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

March 16, 2020

Ann Dalton
AHC Administrator
Bureau of Medicaid Policy
2727 Mahan Dr.
Tallahassee, FL. 32308

Re: Section 1135 Flexibilities Requested in March 13, 2020 Communication

Dear Ms. Dalton:

In your email communication to CMS on March 13, 2020, you detailed a number of federal requirements that pose issues for the health care delivery system in all counties in Florida. Approval of the flexibilities requested, where permitted, are outlined in the attached appendix.

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

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

Sincerely,

[redacted]

Calder Lynch
Director

STATE OF FLORIDA

FEDERAL SECTION 1135 WAIVER REQUESTS

CMS Response: March 16, 2020

Provider Participation

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

Under current CMS policy, as explained in the Medicaid Provider Enrollment Compendium (7/24/18), at pg. 42, https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf, Florida may reimburse otherwise payable claims from out-of-state providers not enrolled in Florida's Medicaid program if the following criteria are met:

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

For claims for services provided to Medicaid participants enrolled with Florida's Medicaid program, CMS will waive the fifth criterion listed above under section 1135(b)(1)(A) and (B), or 1135(b)(1)(C). Therefore, there is no limit to the instances of care furnished or to how many participants received care in a 180-day period for the duration of this section 1135 waiver. For the duration of the emergency.

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

With respect to providers not already enrolled with another SMA or Medicare, CMS will waive the following screening requirements under 1135(b)(1)(A) and (B) so the state may provisionally, temporarily, enroll the providers:

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

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

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

Florida may also temporarily cease revalidation of providers who are located in Florida or are otherwise directly impacted by the emergency.

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

Waiver of Service Prior Authorization (PA) Requirements

Prior authorization and medical necessity processes in fee-for-service delivery systems are established, defined and administered at state/territory discretion and may vary depending on the benefit. See 42 CFR §440.230(d). The State of Florida may have indicated in its approved state plan specific requirements about prior authorization processes for benefits administered through the fee-for-service delivery system. We interpret prior authorization requirements to be a type of

pre-approval requirement for which waiver and modification authority under section 1135(b)(1)(C) of the Act is available. If prior authorization processes are outlined in detail in the State of Florida's state plan for particular benefits, CMS is using the flexibilities afforded under section 1135(b)(1)(C) of the Act that allow for waiver or modification of pre-approval requirements to permit services provided on or after March 1, 2020 through the termination of the emergency declaration for at least 90 days and up to 180 days (up to the last day of the emergency period under Section 1135(e) of the Act), for beneficiaries with a permanent residence in the geographic area of the public health emergency declared by the Secretary.

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

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

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

The 7-9-day timeframe for Level 2 completion is an annual average for all preadmission screens, not individual assessments, and only applies to the preadmission screens (42 C.F.R. 483.112(c)). There is not a set timeframe for when a Resident Review must be completed, but it should be conducted as resources become available.

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

CMS approves a waiver under section 1135(b)(1) of the Act to allow facilities, including NFs, intermediate care facilities for individuals with intellectual and developmental disabilities (ICF/IDDs), psychiatric residential treatment facilities (PRTFs) and hospitals NFs, to be fully reimbursed for services rendered during an emergency evacuation to an unlicensed facility (where an evacuating facility continues to render services). The facility would be responsible for determining how to reimburse the unlicensed facility. This arrangement would only be effective for the duration of the Section 1135 waiver. However, after the initial 30 days, CMS would require that the unlicensed facility either seek licensure or the evacuating facility would need to seek new placement for the individuals. The

duration time for the Section 1135 waiver will allow the state to accommodate these changes.

State fair hearing requests and appeal deadlines

Florida requested flexibility to temporarily delay scheduling of Medicaid Fair Hearings and issuing Fair Hearing Decisions during the Emergency Period. CMS cannot waive parts of 42 CFR 438 Subpart F related to appeals of adverse benefit determinations which occur before Fair Hearings for Medicaid managed care enrollees or parts of 42 CFR 431, subpart E. However, CMS is able to modify the timeframes associated with appeals and fair hearings. Therefore, CMS approves the following:

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

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

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

In addition, CMS approves a modification of timeframe, under 42 CFR 438.408(f)(2), for managed care enrollees to exercise their appeal rights. Specifically, any managed care enrollees for whom the 120 day deadline described in 42 CFR 328.408(f)(2) would have occurred between March 1, 2020 through June 29, 2020, are allowed more than 120 days, up to an additional 120 days to request a State Fair Hearing provided that the enrollee makes the request no later than June 29, 2020.

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

The following are flexibilities the state may utilize in operating their appeals and fair hearing process under authority of current regulations and state plan. The state may suspend adverse actions for individuals for whom the state has completed a determination but either: 1) has not yet sent the notice; or 2) who the state believes likely did not receive the notice. This is consistent with 42 CFR 431.211, which requires the state to provide at least 10 days advance notice before taking adverse action. The state must document its policy in compliance with the state's record keeping practices.

Similarly, the state may delay scheduling fair hearings and issuing fair hearing decisions. Section 42 CFR 431.244(f)(4)(i)(B) allows the agency to delay taking final administrative action for state fair hearing decisions when there is an emergency beyond the agency's control. The agency must document the reason for delay in the beneficiary's record and document the policy in compliance with the state's record keeping practices. If this flexibility is utilized, the state should prioritize completing hearings requested by beneficiaries who would be most impacted by the delay, specifically those who meet the standard for an expedited fair hearing under 42 CFR 431.224. The state also may offer to continue benefits to individuals who are requesting a fair hearing if the request comes later than the date of the action under 42 CFR 431.230.