March 23, 2020

Mr. Calder Lynch
Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Sent via electronic mail

Re: Federal authority for Emergency Needs for Minnesota's Medicaid, Basic Health, and CHIP Programs

Dear Mr. Lynch:

The purpose of this letter is to request temporary flexibility in the Medicaid, Children's Health and Basic Health Programs due to the 2019 Novel Coronavirus (COVID-19), effective March 18, 2020.

The President declared a nationwide state of emergency, and the Secretary of Health and Human Services declared COVID-19 a public health emergency on January 30, 2020. These emergency declarations invoke section 1135 of the Social Security Act to allow CMS to waive programmatic requirements under Titles XVIII, XIX, and XXI, as well as laws and regulations governing the Basic Health Program at Section 1331 of the Affordable Care Act and 42 C.F.R. Part 600. To the extent that some of these requests require authority under section 1115 of the Social Security Act, we request approval of those provisions under section 1115.

We request a broad range of temporary waivers that can be invoked as necessary by the State, at different points in time as health and safety, work force and infrastructure needs change, in order to ensure that resources are deployed in the most efficient manner. We also request the corollary range of temporary authorities to end the waivers and revert back to the current agreements and regulatory structures as appropriate. To that end, we request the following waiver authority, with the understanding that:

a. The state will also apply for emergency-related flexibilities authorized under federal regulation that do not require an amendment to the State Plan, BHP Blueprint, verification plans, and other federal authorities. We will follow up with a concurrence letter to CMS for those flexibilities for which federal law allows based on emergency needs;

b. The state will follow up with any more specific amendments to the Home and Community-based Waivers, the State Plan, the Blueprint, and other standing authorities as necessary;

c. The state will follow up with any requests for 1115 waivers as necessary; and

d. The state will notify CMS in writing when granted authorities and flexibilities invoked by the state end.

Eligibility. We request flexibility to ensure that enrollees in the Medicaid, CHIP and BHP programs maintain eligibility, and to facilitate eligibility for those not yet enrolled. These flexibilities may include:

Allow self-attestation for all eligibility criteria (excluding citizenship and immigration status) on a case-by-case basis for Medicaid, CHIP and BHP eligible individuals subject to a disaster when documentation is not available as outlined at 42 CFR 435.952(c)(3); 42 CFR 457.380 or 42 CFR Part 600.

Allow presumptive Medicaid eligibility for the Aged, Blind, and Disabled population, and to make the state a qualified PE entity in order to conduct PE for all populations in a wide variety of sites as may be necessary.

Allow presumptive eligibility for the Aged, Blind and Disability population for long term care services based on an abbreviated level of care assessment and financial eligibility screening to ensure more immediate discharge from hospitals of people who are ready but must await application for long term care benefits so we can free hospital beds more timely. Also, we request the state to be established as a PE entity to enroll applicants based on preliminary application information.

Consider Medicaid and CHIP enrollees who are quarantined from the state as "temporarily absent" when assessing residency in order to maintain enrollment (for home state where disaster occurred or public health emergency exists) as permissible under 42 CFR 435.403(j)(3); 42 CFR 457.320(e); 42 FR 431.52; 42 CFR 457.320.

Extend redetermination timelines for current Medicaid, CHIP and BHP enrollees to maintain continuity of coverage as permissible under 42 CFR 435.912(e) and [add CHIP and BHP cites].

Waive requirements related to the post-eligibility treatment of income which will enable affected beneficiaries to retain funds otherwise required to be collected and applied toward the cost of care. (42 CFR 435.217).

Annual Redeterminations of Eligibility – Sections 1902(a)(4) and 1902(a)(19). To permit delay of otherwise required redeterminations for the State's XIX and XXI programs, and the Basic Health Program.

We request enhanced eligibility levels for those uninsured under the crisis period who may be above the 135% to 200% FPL and lift the 5-year bar period.

Requirements related to the post eligibility treatment of income which will enable affected beneficiaries to retain funds otherwise required to be collected (42 CFR 435.217)

Waivers of or revisions to premiums and cost-sharing, and to continue coverage when premiums are not paid.

Expanded presumptive eligibility, for additional eligibility groups, simplified eligibility and the ability to use currently uncertified agencies and providers to conduct PE.

Extending reasonable opportunity periods and application and renewal processing time, delaying renewal processing, delaying action on changes in circumstance for those changes that might negatively affect eligibility.

Establish a new Medicaid eligibility category that will be linked to a limited benefit set for testing, diagnosis and treatment of COVID-19 illness, that may be available to those whose eligibility for Medicaid, CHIP or the BHP is unable to be determined, or who are otherwise uninsured.

Provider participation and conditions for payment.

Flexibility to allow facilities such as nursing homes, ICFs, hospitals and residential providers to provide services in alternative physical settings such as temporary shelters or other care facilities when such facilities are inaccessible.

Temporarily suspending 2-week aide supervision requirement by a registered nurse for home health agencies.

Temporarily suspending the supervision of hospice aides by a registered nurse every 14 days requirement for hospice agencies.

Temporarily waive requirements that out-of-state providers be licensed in Minnesota when they are licensed by another state Medicaid agency or by Medicare.

Modify or waive state licensing standards as delineated in state plan and other federal authorities to ensure timely and safe delivery of services.

Settings.

Allow facilities and other providers to provide services in alternative settings, including temporary shelters and mobile-units.

Allow day providers to provide services in-home and at other alternative settings.

Telehealth and Telemedicine.

Any authority that may be needed to remove barriers to employing the use of telemedicine to diagnose or treat COVID-19, and to provide other necessary health services, including increasing the number of visits allowed per week, expanding the types of providers eligible to provide telemedicine, and modifying the modes of delivery for telemedicine.

Modification of Service Delivery Requirements.

Flexibility to reduce or remove potential barriers to service delivery, including requirements to receive services and assessments and evaluations in person; prior authorization requirements; requirements to receive behavioral health or functional assessments to authorize services;

removing barriers to telemedicine and telehealth, such as but not limited to increasing the number of visits allowed per week for individual therapy, allowing for group therapy, expanding the types of providers eligible to provide telemedicine or telehealth, recognizing the patient's home or current location as an originating site, and modifying the modes of delivery for telehealth and telehealth; and removing or expanding limits on early prescription refills for covered drugs.

Waiver of Conditions of Participation and Certification

Flexibility to alter conditions of participation, certification requirements, enrollment and validation, program participation or similar requirements for individual health care providers or types of providers. This includes the ability to waive Medicaid program requirements similar or related to blanket waivers issued by CMS on 3/13/20 by CMS for Medicare and/or other federal programs, such as:

- Any limits on NF benefit related to length of hospital stay
- Time limits for MDS assessments and transmission
- Critical Access Hospitals—limits on length of stay and number of beds
- Requirements to allow acute care hospitals to house inpatients in excluded distinct part units
- Where DME, prosthetics, orthotics and supplies are lost, destroyed, damaged or otherwise unusable, waive the replacement requirements related to new physician orders, face-to-face requirements, new prior authorization.
- Waive the length of stay requirement for long term care hospitals
- Waive the timeframe for OASIS transmission
- Temporarily waive requirements that out-of-state providers be licensed in the state in which they are providing services when they are licensed in another state.
- Provider enrollment:
    - waive application fees
    - waive criminal background checks
    - waive site visits
    - postpone revalidation actions

Modification of Payment Rates and Managed Care Capitation Rates and Contracts.

Flexibility to modify payment rates, capitation rates, and managed care contracts as necessary to maintain access to health care services and to execute those amendments without advance approval by CMS.

Flexibility to delay managed care enrollment if necessary in order to pay claims in fee-for-service.

We request a waiver of the requirement for actuarially sound Medicaid managed care rates, under 42 C.F.R. Part 438, for calendar years 2020 and 2021. This waiver would apply to all Medicaid managed care programs and contracts.

HCBS Waiver Programs.

Minnesota operates five waiver programs under 1915(c) authority. We request the following authority generally, with the understanding that revisions to Appendix K will be submitted as necessary when needs are identified with more specificity.

Cost and budget neutrality requirements and limitations on numbers of individuals served in order to enable the state to deliver long-term services and supports as needed to affected beneficiaries. Minnesota will not be required to meet budget neutrality tests under the waiver during the period of the emergency.

Requirements prohibiting the provision of home and community-based services to affected beneficiaries who are being served in an inpatient setting in order to enable direct care workers or other home and community-based providers to accompany individuals to any setting necessary [42 CFR 441(b)(1)(ii)].

Requirements related to conflict of interest and person-centered plan development in order to enable sufficient provider capacity to serve affected beneficiaries as applicable to the authorities selected for this demonstration.

Requirements related to home and community-based settings in order to ensure the health, safety and welfare of affected beneficiaries [441.301(c)(4)].

Waive signature requirements on level of care assessments, plans of care and other required supporting documentation.

Uninsured Individuals Who Require COVID-19 Testing or Treatment.

Provide for Medicaid eligibility for uninsured individuals and to cover tests, labs and related provider visits necessary for the diagnosis of COVID-19. Provides for all necessary treatment for uninsured individuals who have COVID-19. Provides for Medicaid matching funds for all testing and necessary treatment. This coverage extends to no more than 90 days after the end of the declared emergency period. No cost-sharing or premiums will apply.

Federal Funding.

Permit requests for funds ahead of scheduled release of federal funding to address COVID-19 needs.

Temporary Relief from Administrative Requirements.

Waivers from related reporting and evaluation requirements, participation in federal audits and reviews during crises periods, state plan, waiver and contract deadlines. An exception to timely claims processing requirements to accommodate temporary pandemic related changes to the state's Medicaid program.

Waive requirement that State must submit and receive CMS approval of a Title XIX, Title XXI state plan amendment or BHP Blueprint in order to temporarily waive any patient cost-sharing associated with COVID-9 screening, testing, and treatment.

Temporarily cease the revalidation of and waive provider renewal requirements during this state of emergency.

Transparency requirements. Temporarily waive all requirements regarding public notice and comment, consultation and public hearings with respect to waiver, state plan, blueprint amendments.

Blanket waivers for purposes of general flexibility.

Fair Hearings and Notices – Section 1902(a)(3). To enable the State to extend fair hearing timeframes as needed.

Proper and Efficient Administration of the State Plan - Section 1902(a)(4)(A). To enable the State to use streamlined eligibility procedures for individuals who would be affected beneficiaries.

Reasonable Promptness - Section 1902(a)(8). To enable the State to limit enrollment or to reasonably triage access to needed long-term services and supports for affected beneficiaries.

Comparability – Section 1902(a)(10)(B). To enable the State to deliver different services and service delivery methods to affected beneficiaries than are otherwise available to non-affected beneficiaries.

Reasonable Standards for Eligibility – Section 1902(a)(17). To enable the State to modify eligibility criteria as necessary to make individuals affected beneficiaries in need of long term services and supports.

Statewideness – Section 1902(a)(1) and 1902(a)(17) To enable the State to vary services and service delivery methods in geographic regions as appropriate for affected beneficiaries.

Freedom of Choice - Section 1902(a)(23)(A). To enable the State to restrict freedom of choice of provider.

Provider Agreements and Direct Payment to Providers - Section 1902(a)(32). To permit the provision of care to affected beneficiaries by individuals or entities who have not executed a Provider Agreement with the State but have such an agreement with another State.

Amount, Duration, and Scope – Section 1902(a)(10)(B). To the extent necessary to enable the state to offer different benefits to affected beneficiaries.

Timely Filing Requirements for Billing -- 42 CFR 424.44 Waive of timely filing requirements that will allow providers getting correct coding and other structural pieces built into their systems and even payer ability to adjudicate.

Third Party Liability -- Modify or waive requirements related to identifying liable third parties, in order to facilitate enrollment, the requirement to remain enrolled in cost-effective health insurance, and Medicaid payment for cost-effective health insurance.

We look forward to working with your team to move forward with approval with these flexibilities.

Sincerely,

Matt Anderson, Medicaid Director

cc: Jackie Glaze, CMS