During the COVID-19 PHE, submit Disaster Relief SPA (if such coverage is not currently provided for in the approved state plan).	

Table I (*continued*)

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
I2. LTSS			
Temporarily increase payment rates for 1915(c) waiver services with no changes to rate methodology and with no impact on cost neutrality	Already permitted within scope of 1915(c) waiver.	Already permitted within scope of 1915(c) waiver.	
Temporarily increase payment rates for 1915(c) waiver services with temporary change to rate methodology and/or with impact on cost neutrality	1915(c) waiver Appendix K amendment	Submit Appendix K. *Example*: Can be used to account for increased costs in personal protective equipment (PPE) for homecare workers and/or to make acuity adjustments.	Colorado 1915(c) waiver Appendix K (combined) (effective 3/10/20)
Ability to pay higher rates for HCBS providers in order to maintain capacity.		During COVID-19, PHE, submit Disaster Relief SPA. Submit Appendix K.	

Table J: Reporting and Oversight

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
Adjust performance deadlines and timetables for required activities.	section 1135 waiver 1135 Waiver - At A Glance	Deadlines may be adjusted but not waived; request adjustment for the federal fiscal year, or longer if the emergency extends beyond the current federal fiscal year Submit section 1135 waiver request.	
Modify deadlines for OASIS and Minimum Data Set (MDS) assessments and transmission.	section 1135 waiver	Submit section 1135 waiver request. During the COVID-19 PHE, submit section 1135 Waiver State/Territory Request Template.	Hurricane Irma 1135 Approval Letter (9/11/17)
Temporarily delay or suspend onsite re-certification and revisit surveys, and some enforcement actions, and/or allow additional time for facilities to submit plans of correction.	section 1135 waiver	Submit section 1135 waiver request.	Hurricane Irma 1135 Approval Letter (9/11/17)
Temporarily suspend 2-week aide supervision requirement by a registered nurse for home health agencies.	section 1135 waiver	Submit section 1135 waiver request.	Hurricane Sandy 1135 Blanket Waivers (11/3/12)
Temporarily suspend supervision of hospice aides by a registered nurse every 14 days requirement for hospice agencies.	section 1135 waiver	Submit section 1135 waiver request.	Hurricane Sandy 1135 Blanket Waivers (11/3/12)
Temporarily modify 1915(c) requirements for incident reporting, medication management, or other enrollee safeguards.	1915(c) waiver Appendix K amendment	Submit Appendix K.	New Mexico 1915(c) waiver Appendix K (combined) (effective 1/27/20)

Table J (*continued*)

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action	Select state example
Modify or suspend certain state survey agency activities.	section 1135 waiver Provider Survey and Certification FAQs	CMS will review each pending action on a case-by-case basis to determine if there are activities that need to be completed by the CMS regional office while survey activities are suspended. Submit section 1135 waiver request for blanket authority.	

Table K: HIPAA Compliance

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action
Temporarily suspend application of sanctions and penalties arising from non-compliance with HIPAA requirements to/related to: • Obtain a patient's agreement to speak with family members or friends; • Honor a request to opt out of the facility directory; • Distribute a notice; • The patient's right to request privacy restrictions; • The patient's right to request confidential communications; • Use existing permissions and flexibilities in the HIPAA Rules that apply in emergencies and other circumstances.	section 1135 waiver 1135 Waiver - At A Glance HIPAA Special Topics (Emergency Situations: Preparedness, Planning, and Response) 45 CFR 160 and 164, 85 FR 19392 (Apr. 7, 2020) HHS Office for Civil Rights, Guidance on HIPAA, Health Information Exchanges, and Disclosures of Protected Health Information for Public Health Purposes, Dec. 18, 2020 HHS OCR guidance, HIPAA and Contacting Former COVID-19 Patients about Plasma Donation, Aug. 20, 2020 HHS OCR guidance, COVID-19 and HIPAA: Disclosures to law enforcement, paramedics, other first responders and public health authorities, March 24, 2020	Seek section 1135 waiver. Waivers for HIPAA requirements are limited to the 72-hour period beginning upon implementation of a hospital disaster protocol.

Table L: EMTALA Requirements

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action
Temporarily suspend application of EMTALA sanctions for redirection of an individual to receive a medical screening examination in an alternative location or transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared emergency.	section 1135 waiver 1135 Waiver - At A Glance	Waivers for PHEs that do not involve a pandemic disease are limited to 72 hours from implementation of a hospital disaster protocol. Waivers for emergencies that involve a pandemic disease last until termination of the pandemic-related emergency. Hospitals that activate their disaster plan and are invoking EMTALA waiver of sanctions must provide notice to their state survey agency. Submit section 1135 waiver request.

Table M: Emergency IT Systems Funding

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action
Request FFP for automated data processing (ADP) equipment and services in response to emergency situations. Upon receipt of an emergency FFP request meeting standards specified in regulation at 45 CFR § 95.624, CMS must take action (i.e., approve or disapprove) within 14 days.	45 CFR § 95.624 (Consideration for FFP in emergency situations) 42 CFR Part 433 Subpart C (Mechanized Claims Processing and Information Retrieval Systems) COVID-19 FAQs for State Medicaid and Children's Health Insurance Program (CHIP) Agencies	For emergency FFP, a state must send request to CMS that includes the following: (1) brief description of the equipment and/or services to be acquired and an estimate of their costs; (2) brief description of the circumstances driving the state's need to proceed prior to obtaining CMS approval for the FFP; and (3) description of the harm that will be caused if the state does not immediately acquire the requested equipment and/or services. Note: States are not required to use the emergency process to obtain FFP for technology in an emergency. This emergency process provides an expedited process for obtaining FFP in advance of following the usual prior approval requirements in 45 CFR § 95.611. Once emergency approval is received, the state then has 90 days to submit a formal request through regular Advanced Planning Document (APD) processes.
Request FFP to deploy Patient Unified Lookup System for Emergencies (PULSE) resources to support PHE or disaster efforts. The PULSE system provides first responders with information critical to patient care and is designed to be deployed immediately to assist in emergency response. A COVID-19 iteration of PULSE (PULSE-COVID) is now available.	45 CFR § 95.624 (Consideration for FFP in emergency situations) 42 CFR Part 433 Subpart C (Mechanized Claims Processing and Information Retrieval Systems) COVID-19 FAQs for State Medicaid and Children's Health Insurance Program (CHIP) Agencies	For emergency FFP, a state must send request to CMS that includes the following: (1) brief description of the equipment and/or services to be acquired and an estimate of their costs; (2) brief description of the circumstances driving the state's need to proceed prior to obtaining CMS approval for the FFP; and (3) description of the harm that will be caused if the state does not immediately acquire the requested equipment and/or services. Note: States are not required to use the emergency process to obtain FFP for technology in an emergency. This emergency process provides an expedited process for obtaining FFP in advance of following the usual prior approval requirements in 45 CFR § 95.611. Once emergency approval is received, the state then has 90 days to submit a formal request through regular Advanced Planning Document (APD) processes.

Table M (*continued*)

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action
Request FFP to establish, implement, and enhance certain State Medicaid Agency telehealth capabilities as part of the state's response to a PHE.	45 CFR § 95.624 (Consideration for FFP in emergency situations) 42 CFR Part 433 Subpart C (Mechanized Claims Processing and Information Retrieval Systems) COVID-19 FAQs for State Medicaid and Children's Health Insurance Program (CHIP) Agencies	For emergency FFP, a state must send request to CMS that includes the following: (1) brief description of the equipment and/or services to be acquired and an estimate of their costs; (2) brief description of the circumstances driving the state's need to proceed prior to obtaining CMS approval for the FFP; and (3) description of the harm that will be caused if the state does not immediately acquire the requested equipment and/or services. Note: States are not required to use the emergency process to obtain FFP for technology in an emergency. This emergency process provides an expedited process for obtaining FFP in advance of following the usual prior approval requirements in 45 CFR § 95.611. Once emergency approval is received, the state then has 90 days to submit a formal request through regular Advanced Planning Document (APD) processes.
Request FFP to connect non-pediatric Medicaid providers to Immunization Information Systems for tracking vaccine administration in the adult population during a PHE.	45 CFR § 95.624 (Consideration for FFP in emergency situations) 42 CFR Part 433 Subpart C (Mechanized Claims Processing and Information Retrieval Systems) COVID-19 FAQs for State Medicaid and Children's Health Insurance Program (CHIP) Agencies	For emergency FFP, a state must send request to CMS that includes the following: (1) brief description of the equipment and/or services to be acquired and an estimate of their costs; (2) brief description of the circumstances driving the state's need to proceed prior to obtaining CMS approval for the FFP; and (3) description of the harm that will be caused if the state does not immediately acquire the requested equipment and/or services. Note: States are not required to use the emergency process to obtain FFP for technology in an emergency. This emergency process provides an expedited process for obtaining FFP in advance of following the usual prior approval requirements in 45 CFR § 95.611. Once emergency approval is received, the state then has 90 days to submit a formal request through regular Advanced Planning Document (APD) processes.

Table M (*continued*)

Available flexibilities and exceptions	Authorities and sources	Notes on implementation and necessary state action
Request FFP for costs associated with information technology that facilitates telework capabilities and supports a remote state workforce during a PHE, including but not limited to: 90 percent FFP to procure and install state hardware and software, and to enhance and/or configure software; 90 percent FFP to establish and test access by remote staff to the state's virtual private network; and 75 percent FFP to support ongoing state IT operations, in accordance with applicable regulations.	45 CFR § 95.624 (Consideration for FFP in emergency situations) 42 CFR Part 433 Subpart C (Mechanized Claims Processing and Information Retrieval Systems) COVID-19 FAQs for State Medicaid and Children's Health Insurance Program (CHIP) Agencies	For emergency FFP, a state must send request to CMS that includes the following: (1) brief description of the equipment and/or services to be acquired and an estimate of their costs; (2) brief description of the circumstances driving the state's need to proceed prior to obtaining CMS approval for the FFP; and (3) description of the harm that will be caused if the state does not immediately acquire the requested equipment and/or services. Note: States are not required to use the emergency process to obtain FFP for technology in an emergency. This emergency process provides an expedited process for obtaining FFP in advance of following the usual prior approval requirements in 45 CFR § 95.611. Once emergency approval is received, the state then has 90 days to submit a formal request through regular Advanced Planning Document (APD) processes.

Table N: Section 1115 Demonstrations

The table below provides an overview of potential section 1115 flexibilities that states may pursue to respond to PHEs or disasters. The Secretary of HHS has discretion with respect to approving demonstration projects and will evaluate state requests on a case-by-case basis. Generally, CMS encourages states to rely on other flexibilities – including those available under section 1135, the Medicaid or CHIP state plan, or as part of an HCBS Appendix K request – before requesting section 1115 waiver or expenditure authority.

Desired Flexibilities and Exceptions	Authorities For Which the State Needs Flexibility
Expand eligibility for adult expansion group to a subset of the population below 133% FPL, at regular match (for non-expansion states).	42 CFR § 435.119 SSA § 1902(a)(10)(A)(i)(VIII)
Expand eligibility to specified populations above 133% FPL, with limited benefits and/or in a targeted geographic area.	42 CFR § 435.218 SSA § 1902(a)(10)(A)(ii)(XX) SSA § 1902(a)(1) (Requires services to be covered on a statewide basis) 1902(a)(10) and 42 CFR § 440.240 (Except as limited in § 440.250, requires states to make benefits available in the same amount, duration, and scope to all individuals within the same eligibility category, to ensure that most categorically needy groups (including the (a)(10)(ii)(XX) group) have a benefit package that includes certain services described in section 1905(a) of the Act, and to ensure that the services available to any categorically needy beneficiary be no less in amount, duration, and scope than the services available to a medically needy beneficiary).
Increase income and/or resource eligibility standards, or adopt (where permissible) less restrictive income and/or resource methodologies, for specific eligibility categories within specific geographic region.	SSA § 1902(a)(1) (Requires services to be covered on a statewide basis) 1902(a)(17), 1902(r)(2)(A), and 42 CFR § 435.601(d)(4) require that states apply comparability financial eligibility standards and utilize less restrictive financial methodologies in a comparable manner.
Apply either host state's resource test criteria or, if less restrictive, resource criteria of the state from where the applicant evacuated (for all of the population or a subset of the population).	SSA § 1902(r)(2) 1902(a)(10) and 42 CFR § 440.240 (Except as limited in § 440.250, requires states to make benefits available in the same amount, duration, and scope to all individuals within the same eligibility category and to ensure that the services available to any categorically needy beneficiary be no less in amount, duration, and scope than the services available to a medically needy beneficiary) 1902(a)(17), 1902(r)(2)(A), and 42 CFR § 435.601(d)(4) require that states apply comparability financial eligibility standards and utilize less restrictive financial methodologies in a comparable manner.

Table N (*continued*)

Desired Flexibilities and Exceptions	Authorities For Which the State Needs Flexibility
Temporarily suspend requirement that beneficiaries eligible for the "special income level group" (SSA § 1902(a)(10)(A)(ii)(V)) be institutionalized in a medical institution or institution for individuals with intellectual disabilities for at least 30 days and have income below 300% of the SSI federal benefit rate.	SSA § 1902(a)(10)(A)(ii)(V)
Temporarily suspend transfer-of-asset rules (SSA § 1917(c)) for individuals placed into nursing facilities or comparable institutions.	SSA § 1902(a)(18) (Requires compliance with section 1917 with respect to liens, adjustments and recoveries of medical assistance correctly paid, transfers of assets, and treatment of certain trusts.)
Establish continuous eligibility for (1) adults; or (2) only a subset of children in the state (e.g., children in a particular geographic area).	SSA § 1902(a)(1) (Requires services to be covered on a statewide basis) SSA § 1902(e)(12) 1902(a)(1) requires that a state plan be in effect in all political subdivisions in a state, and 1902(a)(10) and 42 CFR § 440.240 (Except as limited in § 440.250, requires states to make benefits available in the same amount, duration, and scope to all individuals within the same eligibility category and to ensure that the services available to any categorically needy beneficiary be no less in amount, duration and scope than the services available to a medically needy beneficiary) 1902(a)(17), 1902(r)(2)(A), and 42 CFR § 435.601(d)(4) require that states apply comparability financial eligibility standards and utilize less restrictive financial methodologies in a comparable manner.
Excuse state from mandate to reduce payments to medical institutions and to intermediate care facilities for individuals with intellectual disabilities for the medical assistance provided by the amount of available income such individuals have based on post-eligibility treatment of income (PETI).	1902(a)(17), 1902(r)(2)(A), and 42 CFR § 435.601(d)(4) require that states apply comparability financial eligibility standards and utilize less restrictive financial methodologies in a comparable manner.
Target coverage of services on a geographic basis that is less than statewide to limit provision of Medicaid benefits to specific eligibility groups impacted by a PHE or disaster.	SSA § 1902(a)(1) (Requires services to be covered on a statewide basis) SSA § 1902(a)(10) and 42 CFR § 440.240 (Except as limited in § 440.250, requires states to make benefits available in the same amount, duration, and scope to all individuals within the same eligibility category, and to ensure that the services available to any categorically needy beneficiary be no less in amount, duration, and scope than the services available to a medically needy beneficiary)
Vary the amount, duration, and scope of covered services based on population needs.	SSA § 1902(a)(10) and 42 CFR § 440.240 (Except as limited in § 440.250, requires that a state plan make services available in the same amount, duration, and scope to all categorically needy individuals and all individuals within a covered medically needy group.

Table N (*continued*)

Desired Flexibilities and Exceptions	Authorities For Which the State Needs Flexibility
Cover different services for beneficiaries in the same eligibility group or cover different services for beneficiaries in the categorically needy or medically needy groups.	SSA § 1902(a)(10) and 42 CFR § 440.240 (Except as limited in § 440.250, requires states to make benefits available in the same amount, duration, and scope to all individuals within the same eligibility category, and to ensure that the services available to any categorically needy beneficiary be no less in amount, duration and scope than the services available to a medically needy beneficiary.)[4]

[4] States should consult with CMS on whether a waiver is necessary to limit comparability of services by group.

Module 3: Strategic Planning Framework to Respond to a Disaster or Public Health Emergency

I. Introduction

Medicaid and the Children's Health Insurance Program (CHIP) have played a critical role in helping states and territories respond to public health emergencies (PHEs) (e.g., Flint, Michigan lead contamination, H1N1 and the 2019 Novel Coronavirus (COVID-19) outbreak), human-made disasters, and natural disasters such as hurricanes (e.g., Hurricanes Katrina, Maria, Harvey and Irma), wildfires (e.g., California wildfires), and flooding (e.g., Hurricane Harvey floods in Texas). The Centers for Medicare & Medicaid Services (CMS) Medicaid and CHIP Coverage Learning Collaborative developed this strategic framework to serve as a step-by-step guide for Medicaid and CHIP agencies as they prepare to respond to a disaster or PHE. This strategic framework is intended to help states assess the situation, set priorities and design comprehensive disaster and PHE response efforts.

Each step below includes a cross reference to relevant sections in Module 2: Toolkit Inventory for more detailed information on the available flexibilities and necessary legal authorities. This framework is designed to help states identify the specific flexibilities and authorities needed to prepare their disaster/PHE response plan.

II. Step-by-Step Guidance to Prepare a Disaster/PHE Response Plan

Step 1: Activate or Establish Leadership Team and Conduct a Situational Analysis

At the onset of any disaster or PHE, establishing a leadership team, or leveraging an existing team, is critical to operationalizing and coordinating the state's response. The leadership team will need to develop processes for decision making, coordinating, and tracking the Agency's response. The team will need to assess the nature and scope of the disaster or PHE to shape the Agency's response and identify the impact of the emergency on the people, infrastructure, and systems. Consider the following:

A. **Activate or establish leadership team.** Does the emergency warrant the creation of centralized structure at the Agency or Governor's Cabinet level to coordinate the response across state agencies, if one does not already exist? Is a "SWAT team" approach more appropriate for a regional/geographic emergency? Will the leadership team develop the full staffing plan, including equipment and other needed resources, or delegate to individual components?

B. **Establish mechanisms for decision making and coordination.** Has a department or team been appointed to take the lead for each component of the response effort? What component or team will coordinate with the federal government? What component or team will develop and deploy communication strategies? What is the plan for establishing standing meetings and developing expedited processes for decision making? What is the plan and timeline for submitting actions to CMS (e.g., section 1135 waiver requests, state plan amendments, 1915(c) waiver requests, Appendix K submissions, emergency IT funding requests, etc.)?

C. **Establish mechanisms for tracking and monitoring.** Is there a process in place to monitor emerging issues and the Agency's response? Is there a process in place to capture real-time feedback, and adjust the implementation plan as needs evolve on the ground?

D. **Nature and scope.** Is it a natural or human-made disaster? If it is a PHE, what research and expertise is available regarding the issue or condition? Is the emergency state-wide or is it

concentrated in one or more geographic regions? Does the emergency disproportionately impact one area of the state or have a larger impact on urban or rural areas? Does it impact neighboring/border states or is it nationwide?

E. **Impact on specific populations.** How many people are expected to be affected by the disaster or PHE? What is known about the typical health impact on a population (e.g., flood waters may contain contaminants, smoke from wildfires may exacerbate asthma, malware attacks may cause ambulance diversion and cancellations in surgeries)? Does the situation disproportionately impact specific subsets of the population (e.g., children, older adults, disabled individuals, specific ethnic or racial groups)? Natural disasters and public health emergencies typically have a disproportionate impact on low-income populations and people of color who have a greater likelihood of experiencing health care disparities. It is important to consider how to better support underserved populations.

F. **Impact on infrastructure and vital services.** Are utilities functional (e.g., electricity, water, internet, heating)? Is there an impact on transportation (e.g., roadways, airports, public transportation including non-emergency medical transportation for Medicaid beneficiaries)? Have structures like homes, businesses, and government offices been impacted? Have individuals been displaced as a result of the disaster or PHE, are they in-state or moved out of state?

G. **Continuity of Operations Plan (COOP).** Does your state or local government have a current COOP? If so, how does the COOP come into play in the context of the emergency? Is the COOP applicable to this situation?

H. **Anticipated duration.** What is the anticipated duration of the disaster or PHE period, if known? Following this period, what is the anticipated length of time that will be required to address the long-term impact of the emergency?

Step 2: Assess State Agency Operations

The Agency should seek to understand the impact of the emergency on its ability to execute its regular daily operations and serve Medicaid /CHIP beneficiaries, applicants, providers and other key stakeholders. The Agency should conduct a high-level analysis of the impact of the emergency on its workforce, offices, and IT systems.[5]

Consider the following:

A. **Offices.** Are government buildings or offices damaged or closed? Are there alternative locations to conduct business if buildings are damaged? If buildings are open, are they open to just staff or can the public, including individuals with limited English proficiency (LEP) and individuals with disabilities, enter to conduct business?

B. **Capacity of Agency workforce.** Is the Agency workforce impacted and/or diminished as a result of the disaster or PHE (e.g., break down in transportation, personal injury or illness, loss of home, loss of childcare, school closings)? Is the Agency workforce equipped and trained to telework? Do existing telework policies need to be modified? Does the workforce have the hardware required to telework (e.g., laptops with access to Agency files, cellphones, and portable devices to access WIFI)? If the telework hardware is insufficient to meet demand, can the agency prioritize assigning the

[5] When managing operations, the Agency should remember that civil rights laws that prohibit discrimination on the basis of race, color, national origin, disability, age, sex (including sexual orientation, gender identity, and pregnancy) remain in effect during national emergencies.

hardware first to mission critical staff? Do staff need any special training, including serving individuals with LEP and individuals with disabilities? (*For more information on expanding telework see: State Medicaid & CHIP Telework Playbook.*)

C. **State Information Technology (IT) systems.** If the Agency workforce needs to telework, can the existing network accommodate sustained expanded remote access? Are there any IT systems modifications, enhancements, software and/or hardware procurement(s) needed to facilitate maximizing telework? Are there particular concerns related to privacy? Are any IT systems compromised and unable to support essential Agency operations (e.g., eligibility and enrollment processes)? Will the state be requesting emergency consideration for FFP in order to procure any necessary hardware, software and/or services? With respect to scheduled IT systems updates, are there maintenance or operations activities in the queue that must be re-prioritized?

D. **Assessing essential operations.** What is the Agency's ability to carry out eligibility operations (e.g., application processing, redeterminations of eligibility, long term care supports and services assessments)? Are there hard-copy processes that can only be done onsite or need to be adapted to be conducted electronically? What is the Agency's ability to process claims and submit quarterly claims submissions to CMS? Is the Agency's ability to submit required reporting to CMS impacted?

E. **State vendors.** Which vendors are impacted by the emergency? How will contractors maintain business operations and fulfill contract obligations? Are there contract clauses that address unforeseen circumstances? Are there factors outside of the contractor's control that may result in interruptions or delays (e.g., mandated building closures, disruptions to supply chains, unavailability of federal employees to review and accept deliverables)? Are there flexible solutions for maintaining contract obligations such as telework options or extending contract completion dates?

Step 3: Assess the Impact on Applicants and Beneficiaries

The Agency should evaluate the impact of the emergency on its ability to continue to provide high quality medical, behavioral health, and long-term care services to Medicaid and CHIP beneficiaries. The Agency should identify interim accommodations that are required to prevent disruptions in access to coverage and care. CMS can use existing flexibilities in statute and regulation that can be supplemented with emergency authority to provide state Medicaid and CHIP agencies with additional flexibilities in running their programs. Authorizing the use of these temporary flexibilities typically requires a state to request the use of a certain authority from CMS and CMS to approve its use. These flexibilities could include authorities available under section 1135 waivers, section 1115(a) demonstrations, the Medicaid and CHIP state plan, Home and Community Based Services (HCBS) Appendix K, emergency IT funding, and existing regulatory flexibility. Consider the following:

A. **Application and redetermination eligibility policies and operational processes.** Based on the assessment of essential eligibility operations described above, are changes needed to the application and redetermination processes to ensure that individuals can apply for and retain coverage in light of the emergency (e.g., Medicaid/CHIP application streamlining or implement/modify presumptive eligibility processes)? (*See Module 2, Section B2.*) Are there verification processes for MAGI and non-MAGI eligibility groups that the Agency should consider to support enrollment and reduce administrative burden on the agency and applicants/beneficiaries (e.g., permit self-attestation and conduct post-enrollment verification, implement or expand upon a reasonable compatibility threshold, extend reasonable opportunity periods) while maintaining program integrity? (*See Module 2, Section B4.*) Are there eligibility criteria the Agency should consider modifying during the emergency to ensure access to coverage for vulnerable populations impacted by the emergency (e.g., consider

Medicaid beneficiaries from the state to be only temporarily absent or modify eligibility criteria and functional assessment processes for long-term services and supports)? (*See Module 2, Sections B1 and D2.*)

B. Coverage options. Do the existing Medicaid eligibility groups and corresponding income levels sufficiently address coverage needs for the populations affected by the emergency? If not, are there optional coverage options the Agency should consider implementing (e.g., expand eligibility for optional Medicaid eligibility groups, including age and disability-related poverty level group and adult expansion group; consider beneficiaries evacuated from the state temporarily absent and maintain enrollment in their home state; temporarily apply less restrictive income and resource disregards statewide for non-MAGI eligibility determinations)? (*See Module 2, Section B1.*)

C. Access to services. Do current cost-sharing or premium requirements potentially limit access to treatment and care related to the disaster or PHE and should current cost sharing requirements be temporarily modified (e.g., temporarily waive Medicaid/CHIP co-payments, premiums, and deductibles)? (*See Module 2, Table C.*) Are there other barriers to treatment that the Agency needs to remove to advance the emergency response effort (e.g., temporarily suspend and extend prior authorization requirements in FFS and managed care)? (*See Module 2, Section D3.*)

D. Continuity of coverage. Does the Agency need to establish temporary policies to ensure continuity of coverage for beneficiaries throughout the duration of the emergency (e.g., use regulatory exception in meeting renewal timeliness standards or when unable to promptly act on changes in circumstances, establish continuous eligibility for children for up to 12 months, extend the redetermination period for non-MAGI populations, suspend CHIP waiting periods)? (*See Module 2, Sections B2 and B3.*)

E. Benefits. Is the current benefits package sufficient to address existing and emerging needs of beneficiaries (e.g., modify the scope and duration of current coverage benefits, adjust the providers who can deliver services, temporarily suspend or increase limits on prescription refills, add new benefits, utilize telehealth in a different manner than outlined in the state's approved state plan)? (*See Module 2, Sections D1 and D2.*)

F. Fair hearings and appeals. Does the Agency need to modify fair hearing appeals processes and operations in response to the emergency? *(See Module 2, Table E.*)

Step 4: Assess the Impact on the Health Care Delivery System

The Agency should assess the impact of the disaster or PHE on providers and identify accommodations that are necessary to ensure that a robust workforce and necessary supplies are available to deliver health care services during the period of the emergency. The Agency may also want to consider various mechanisms to modify payment methodologies and leverage managed care flexibilities, including modifications to managed care contracts and rates. Consider the following:

A. Workforce size and capacity. Is the provider workforce impacted by the emergency and does the Agency need to pursue strategies that would support adequate access to provider services or necessary changes in provider operations (e.g., enable alternate site locations for the provision of services, modify licensure requirements for physicians in an affected state, expand telehealth policies)? (*See Module 2, Tables G, H, and K.*) Are home and community-based service waiver enrollees impacted by the emergency and are there changes to current policies that should be implemented to keep this vulnerable population safely at home? (*See Module 2, Section D2.)*

B. Supplies. Does the disaster or PHE warrant bolstering particular medical supplies (e.g., testing equipment, ventilators, and personal protective equipment)? Are other non-medical supplies critical

(e.g., bottled water, water filtration devices, and generators)? Is medical equipment accessible to individuals with disabilities? Are general population shelters accessible by individuals with disabilities who do not need medical care?

C. **Payment methodologies, rates, and managed care contracts.** Do existing payment methodologies and rates sufficiently reimburse providers in order to sustain service provision in light of the emergency (e.g., increase payment rates, implement interim payments)? If there is a dramatic shift in utilization across the healthcare industry, are there options under the managed care contracts that are important to consider (e.g., adjusting managed care capitation rates exclusively to reflect temporary increases in Medicaid fee for service provider payments, requiring managed care plans to make retainer payments to maintain provider capacity and access to services, make directed payments to temporarily enhance provider payment in managed care)? (*See Module 2, Sections D2 and F5, Table I, and Medicaid Managed Care Options in Responding to COVID-19.*)

Step 5: Establish Communication Strategies

The Agency should develop a communication strategy in response to the emergency to ensure clear and timely information exchanges across state agencies and between the state and key stakeholders, including beneficiaries, providers, stakeholders, and CMS. Consider the following:

A. **Leadership and other state agencies.** How will state leadership presiding over the emergency response ensure that communication of response efforts is well coordinated across agencies? What will the format and cadence of information-sharing be across agencies? Will there be standing meetings/calls, daily reporting requirements?

B. **State workforce.** How does the Agency plan to keep staff apprised of changes to operations and developments in the Agency's response to the emergency (e.g., regular administrative directives, conference calls, daily meetings)?

C. **General public/stakeholders.** How does the Agency plan to communicate information in a timely fashion with stakeholders and the public (e.g., weekly webinars or conference calls with the Agency, centralized emergency response hub on state website, publicly posted Frequently Asked Questions memos)?

D. **Applicants/beneficiaries.** Do scripts, talking points, or consumer materials in multiple languages need to be developed to help local departments of health communicate information to beneficiaries?

E. **Providers.** Does the Agency need to need to modify communication channels with providers – update materials, send alerts on changes? How will the Agency share information and cultivate a meaningful feedback loop to understand providers' evolving needs? Do you need to host meetings or listening sessions with provider groups?

F. **Managed care plans.** Are managed care plans prepared to support the Agency's efforts to communicate information to enrollees? How will the Agency share information and cultivate a meaningful feedback loop to understand plans' evolving needs?

The Agency should also determine the process and timeline for resuming regular operations following the disaster or PHE period. Restoring baseline operations requires a plan and timeline to terminate temporary accommodations and flexibilities effectuated as part of the emergency response. The Agency may also want to consider which, if any, of the flexibilities effectuated during the disaster or PHE should remain post-disaster/PHE.

Appendix A: COVID-19 Resources

During the COVID-19 PHE, CMS released a number of resources to support states and territories. These resources are noted below.

Federal guidance:

- COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies
- CMCS Informational Bulletin: Medicaid Managed Care Options in Responding to COVID-19
- CMS-9912 Interim Final Rule with Comment Factsheet on Updated Policy for Maintaining Medicaid Enrollment during the Public Health Emergency for COVID-19 Fact Sheet

Tools for Implementation:

- Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration and Cost-Sharing under Medicaid, the Children's Health Insurance Program, and Basic Health Program Toolkit
- State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth
- COVID-19 Managed Care Delivery System and Provider Payment Initiatives
- COVID-19 Medicaid Disaster Relief State Plan Amendment Template and Instructions
- Operationalizing Implementation of the Optional COVID-19 Testing (XXIII) Group, Potential State Flexibilities
- 1915(c) HCBS Waiver Program Appendix K Template and Instructions
- CMS 1135 Waiver / Flexibility Request and Inquiry Form - CMS 1135 Form (CMS 1135 waiver portal)
- Medicaid and CHIP Disaster Relief MAGI-Based Verification Plan Addendum
- Section 1115 Waiver Opportunity and Application Checklist ("Section 1115 Disaster Relief Template")
- CHIP Disaster Relief State Plan Amendment Example

At the time of this publication, the COVID-19 PHE is an ongoing situation. Resources will continue to be updated and developed. A complete inventory of Medicaid and CHIP resources specific to COVID-19, as well as additional U.S. Department of Health and Human Services resources, is located here.

In addition to the above resources, relevant legislation/statutory authorities and Interim Final Rules are below.

Legislation/statutory authorities:

- American Rescue Plan Act of 2021 (ARP; Pub. L. 117-2)
- The Families First Coronavirus Response Act (Pub. L. No. 116-127)
- The Coronavirus Aid, Relief, and Economic Security Act (Pub. L. No. 116-136)

Interim Final Rules

- Interim Final Rule, CMS-1744-IFC, Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (85 Fed. Reg. 19230-19292) (April 6, 2020)
- Interim Final Rule, CMS-5531-IFC, 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 (85 Fed. Reg. 27550-27629) (May 8, 2020)
- Interim Final Rule, CMS-3401-IFC, Medicare and Medicaid Programs, Clinical Laboratory Improvement Amendments (CLIA), and Patient Protection and Affordable Care Act; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (85 FR 54820-54874) (September 2, 2020)
- Interim Final Rule, CMS-9912-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (85 Fed. 71142-71204) (November 6, 2020)
- Interim Final Rule, CMS-3414-IFC, Medicare and Medicaid Programs; COVID-19 Vaccine Requirements for Long-Term Care (LTC) Facilities and Intermediate Care Facilities for Individuals With Intellectual Disabilities (ICFs-IID) Residents, Clients, and Staff. (86 FR 26306-26336) (May 13, 2021)