1135 Waiver Issued by CMS

CMS approved certain of the flexibilities requested by California in an 1135 waiver issued on March 23, 2020. The provisions of the waiver are retroactive to March 1, 2020 (DHCS had requested they be retroactive to January 27, 2020, the start of the emergency). The approved requests are as follows.

**Suspension of prior authorization.** CMS is waiving requirements for prior authorization in the Medi-Cal fee-for-service (FFS) delivery system.

**Extension of pre-existing authorizations.** CMS is extending prior authorizations which a beneficiary has already received in Medi-Cal FFS through the end of the declared public health emergency.

**State Fair Hearing Requests and Appeals Timelines.** CMS has approved allowing enrollees to have an additional 120 days (above the current 90 days granted) to appeal or request a fair hearing on eligibility or fee for service issues. For managed care, CMS cannot waive the requirement that enrollees receive an adverse benefit determination from the managed care plan (MCP) before proceeding to a state fair hearing. However, CMS has reduced the time required for managed care plans to resolve appeals to only one day; therefore, all beneficiary claims will almost immediately meet the exhaustion criteria due to MCPs not meeting the timing requirements.

**Provider Enrollment.** California already has the authority under current CMS policy to provisionally, temporarily enroll providers who are enrolled with another State Medicaid Agency (SMA) or Medicare for the duration of the public health emergency, provided certain criteria are met. The waiver additionally permits California to reimburse out-of-state providers for multiple instances of care to multiple beneficiaries, as long as the other criteria continue to be met. (Current policy only allows reimbursement for either one instance of care over a 180-day period or multiple instances of care for a single participant over a 180-day period).

For providers that are not already enrolled with another SMA or Medicare, CMS is waiving certain requirements, such as the fingerprint background check, so that the provider can be temporarily
enrolled for the duration of the emergency, as long as the state maintains certain requirements, including checking the OIG exclusion list. California must cease provisionally enrolling providers after the end of the emergency, and cease payments to all provisionally enrolled providers within 6 months following the end of the emergency. CMS also approved California’s request to temporarily cease revalidation of current providers who are located in California or otherwise impacted by the emergency.

**Provision of Services in Alternative Settings.** CMS is permitting certain types of licensed facilities, including nursing facilities, to be fully reimbursed for services rendered to an unlicensed facility, provided that the unlicensed facility meets minimum standards.

DHCS requested many additional flexibilities that were not approved by CMS in this waiver. These include:

**Reimbursement for Telephone Visits.** DHCS had requested a waiver of 42 C.F.R. §438.6(c)(1), as necessary, to permit the State to direct MCP payments to network providers, where telehealth/telephonic service is medically appropriate and feasible, at the same rate the MCP would pay if the service was provided in person, unless the MCP and the provider otherwise agree to a different rate for the telehealth modality.

**Telehealth Requirements for FQHCs and RHCs.** DHCS had requested a waiver of the face-to-face encounter requirement for reimbursement in FQHCs, RHCs, and Tribal 638 Clinics relative to covered services via telehealth provided by clinic providers. Additionally, it had asked to allow flexibility to provide these covered services via telehealth without regard to the date of the patient’s last visit and for new or established clinic patients; to permit reimbursement for E-consult; and to allow reimbursement for virtual communication by billing HCPCS code G0071.

**Informed Consent.** DHCS had requested that the waivers would extend to any limitations for elective procedures and informed consent to enable providers to postpone elective procedures to prioritize COVID-19 response activities. DHCS suggested extending the current 180-day limit for beneficiary informed consent to 360 days.

**100 Day Prescription Drug Supply.** DHCS had requested a Waiver of State Plan Attachment 3.1 B, which limits dispensing of a covered drug up to a 100-day supply. DHCS is requesting authority to temporarily suspend these limitations for all drugs, excluding narcotics/opioids, thus allowing up to 100-day supply to be dispensed, without a TAR/SAR, if medically necessary and the prescriber writes for that quantity. DHCS also requested authority to suspend other frequency and maximum daily quantity edits.