DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 355
Kansas City, Missouri 64106-2898

Medicaid and CHIP Operations Group

January 17, 2025

Tyler Sadwith, State Medicaid Director
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Re: Section 1135 Flexibilities Requested on January 14, 2025

Dear State Medicaid Director Tyler Sadwith:

On January 8, 2025, the President of the United States issued a proclamation retroactive to January 7, 2025, that the 2025 Southern California Wildfires constitutes an emergency by the authorities vested in the President 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 (the Act). On January 7, 2025, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services (HHS) declared a public health emergency (PHE), invoking the authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act. During a PHE, the Centers for Medicare and Medicaid Services (CMS) may approve the use of section 1135 authority to help ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in CMS 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, 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 January 10, 2025, with a retroactive effective date of January 7, 2025. The emergency period will terminate, and section 1135 waivers will no longer be available, upon termination of the PHE, including any extensions.

Your submission to CMS on January 14, 2025 detailed federal Medicaid requirements that pose issues or challenges for the health care delivery system in California. Below, please find a response to each of your requests for waivers or modifications, pursuant to section 1135 of the Act, to address the challenges posed by the 2025 Southern California Wildfires. To the extent the requirements the state requested to waive or modify apply to the Children's Health Insurance Program (CHIP), the state may apply the approved flexibilities to CHIP.

We appreciate the efforts of you and your staff in responding to the needs of the residents and health care community in California. Please contact your state lead if you have any questions or need additional

information.

Sincerely,

Courtney Miller
Director

cc: Courtney Miller
Anne Marie Costello
Daniel Tsai

CALIFORNIA

APPROVAL OF FEDERAL SECTION 1135 WAIVER REQUESTS

CMS Response: January 17, 2025

To the extent applicable, the following waivers and modifications also apply to CHIP.

Long Term Services and Supports (LTSS)

PASRR

Pursuant to section 1135(b)(5) of the Act, CMS approves a modification of Section 1919(e)(7) and 42 C.F.R. § 483.112 to allow Level I and Level II assessments to be waived by the state for 30 days from admission. After 30 days, Level I assessments should be conducted with reasonable promptness and Level II assessments should be coordinated with the resident review.

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. Positive Level I screens necessitate a Resident Review.

HCBS Settings Requirements

Pursuant to section 1135(b)(1)(B) of the Act, CMS approves a waiver or modification of the Home and Community Based Services (HCBS) Settings Requirements for HCBS services delivered through the 1915(c) and 1915(i) authorities. In order to ensure the continuation of needed HCBS during a disaster and/or emergency, states may deliver HCBS in settings that have not been assessed for compliance with the HCBS settings criteria and may accommodate circumstances in which an individual requires relocation to an alternative setting or must modify how the settings requirements can be implemented during the emergency.

1915(c) Level of Care and Person-Centered Service Plan Timelines

Initial Evaluation of Need

Pursuant to section 1135(b)(1)(B) of the Act, CMS is granting the authority to delay 1915(c) HCBS Waiver Level of Care (LOC) Evaluation of Need until after the individual begins receiving services to facilitate access to initial services. Initial evaluations of eligibility must be completed within 90 days of the PHE conclusion. - 42 C.F.R. § 441.302(c)(1)

1915(c) Level of Care and Person-Centered Service Plan Timelines

Reevaluation

Pursuant to section 1135(b)(1)(B) of the Act, CMS is granting the authority to extend the 1915(c) HCBS Waiver Level of Care (LOC) reevaluation to allow services to continue until the reassessment can occur. All reevaluations delayed by the PHE must be completed within 12 months of the original due date. - 42 C.F.R. § 441.302(c)(2)

1915(c) Level of Care and Person-Centered Service Plan Timelines

Review and Revision of Person-Centered Service Plan

Pursuant to section 1135(b)(1)(B) of the Act, CMS is granting the authority to delay the review and revision of the person-centered service plan beyond 12 months. This waiver does not eliminate the requirement that the person-centered service plan be updated when the individual requests a revision and/or when the circumstances or needs of the individual change significantly. CMS also encourages states to complete these reviews and revisions of the person-centered service plan via telehealth as resources permit during the PHE. All reviews/revisions delayed by the PHE must be completed within 12 months of the original due date. - 42 C.F.R. § 441.301(c)(3)

1915(i) Evaluations, Assessments and Person-Centered Service Plans

Initial Evaluation of 1915(i) Eligibility

Pursuant to section 1135(b)(1)(B) of the Act, CMS is granting the authority to delay the initial evaluation of 1915(i) eligibility until after the individual begins receiving services in order to facilitate access to initial services. CMS encourages states to complete these initial evaluations via telehealth as resources permit during the PHE. All initial evaluations delayed by the PHE must be completed within 90 days of the PHE conclusion. - 42 C.F.R. § 441.715(d)

1915(i) Evaluations, Assessments and Person-Centered Service Plans

Reevaluation of 1915(i) Eligibility

Pursuant to section 1135(b)(1)(B) of the Act, CMS is granting the authority to delay the 1915(i) State Plan HCBS benefit annual required re-evaluation of 1915(i) eligibility in order to allow services to continue until the re-evaluation can occur. All reevaluations delayed by the PHE must be completed within 12 months of the original due date. - 42 C.F.R. § 441.715(e)

1915(i) Evaluations, Assessments and Person-Centered Service Plans

Initial Independent Assessment of Need

Pursuant to section 1135(b)(1)(B) of the Act, CMS is granting the authority to delay the initial 1915(i) State Plan HCBS benefit independent assessment of need until after the individual begins receiving services in order to facilitate access to initial services. CMS encourages states to complete these initial assessments via telehealth as resources permit during the PHE. All initial assessments delayed by the PHE must be completed within 90 days of the of the PHE conclusion. - 42 C.F.R. § 441.720(a)

1915(i) Evaluations, Assessments and Person-Centered Service Plans

Reassessments of Need

Pursuant to section 1135(b)(1)(B) of the Act, CMS is granting the authority to delay the 1915(i) State Plan HCBS benefit annual required independent reassessment of need to allow services to continue until the reassessment can occur. All reevaluations delayed by the PHE must be completed within 12 months of the original due date. - 42 C.F.R. § 441.720(b)

1915(i) Evaluations, Assessments and Person-Centered Service Plans

Review and Revision of the Person-Centered Service Plan

Pursuant to section 1135(b)(1)(B) of the Act, CMS is granting the authority to delay the review and revision of the person-centered service plan beyond 12 months. CMS clarifies that this waiver does not eliminate the requirements that the person-centered plan is updated when the individual requests a revision and/or when the circumstances or needs of the individual change significantly. CMS also encourages states to complete the reviews/revisions via telehealth as resources permit during the PHE. All reviews/revisions delayed by the PHE must be completed within 12 months of the original due date. - 42 C.F.R. § 441.725(c)

1915(j) State Plan Benefit

Initial Assessments

Pursuant to section 1135(b)(5) of the Act, CMS is granting the authority to modify the 1915(j) timeframes for conducting the initial assessments to determine an individual requires Personal Assistance Services (PAS) and supports and for the development of the service plan and budget. CMS encourages states to complete the initial assessments via telehealth as resources permit during the PHE. Activities delayed by the PHE do not need to be completed before the start of care but must be completed within 90 days of the PHE conclusion. - 42 C.F.R. § 441.466

1915(j) State Plan Benefit

Annual Reviews

Pursuant to section 1135(b)(5) of the Act, CMS is granting the authority to modify the deadline for annual review of the service plan required for the 1915(j) state plan benefit beyond 12 months. CMS clarifies that this approval does not eliminate the requirement that the service plan be updated when the individual requests a revision and/or when the circumstances or needs of the individual change significantly. CMS also encourages states to complete the review/revisions via telehealth as resources permit during the PHE. All reviews delayed by the PHE must be completed within 12 months of the original due date. - 42 C.F.R. § 441.468(c)(7)

1915(k) State Plan Benefit

Initial Assessments

Pursuant to section 1135(b)(5) of the Act, CMS is granting the authority to modify the deadline for initial assessments of functional need. CMS encourages states to complete the assessments via telehealth as resources permit during the PHE. Initial assessments delayed by the PHE must be completed within 90 days of the PHE conclusion. - 42 C.F.R. § 441.535

1915(k) State Plan Benefit

Annual Reassessments

Pursuant to section 1135(b)(5) of the Act, CMS is granting the authority to modify the deadlines for annual reassessments of functional need. Reassessments delayed by the PHE must be completed within 12 months of the original due date. - 42 C.F.R. § 441.535(c)

1915(k) State Plan Benefit

Person-Centered Service Plan Reviews

Pursuant to section 1135(b)(5) of the Act, CMS is granting the authority to modify deadlines for review of the person-centered service plan beyond 12 months. CMS clarifies that this approach does not eliminate the requirements that the person-centered plan be updated when the individual requests a revision and/or when the circumstances or needs of the individual change significantly. CMS also encourages states to complete the person-centered service plan reviews via telehealth as resources permit during the PHE. All reviews delayed by the PHE must be completed within 12 months of the original due date. - 42 C.F.R. § 441.540(c)

1915(k) State Plan Benefit

Level of Care Determinations

Pursuant to section 1135(b)(5) of the Act, CMS is granting the authority to delay Level of Care (LOC) Determination timelines until after the individual begins receiving services in order to facilitate access to initial services. CMS encourages states to complete initial determinations via telehealth as resources permit during the PHE. Assessments delayed by the PHE must be completed within 90 days of the PHE conclusion. - 42 C.F.R. § 441.510(c)

1915(k) State Plan Benefit

Level of Care Redeterminations

Pursuant to section 1135(b)(5) of the Act, CMS is granting the authority to extend the timeline for the required annual Level of Care (LOC) redetermination to allow services to continue until the reassessment can occur. All redeterminations delayed by the PHE must be completed within 12 months of the original due date. - 42 C.F.R. § 441.510(c)

Fee for Service and Eligibility Fair Hearings

Extend fair hearing request timelines

Pursuant to section 1135(b)(5) of the Act, CMS is granting the authority to modify requirements in 42 C.F.R. § 431.221(d) to allow applicants and beneficiaries to have more than 90 days to request a fair hearing for eligibility or fee-for-service appeals by permitting extensions of the timeline to file a fair hearing request (e.g. additional time more than 90 days). This waiver supplements the timeframe in 42 C.F.R. § 431.221(d), which requires states to choose a reasonable timeframe for individuals to request a fair hearing not to exceed 90 days for eligibility or fee-for-service appeals.

Extend timelines for reinstatement of benefits

Pursuant to section 1135(b)(5) of the Act, CMS is granting the authority to modify requirements in 42 C.F.R. § 431.231(a) to allow states the option to reinstate services if a beneficiary requests a fair hearing more than 10 days after the date of action (e.g., the date of termination), but not to exceed the time permitted (under either the state plan or under an approved section 1135 waiver) for beneficiaries to request a fair hearing. This waiver supplements the timeframe in 42 C.F.R. § 431.231(a), which gives states the option to reinstate services and benefits for beneficiaries who request a fair hearing not more than 10 days after the date of action. The state should reinstate the beneficiary's services and benefits as quickly as practicable.

Managed Care Appeals, Fair Hearings, and Continuation of Benefits

Modify timelines to resolve appeals

The requirements of 42 C.F.R. § 438.408(f)(1) establish that an enrollee may request a state fair hearing only after receiving a notice that the Managed Care Organization, Prepaid Inpatient Health Plan or Prepaid Ambulatory Health Plan is upholding the adverse benefit determination but also permits, at 42 C.F.R. § 438.408(c)(3) and (f)(l)(i) that an enrollee's appeal may be deemed denied and the appeal process of the managed care plan exhausted (such that the state fair hearing may be requested) if the managed care plan fails to meet the timing and notice requirements of 42 C.F.R. § 438.408. Pursuant to section 1135(b)(5) of the Act, CMS is granting authority to modify requirements in 42 C.F.R. § 438.408(f)(1) which authorizes the state to modify the timeline for managed care plans to resolve appeals to no less than one day. If the state uses this authority, it would mean that all appeals filed through the end of the PHE are deemed to satisfy the exhaustion requirement in 42 C.F.R. § 438.408(f)(1) after one day (or more, if that is the timeline elected by the state) and allow enrollees to file an appeal to the state fair hearing level.

Modify state fair hearings timelines

Pursuant to section 1135(b)(5) of the Act, CMS is granting the authority to modify timeframes in 42 C.F.R. § 438.408(f)(2) for managed care enrollees to exercise their appeal rights. If the 120-day deadline to request an appeal occurred during the PHE, managed care enrollees will have more than 120 days from the date of

the managed care plan's notice of resolution of an appeal to request a state fair hearing (e.g. additional 120 days).

Modify continuation of benefits timelines

Pursuant to section 1135(b)(5) of the Act, CMS is granting the authority to modify timeframes at 42 C.F.R. § 438.420(a)(i) through the end of the PHE. The modified timeframes will allow the managed care plan to continue benefits if requested within the current 10-day timeframe or reinstate benefits when the individual requests continuation of benefits between 11 and 30 days after receiving notice if the managed care plan has not yet made a decision on the appeal or the state fair hearing is pending. This flexibility may be used provided that the managed care plan may not seek reimbursement or payment for the additional days of services furnished during this period (aside from otherwise applicable cost sharing, if any) from the enrollee.

Modify authorization decision timelines

Pursuant to section 1135(b)(5) of the Act, CMS is granting the authority to modify timeframes in 42 C.F.R. § 438.210(d)(1)(ii) and (2)(ii) for two possible extensions up to 90 days each to allow the managed care plan more time to collect additional information needed to make an authorization decision that is favorable to the enrollee. If an authorization decision is not made within the first 90-day extension timeframe due to the PHE, the managed care plan may modify the timeframe to provide an additional 90-day extension, provided that the managed care plan continue to authorize and pay for the service(s) until a decision is made and does not seek reimbursement or payment for the services furnished during this additional period (other than otherwise applicable cost sharing, if any) from the enrollee in the event of an adverse decision. If the service authorization decision is adverse to the enrollee, the plan must provide timely and adequate notice of adverse benefit determination per the requirements of 42 C.F.R. § 438.404. For example, insufficient information within the 14-day time period could lead to a decision to deny the service authorization. During the extension period of up to 180 days, the managed care plan will authorize and pay for the services based on the information available until the assessment can be completed.

Modify adverse benefit appeals filing timelines

Pursuant to section 1135(b)(5) of the Act, CMS is granting the authority to modify timeframes in 42 C.F.R. § 438.402(c)(2)(ii) to extend the time period to file an appeal from 60 to 120 days following the receipt of an adverse benefit determination to allow more time for the enrollee to file a request for an internal appeal with the managed care plan. The managed care plan will continue to authorize and pay for the service(s) until a decision is made and may not seek reimbursement or payment for the services furnished during this additional period (other than otherwise applicable cost sharing, if any) from the enrollee in the event of an adverse decision. For example, the timeframe extension from 60 to 120 will allow the enrollee more time to effectively utilize the managed care plan’s appeal process. This ensures the enrollees continued access to services extension period and does not impact the enrollee’s right to fair hearing should they exhaust the plan’s appeal process.

Modify standard appeals timelines

Pursuant to section 1135(b)(5) of the Act, CMS is granting the authority to modify timeframes in 42 C.F.R. § 438.408(c)(1)(ii) for standard appeals from 14 days to 30 days. This modification allows the managed care plan additional time to obtain necessary information, if the delay is in the enrollee's interest such as to gather information necessary for a decision that is favorable to the enrollee; the managed care plan must continue to authorize and pay for the service(s) until a decision is made and may not seek reimbursement or payment for the services furnished during this additional period (aside from otherwise applicable cost sharing, if any) from the enrollee in the event of an adverse decision. For example, insufficient information within the 14-day time period could lead a decision to deny the service authorization. During the extension period of up to 30 days, the managed care plan will authorize and pay for the services based on the information available until the assessment can be completed.

Home Health State Plan Services Timeframe (Face-to-Face Encounters)

Pursuant to section 1135(b)(5) of the Act, CMS approves a waiver allowing the state to modify the deadline so home health state plan face-to-face encounters do not need to be completed before the start of services and may occur at the earliest time, not to exceed 12 months from the start of service. - 42 C.F.R §§ 440.70(f)(1), 440.70(f)(2)

Private Duty Nursing

Modify practitioner requirements

Pursuant to section 1135(b)(1)(B) of the Act, CMS approves a waiver to allow Private Duty Nursing services to be delivered by a graduate registered nurse and/or graduate licensed practical nurse. The state may reimburse for services delivered by these providers whose practice is consistent with the functions of and requirements for registered nurses and licensed practical nurses, but do not yet have the title "Registered Nurse" or "Licensed Practical Nurse." - 42 C.F.R. § 440.80(a)

Modify supervision requirements

Pursuant to section 1135(b)(1)(A) of the Act, CMS approved a waiver to allow Private Duty Nursing (PDN) services to be directed by a nurse practitioner, clinical nurse specialist, and/or physician assistant. It also allows the state to reimburse for PDN services provided by qualified providers under the direction of nurse practitioners, clinical nurse specialists and/or physician assistants during the PHE. – 42 C.F.R. § 440.80(b)

Clinic Facility Requirement

Allow provision of clinic services in alternative settings

Pursuant to section 1135(b)(1)(B) of the Act, CMS approves a waiver allowing the state and clinic to

temporarily designate a clinic practitioner's location as part of the clinic facility in order to ensure access to health services that would otherwise be unavailable during the PHE. This waiver is provided only to the extent necessary so that clinic services may be delivered when neither the patient nor practitioner is physically onsite at the clinic. The waiver permits services provided in California is looking to temporarily designate the following locations as part of the clinic facility to ensure access to health services that would otherwise be unavailable during the Public Health Emergency to be considered as provided at the clinic for purposes of 42 C.F.R. § 440.90(a): (1) senior centers, (2) evacuation centers and/or shelters, (3) churches, (4) schools, (5) libraries, and (6) other emergency location as deemed appropriate by the State Medicaid Agency.