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**Provision of Care in Alternative Settings, Hospital Capacity, State Plan
and Blanket Section 1135 Waiver Flexibilities for Medicare and Medicaid
Enrolled Providers Relative to COVID-19**

June 3, 2020 (supersedes April 22, 2020, guidance)

On March 16, 2020, March 19, 2020 and April 10, 2020, the Department of Health Care Services (DHCS) submitted requests to waive or modify a number of federal requirements under Section 1135 of the Social Security Act (SSA) (Title 42 United States Code (USC) section 1320b-5) and a disaster State Plan Amendment (SPA) 20-0024 on April 3, 2020, to the federal Centers for Medicare and Medicaid Services (CMS). DHCS' Section 1135 Waiver submission requested various flexibilities related to the COVID-19 public health emergency, including flexibility on the provisions of services provided in alternative care settings during the emergency period.

On March 23, 2020, CMS submitted [an approval letter](#) to DHCS summarizing its approval of specific requested Section 1135 Waiver flexibilities. On [May 8, 2020](#), CMS approved additional Section 1135 waiver requests, and also specified that it granted numerous [blanket waivers](#) of Medicare provisions to help healthcare providers combat and contain the spread of COVID- 19.

On May 13, 2020, CMS approved [SPA 20-0024](#), which granted DHCS the ability to temporarily modify policies in its Medicaid State Plan related to eligibility, enrollment, benefits, premiums and cost sharing, and payments.

Based on the March 23, 2020, May 8, 2020, and May 13, 2020 Section 1135 Waiver request approvals, the SPA 20-0024 approval and the additional CMS blanket waiver guidance, DHCS is issuing the following guidance relative to provision of care in alternative settings, hospital capacity, and blanket waiver flexibilities, as described in detail below. These policies will remain in effect through the end of the COVID-19 public health emergency (PHE).

This revised notice is to inform providers of the additional waivers flexibilities applicable to Medi-Cal providers enrolled in Medicare and Medicaid Programs. These waivers are in effect, with a retroactive effective date of March 1, 2020, through the end of the PHE. Where these flexibilities affect Medi-Cal billing or prior approval policies, DHCS has included additional billing guidance, where warranted, at the end of the flexibility, and added applicable website links to the additional CMS fact sheets. To the extent there is no additional billing guidance noted after the applicable flexibility, Medi-Cal providers

should continue to bill in accordance with existing policies. DHCS will continue to work with CMS on additional waiver or modification requests that are not yet approved and reflected below.

Provision of Services in Alternative Settings

Under SSA Section 1135(b)(1), CMS approved DHCS' waiver request to allow inpatient facilities, including nursing facilities (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 in an unlicensed facility (during an emergency evacuation or due to other needs to relocate residents where the placing facility continues to render services) provided that the California Department of Public Health 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 approved Section 1135 waiver.

Under this Section 1135 Waiver authority, Medi-Cal covered benefits or services can be delivered to eligible Medi-Cal beneficiaries in alternative settings, as defined, by licensed health care practitioners acting within their scope of practice. Regardless of setting, the rendering health care practitioners would be expected to follow all applicable DHCS policies relative to the Medi-Cal covered benefits or services being provided. The Medi-Cal enrolled placing facility will submit a claim to Medi-Cal fiscal intermediary or to their Medi-Cal Managed Care Plan (MCP), as appropriate, with their designated National Provider Identifier (NPI) and in accordance with existing billing policies and processes. Reimbursement to the unlicensed facility would be determined based upon whatever financial arrangement exists between the unlicensed facility and the placing facility, and would not be payable by the Medi-Cal FI or Medi-Cal MCP.

Long-Term Care Facilities and Skilled Nursing Facilities (SNFs) and/or Nursing Facilities (NFs)

CMS is waiving the [SSA Section 1812\(f\)](#) requirement for a three (3)-day prior hospitalization for coverage of a SNF stay to provide temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who need to be transferred as a result of the effect of a disaster or emergency. In addition, for certain beneficiaries who recently exhausted their SNF benefits, CMS has authorized renewed SNF coverage without first having to start a new benefit period. Second, CMS is waiving Title 42 of the Code of Federal Regulations (CFR) Section 483.20 to provide relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission.

DHCS is adhering to the blanket flexibility and where applicable to Medi-Cal enrolled SNFs, it is our expectation that facilities will ensure that Medi-Cal beneficiaries affected by COVID-19 receive the flexibilities outlined in the waiver and are not negatively

impacted or require prior hospitalization. For billing purposes, SNFs can annotate in the beneficiary's medical record and on the Treatment Authorization Request (TAR) "Patient impacted by COVID-19" when the beneficiary's three-day prior hospitalization is waived because of capacity or other exigent circumstances related to the COVID-19 PHE.

Approval of SPA 20-0024 enables DHCS to temporarily provide an additional 10 percent reimbursement for Long Term Care (LTC) per diem rates, effective March 1, 2020. Additional information can be found on the following LTC webpages:

- **LTC Reimbursement:** <https://www.dhcs.ca.gov/services/medi-cal/Pages/LTCRU.aspx>
- **LTC Reimbursement Assembly Bill (AB)1629:**
<https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTCAB1629.aspx>

For additional information on the guidance, please see the following related CMS Waiver Fact Sheet

- [LTC Facilities \(Skilled Nursing Facilities and/or Nursing Facilities\)](#)

Hospitals, Psychiatric Hospitals, and Critical Access Hospitals (CAHs), including Cancer Centers and Long-Term Care Hospitals (LTCHs)

CAHs

CMS is waiving the requirements that CAHs limit the number of beds to 25, and that the length of stay be limited to 96 hours. This waiver affects CAHs that are also considered "transfer and referral hospitals" and the waiver flexibility removes the bed and hours limits to allow CAHs to increase capacity for community pandemic needs as well as function as "overflow" facilities in the event that tertiary hospitals reach their surge capacity with COVID-19 patients. There are no changes in Medi-Cal billing policies.

Housing Acute Care Patients In Excluded Distinct Part Units

CMS is waiving requirements to allow acute care hospitals to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatient. The Inpatient Prospective Payment System (IPPS) hospital should bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to the disaster or emergency.

DHCS is adhering to this blanket waiver flexibility and if a hospital has the ability to relocate acute care inpatients to an excluded distinct part bed, the hospital should continue to bill Medi-Cal for acute care inpatient services with the facilities NPI and the

general acute care revenue and accommodations code(s) in the "[Revenue Codes for Inpatient Services](#)" section of the Medi-Cal Provider Manual and annotate in the beneficiary's medical record and on the TAR "Patient impacted by COVID-19" when the beneficiary is an acute inpatient being cared for in an excluded distinct part unit because of capacity or other exigent circumstances related to the disaster or emergency.

Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital

CMS is waiving requirements to allow acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of a disaster or emergency, need to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. This waiver may be utilized where the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

DHCS is adhering to this flexibility and as long as the hospital providing the psychiatric care in an acute care setting is properly enrolled in Medi-Cal to provide psychiatric inpatient hospital services, the hospital should continue to bill the same as it would bill for a patient receiving psychiatric inpatient hospital services in a psychiatric unit of the hospital with their NPI, psychiatric revenue and accommodation codes, and annotate in the medical record and on the TAR "Patient impacted by COVID-19" when the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the disaster or emergency. Also, hospitals that are not already enrolled in Medi-Cal may use the [expedited enrollment process](#) during the COVID-19 emergency.

Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital

CMS is waiving requirements to allow acute care hospitals with excluded distinct part inpatient rehabilitation units that, as a result of a disaster or emergency, need to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the disaster or emergency. This waiver may be utilized where the hospital's acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

DHCS is adhering to this flexibility and if a hospital has the ability to relocate inpatients from an excluded distinct part rehabilitation unit to an acute care bed unit, the hospital should continue to bill for inpatient rehabilitation services with the revenue and accommodations codes for rehabilitation services and annotate in the medical record

and on the TAR “Patient impacted by COVID-19” when the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the disaster or emergency.

Supporting Care for Patients in LTCHs

CMS is waiving requirements to allow LTCHs to exclude patient stays where an LTCH admits or discharges patients in order to meet the demands of the emergency from the 25-day average length of stay requirement, which allows these facilities to be paid as LTCHs.

In California, LTCHs are recognized as acute-care hospitals. Under the blanket waiver flexibility, Medi-Cal enrolled general acute care hospitals may comply with the waived average 25-day average length of stay to meet the demand of the COVID-19 emergency. This flexibility will not affect the existing billing policies relative to Diagnostic Reimbursement Group (DRG); however, hospitals should annotate in the medical record and on the TAR “Patient impacted by COVID-19” to indicate the CMS approved flexibility on the 25-day average length of stay requirement.

For additional information on the guidance, please see the following related CMS Waiver Fact Sheets

- [Hospitals](#)
- [Teaching Hospitals, Teaching Physicians and Medical Residents](#)
- [Inpatient Rehabilitation Facilities](#)
- [LTC Hospitals & Extended Neoplastic Disease Care Hospitals](#)

Ambulance Services - Temporary Expansion Sites

CMS is temporarily expanding the list of allowable destinations for ambulance transports. During the COVID 19 PHE, ambulance transports may include any destination that is able to provide treatment to the patient in a manner consistent with state and local Emergency Medical Services (EMS) protocols in use where the services are being furnished. These destinations may include, but are not limited to: any location that is an alternative site determined to be part of a hospital, CAH or SNF, community mental health centers, federally qualified health centers (FQHCs), physician’s offices, urgent care facilities, ambulatory surgery centers, any other location furnishing dialysis services outside of the End Stage Renal Disease (ESRD) facility, and the beneficiary’s home.

Additionally, in response to the Section 1135 Waiver request, CMS informed DHCS that the temporary expansion of allowable destinations for ambulance transports is applicable to Medi-Cal ambulance providers through the existing State Plan authority. DHCS is acknowledging this flexibility and require Medi-Cal ambulance transports to be billed at the standard ambulance transport rate, but when or if a TAR is required,

ambulance providers should follow the prior authorization and TAR flexibility requirements in the [April 2, 2020](#), DHCS [notice](#). These flexibilities will remain in effect through the end of the COVID-19 PHE.

For additional information on this guidance, please see the following related CMS Waiver Fact Sheet

- [Ambulances](#)

Hospice

Medi-Cal hospice is covered when provided by a Medicare certified hospice in the same scope and duration as Medicare. DHCS acknowledges these flexibilities when providing hospice services to Medi-Cal beneficiaries during the PHE. On April 2, 2020, DHCS released guidance to inform providers of the waiver flexibilities for [prior authorization](#), these flexibilities are afforded to hospice providers for Medi-Cal hospice services. Hospice providers should continue to bill Medi-Cal with existing hospice billing policies and annotate in the medical record and on the TAR “Patient impacted by COVID-19”.

For additional information on this guidance, please see the following related CMS Waiver Fact Sheet

- [Hospices](#)

Below are additional CMS Waiver Fact Sheets for covered benefits and services under the Medi-Cal program. Please follow existing policies and procedures, including the use of [previously released](#) COVID-19 program flexibilities, for claiming purposes.

- [Physicians and Other Practitioners](#)

Home Health Agencies

[Approval of SPA 20-0024](#) allows home health agency services to be prescribed by other licensed providers to establish a plan of care. Also, in accordance with the Interim Final Rule Comment Period, CMS also gave DHCS flexibility to waive the onsite visits for home health aide supervision which require a nurse to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time. All comments on the Interim Final Rule are due by July 7, 2020, and DHCS will issue additional guidance and/or further clarifications, as applicable, upon publication of the Final Rule

For additional information on this guidance, please see the following related CMS Waiver Fact Sheet

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- [Home Health Agencies](#)
- [ESRD Facilities](#)
- [Durable Medical Equipment](#)
- [Rural Health Clinics \(RHCs\), FQHCs and Tribal 638 clinics](#)

Approved SPA 20-0024 modifies face-to-face requirements for a reimbursable visit at a RHC, FQHC, and Tribal 638 clinic including telephonic visits. Specifically, when a RHC, FQHC or Tribal 638 clinic satisfies all the procedural and technical components of a patient visit, except for the face-to-face component, reimbursement will be permitted at the Prospective Payment System (PPS) rate or the All-Inclusive Rate (AIR) for new or established patients. Additionally, telephonic/virtual communication for five minutes or more between an RHC, FQHC, and Tribal 638 practitioner and a new or established patient will be reimbursed using Healthcare Common Procedure Coding System (HCPCS) code G0071 on the UB 04 claim form.

Lastly, services provided by Associate Clinical Social Workers (ACSW) and Associate Marriage and Family Therapists (AMFT) are reimbursable to RHCs and FQHCs, when these services are supervised by appropriate licensed and billable RHC and FQHC practitioners. Please note, Tribal 638 clinics have existing authority under the State Plan to bill for the services provided by an ACSW and AMFT under the supervision of a licensed mental health professional.

Laboratories

Approval of [SPA 20-0024](#) allows DHCS to reimburse for clinical laboratory or laboratory services. DHCS has approval to establish COVID-19 procedure codes and reimbursement rates for HCPCS codes U0001, U0002, and Current Procedural Terminology-4 (CPT-4) code 87635 for diagnostic laboratory testing, HCPCS codes G2023 and G2024 for related specimen collection, and any COVID-19 diagnostic testing or collection procedure code, or equivalent code, adopted or established by CMS in the future. The reimbursement will be effective for dates of service on or after March 1, 2020, or the date the procedure code is adopted or established by CMS. This approval allows DHCS to reimburse Medi-Cal providers at 100 percent of the Medicare rate for procedure codes related to COVID-19. Additional information on COVID-19 billing and policy is located in the [Pathology: Microbiology](#) section of the Provider Manual.

For additional information on laboratory flexibilities, please see the following related CMS Waiver Fact Sheet

- [Laboratories](#)

Additional Resources

For additional COVID-19 information and resources, we encourage you to review the following resources:

- [DHCS COVID-19 Response](#)
- [Latest news from California Department of Public Health \(CDPH\) about COVID-19 | En Español](#)
- [CDPH COVID-19 guidance](#)
- [Centers for Disease Control and Prevention \(CDC\) COVID-19 response | En Español | 中文](#)
- [Follow CDPH Twitter for the latest COVID-19 information](#)