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

April 2, 2020

Mr. Jeremy Brunssen, Interim Director
Division of Medicaid and Long-Term Care
Nebraska Department of Health & Human Services
301 Centennial Mall South
Lincoln, Nebraska 68509

Re: Section 1135 Flexibilities Requested in March 30, 2020 Communication

Dear Mr. Brunssen:

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 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 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and section 1135 waivers will no longer be available, upon termination of the public health emergency, including any extensions.

Your communication to CMS on March 30, 2020, detai1ed a number of federal Medicaid and Medicare requirements that pose issues or challenges for the health care delivery system in all counties in Nebraska and requested a waiver or modification of those requirements. Attached, please find a response to your requests for waivers or modifications, pursuant to section 1135 of the Social Security Act, to address the challenges posed by COVID-19. This approval addresses those requests related to Medicaid and Medicare.

To streamline the section 1135 waiver request and approval process, CMS has issued a number of blanket waivers for many Medicare provisions, which primarily affect requirements for

individual facilities, such as hospitals, long term care facilities, home health agencies, and so on. Waiver or modification of these provisions does not require individualized approval, and, therefore, these authorities are not addressed in this letter. Please refer to the current blanket waiver issued by CMS that can be found at: https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf.

This letter is in response to all requests submitted to CMS. If Nebraska determines that it has additional needs, please contact your state lead and CMS will provide the necessary technical assistance for any additional submissions.

Please contact Jackie Glaze, Acting Director, Medicaid and CHIP Operations Group, 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 residents of the State of Nebraska and the health care community.

Sincerely,

Calder Lynch
Deputy Administrator and Director

STATE OF NEBRASKA
APPROVAL OF FEDERAL SECTION 1135 WAIVER REQUESTS

CMS Response: April 2, 2020

Temporarily suspend Medicaid fee-for-service prior authorization requirements. Section 1135(b)(1)(C) allows for a waiver or modification of pre-approval requirements, including prior authorization processes required under the State Plan for particular benefits.

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 C.F.R. §440.230(d). The State of Nebraska 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.

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

Section 1919(e)(7) of the Act allows Level I and Level II assessments to 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 II 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 I screens would require a Resident Review.

The 7-9-day timeframe for Level II 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.

State Fair Hearing Requests and Appeal Timelines

Nebraska requested flexibility to temporarily delay scheduling of Medicaid fair hearings and issuing fair hearings decisions during the emergency period. CMS approves a waiver under section 1135 that allows enrollees to have more than 90 days, up to an additional 120 days for an eligibility or fee for service appeal to request a fair hearing. The timeframes in 42 C.F.R. §431.221(d) provides that states can choose a reasonable timeframe for individuals to request a fair hearing not to exceed 90 days for eligibility or fee-for-service issues.

Provider Enrollment

Nebraska currently has the authority to rely upon provider screening that is performed by other State Medicaid Agencies (SMAs) and/or Medicare. As a result, Nebraska is authorized to provisionally, temporarily enroll providers who are enrolled with another SMA or Medicare for the duration of the public health emergency.

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, Nebraska may reimburse otherwise payable claims from out-of-state providers not enrolled in Nebraska 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 Nebraska Medicaid program, CMS will waive the fifth criterion listed above under section 1135(b)(1) of the Act. Therefore, for the duration of the public health emergency, Nebraska may reimburse out-of-state providers for multiple instances of care to multiple participants, so long as the other criteria listed above are met.

If a certified provider is enrolled in Medicare or with a state Medicaid program other than Nebraska, Nebraska may provisionally, temporarily enroll the out-of-state provider for the duration of the public health emergency 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) and (b)(2) of the Act, so the state may provisionally, temporarily enroll the providers for the duration of the public health emergency:

1. Site visits - 42 C.F.R. §455.432
2. In-state/territory licensure requirements - 42 C.F.R. §455.412

CMS is granting this waiver authority to allow Nebraska 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), as applicable, in order to perform the following screening requirements:
    a. OIG exclusion list
    b. State licensure – provider must be licensed, and legally authorized to practice or deliver the services for which they file claims, in at least one state/territory
3. Nebraska 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 termination of the public health emergency, including any extensions, unless a provider has submitted an application that meets all requirements for Medicaid participation and that application was subsequently reviewed and approved by Nebraska before the end of the six month period after the termination of the public health emergency, including any extensions, and
    c. Allow a retroactive effective date for provisional temporary enrollments that is no earlier than March 1, 2020.

Under section 1135(b)(1)(B), CMS is also approving Nebraska's request to temporarily cease revalidation of providers who are located in Nebraska or are otherwise directly impacted by the emergency.

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

Provision of Services in Alternative Settings

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 hospital NFs, to be fully reimbursed for services rendered to an unlicensed facility (during an emergency evacuation or due to other need to relocate residents where the placing facility continues to render services) provided that the State makes a reasonable assessment that the facility meets minimum standards, consistent with reasonable expectations in the context of the current public health emergency, to ensure the health, safety and comfort of beneficiaries and staff. The placing 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.

State Plan Amendment Flexibilities: Submission Deadline, Public Notice, and Tribal Consultation

The State of Nebraska also requested a modification of the requirement to submit SPAs related to the COVID-19 emergency by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 C.F.R. §430.20. CMS is approving this request pursuant to section 1135(b)(5) of the Act. This approval applies only with respect to SPAs that provide or increase beneficiary access to items and services related to COVID-19 (such as cost sharing waivers, payment rate increases, or amendments to alternative benefit plans (ABPs) to add services or providers) and that would not restrict or limit payment or services or otherwise burden beneficiaries and providers, and that are temporary, with a specified sunset date that is not later than the last day of the declared COVID-19 emergency (or any extension thereof).

The State of Nebraska also requested a waiver of public notice requirements applicable to the state plan amendment (SPA) submission process. Public notice for SPAs is required under 42 C.F.R §447.205 for changes in statewide methods and standards for setting Medicaid payment rates, 42 C.F.R. §447.57 for changes to premiums and cost sharing, and 42 C.F.R. §440.386 for changes to ABPs. These requirements help to ensure that the affected public has reasonable opportunity to comment on these SPAs.

CMS recognizes that during this public health emergency, Nebraska must act expeditiously to protect and serve the general public. Therefore, under section 1135(b)(1)(C) and 1135(b)(5) of the Act, CMS is approving the state's request to waive and modify these notice requirements applicable to SPA submissions. This approval applies only with respect to SPAs that provide or increase beneficiary access to items and services related to COVID-19 (such as cost sharing waivers, payment rate increases, or amendments to ABPs to add services or providers) and that would not restrict or limit payment or services or otherwise burden beneficiaries and providers, and that are temporary, with a specified sunset date that is not later than the last day of the declared COVID-19 emergency (or any extension thereof). Even though CMS is approving this waiver, we encourage the state to make all relevant information available to the public so they are aware of the changes.

Under section 1135(b)(5) of the Act, CMS is also approving the State of Nebraska's request for flexibility to modify the timeframes associated with tribal consultation required under section 1902(a)(73) of the Act, including shortening the number of days before submission or conducting consultation after submission of the SPA. Again, this approval applies only with respect to SPAs that provide or increase beneficiary access to items and services related to COVID-19 (such as cost sharing waivers, payment rate increases, or amendments to ABPs to add services or providers) and that would not restrict or limit payment or services or otherwise burden beneficiaries and providers, and that are temporary, with a specified sunset date that is not later than the last day of the declared COVID-19 emergency (or any extension thereof).

Duration of Approved Waivers

Unless otherwise specified above, the section 1135 waivers described herein are effective March 1, 2020 and will terminate upon termination of the public health emergency, including any extensions. In no case will any of these waivers extend past the last day of the public health emergency (or any extension thereof).