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

October 16, 2024

Jay Ludlam
Deputy Secretary of Medical Assistance
Division of Medical Assistance
2001 Mail Service Center
1985 Umstead Drive
Raleigh, NC 27699-20014

Re: Section 1135 Flexibilities Requested on October 1, 2024

Dear Deputy Secretary Jay Ludlam:

On September 25, 2024, the President of the United States issued a proclamation that 2024 Hurricane Helene 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 September 28, 2024, 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 September 28, 2024, with a retroactive effective date of September 25, 2024. 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 October 1, 2024 detailed federal Medicaid requirements that pose issues or challenges for the health care delivery system in North Carolina. 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 2024 Hurricane Helene. 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 North Carolina. 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

NORTH CAROLINA
APPROVAL OF FEDERAL SECTION 1135 WAIVER REQUESTS

CMS Response: October 16, 2024

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

Provider Enrollment

With respect to providers not already enrolled with another State Medicaid Agency (SMA) or Medicare, pursuant to section 1135(b)(1) and (b)(2) of the Act, CMS waives the following screening requirements: application fees, criminal background checks, licensing requirements, and site visits, so the state may provisionally, temporarily enroll the providers for the duration of the PHE.

CMS is granting this waiver authority to allow the state to temporarily 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. The state must also:
    a. Issue no new temporary provisional enrollments after the date that the PHE is lifted,
    b. Cease payment to providers who are temporarily enrolled within six months from the termination of the PHE, 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 the state before the end of the six-month period after the termination of the PHE, including any extensions, and
    c. Allow a retroactive effective date for provisional temporary enrollments that is no earlier than September 25, 2024.

Pause revalidation deadlines

Pursuant to section 1135(b)(1)(B) of the Act, CMS is approving the state's request to temporarily pause revalidation for providers located in the state or are otherwise directly impacted by the emergency.

If the state pauses revalidation for providers with revalidation due dates that fall during the PHE, the state would recalculate the provider's revalidation due date by adding six months plus the length of the PHE to the provider's original revalidation due date. For instance, if the provider's revalidation due date was April 1, 2021 and the PHE lasted 12 months, the provider's new revalidation due date would be October 1, 2022 (April 1, 2021 + six months + 12 months).

Allow out-of-state provider reimbursement

Your State Medicaid Agency (SMA) currently has the authority to rely upon provider enrollment screenings performed by other SMAs and by Medicare. This guidance can be found in section 1.5.3.B. of the Medicaid Provider Enrollment Compendium (MPEC) https://www.medicaid.gov/sites/default/files/2021-05/mpec-3222021.pdf. As a result, your SMA is authorized to provisionally, temporarily enroll providers who are enrolled with another SMA or Medicare for the duration of the PHE.

As described in section 1.5.1.B.2.c of the MPEC, your SMA may reimburse otherwise payable claims from out-of-state providers not enrolled with your SMA 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 your SMA, CMS waives the fifth criterion listed above under section 1135(b)(1) of the Act. Therefore, for the duration of the PHE, your SMA may reimburse out-of-state providers for multiple instances of care to multiple participants, so long as the other criteria listed above are met.