Appendix: Detailed Provisions of California's 1135 Waiver Requests

Category	Specific Provision	Approved	Not Addressed	Notes
Provider Participation, Billing Requirements, And Conditions For Payment	Permits reimbursement for out-of-state providers not enrolled in Medi-Cal who provide care to Medi-Cal beneficiaries, also applies to those out-of-state providers who provide telehealth services.			Approved in California's individual 1135 waiver
	Temporary and provisional enrollment of out-of-state providers who are enrolled in Medicare *or* with another State Medicaid Agency (SMA).			Approved in California's individual 1135 waiver
	Permits reimbursement to facilities for services rendered at unlicensed facility during an emergency evacuation or due to other need to relocate residents.			Approved in California's individual 1135 waiver
	Allows temporary and provisional enrollment of providers *not* otherwise enrolled with a SMA or Medicare without CMS requiring application fees, criminal background checks, site visits and in-state/territory licensure requirements.			Approved in California's individual 1135 waiver
	Permits the temporary suspension of provider revalidation located in California or otherwise directly impacted by the emergency.			Approved in California's individual 1135 waiver
	Permits reimbursement for out-of-state providers not enrolled in Medi-Cal who provide care to Medi-Cal beneficiaries, also applies to those out-of-state providers who provide telehealth services.			Approved in California's individual 1135 waiver
	Allow flexibility with MCO and PIHP requirements to complete credentialing of providers.			
	Waive DMC-ODS documentation requirements including timelines related to review of medical necessity and suspend financial disallowances for noncompliance with documentation standards.			
	Waive DMC-ODS minimal clinical service hours and group visit requirements to qualify for claiming reimbursement for intensive outpatient and residential SUD treatment as long as care is consistent with the individual care plan.			
	Waive DMC-ODS boilerplate that requires client signature on treatment plan in order to provide treatment by telehealth and telephone.			
	Apply any applicable flexibilities granted in the Medicare blanket waivers to providers that are only certified for Medicaid participation.[1]			Requested through third 1135 waiver, request pending

[1] **Bolded provisions indicate a pending request.**

Category	Specific Provision	Approved	Not Addressed	Notes
Service Authorization And Utilization Controls	Extension of pre-existing authorizations for which a Medi-Cal beneficiary has previously received prior authorization through the end of the public health emergency (COVID-19).			Approved via Blanket Waiver
	Temporary suspension of Medicaid Fee-For-Service (FFS) prior authorization requirements.			Approved via Blanket Waiver
	Waive the requirements that Critical Access Hospitals limit the number of beds to 25 and that the length of stay be limited to 96 hours.			Approved via Blanket Waiver
	Waiver 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.			Approved via Blanket Waiver
	Where Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) is lost, destroyed, irreparably damaged, or otherwise rendered unusable, contractors have the flexibility to waive replacements requirements such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required.			Approved via Blanket Waiver
	Waive the requirement at Section 1812(f) of the Social Security Act for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay.			Approved via Blanket Waiver
	Waiver of State plan and waiver-imposed utilization controls on covered benefits to the extent such limits cannot be exceeded based on medical necessity in the relevant approved State plan or waiver authority.			
	Waive limitations on who can prescribe certain covered Medi-Cal benefits.[2]			Requested through the State Plan Amendment waiver, request pending
	Waive in-home face-to-face requirements for reassessments and provide the option to conduct via telephone or remote option for Personal Care Services Program (PCSP), In-Home Supportive Services Plus (IHSS+), and Community Frist Choice Option Program (CFCO).			Requested through the State Plan Amendment waiver, request pending
	Waive 100-day supply limit on dispensing covered drugs (excluding narcotics and opioids).			Requested through the State Plan Amendment waiver, request pending

[2] Medi-Cal benefits requested to be waived: nonemergency medical transportation, to allow licensed practitioners to prescribe instead of only a physician, podiatrist, or dentist); home health services, to allow licensed practitioners to prescribe services such as DME, medical supplies, enteral nutrition and home health agency services instead of only a physician; physical, occupational and speech therapies, to allow licensed practitioners to prescribe; prosthetics, to allow licensed practitioners to prescribe within their scope of practice.

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	Authority to cover and reimburse unlabeled medications shown to be safe and effective, but not yet having the required published documentation for use in COVID 19.			
	Exclusion of adult receipt of acetaminophen-containing and cough/cold products.			
	Retainer payments for individuals with developments disabilities receiving services under State Plan 1915(i) authority.			Approved through a 1915(c) Appendix K waiver
	Community-Based Adult Services (CBAS) flexibility to reduce day center/activities/gathering and limiting exposure to vulnerable populations.			Approved via Blanket Waiver
	CBAS flexibility to use of telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and assessments.			Approved via Blanket Waiver
	CBAS flexibility to allow services physical and occupational therapy services to be provided in a beneficiary's home.			Approved through a 1915(c) Appendix K waiver
	CBAS flexibility to provide home delivered meals.			
	Waiver of medical necessity criteria for non-medical transportation and nonemergency medical transportation, and instead permit beneficiaries to use whatever available transportation service is the safest for them during the pandemic.			Requested through third 1135 waiver, request pending
	Allow for verbal acceptance by a beneficiary of necessary changes to care plans for services provided under HCBS waivers pursuant to Section 1915(c) that require written confirmation from beneficiaries.			Requested through third 1135 waiver, request pending
	Reimburse any paramedics (EMT-P) licensees to transport patients to medical facilities other than acute care hospitals when approved by California Emergency Medical Services (EMS) Authority.			Requested through third 1135 waiver, request pending
Flexibilities On State Fair Hearing Requests And Appeal Deadlines For Managed Care Beneficiaries	Permits beneficiaries to request a state fair hearing if their managed care plan does not resolve an appeal within one day.			Approved in California's individual 1135 waiver
	Provides an additional 120 days for Medi-Cal beneficiaries to request a fair hearing when the initial 120-day deadline occurred during the period of the approved 1135 waiver.			Approved in California's individual 1135 waiver
Benefit Flexibilities	**Request for recognition of any COVID-19 testing and related treatment of a Medi-Cal beneficiary outside of an emergency room setting as constituting "emergency services" or services for an "emergency medical condition".**			Requested through an emergency 1115(a) waiver, request pending

Category	Specific Provision	Approved	Not Addressed	Notes
	Waive requirement for Tribal 638 clinics that services be provided within the clinic four walls except homeless population.[3]			Approved via Blanket Waiver
	Allow federal financial participation for expenditures related to temporary housing for the homeless as a result of the emergency.			
Telehealth/Telephonic/ Virtual Visit Flexibilities	**Flexibility to allow for virtual/telephonic communication/telehealth modalities for covered State plan benefits, including but not limited to Behavioral Health Treatment, where medically appropriate and feasible.**			Requested through the State Plan Amendment waiver, request pending
	Waive "face-to-face" requirement for reimbursement for Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Tribal 638 clinics.			
	Allow reimbursement of virtual communication for FQHCs, RHCs, and Tribal 638 clinics.			
	Allow group counselling to be provided via telehealth.			Approved via Blanket Waiver
	Waive "face-to-face" requirement for Adult Residential Treatment Services and Crisis Residential.			
	Allow states to direct Managed Care Organizations (MCO) and Prepaid In-Patient Health Plans (PIHP) payments to network providers where telehealth/telephonic service is medically appropriate and feasible.			
	Allow State to exercise authority to *not* impose penalties for noncompliance with regulatory requirements under the Health Insurance Portability and Accountability Act (HIPAA).			
	Waive Drug Medi-Cal Organized Delivery System (DMC-ODS) authorization requirements of the Medi-Cal 2020 Demonstration to allow flexibility to perform the initial medical necessity determination for DMC-ODS benefits by telephone by a Medical Director, Licensed Physician, or Licensed Practitioner of the Healing Arts (LPHA).			Requested through third 1135 waiver, request pending
	Waive the requirement of the CMS-approved DMC-ODS Intergovernmental Agreement to authorize a certified Alcohol or Other Drug certified counselor to perform intake and assessment by telephone.			Requested through third 1135 waiver, request pending
Payment Rate Flexibilities	**Waive State Plan Amendment which limits reimbursement rates for clinical lab services to no more than 80% of Medicare and requires a 10% reduction in the established fee schedule rates for clinical laboratory services.**			Requested through the State Plan Amendment waiver, request pending

[3] On Monday, March 31, 2020, the Trump Administration released a list of regulatory changes that permits services rendered outside of the "four walls" of a hospital or healthcare facility is permitted during the COVID-19 emergency.

Category	Specific Provision	Approved	Not Addressed	Notes
	Waive the current ICF-DD rate setting methodology to provide an add-on to facility rates to compensate for the increased cost of staff time not accounted for in the current facility daily rates during the duration of the emergency.			Requested through the State Plan Amendment waiver, request pending
	Waive county interim rate setting methodology in the Certified Public Expenditure (CPE) Protocol.			
	Waive the interim rate setting methodology for DMC-ODS in the CPE protocol.			Requested through an emergency 1115(a) waiver, request pending
	Waive the Statewide Maximum Allowance (SMA) rate limitation on interim reimbursement and final settlement for DMC-ODS services provided in state plan counties.			
Eligibility Flexibilities	**Allow Hospital Presumptive Eligibility (HPE) program[4] to cover more than one HPE period in a given 12-month timeframe.**			Requested through the State Plan Amendment waiver, request pending
	Allow the HPE program to include the over 65/aged & disabled population.			Requested through the State Plan Amendment waiver, request pending
	Waive costs associated with COVID-19 testing for those who test positive and all costs associated with the treatment of the virus for those beneficiaries that are subject to a share of cost.			Requested through the State Plan Amendment waiver, request pending
Administrative Flexibilities Related to Deadlines & Performance Timetables	Allow MCO flexibilities in obtaining contract signatures that require a "face-to-face" interaction at board meetings			
	Waive network adequacy standards			
	Allow modifications to the annual network certification timeframe			
	Allow modification of timeframe for monthly T-MSIS reporting			
	Waive requirement of "timely completion" of External Quality Review (EQR) activities			
	Modify timeframe for submitting EQR technical reports to CMS and public posting			
	Modify submission timeframe for DHCS' quality strategy report			
	Modify DMC-ODS evaluation timeframe			

[4] The HPE Program provides qualified individuals immediate access to temporary, no-cost Medi-Cal while applying for permanent Medi-Cal coverage or other health coverage.

Category	Specific Provision	Approved	Not Addressed	Notes
	Waive two-year claiming submission limit for federal financial participation or claiming adjustments			
	Waive requirement that providers must submit all claims no later than 12 months from the date of service.			
	Allow the State to modify federal deadlines for cost report submissions from Medicaid and Medicare by at least six months with no late penalties.			
	Waive timeframe required for financial oversight and medical compliance audits for PIHPs and State Plan Drug Medi-Cal Organized Delivery System (DMC-ODS) counties.			
	Waiver to modify the timeframe (i.e., within 90 days of enrollment) for completion of initial health assessment required of MCOs			Requested through third 1135 waiver, request pending
	Waiver of quality assessment and performance improvement activities required for the duration of the public health emergency.			Requested through third 1135 waiver, request pending