Operationalizing Implementation of the Optional COVID-19 Testing (XXIII) Group
Potential State Flexibilities

Section 6004(a)(3) of the Families First Coronavirus Response Act (FFCRA) (Pub. L. No. 116-127) added section 1902(a)(10)(A)(ii)(XXIII) to the Social Security Act which describes a new optional Medicaid eligibility group for uninsured individuals and covers COVID-19 testing. Coverage under this new group may be effective no earlier than March 18, 2020. In order to be eligible for this COVID-19 testing group, an individual must be an "uninsured individual" as described in section 1902(ss) of the Social Security Act. Benefits for individuals eligible for coverage under this group are limited to COVID-19 testing and testing-related services. The Federal Medical Assistance Percentage (FMAP) for services furnished to beneficiaries eligible under the COVID-19 testing group is 100 percent.

Recognizing the challenges states face in implementing the new COVID-19 testing group, and its expiration at the end of the current public health emergency (PHE), this document identifies the different requirements associated with implementing the new group (including eligibility and enrollment, claiming and data reporting), and provides guidance on alternative strategies that states may employ to meet these requirements. States that amend their state plans to cover the optional COVID-19 testing eligibility group under section 1902(a)(10)(A)(ii)(XXIII) of the Act can use the 100 percent FMAP rate provided under section 6004(a)(3)(D) of the FFCRA for certain administrative expenditures, including systems development, described in section 1903(a)(7) of the Act that otherwise would be eligible for 50 percent FMAP. This document also describes flexibilities available to help states streamline implementation of the new group. States can refer to Section B of the FFCRA and Coronavirus Aid, Relief, and Economic Security (CARES) Act Frequently Asked Questions (FAQs) posted April 13, 2020, for more detailed information on the eligibility requirements, benefits and FMAP available for coverage under the optional COVID-19 testing group.

	Requirements[1]	**Options & Implementation Details**
Eligibility & Enrollment in the COVID-19 Testing Group		
Application	• States must provide an individual with an application that collects contact information, applicant social security number (SSN), attestation of applicant citizenship/immigration status, an attestation that the applicant is not enrolled in other federally-funded coverage, and a signature. (42 CFR 435.907(c) and 435.910(a))	• States may develop a simplified application for the COVID-19 testing group that minimizes burden on applicants. • Applicants who fill out a single streamlined or other Medicaid application not designed for the COVID-19 testing group and are found ineligible on other bases should be considered for the COVID-19 testing group. • If the state's system is not able to enroll individuals who complete a single streamlined or other application in the uninsured group, the state should

[1] The relevant statutory and regulatory citation(s) is noted for the basis of the various requirements listed in this document. States must continue to comply with all applicable Medicaid requirements not expressly described in this document.

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	• Out-stationing locations must be able to determine eligibility for the COVID-19 testing group. (Section 1902(a)(55) of the Social Security Act and 42 CFR 435.904) • Applications or supplemental forms must be accessible to persons who have limited English proficiency and people with disabilities. (42 CFR 435.907(g) and 435.905(b))	notify applicants found ineligible based on such application how to apply for the COVID-19 testing group. • States adopting the COVID-19 testing group can consider other ways to inform individuals of this coverage option such as, providing information on the state website, including an insert with application forms, instructing call center representatives to tell applicants they may be eligible, and providing messaging to individuals applying for or receiving services through other human services programs like SNAP or TANF. • States may designate testing sites or other locations as out-stationing locations.
Obtaining an Applicant's Signature	• States must obtain the applicant's signature, under penalty of perjury, on the application. (42 CFR 435.907(f))	• States may adopt a variety of strategies to obtain the required signature when a person is unable to physically sign an application or to support social distancing: ○ Obtain consent for enrollment/signature for Medicaid in the same way the state obtains signature to receive a COVID-19 diagnostic test (if applicable). ○ Accept an electronic signature through an online application, fillable PDF, telephonic signature or signature or handwritten signature through any other electronic transmission. ○ Permit applicants to verbally designate a provider as an authorized representative for purposes of submitting the application. The provider must submit documentation of the designation to the state along with the application. The provider may not act as authorized representative unless affirmatively designated by the applicant (see additional information in Section II.A of CMS's COVID-19 FAQs).
Verification	• States may accept self-attestation of all eligibility factors, except for citizenship/immigration status, to determine eligibility for the group (42 CFR 435.945(a)). • States must obtain a declaration of citizenship or satisfactory immigration status (1137(d) of the Social Security Act, 42 CFR 435.406).	• States must check federal data sources (SSA and Systematic Alien Verification for Entitlements (SAVE)) to verify citizenship/immigration status, but may do so post-enrollment if unable to access the data sources at the time of application. • States must enroll individuals who attest to citizenship and satisfactory immigration status and whose citizenship/immigration cannot be verified

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	• States must access electronic data sources to verify citizenship/immigration status (42 CFR 435.956(a)).	upon application and provide covered benefits during a reasonable opportunity period (ROP), provided they are otherwise eligible for coverage under the group. The state must continue efforts to verify the individual's citizenship or satisfactory immigration status during the ROP until a citizen/immigration status determination is made • If the state determines that an individual is not a U.S. citizen or in a satisfactory immigration status, coverage of the testing and diagnostic services available under the COVID testing group would be available only if necessary for treatment of an emergency medical condition. See Questions 28 and 35 in the FFCRA and CARES Act FAQs, posted on 4/13/2020 and available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-CARES-faqs.pdf, for more information.
Hospital Presumptive Eligibility (HPE)	• States may elect to provide hospital presumptive eligibility (HPE) for the COVID-19 testing group. (42 CFR 435.1110(c)(2)) • Under CMS' Hospitals Without Walls initiative, hospitals providing services in other healthcare facilities and sites that would not otherwise be considered to be part of a healthcare facility, or that have set up temporary hospital expansions sites under the 1135 Medicare blanket waiver may be considered hospitals for purposes of HPE as well. (See https://www.cms.gov/files/document/covid-hospitals.pdf for additional information on the CMS Hospitals Without Walls initiative.) States may only elect to cover the COVID-19 testing group in HPE, and may not designate other non-hospital entities as presumptive eligibility (PE) qualified entities to conduct PE reviews for the COVID-19 testing group. (42 CFR 435.1110 (c)(2))	• States that elect coverage of the COVID-19 testing group in the disaster state plan amendment (SPA) can submit a disaster SPA to add the COVID-19 testing group to the groups covered under HPE. • States may implement HPE with the support of contractors, as long as a hospital employee completes the HPE determination. The way in which HPE participating hospitals may use contractors is further described in Q. 20 of CMS's 2014 HPE FAQs. • States and hospitals seeking further guidance on the way in which alternative hospital care sites may be used and the conditions of participation requirements that apply under the 1135 Medicare blanket waiver may visit: https://www.cms.gov/files/document/covid-hospitals.pdf • 100 percent FMAP is not available for individuals only enrolled through HPE. However, states may retroactively claim the 100 percent FMAP if the individual is determined eligible for Medicaid after completing a full application. • States elect the number of PE periods that may be available for the COVID-19 testing group. There is no limit on the number of PE periods states may elect during the PHE.

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		• Because HPE does not require a signature or that the person be a patient, hospitals participating in HPE could allow individuals at testing sites to call a hospital to apply for the COVID-19 testing group through HPE.
Notices	• When an applicant is determined eligible for only the COVID-19 testing group, states must clearly explain in the eligibility determination notice that the individual is only eligible for coverage of in vitro diagnostic testing and testing-related services furnished during a provider visit related to that testing during the PHE. Notices may further specify that COVID-19 retesting is permitted under this eligibility group and that the coverage continues for 12 months (or the state can elect a more frequent non-MAGI renewal period designated under the state plan) or until the end of the emergency period, whichever comes first. • States must provide an individualized, tailored notice to individuals consistent with 42 CFR 435.917, and notice and fair hearing rights in accordance with 42 CFR Part 431 Subpart E if the individual is denied eligibility.	• States may update their notices to include language regarding covered benefits for individuals determined eligible for the testing group. • If notice changes are not possible, states may create an insert that includes language regarding covered benefits along with the notice.
Effective Date of Coverage & Eligibility Period	• The effective date of coverage for individuals determined eligible for the COVID-19 testing group is the date of application or the first of the month in which application is made as indicated in the state's plan. (42 CFR 435.915(b)) • States must provide up to three months of retroactive eligibility for individuals enrolled in the COVID-19 testing group, except that retroactive eligibility may be available no earlier than March 18, 2020 or the effective date of coverage under this group specified in the state plan (if later). States that have been authorized under section 1115(a)(1) of the Social Security Act to waive retroactive eligibility may work with CMS to opt to provide retroactive	• If a real-time determination is not made (e.g., over the phone, by an out-stationed worker, or through HPE), the Medicaid agency may not be able to determine eligibility on the same day as the test is administered. However: o If the application is completed and submitted on that day, testing services will be covered, unless the individual is found ineligible. o Tests administered prior to application submission in the same month could be covered if the state begins enrollment on the first day of the month. o Testing-related services obtained up to three months prior to the date of application (but no earlier than March 18, 2020)

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	coverage for the COVID-19 testing group. (42 CFR 435.915(a)) • Individuals enrolled in the COVID-19 testing group are eligible for up to 12 months (or a shorter non-MAGI renewal period designated under the state plan), or until the end of the emergency period, whichever comes first. (42 CFR 435.916(b))	can be covered if the applicant was eligible at the time he or she received covered services.
Termination	• The COVID-19 testing group is only available through the last day of the PHE. No FMAP is available for testing or testing-related services provided for individuals enrolled in the COVID-19 testing group after the PHE ends. (Section 1902(a)(10)(A)(ii)(XXIII) of the Social Security Act) • States must determine eligibility on all bases prior to determining a beneficiary ineligible and provide advance notice prior to termination (42 CFR 435.916(f)(1); 42 CFR 431.210, 42 CFR 431.211).	• If a state is unable to terminate coverage for the COVID-19 testing group by the last day of the PHE, either because the state terminates coverage at the end of the month or because there was insufficient notification of the end of the PHE for states to terminate coverage timely, the state must ensure that claims are not made for testing services after the end of the PHE. States may, for example, add a claims edit to ensure the state does not continue to pay for services provided to individuals enrolled in the COVID-testing group after the last day of the PHE. • States are encouraged to conduct outreach in advance of the end of the PHE to inform beneficiaries enrolled in the COVID-19 testing group to submit a full application and receive a full determination for Medicaid on all bases. Individuals determined eligible for another Medicaid eligibility group should be transferred into that other group. • States have the flexibility to satisfy the requirement to determine eligibility on other bases prior to terminating eligibility at the end of the PHE for beneficiaries enrolled in the COVID-19 testing group by providing notice at the time the initial eligibility notice is sent: (1) that coverage in the COVID-19 testing group will be terminated on the last day of the PHE; (2) that the individual may be eligible for full benefits; and (3) how to submit a full Medicaid application in order to be considered for full Medicaid benefits. States electing this option must also provide a minimum of 10-days advance notice to beneficiaries prior to terminating a beneficiary's eligibility at the end of the PHE. As part of this final termination notice, states must again inform individuals who want to be considered for full Medicaid benefits that they must submit a full Medicaid application and

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		how to do so, as well as the circumstances when fair hearing rights would apply in accordance with 42 CFR 431.210(d)(2). Beneficiaries terminated from coverage under the COVID-19 testing group in a state electing this option would have fair hearing rights if eligibility is denied based on a full application. However, the state would not be required to provide fair hearing rights to contest termination of coverage under the COVID-19 testing group, consistent with 42 CFR 431.220(b).
Claiming & Data Reporting		
Enrollment Claiming Systems	• States are not required to enroll individuals determined eligible for the COVID-19 testing group in the Medicaid eligibility system/Management Information System (MMIS) for claiming purposes. • However, to meet the continuous coverage requirements under the FFCRA, in order to receive increased FMAP, states must ensure that individuals who are determined eligible for the group and may require a subsequent test are able to receive one without needing to submit a new application.	• States may leverage their existing presumptive eligibility or family planning portals to complete the eligibility determination and enroll individuals in the COVID-19 testing group, if programming within those systems is easier to do than in the state's regular eligibility system/MMIS. • If individuals are not enrolled in a system accessible to providers, providers could call the state agency before requesting a new application to determine whether individuals have already been determined eligible for the COVID-19 testing group. • States may leverage existing portions of their regular eligibility system/MMIS, such as for former foster youth, if minor updates to the existing system permits. ○ For example, a state could create a new eligibility code to distinguish individuals enrolled in the COVID-19 testing group versus individuals enrolled in other groups for the purposes of tracking and limiting the benefits package to covered testing costs. • States may enroll individuals manually determined eligible for the COVID-19 testing group directly into the claims system, bypassing the eligibility system.
Provider Claiming	• States are not required to utilize MMIS for claiming purposes. However, states must maintain a process to receive provider claims that has the necessary aspects to allow for proper claiming on the CMS-64.	• States could leverage existing MMIS functionality, with updated COVID-19 related codes, to allow the state to properly adjudicate claims for the purposes of tracking covered costs. • States could develop and/or utilize processes external to the MMIS to process the payment for covered costs. These processes would be

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		expected to have the necessary aspects related to the proper claiming on the CMS-64. For example, ○ Providers could utilize non-standard claims forms as part of these external processes. ○ Providers could submit rosters of patients who received testing which could be manually entered or batch processed for payment. • While the format and periodicity of the output for these external processes may not be standard, the minimum data elements required should be consistent and include the information necessary for proper claiming.
T-MSIS Reporting Requirements	**Eligibility and Enrollment Reporting:** States should include records for their COVID-19 testing group beneficiaries in their T-MSIS Eligibility File Submissions. • At a minimum, states should submit the following T-MSIS eligibility record segments: (1) PRIMARY-DEMOGRAPHICS-ELIGIBILITY (2) ELIGIBILITY-DETERMINANTS (3) ENROLLMENT-TIME-SPAN-SEGMENT • There are two data elements on the ELIGIBILITY-DETERMINANTS record segment that must be used to document COVID-19 testing beneficiaries' enrollment in Medicaid: (1) ELIGIBILITY-GROUP (2) RESTRICTED-BENEFITS-CODE **Claims Reporting:** • There are three data elements in the T-MSIS Claims files that are necessary to identify COVID-19 diagnostic products and testing-related services: (1) BENEFIT-TYPE (2) PROGRAM-TYPE (3) TYPE-OF-SERVICE	States that may have questions about COVID-19 testing group inclusion, or may need technical assistance, are encouraged to contact the T-MSIS testing team. T-MSIS related Definitions: **ELIGIBILITY-GROUP "76"** = Uninsured Individual eligible for COVID-19 testing **RESTRICTED-BENEFITS-CODE "F"** = Individual is eligible for Medicaid but is only entitled to restricted benefits for medical assistance for COVID-19 diagnostic products and any visit described as a COVID-19 testing-related service for which payment may be made under the State plan during any portion of the public health emergency period, beginning March 18, 2020, as described in sections 1902(a)(10)(A)(ii)(XXIII), 1902(ss), and subclause (XVIII) (limiting the COVID-19 testing group to COVID-19 testing and related services only) in the matter following section 1902(a)(10)(G) of the Social Security Act. **BENEFIT-TYPE "107"** = COVID-19 diagnostic product that is administered during any portion of the emergency period, beginning March 18, 2020. **BENEFIT-TYPE "108"** = COVID-19 testing-related services for which payment may be made under the State plan. **PROGRAM-TYPE "17"** = COVID-19 diagnostic product administered during any portion of the emergency period, beginning March 18, 2020, or COVID-19 testing-related services for which payment may be made under the State plan.

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	• In addition, at a minimum, it is critical for the states to also populate the following data elements on the T-MSIS claim records: (4) DIAGNOSIS-CODE-1 (5) PROCEDURE-CODE (6) BILLING-PROV-NPI-NUM (7) SERVICING-PROV-NPI-NUM (8) MSIS-IDENTIFICATION-NUM (9) BILLED-AMT (10) MEDICAID-PAID-AMT (11) PROCEDURE-CODE-DATE (12) MEDICAID-PAID-DATE	**TYPE-OF-SERVICE "136"** = COVID-19 diagnostic product that is administered during any portion of the emergency period, beginning March 18, 2020. **TYPE-OF-SERVICE "137"** = COVID-19 testing-related services for which payment may be made under the State plan. ***NOTE**: Each beneficiary's identifier used on the T-MSIS claim records (MSIS-IDENTIFICATION-NUM) must be the same as the identifier used on the T-MSIS eligibility & enrollment record.*
Claiming Federal Medical Assistance Percentages (FMAP) on the CMS-64	• States are required to isolate expenditures eligible at the 100 percent FMAP on a new, separate form when reporting on the CMS-64.	• The Medicaid Budget and Expenditure System will be reprogrammed to create a separate form for the new optional eligibility group that includes all existing CMS-64 lines (similar to existing reporting for the adult group). To be eligible for the 100 percent FMAP, states are required to report expenditures for eligible testing and testing-related services and related state administrative costs on these new forms. • The new forms should be operational sometime in June 2020. • CMS will provide a demo/training to states through a webinar once the new forms are released.
Recordkeeping (Preserving an audit trail)	• States are expected to meet existing federal requirements regarding documentation to support claims for FMAP. (2 CFR Part 200 and 42 CFR 430.30 and 433.32)	• To ensure that expenditures are allowable and create a clear audit trail, the minimum level of supporting documentation states need to maintain associated with expenditures at 100 percent match claimed on the CMS-64 include the patient's name, SSN, birth date, date of service, services provided, name of provider and location/address, and unique billing codes for services. This information can be maintained in MMIS, on an Excel file in the state system, in state accounting records, or in some other similar record.
Coordination of Benefits		

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Coordination of Benefits & Third-Party Liability	• States are expected to meet existing federal requirements regarding coordination of benefits and third-party liability found at 42 CFR 433 Subpart D. • The Health Resources and Services Administration (HRSA) is administering a separate program, referred to as the COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured Program (COVID-19 Claims Reimbursement program). This program provides reimbursement directly to eligible providers and has two separate components which include reimbursement for testing and reimbursement for treatment. To access these funds, health care providers must enroll in the program as a provider participant. Once they have done so, they can submit claims for direct reimbursement for COVID-19 testing and treatment services furnished to uninsured individuals on or after February 4, 2020. • Individuals who are enrolled in a state's Medicaid program, including uninsured individuals enrolled in the new optional COVID-19 testing group, are not considered uninsured for purposes of provider reimbursement of COVID-19 testing services through the HRSA-administered COVID-19 Claims Reimbursement program. However, since the COVID-19 testing group only provides testing and testing-related services, providers may be reimbursed for COVID-19 treatment services provided to otherwise uninsured individuals enrolled in the COVID-testing group through the HRSA-administered COVID-19 Claims Reimbursement program. Uninsured patients are not required to meet citizenship or immigration requirements for providers to receive reimbursement for testing or treatment services under the HRSA-administered program.	• While states must continue to coordinate benefits with all identified liable third parties, in relation to the HRSA COVID-19 Claims Reimbursement program, Medicaid is the primary payer for beneficiaries receiving COVID-19 testing services, including individuals receiving coverage for testing services under the new optional COVID-19 testing group (see definition of "uninsured" for purposes of the Public Health and Social Services Emergency Fund established under Title V of the FFCRA). HRSA, via its claims contractor, United Health Care (UHC), will perform third party clearances with states' MMIS to ensure proper coordination of benefits for Medicaid beneficiaries. Because entry of beneficiaries enrolled in the COVD testing group into the MMIS may be delayed in some states, UHC will perform third party clearances at the initial receipt of a claim from providers and conduct periodic retrospective reviews. • Individuals who are enrolled in a state's Medicaid program, including uninsured individuals enrolled in the new optional COVID-19 testing group, are not considered uninsured for purposes of provider reimbursement of COVID-19 testing services through the HRSA-administered program, and providers should bill Medicaid for testing services. However, providers can submit claims through the HRSA-administered program for COVID-19 treatment services provided to uninsured individuals who are enrolled in the new optional COVID-19 testing eligibility group but who do not have coverage for treatment services. • If the state does not enroll individuals eligible under the new optional COVID-19 testing group in the state's MMIS, the state will need to provide separate enrollment information for this group to HRSA for coordination of benefits to ensure that the HRSA-administered funds are not used for individuals enrolled in Medicaid.

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	• See https://www.hrsa.gov/coviduninsuredclaim for additional information about the COVID-19 Claims Reimbursement program.	

***Additional Information**:*

CMS interprets the COVID-19 testing-related services language in section 6004(a)(2)(A) of the FFCRA to include items and services for which payment is available under the state plan that are directly related to the administration of an in vitro diagnostic product described in section 1905(a)(3)(B) of the Social Security Act or to the evaluation of a beneficiary for purposes of determining the need for such product, such as an X-ray. COVID-19 testing-related services do not include services for the treatment of COVID-19.