DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

April 21, 2020

MaryAnne Lindeblad
Medicaid Director
Washington State Health Care Authority and Department of Social and Health Services
626 8th Avenue SE
P.O. Box 45502
Olympia, Washington 98504-5010

Dear Ms. Lindeblad:

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

In response to the section 1115(a) demonstration opportunity announced to states on March 22, 2020 in State Medicaid Director Letter (SMDL) #20-002,[1] on March 24, 2020, Washington submitted a request for a section 1115(a) demonstration to address the COVID-19 PHE. CMS has determined that the state's application is complete, consistent with the exemptions and flexibilities outlined in 42 CFR 431.416(e)(2) and 431.416(g).[2] CMS expects that states will

[1] See SMDL #20-002, "COVID-19 Public Health Emergency Section 1115(a) Opportunity for States," available at https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20002-1115template.docx.
[2] Pursuant to 42 CFR 431.416(g), CMS has determined that the existence of unforeseen circumstances resulting from the COVID-19 PHE warrants an exception to the normal state and federal public notice procedures to expedite a decision on a proposed COVID-19 section 1115 demonstration. States applying for a COVID-19 section 1115 demonstration are not required to conduct a public notice and input process. CMS is also exercising its discretionary authority to expedite its normal review and approval processes to render timely decisions on state applications for

offer, in good faith and in a prudent manner, a post-submission public notice process, including tribal consultation as applicable, to the extent circumstances permit. This letter also serves as time-limited approval of several of the requests included in the "Washington COVID-19 Public Health Emergency (PHE)" section 1115(a) demonstration (Project Number 11-W-00345/0) which is hereby authorized retroactively from March 1, 2020, through the date that is 60 days after the end of the PHE (including any renewal of the PHE).

CMS has determined that the Washington COVID-19 section 1115(a) demonstration – including the waiver and expenditure authorities detailed below – is necessary to assist the state in delivering the most effective care to its beneficiaries in light of the COVID-19 PHE. The demonstration is likely to assist in promoting the objectives of the Medicaid statute because it is expected to help the state furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID-19.

In addition, in light of the unprecedented emergency circumstances associated with the COVID-19 pandemic and consistent with the President's declaration detailed above – and in consequence of the time-limited nature of this demonstration – CMS did not require the state to submit budget neutrality calculations for the Washington COVID-19 section 1115(a) demonstration. In general, CMS has determined that the costs to the federal government are likely to have been otherwise incurred and allowable. Washington will still be required to track demonstration expenditures and will be expected to evaluate the connection between those expenditures and the state's response to the PHE, as well as the cost-effectiveness of those expenditures.

The state will be required to complete a final report, which will consolidate monitoring and evaluation reporting deliverables associated with the approved waiver and expenditure authorities and demonstration Special Terms and Conditions (STCs), no later than one year after the end of the COVID-19 section 1115 demonstration authority. CMS will provide guidance for the evaluation design and final report, specifically developed for the COVID-19 section 1115 demonstration to facilitate state compliance with 42 CFR 431.424(c); an evaluation design will be due to CMS within 60 days of demonstration approval.

The state will test whether and how the approved waivers and expenditure authorities affect the state's response to the PHE. To that end, the state will use research questions that pertain to the approved waivers and expenditure authorities. The evaluation will also assess cost-effectiveness by tracking administrative costs and health services expenditures for demonstration beneficiaries and assessing how these outlays affected the state's response to the PHE.

Requests CMS is Approving at this Time

The state submitted a number of requests, many of which may be approved under the state plan or Appendix K for 1915(c) waivers, and are not described below. CMS continues to work with the state on the approval of those requests.

COVID-19 section 1115 demonstrations. CMS will post all section 1115 demonstrations approved under this COVID-19 demonstration opportunity on the Medicaid.gov website.

Consistent with the flexibilities described in the SMDL #20-002, CMS approves the following requests:

Waiver Authorities

1. Statewideness **Section 1902(a)(1)**

To the extent necessary to permit the state to target services on a geographic basis that is less than statewide.

2. Reasonable Promptness; Amount, Duration, Scope; Comparability **Section 1902(a)(8) and 1902(a)(10)(B) and 1902(a)(17)**

To the extent necessary to permit the state to vary the amount, duration, and scope of services based on population needs; to provide different services to different beneficiaries in the same eligibility group, or different services to beneficiaries in the categorically needy and medically needy groups; and to allow states to triage access to long-term services and supports based on highest need.

Expenditure Authorities

1. **Expedited Eligibility for Long-Term Care Services and Supports (LTSS).** Expenditures to allow for self-attestation or alternative verification of individuals' eligibility (income/assets) and level of care (LOC) to qualify for 1915(k) LTSS services. This authority allows an individual to self-attest to income or assets. The individual may remain eligible until such time that the state verifies that the individual has income or assets greater than what is allowable under the Medicaid state plan. The state may also accept self-attestation of LOC requirements. The individual may receive 1915(k) LTSS services up until the state verifies that the individual does not meet LOC requirements. This authority allows the state to: a) delay the need for income and asset verification for one year, and b) delay the need for a level of care assessment for one year.

2. **LTSS.** Expenditures for 1915(k) LTSS services for individuals even if services are not timely updated in the plan of care, or are delivered in allowable alternative settings for the period of the public health emergency. The state defines alternative settings as those which would have been otherwise-approvable via 1915(c), Appendix K (e.g. hotels, shelters, schools and churches).[3]

3. **Home and Community-Based Services (HCBS) Rates.** Expenditures for the state to pay higher rates to 1915(k) HCBS providers for 1915(k) HCBS services provided in accordance with Section 1902(a)(30)(A) in order to maintain capacity to ensure an adequate pool of

[3] See "APPENDIX K: Emergency Preparedness and Response" template, available at https://www.medicaid.gov/medicaid/home-community-based-services/downloads/1915c-appendix-k-template.pdf.

providers to address the needs of the individuals who require Medicaid services during the PHE. The state will allow rates to be increased by up to 50 percent over otherwise approved rates. In case of extraordinary circumstances, the state may request approval from CMS for rate increases in excess of 50 percent.

4. **Retainer Payments.** Expenditures for the state to make retainer payments to providers of personal care services and habilitation services that include personal care as a component as a component as defined under section 1915(k) of the Act to maintain capacity during the emergency. The retainer time limit may not exceed the lesser of 30 consecutive days or the number of days for which the state authorizes a payment of "bed hold" in a nursing facility. In addition, retainer payments may only be paid to providers with treatment relationships to beneficiaries that existed at the time the PHE was declared and who continues to bill for personal care services or habilitation services as though they were still providing these services to those beneficiaries in their absence. The retainer payments may not exceed the approved rate(s) or average expenditure amounts paid during the previous quarter for the service(s) that would have been provided.

5. **Modified Eligibility.** Expenditures for the state to modify eligibility criteria for LTSS that are no more restrictive than the criteria prior to March 1, 2020. This authority allows the state to expand the federal poverty level (FPL) for beneficiaries who self-attest to determine eligibility but are found ineligible for 1915(k) LTSS services when income/asset eligibility verification is conducted. This authority allows beneficiaries to self-attest to disability or level of care (LOC) to receive LTSS for the period of the PHE.

6. **Functional Assessments.** Expenditures to temporarily reduce or delay the need for states to conduct functional assessments to determine LOC and Person-Centered Care Plans for beneficiaries needing 1915(c) and 1915(k) LTSS services (provided that the functional assessment otherwise complies with the regulatory requirements under 42 CFR 441.720). This authority allows the state to delay the need for a functional assessment and LOC determination for one year, and for reassessments to be delayed one year.

Requests CMS Is Not Approving at this Time

CMS will not be approving Washington's request to establish a temporary eligibility group for individuals with incomes at or below 200 percent FPL and for whom the state would subsidize the cost of new or existing Qualified Health Plan coverage in the marketplace. The CMS Center for Consumer Information and Insurance Oversight has provided flexibility to states/issuers on extending payment deadlines and the 3-month grace period. This provides consumers with extra time to make payments and for the issuer to continue receiving Advanced Premium Tax Credits during that time. A description of that flexibility can be found in the Guidance on Payment and Grace Period Flexibilities for Issuers Offering Coverage on the Federally-facilitated Exchanges and State-based Exchanges on the Federal Platform: https://www.cms.gov/files/document/faqs-payment-and-grace-period-covid-19.pdf.

The state also requested approval for flexibilities to assist the state during the COVID-19 emergency where other federal resources may be available for these purposes, including under

the recently approved Families First Coronavirus Relief Act and the Coronavirus Aid, Relief, and Economic Security Act. Therefore, at this time CMS is continuing to review the state's request for Medicaid expenditure authority for a Disaster Relief Fund to cover costs associated with treatment for uninsured individuals with COVID-19, housing, nutrition supports and other COVID related expenditures for states and individuals.

In addition, CMS is continuing to review the state's requests for other flexibilities described below:

- Washington requested expenditure authority for retainer payments beyond the 30-day limits described above for HCBS providers, as well as payments to providers beyond those described above; and
- The state requested to provide coverage for non-emergency medical transportation (NEMT) without regard to the requirements at 42 CFR 440.170(a)(4)(ii)(A) to increase the availability of NEMT, which would effectively allow transportation brokers to directly provide NEMT.

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

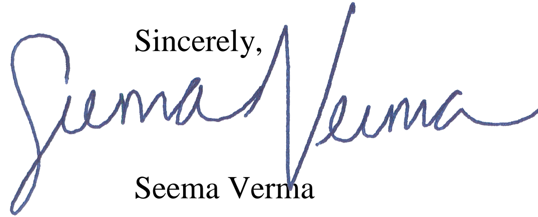
The award is subject to CMS receiving written acceptance of this award within 15 days of the date of this approval letter. Your project officer is Mr. Eli Greenfield. Mr. Greenfield is available to answer any questions concerning implementation of the state's section 1115(a) demonstration and his contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-25-26
7500 Security Boulevard
Baltimore, Maryland 21244-1850
Telephone: (410) 786-6157
Email: eli.greenfield@cms.hhs.gov

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

If you have any questions regarding this approval, please contact Mrs. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,



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Enclosure

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: **11-W-00345/0**

TITLE: **Washington COVID-19 Public Health Emergency Demonstration**

AWARDEE: **Washington Department of Health and Human Services**

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in accompanying authorities, shall apply to the demonstration project effective from March 1, 2020, through the date that is 60 days after the public health emergency (PHE) described in section 1135(g)(1)(B) of the Social Security Act (the Act), including any extension, expires. In addition, these waivers may only be implemented consistent with the approved special terms and conditions (STC).

Under the authority of section 1115(a)(1) of the Act, the following waivers of state plan requirements contained in section 1902 of the Act are granted subject to the STCs for the section 1115 demonstration.

1. **Statewideness** **Section 1902(a)(1)**

   To the extent necessary to permit the state to target services on a geographic basis that is less than statewide.

2. **Reasonable Promptness; Amount, Duration, and Scope; Comparability** **Section 1902(a)(8) 1902(a)(10)(B) and 1902(a)(17)**

   To the extent necessary to permit the state to vary the amount, duration, and scope of services based on population needs; to provide different services to different beneficiaries in the same eligibility group, or different services to beneficiaries in the categorically needy and medically needy groups; and to allow states to triage access to long-term services and supports based on highest need.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00345/0**

TITLE: **Washington COVID-19 Public Health Emergency Demonstration**

AWARDEE: **Washington Department of Health and Human Services**

Under the authority of section 1115(a)(2) of the Act, expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from March 1, 2020, through the date that is sixty (60) days after the PHE described in section 1135(g)(1)(B) of the Act, including any extension, expires, unless otherwise specified, be regarded as expenditures under the state's title XIX plan.

As discussed in the Centers for Medicare & Medicaid Services' (CMS) approval letter, the United States Secretary of Health and Human Services has determined that the demonstration, including the granting of the expenditure authorities described below, is likely to assist in promoting the objectives of title XIX of the Act.

The following expenditure authority may only be implemented consistent with the approved STCs and shall enable the state to operate the above-identified section 1115(a) demonstration.

1. **Expedited Eligibility for Long-Term Care Services and Supports (LTSS).** Expenditures to allow for self-attestation or alternative verification of individuals' eligibility (income/assets) and level of care (LOC) to qualify for 1915(k) LTSS services. This authority allows an individual to self-attest to income or assets. The individual may remain eligible until such time that the state verifies that the individual has income or assets greater than what is allowable under the Medicaid state plan. The state may also accept self-attestation of LOC requirements. The individual may receive 1915(k) LTSS services up until the state verifies that the individual does not meet LOC requirements. This authority allows the state to: a) delay the need for income and asset verification for one year, and b) delay the need for a level of care assessment for one year.

2. **LTSS.** Expenditures for 1915(k) LTSS services for individuals even if services are not timely updated in the plan of care, or are delivered in allowable alternative settings for the period of the public health emergency. The state defines alternative settings as those which would have been otherwise-approvable via 1915(c), Appendix K (e.g. hotels, shelters, schools and churches).[1]

3. **Home and Community-Based Services (HCBS) Rates.** Expenditures for the state to pay higher rates to 1915(k) HCBS providers for 1915(k) HCBS services provided in accordance with Section 1902(a)(30)(A) in order to maintain capacity to ensure an

[1] See "APPENDIX K: Emergency Preparedness and Response" template, available at https://www.medicaid.gov/medicaid/home-community-based-services/downloads/1915c-appendix-k-template.pdf.

adequate pool of providers to address the needs of the individuals who require Medicaid services during the PHE. The state will allow rates to be increased by up to 50 percent over otherwise approved rates. In case of extraordinary circumstances, the state may request approval from CMS for rate increases in excess of 50 percent.

4. **Retainer Payments.** Expenditures for the state to make retainer payments to providers of personal care services and habilitation services that include personal care as a component as defined under section 1915(k) of the Act to maintain capacity during the emergency. The retainer time limit may not exceed the lesser of 30 consecutive days or the number of days for which the state authorizes a payment of "bed hold" in a nursing facility. In addition, retainer payments may only be paid to providers with treatment relationships to beneficiaries that existed at the time the PHE was declared and who continues to bill for personal care services or habilitation services as though they were still providing these services to those beneficiaries in their absence. The retainer payments may not exceed the approved rate(s) or average expenditure amounts paid during the previous quarter for the service(s) that would have been provided.

5. **Modified Eligibility.** Expenditures for the state to modify eligibility criteria for LTSS that are no more restrictive than the criteria prior to March 1, 2020. This authority allows the state to expand the federal poverty level (FPL) for beneficiaries who self-attest to determine eligibility but are found ineligible for 1915(k) LTSS services when income/asset eligibility verification is conducted. This authority allows beneficiaries to self-attest to disability or level of care (LOC) to receive LTSS for the period of the PHE.

6. **Functional Assessments.** Expenditures to temporarily reduce or delay the need for states to conduct functional assessments to determine LOC and Person-Centered Care Plans for beneficiaries needing 1915(c) and 1915(k) LTSS services (provided that the functional assessment otherwise complies with the regulatory requirements under 42 CFR 441.720). This authority allows the state to delay the need for a functional assessment and LOC determination for one year, and for reassessments to be delayed one year.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00345/0**

TITLE: **Washington COVID-19 Public Health Emergency Demonstration**

AWARDEE: **Washington Department of Health and Human Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Washington COVID-19 Public Health Emergency section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"), operated by the state and partially funded by CMS. The STCs set forth in detail the state's obligations to CMS during the life of the demonstration. The STCs are effective March 1, 2020, unless otherwise specified. This demonstration is approved through the date that is 60 days after the Public Health Emergency (PHE) described in section 1135(g)(1)(B) of the Act, including any extension, expires.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. COVID-19 Public Health Emergency Program and Benefits
V. Cost Sharing
VI. Delivery System
VII. General Reporting Requirements
VIII. General Financial Requirements Under Title XIX
IX. Schedule of State Deliverables for the Demonstration Period

II. PROGRAM DESCRIPTION AND OBJECTIVES

The demonstration is approved in recognition of the PHE as a result of the COVID-19 pandemic. The demonstration will help the state to furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID-19.

The state's title XIX state plan and waivers, as approved, will continue to operate concurrently with this section 1115 demonstration.

The demonstration also provides flexibility for the delivery of long term supports and services during the PHE.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state agrees that it must comply with all applicable federal statutes relating to non-discrimination in services and benefits in its programs and activities. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Section 1557 of the Patient Protection and Affordable Care Act (Section 1557). Such compliance includes providing reasonable modifications to individuals with disabilities under the ADA, Section 504, and Section 1557 with eligibility and documentation requirements, and in understanding program rules and notices.

2. **Compliance with Medicaid and CHIP Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents of which these terms and conditions are part, must apply to the demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, court order, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is explicitly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration pursuant to STC 6. CMS will notify the state 15 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

4. **Impact of Changes in Federal Law, Regulation, and Policy on the Demonstration.** If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under federal law, whichever is sooner.

5. **Changes Subject to the Amendment Process.** Changes related to demonstration features such as eligibility, enrollment, benefits, delivery systems, cost sharing, sources of non-federal share of funding, and other comparable program elements in these STCs must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The state must not implement changes to these demonstration elements without prior approval by CMS. Federal Financial Participation (FFP) will not be available for amendments to the demonstration that have

not been approved through the amendment process set forth in STC 6 below, except as provided in STC 3.

6. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as specified in this STC. Amendment requests must include, but are not limited to, the following:

    a) *Demonstration Amendment Summary and Objectives.* The state must provide a detailed description of the amendment, including the expected impact on beneficiaries with sufficient supporting documentation, the objective of the change and desired outcomes, and a conforming title XIX and/or title XXI state plan amendment if necessary;

    b) *Waiver and Expenditure Authorities.* The state must provide a list of waivers and expenditure authorities that are being requested or terminated, along with the programmatic description of why these waivers and expenditure authorities are being requested for the amendment;

    c) *Public Notice.* The state must provide either an explanation of the public process used by the state consistent with the requirements set forth in 59 Fed. Reg. 49249 (September 27, 1994) or an explanation of how the state meets the criteria outlined in 42 CFR 431.416(g)(3) for discharge from normal state public notice and input responsibilities to address any of the circumstances describe in 42 CFR 431.416(g)(1).

    In states with Federally-recognized Indian tribes, Indian health programs, and/or Urban Indian health organizations, the state is required to comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid state plan, unless the state has established the criteria necessary to obtain an exemption from the normal state public notice process requirements in accordance with 42 CFR 431.416(g)(3).

7. **Federal Financial Participation.** No federal matching funds for expenditures for this demonstration, including administrative and medical assistance expenditures, will be available until the effective date identified in the CMS demonstration approval letter.

8. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining

Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs or procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

9. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines, following a hearing that the state has materially failed to comply with the terms of the project. CMS must promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

10. **Withdrawal of Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX, as applicable. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authorities, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

11. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge CMS' finding that the state materially failed to comply.

IV. COVID-19 PUBLIC HEALTH EMERGENCY PROGRAM AND BENEFITS

12. **COVID-19 PHE Program Benefits.** The state's COVID-19 section 1115(a) demonstration is necessary to assist the state in delivering the most effective care to its beneficiaries in light of the COVID-19 PHE. The demonstration is likely to assist in promoting the objectives of the Medicaid statute because it is expected to help the state furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID-19. The waiver and expenditure authorities provided via this demonstration assist the state in achieving these goals.

V. COST SHARING

13. **Cost Sharing.** There will be no premium, enrollment fee, or similar charge, or cost-sharing (including copayments and deductibles) required of individuals affected by this demonstration that varies from the state's current state plan.

VI. DELIVERY SYSTEM

14. **Delivery System.** The health care delivery system for the provision of services under this demonstration will be implemented in the same manner as currently authorized prior to March 1, 2020.

VII. GENERAL REPORTING REQUIREMENTS

15. **Monthly Calls.** CMS may schedule monthly conference calls with the state. CMS may also schedule these conference calls at some other regular frequency, as determined by CMS. The purpose of these calls will be to discuss any significant, actual or anticipated, developments affecting the demonstration. The state and CMS will jointly develop the agenda for the calls. The monitoring calls for this demonstration may be scheduled in conjunction with other approved section 1115 demonstration monitoring calls.

16. **Final Report.** The final report will consolidate Monitoring and Evaluation reporting requirements for the demonstration. The state must submit this final report no later than one year after the end of the COVID-19 section 1115 demonstration authority. The final report will capture data on the demonstration implementation, lessons learned, and best practices for similar situations. The state will be required to track separately all expenditures associated with this demonstration, including but not limited to, administrative costs and program expenditures. CMS will provide additional guidance on the structure and content of the final report.

    Should the approval period of this demonstration exceed one year, for each year of the demonstration that the state is required to complete per the annual report required under 42 CFR 431.428(a), the state may submit that information in the Final Report.

17. **Evaluation Design.** The state must submit an evaluation design to CMS within 60 days of the demonstration approval. CMS will provide guidance on an evaluation design specifically for the waivers and expenditure authorities approved for the COVID-19 emergency, including any amendments. The state is required to post its evaluation design to the state's website within 30 days of CMS approval of the evaluation design, per 42 CFR 431.424(e).

    The state will test whether and how the approved waivers and expenditure authorities affect the state's response to the public health emergency. To that end, the state will use research questions that pertain to the approved waivers and expenditure authorities. The evaluation will also assess cost-effectiveness by tracking administrative costs and health services expenditures for demonstration beneficiaries and assessing how these outlays affected the state's response to the public health emergency.

VIII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

18. **Allowable Expenditures.** In consequence of the unprecedented emergency circumstances associated with the COVID-19 pandemic and consistent with the President of the United States' 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 – and in consequence of the time-limited nature of this

demonstration – CMS did not require the state to submit budget neutrality calculations for this section 1115(a) demonstration. In general, CMS has determined that the costs to the federal government are likely to have been otherwise incurred and allowable. The state will still be required to track demonstration expenditures and will be expected to evaluate the connection between those expenditures and the state's response to the public health emergency, as well as the cost-effectiveness of those expenditures. This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval period designated by CMS.

19. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The State will estimate matchable demonstration expenditures (total computable and federal share) authorized for this demonstration and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and State and local administration costs (ADM). CMS shall make federal funds available based upon the State's estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the State shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

20. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following:

    a. Administrative costs, including those associated with the administration of the demonstration;

    b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

    c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

21. **Sources of Non-Federal Share.** The state certifies that its match for the non-federal share of funds for this demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section

1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. The state acknowledges that CMS has authority to review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. The state acknowledges that any amendments that impact the financial status of the demonstration must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

22. **Certification of Funding Conditions.** The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers, may certify that state or local monies have been expended as the non-federal share of funds under the demonstration.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the state share of title XIX payments, including expenditures authorized under a section 1115 demonstration, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies that are allowable under 42 CFR 433.51 to satisfy demonstration expenditures. If the CPE is claimed under a Medicaid authority, the federal matching funds received cannot then be used as the state share needed to receive other federal matching funds under 42 CFR 433.51(c). The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d. The state may use intergovernmental transfers (IGT) to the extent that such funds are derived from state or local monies and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.

e. Under all circumstances, health care providers must retain 100 percent of the reimbursement for claimed expenditures. Moreover, consistent with 42 CFR 447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local government to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating

expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

23. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

24. **Reporting Expenditures.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00331/3). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two digit project number extension). Unless specified otherwise, expenditures must be reported by demonstration year according to date of payment. All MEGs that must be reported are identified below in the MEG Detail for Expenditure Reporting table.

    a. <u>Cost Settlements.</u> The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b, in lieu of lines 9 or 10c. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

    b. <u>Administrative Costs.</u> The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER.

    c. <u>Financial Reporting Specifications Manual.</u> The state will create and maintain a Specifications Manual that describes in detail how the state will compile data on actual expenditures under the demonstration, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Financial Reporting Specifications Manual must be made available to CMS on request.

Table 1. MEG Detail for Expenditure Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	MAP or ADM
Expedited Eligibility	Additional expenditures associated with LTSS individuals who are not determined eligible after the expedited process, self-attestation, or alternative verification of individuals' eligibility (income/assets) and level of care to qualify for LTSS [Expenditure Authority 1]	N/A	Line 19A, 19B, 19C, or 19D	MAP
LTSS	Expenditures for LTSS for individuals even if services are not timely updated in the plan of care, or are delivered in allowable alternative settings [Expenditure Authority 2]	N/A	Line 19A, 19B, 19C, or 19D	MAP
HCBS Rates	Additional expenditures associated with higher rates for HCBS providers in order to maintain capacity [Expenditure Authority 3]	N/A	Line 19A, 19B, 19C, or 19D	MAP
Retainer Payment	Expenditures for retainer payments to certain habilitation and personal care providers to maintain capacity during the emergency [Expenditure Authority 4]	N/A	Line 19A, 19B, or 23B	MAP
Modified Eligibility	Expenditures for the state to modify eligibility criteria for long-term services and supports that are no more restrictive than the criteria prior to March 1, 2020 [Expenditure Authority 5]	N/A	Line 19A, 19B, 19C, or 19D	MAP
Functional Assessments	Additional expenditures associated with individuals who received a higher level of care than they otherwise would have because of a delayed functional assessment [Expenditure Authority 6]	N/A	Line 19A, 19B, 19C, or 19D	MAP

25. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the Demonstration Years table below.

Table 2. Demonstration Years

Demonstration Year	Start Sate	End Date

DY 1	March 1, 2020	60 days after the PHE expires[2]

26. Claiming Period. The state will report all claims for demonstration expenditures (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures.

IX. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION PERIOD

Due Date	Deliverable
Fifteen days from date of demonstration approval	State Acceptance of Demonstration, STCs, Waivers and Expenditure Authorities.
Sixty days from date of the demonstration approval	Evaluation Design is Submitted to CMS
Thirty days from date of evaluation design approval	Approved Evaluation Design is posted on state website
One year after expiration of demonstration	Final report with consolidated Monitoring and Evaluation requirements

[2] To the extent that the PHE for COVID-19 and/or this demonstration is extended beyond a single DY, CMS will update this chart to include additional DYs, as applicable/necessary.