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## ***CMCS Informational Bulletin***

**DATE:** March 15, 2024

**FROM:** Daniel Tsai, Deputy Administrator and Director

**SUBJECT:** **Change Healthcare Cybersecurity Incident – CMS Response and State Flexibilities**

Change Healthcare – a unit of UnitedHealth Group – has been experiencing a cybersecurity incident that began in late February 2024. The Centers for Medicare & Medicaid Services (CMS) recognizes the evolving impact this incident is having on health care operations across the country. Our first priority is to help coordinate efforts to avoid disruptions to care throughout CMS programs, including Medicaid and the Children’s Health Insurance Program (CHIP).

The Center for Medicaid & CHIP Services (CMCS) is issuing this CMCS Informational Bulletin (CIB) to advise state Medicaid agencies that we do not intend to take enforcement action with respect to certain Medicaid requirements under a limited set of circumstances described below to enable critical Medicaid funds to continue to flow to providers and to prevent disruption of access to Medicaid services, prevent associated negative health outcomes, and avoid solvency issues for providers. This period of non-enforcement will be in place through June 30, 2024. This CIB also outlines other options available to states to assist in mitigating the impact of the cybersecurity incident on Medicaid; the discussions in this CIB about CMS nonenforcement of certain requirements for a limited time period and in limited circumstances related to the Change Healthcare cybersecurity incident do not apply to these additional options. CMS also reminds states that there is broad flexibility within Medicaid managed care to make interim payments to providers and leverage other flexibilities without additional authority from CMS.

CMS recognizes the unprecedented impact of the Change Healthcare cybersecurity incident and its implications for Medicaid providers. Given many Medicaid providers’ urgent need for support in order to continue to provide essential care for Medicaid enrollees, as one of the key flexibilities described in this CIB, we will not take enforcement action with respect to certain requirements for a limited period of time, under limited circumstances specified below, in order to permit states to rapidly implement interim payments to fee-for-service (FFS) Medicaid providers affected by the cybersecurity incident. CMS routinely approves interim Medicaid payment methodologies in the Medicaid state plan, but we would like to provide states with the ability to make these interim payments to providers on a timeframe faster than would typically apply under the regular state plan amendment (SPA) submission and approval timelines.

This CIB outlines a framework under which CMS will permit states to expedite these interim payments to providers while maintaining key guardrails to protect program integrity. As discussed in more detail below, the interim payments that CMS would permit under this framework would be limited to no more than recent prior period (that produces the most accurate interim payment amounts) Medicaid payments for an equivalent service period on a provider-specific basis. The flexibility would only be available for affected providers, and for affected service periods through no later than June 30, 2024, and subject to reconciliation using actual individual service-specific data once states regain access to this data at the resolution of the cybersecurity incident. CMS will permit states to take advantage of this framework only if they develop and submit a Medicaid SPA, within timeframes described in this CIB and have CMS approval prior to June 30, 2024, to obtain authority to make payments in this manner until regular operations can resume.

As a condition of CMS's approval of these SPAs and non-enforcement of the related federal requirements, states must document their interim payment and reconciliation methods within their SPA submission consistent with the guidance discussed in this CIB. If states do so, then upon submission of such a SPA to CMS, a state can begin to draw federal financial participation (FFP) as the federal share of the interim payments under the SPA, based on recent prior period claims. States are expected to adjust interim payments and related draws as necessary based on CMS review of SPA submissions and applicable final approved state plan interim payment language. Prior to submitting a qualifying SPA, states may choose to make the interim payments to affected providers consistent with the framework described in this CIB using state-only funds. States that choose to use state-only funds to provide immediate payments to providers using the interim payment framework described in this CIB can still receive FFP back to the beginning of the cybersecurity incident as long as the state follows the procedures and meets all of the conditions discussed within this CIB for federal approval.

As a condition of CMS approval and non-enforcement, the methodology discussed in the SPA must be limited to a temporary process to establish interim payments in the absence of current provider claims data, which must be reconciled once the cybersecurity incident is resolved and the actual claims data is available to the state Medicaid agency. States should be expeditious in submitting their SPAs to CMS and are strongly encouraged to do so no later than March 31, 2024. If a state intends to submit a SPA consistent with the approach discussed in this CIB but is unable to do so by March 31, 2024, the state should email CMS as soon as possible, but no later than close of business on April 10, 2024, stating that it intends to submit a SPA and the expected date by which it will do so. CMS only intends to approve interim payment SPAs that address the cybersecurity incident that it receives within timeframes specified in this CIB and approved by CMS prior to June 30, 2024. If a state needs additional time to resolve payment for claims impacted by the cybersecurity incident, the state will need to work with CMS to address remediation efforts after June 30, 2024.

**Summary of Requirements CMS Does Not Expect to Enforce - Limited to a Period Starting with the Beginning of Claims Disruption Due to the Change Healthcare Cybersecurity Incident and Ending June 30, 2024**

Subject to the conditions and guidelines discussed in this CIB, CMS does not intend to enforce the following requirements governing SPA submission procedures, state draws of FFP, and the Medicaid mandatory grant award process. Please note that CMS's non-enforcement is limited to the circumstances discussed below, and will apply only for a time-limited period from the beginning of claims disruption due to the Change Healthcare cybersecurity incident and ending June 30, 2024:

1. CMS will permit states to modify required timelines for public notice, public process, and Tribal consultation and to obtain an effective date for certain kinds of SPAs (specified below) that would be earlier than typical effective date, public notice, public process, and Tribal consultation requirements would permit. For example, states can issue public notice or perform Tribal consultation after the SPA submission. This flexibility is available only in certain circumstances (described in detail below) associated with FFS interim payment SPAs, changes to pharmacy dispensing fees that do not increase rates, and cost sharing.
2. CMS will permit states to use interim payment methodologies under FFS state plan authority to pay providers without current period claims data, as long as states follow the instructions and conditions below, including: determining the interim payments by using current state plan rates, limiting the interim payments to the expected claims that the state would receive from an individual provider based on provider-specific recent utilization history, and reconciling the interim payments with final payments based on the actual services provided by the provider during the relevant time period.
3. CMS will permit states to draw FFP as the federal share of FFS interim payments consistent with the framework described in this CIB as soon as the state submits a SPA describing an interim payment methodology and reconciliation process that meets the conditions of approval that are described in this CIB. As necessary, CMS will also include FFP associated with such interim payment SPAs in state grant awards after state submission of the SPA, including while the SPA is under CMS review. (Please note the flexibilities described in this paragraph apply only to the FFS interim payments described in this CIB, not to any of the other state options and flexibilities discussed herein).

**SPA Process Flexibilities Available to States Under this CIB Limited to the Period Starting with the Beginning of the Claims Disruption Due to the Change Healthcare Cybersecurity Incident and Ending June 30, 2024**

For a limited timeframe, from the date when claims processing was disrupted due to the cybersecurity incident until June 30, 2024, CMS will not enforce certain SPA processes and certain other requirements with respect to the kinds of SPAs listed below, to help address the issues created by the Change Healthcare cybersecurity incident, as further discussed below. These options utilize the flexibilities described in the previous section, as applicable.

### *Suspension of Cost Sharing*

States are encouraged to suspend beneficiary cost sharing requirements described in their state plans when necessary to avoid service disruptions for Medicaid beneficiaries for services affected by the Change Healthcare cybersecurity incident, for a time-limited period from the date when claims processing was disrupted due to the incident until June 30, 2024. States wishing to temporarily pause or remove cost sharing for Medicaid beneficiaries during the period described can do so through the submission of a cost-sharing SPA that is approved by CMS no later than June 30, 2024. In light of the urgency created by the incident, CMS will not enforce the requirement under 42 CFR 447.57(c) that states provide public notice prior to the submission of this SPA, and certain other requirements as necessary and applicable, such as those related to Tribal consultation and SPA effective dates (as summarized below). As a condition of the approval of these SPAs and non-enforcement of the applicable requirements, states must provide public notice either by the date of SPA submission or as soon as practicable after submission only for these SPAs related to the Change Healthcare cybersecurity incident. States should clearly identify a sunset date of no later than June 30, 2024, for this SPA submission, at which time the state will revert to cost sharing policy in their state plan.

### *Fee-for-Service (FFS) Interim Payments*

To ensure Medicaid providers affected by the Change Healthcare cybersecurity incident continue to receive service payments, CMS will allow states to submit a SPA describing a FFS interim payment methodology and reconciliation process that could be effective retroactively to the date when claims payment processing was disrupted due to the cybersecurity incident and could last until June 30, 2024. The SPA submission must be limited to the Medicaid services and providers that have experienced claims disruption due to the incident under the FFS delivery system. As soon as a state submits a SPA describing the interim payment methodology and reconciliation process that is fully consistent with the conditions detailed below, the state may begin to draw FFP in these interim payments, as long as they are made in a manner consistent with the framework described in this CIB and with the methodology described in the state's SPA submission. As soon as states resume normal business operations and process provider claims following the resolution of the Change Healthcare cybersecurity incident and no later than June 30, 2024, states are expected to resume making payments in accordance with their approved Medicaid state plan to affected providers. (CMS also encourages Medicaid managed care plans to exercise their existing authority to provide interim payments, as described below, but these managed care interim payments do not require states to submit a SPA, and no special SPA-process-related or other flexibilities are needed in order for managed care plans to make them.)

### *Limited Non-enforcement of Certain State Plan Procedures*

In order to approve the kinds of SPA submissions summarized above, CMS will not enforce the following requirements (as applicable) from the date when claims processing was disrupted due to the cybersecurity incident until June 30, 2024:

- Advance public notice requirements at 42 CFR 447.57(c) for any SPA that substantially modifies existing cost sharing or changes the consequences for non-payment.

- Advance public notice requirements of any significant proposed change in the state plan methods and standards for setting payment rates for services at 42 CFR 447.205.
- Advance Tribal consultation requirements at section 1902(a)(73) of the Act as documented in the state plan. States will be permitted to submit the kinds of SPAs listed above prior to consultation, as needed.
- Public process for determining certain institutional rates at section 1902(a)(13)(A) of the Act.
- Submission of responses to Medicaid Funding Questions to document sources of non-federal share consistent with sections 1902(a)(2) and 1903(a)(1) of the Act.<sup>1</sup>
- Effective dates no later than the state's notice of a significant proposed change in methods and standards for setting payment rates for services, or that are retroactive to no earlier than the first day of a quarter in which the SPA is submitted (42 CFR 430.20).

With respect to the SPA public notice, public process and Tribal consultation requirements, CMS will not permit states to forgo these processes entirely. Rather, we are allowing states flexibility on the timing of the requirements (for example, issuing public notice after the effective date of the SPA). As a condition of our approval of these SPAs and of our non-enforcement of the public notice and Tribal consultation requirements listed above, we expect states to issue applicable public notice, and to conduct Tribal consultation and public process (as applicable), within a reasonable timeframe in conjunction with the submission of a cost-sharing SPA, pharmacy dispensing fee SPA that does not increase rates, and/or an interim payment methodology and reconciliation process SPA as described within this CIB.

CMS will continue to enforce all other federal requirements related to CMS review of SPA submissions to the extent necessary and applicable. Such other federal requirements related to these SPAs include (but are not limited to):

- Submission of a complete and signed CMS Standard Form 179.
- Submission of a SPA that meets the comprehensiveness standard required at 42 CFR 430.10.
- Compliance with section 1902(a)(30)(A) of the Act.
- Adherence to Medicaid Upper Payment Limit (UPL) requirements, such as those in 42 CFR 447.272 and 447.321.<sup>2</sup>
- Federal overpayment requirements in 42 CFR part 433, subpart F.

Additionally, unless a SPA is one of the specific types of SPAs mentioned above, and unless all the conditions listed in this CIB are met, all the typical federal SPA submission and process requirements will continue to apply.

#### *FFS Interim Payment Methodology and Reconciliation Conditions of Approval*

CMS will approve interim payment SPAs under FFS state plan authority consistent with the discussions and flexibilities above only if they have the following characteristics:

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<sup>1</sup> CMS will rely on existing submissions of state responses to Medicaid Funding Questions related to each affected provider class.

<sup>2</sup> CMS will rely on recently accepted Medicaid UPL demonstrations related to the interim payment SPAs, provided that the State is making no changes to the underlying provider base or supplemental payment subject to the UPL.

- The SPA is submitted by March 31, 2024, or the state contacts CMS as soon as possible, but no later than close of business on April 10, 2024, explaining the delay.
- The SPA applies only for services for which payment is affected starting with the beginning of claims disruption due to the Change Healthcare cybersecurity incident and ending June 30, 2024.
- The SPA describes interim payments to providers and for services that have been disrupted by the cybersecurity incident, as identified by the state.
- The SPA describes an interim payment methodology and reconciliation process that authorizes a state to base payments to the affected providers for affected services on claims data from a prior claiming period in lieu of actual claims data.
- The interim payment methodology outlined in the SPA describes how the state will compute interim payment amounts for providers (based on the provider's prior claims payment experience), and how the state will subsequently reconcile the interim payments with final payments based on the actual services provided by the provider.
- The SPA clearly provides that interim payments will be calculated and paid based on an individual provider's claims and payment history.
- The SPA clearly provides that the interim payment methodology is not an advanced payment or prepayment prior to services furnished by providers, but rather a payment for services furnished that are subject to final reconciliation once the state has access to individual claims data currently inaccessible due to the cybersecurity incident.
- The SPA describes how and when the state plans to conduct the reconciliation and settle over- and under-payments made to providers through the interim payment methodology.
- The state includes an assurance that it will return FFP in accordance with 42 CFR part 433, subpart F and within the timeframes established by 42 CFR 433.316 and 433.320 if, after conducting the reconciliation process, it turns out that the state has made an overpayment to a provider through the interim payment process. Except as provided in 42 CFR part 433, subpart F, the federal share of any such overpayment must be returned regardless of whether the state actually recoups the overpayment amount from the provider.
- The state includes an assurance that the state will ensure that all affected service providers continue to furnish services to Medicaid beneficiaries during the interim payment period as a condition of receiving the interim payments, so that access to care is not limited.

CMS expects states to set the interim payments by using the current state plan rates for the affected providers and services, and the anticipated claims for the affected services that the state would receive from an individual provider, based on a provider-specific claims history. States are encouraged to work with providers to ensure that interim payment amounts reflect the provider's historic claims data using a time period that reasonably controls for claims variation.

CMS is providing the below illustrative timeline to generally assist states in understanding the interim payment flexibilities and conditions of approval described within this CIB. We note that individual state processes and provider-specific needs may create additional procedural considerations.

- On 3/1/24, state makes interim payments to affected providers using state-only funds for the period 2/21/24-2/29/24.
- On 3/25/24, state makes additional interim payments to affected providers using state-only funds for the period 3/1/24-3/24/24 and makes necessary adjustments to the 3/1/24 interim payments using state-only funds, consistent with the conditions described in this CIB.
- On 3/31/24, state submits a SPA to CMS that meets the conditions of approval discussed in this CIB.
- On 4/1/24, state draws FFP for both the 3/1/24 and 3/25/24 interim payments since both payments meet the conditions of approval discussed in the CIB.
- On 4/1/24, state issues applicable public notice and conducts Tribal consultation .
- On 4/30/24, CMS approves the state’s interim payment and reconciliation SPA with an effective date of 2/21/24.
- State makes a claim for both the 3/1/24 and 3/25/24 interim payments on the Form CMS-64 for the quarter ended 6/30/24.
- On 7/1/24, after resuming normal business operations and receiving claims data from providers, state conducts a reconciliation between the interim payments and actual claims data.
- Based on the reconciliation, on 7/15/24, the state draws FFP and makes additional final reconciliation payments to providers to account for underpaying providers through the interim payment.
- On 7/15/24, the state also notifies providers of overpayments made through the interim payment and recoups the overpayment by 8/15/24.
- On the Form CMS-64 for the quarter ended 9/30/24, the state makes a prior period adjustment claim for the 7/15/24 final reconciliation payments and returns the federal share of the 8/15/24 collection of the overpayment.

*Essential Elements of Medicaid FFS Interim Payment SPAs Under this Approach*

CMS will approve interim payment SPAs under the approach described above only if they include the following information (see also the list above of SPA characteristics that are a condition of approval):

1. *Comprehensive Language:* The SPA includes comprehensive language describing the affected providers that can receive the interim payment, the affected services for which interim payments could be made, and how the state calculates the amount of the interim payment. This language includes details on when the payments are distributed or the unit of the interim payment (for example, weekly or monthly).
2. *Applicable Time Frame:* The SPA clearly identifies a start date for the interim payments that is no earlier than the first day of claims disruption due to the Change Healthcare cybersecurity incident and ending with services provided through June 30, 2024. If states need additional time to resolve payment for claims impacted by the cybersecurity incident, then states will need to work with CMS to address remediation efforts after June 30, 2024.
3. *Provider-Specific Payment Calculation:* The SPA provides that the interim payments and reconciliation are provider-specific, and that the payments are reconciled to actual provider-specific billed claims at the end of the temporary interim payment period.

Interim payment amounts calculated based on multiple providers' claims and payment data and structured as a single interim payment amount paid to multiple providers will not be accepted.

4. *Reconciliation Process including Applicable Time Frames:* The SPA details the timing between interim payments and actual billed claims, including any timeline differences dependent on service provider type (for example, pharmacy providers due to rebate agreements). The SPA also details the timing of any reconciliation settlement payments and how the state will collect any payments in excess of the individual provider's actual billed claims. The description of the methodology includes the data sources supporting the interim payment calculations and the elements of the reconciliation process.
5. *Program Integrity Assurance:* States include in the proposed SPA language a general assurance that the state will follow all applicable program integrity requirements relating to interim payments to providers and the associated reconciliation process.

As an example, a state's SPA could provide:

*Effective retroactively to [the DATE when claims payment processing was disrupted due to the Change Healthcare cybersecurity incident], and effective for affected services provided through June 30, 2024, [SPECIFIC PROVIDER TYPE (plural)] are eligible to receive payments for [SPECIFIC SERVICE TYPE] in amounts representative of up to thirty days (30) of claims payments for [SPECIFIC SERVICE TYPE] that are not otherwise paid as a result of the Change Healthcare cybersecurity incident. The average 30-day payment is based on the total claims for [SPECIFIC SERVICE TYPE] paid to the individual[PROVIDER/SUPPLIER], inclusive of all Medicaid base payments for [SPECIFIC SERVICE TYPE] made under the Medicaid state plan, between August 1, 2023, and October 31, 2023, divided by three (3). The payment will be made for services provided through June 30, 2024, on a [monthly, or other unit of payment] basis. This is not an advanced payment or prepayment prior to services furnished by providers. These payments will be reconciled to the final payment amount the provider was eligible to receive under the Medicaid state plan for [SPECIFIC SERVICE TYPE] during the timeframe for which it was receiving interim payments under this provision. The reconciliation will be completed within [#] days following the last day of the quarter in which the state is able to again process payments for claims following the resolution of the Change Healthcare cybersecurity incident. If the reconciliation results in discovery of an overpayment to the provider, the state will attempt to recoup the overpayment amounts within [#] days and will return the federal share within the timeframe specified in 42 CFR 433.316 and 433.320 regardless of whether the state actually recoups the overpayment amount from the provider, unless an exception applies under 42 CFR part 433, subpart F. If the reconciliation results in an underpayment to the provider, the state will make an additional payment to the provider in the amount of the underpayment within [#] of days. The state will follow all applicable program integrity requirements relating to interim payments to providers and the associated reconciliation process. The state will ensure that [SPECIFIC PROVIDER TYPE (plural)] receiving payments under this interim methodology for [SPECIFIC SERVICE TYPE] will continue to furnish [SPECIFIC SERVICE TYPE] to Medicaid beneficiaries during the interim payment period and that access to [SPECIFIC SERVICE TYPE] is not limited.*



States may opt to include introductory SPA language applicable to the Medicaid state plan Attachments 4.19-A, 4.19-B, and 4.19-D of the state plan on a single page in the state plan. Alternatively, states may insert language into each relevant section of the Medicaid state plan applicable to each provider type proposed to receive interim payments. For states opting to use introductory language, each type of affected provider must be listed in that introductory language.

Because CMS will need to review each of these SPAs quickly and will not enforce various provisions that would otherwise apply to SPA submissions when doing so, CMS will not approve a SPA for these interim payments if a state also proposes any additional adjustments to the payment methodologies of the providers impacted by this cybersecurity incident in the same SPA submission. SPAs introducing new payment methodologies outside of the interim payment methodology intended to address the cybersecurity incident would follow the standard CMS review process and should be submitted separately.

We encourage states to consider submitting a separate SPA, under the usual SPA submission process, to comprehensively describe circumstances that could be similar in the future and that would warrant a state to initiate interim payments on a time-limited basis in response to an event similar to the current cybersecurity incident. Such a SPA should include all of the elements described above, in addition to a clear description of the types of events that would trigger the interim payment (that is, a data breach that precludes providers from submitting claims to the Medicaid agency or from receiving payments from the Medicaid agency). All applicable federal requirements would apply. Thus, these SPAs would follow standard public notice, Tribal consultation, and other SPA process requirements, and would be subject to all other applicable federal requirements. CMS would consider those SPAs on a standard review timeline.

*Including FFP for Interim and Reconciled Payments on the Forms CMS-37 and CMS-64 and associated Supporting Documentation*

States and territories that choose to make interim payments under the SPAs discussed above may submit budget estimates on the Form CMS-37 for the period identified/approved in the SPA. States should follow existing processes for submitting the budget estimate request and note in the Form CMS-37 narrative that the request is for interim payments under the specific SPA (the state should list the SPA number).

CMS recognizes that some states are making payments using novel processes under time pressures; however, states must ensure that expenditures are accurate and allowable and that all supporting documentation, in readily reviewable form, has been compiled and is available at the time the claim for FFP is filed. Consistent with existing requirements at 42 CFR § 433.32(a), states must document expenditures, for both interim payments and reconciled payments, to ensure a clear audit trail. 42 CFR 433.32 provides that states must maintain an accounting system and supporting fiscal records to assure that claims for federal funds are in accord with applicable federal requirements. In addition, Section 2500.2 of the State Medicaid Manual (SMM) states that supporting documentation includes as a minimum the following: date of service; name of recipient; Medicaid identification number; name of provider agency and person providing the

service; nature, extent, or units of service; and the place of service. CMS is available to provide technical assistance to states regarding required supporting documentation.

Please note that expenditures are considered to be incurred when the state makes a payment to a provider, not based on the date of service (see 45 CFR 95.13(b)). The quarter in which the state makes the interim payment is the quarter in which the expenditure will be considered to be incurred and is the quarter that the expenditure is attributable to for expenditure claiming purposes, including determining the applicable federal match rate.

Please also note that under the timely claims filing requirement at section 1132 of the Act and 45 CFR part 95 subpart A, states must claim federal Medicaid matching funds for qualifying expenditures within the two-year time limit unless one of the four exceptions set forth in the regulations applies (see 45 CFR 95.19).

*Drawing FFP for Interim Payments from State Subaccounts in HHS's Payment Management System (PMS)*

Federal regulation authorizes states and territories to withdraw federal funds as needed to pay the federal share of disbursements (42 CFR 430.30(d)(3)). For Medicaid draw down from a state's PMS subaccounts, CMS defines the term "as needed" based on the criteria provided in 31 CFR 205.11(b), to mean that states and territories must limit the amount of funds transferred to the minimum amount required to meet a state's/territory's actual and immediate cash needs (see CMCS Informational Bulletin).<sup>3</sup> Interim payments made consistent with the process described in this CIB, which will ultimately be included in the Medicaid state plan, are considered actual Medicaid payments that meet the state's actual and immediate cash needs. States and territories may withdraw federal funds as needed to pay the federal share of disbursements relating to these interim payments, beginning from the date of SPA submission, in alignment with all other federal requirements.

State and territories should follow the requirements for funding techniques as provided in 31 CFR 205.11. Regulations at 2 CFR 200.346 provide that any funds paid in excess of the amount to which the non-federal entity is finally determined to be entitled under the terms of the federal award constitutes a debt to the federal government. Regulations at 2 CFR 200.346(b) provide that except where otherwise provided by statutes or regulations, the HHS awarding agency will charge interest on an overdue debt in accordance with the Federal Claims Collection Standards (31 CFR parts 900 through 999). It is the state's or territory's responsibility, as a grantee, to reconcile its draws to actual expenditures that the state/territory has certified on the Form CMS-64 for the applicable expenditure reporting period.

To ensure prompt notification to the Department of Treasury, states should contact their respective CMCS financial analyst to provide advanced notification (four days when feasible) regarding the timing of anticipated draw down associated with interim payments or reconciliation payments associated with this CIB.

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<sup>3</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib10192023.pdf>

## **Additional Options Available to States for Claims Affected by the Change Healthcare Cybersecurity Incident**

We are notifying states of existing options available to states that states could consider in response to the cybersecurity incident. The discussion above about certain requirements that CMS is not enforcing for a limited time period and in limited circumstances related to the Change Healthcare cybersecurity incident does not apply to the options listed below.

### *Pharmacy*

Affected states have the option to submit a pharmacy payment SPA proposing an enhanced professional dispensing fee to affected pharmacy providers to account for the manual and additional time-consuming procedures that pharmacists may perform during the Change Healthcare incident. States should propose the enhanced professional dispensing fee on their 4.19-B, 12.a. Prescribed Drug pages. As part of their submission, states should submit supporting documentation to justify the amount of the increased professional dispensing fee during this interim period. Please note that pharmacy payment SPAs increasing rates are not eligible for the SPA process flexibilities described in this CIB and must be submitted according to the usual SPA requirements and timeline.

Outside of SPAs, states may remove Drug Utilization Review (DUR) evaluations such as “Early Refill” that have been impacted during the Change Healthcare incident, since an evaluation cannot be performed when a claim cannot be processed. States may also waive requirements for tamper-resistant prescription pads for controlled substances during this period, and/or waive prior authorizations. Finally, future drug rebate invoicing requirements will not be impacted by this incident, as the invoices do not need to be generated until the paid date of the claim. As such, the timeframe for invoicing manufacturers will not toll until the claims system is once again operational.

### *Managed Care Flexibilities*

We are continuing to work closely with states with managed care delivery systems and are urging Medicaid managed care plans to make prospective payments to impacted providers. Medicaid managed care plans do not need CMS authority to make prospective payments to providers and suppliers who need them. We are encouraging Medicaid managed care plans to make prospective payments as soon as possible. We also urge Medicaid managed care plans to work with impacted providers to pay existing older claims already filed to enable payment.

Additionally, and as previously described in various COVID-19 public health emergency toolkits and guidance,<sup>456</sup> states can already amend their managed care contracts or work with their managed care plans under 42 CFR part 438 to temporarily:

- Suspend or modify prior authorization requirements;
- Allow early prescription refills and/or extend the length of prescription refills;

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<sup>4</sup> [PHE/Disaster Preparedness/Response Toolkit for Medicaid/CHIP Agencies](#)

<sup>5</sup> [COVID-19 FAQs for State Medicaid and CHIP Agencies](#)

<sup>6</sup> [CIB - Medicaid Managed Care Options in Responding to COVID-19](#)

- Extend existing prior authorizations;
- Suspend out-of-network requirements; or
- Modify or update cost-sharing requirements to be consistent with any changes that are made in the Medicaid state plan.

If states amend their contractual terms, those contract actions should be submitted to CMS for review and approval per 42 CFR 438.3(a), and states should assess with their actuaries if any contractual changes impact the actuarial soundness of rates and require a rate certification.

States can also work with their managed care plans on network provider payment issues that are arising from this event. Managed care plans already have the discretion (without federal approval) to voluntarily implement a number of payment techniques with their network providers, which may include advance payments, in order to fulfill their contractual requirements to ensure access to care and network adequacy.

#### *Prompt Payment Requirements*

Under section 1902(a)(37) of the Act, as implemented in CMS's regulation at 42 CFR § 447.45(d), Medicaid agencies must require providers to submit all claims no later than 12 months from the date of service. The Medicaid agency must then pay 90 percent of all clean claims within 30 days of receipt and 99 percent of all clean claims within 90 days of receipt. Generally, the Medicaid agency must pay all other claims within 12 months of receipt, with certain exceptions. Maintaining timely and accurate processing, submission, adjudication and payment of provider claims for Medicaid services continues to be important during this period affected by the cybersecurity incident. However, if a state has more stringent requirements for claims submission and payment, those state requirements may be relaxed, as long as they continue to meet the minimum requirements of 42 CFR § 447.45(d). If a state encounters problems with the functionality of information technology systems supporting the submission, processing and/or payment of claims, please contact your MES State Officer.

#### **Ongoing Requirements**

The flexibilities and non-enforcement detailed above do not apply to, or represent a waiver of, any requirements or responsibilities not specified in this CIB. We want to highlight some ongoing expectations during this period, and for returning to standard business once claims can be processed again.

#### *Program Integrity*

All Medicaid program integrity requirements, including maintaining adequate documentation to support the allowability of claims, avoiding duplicate payment, and provider enrollment requirements continue to apply. Additionally, as described above, as a condition of CMS approval, the state SPA submissions described above to implement interim payments must include a general assurance that the state will follow all applicable program integrity requirements relating to interim payments to providers and the associated reconciliation process. These SPA submissions will also contain the state's assurance that it will return FFP associated

with any overpayments in accordance with 42 CFR part 433, subpart F and within the timeframes established by 42 CFR 433.316 and 433.320. As a reminder, except as provided in 42 CFR part 433, subpart F, the federal share of any such overpayment must be returned regardless of whether the state actually recoups an overpayment amount from the provider.

To prevent overpayments and strengthen program integrity, states could consider implementing requirements for providers as a condition of receiving interim payments, such as those outlined in CMS's Medicare Program Change Health/Optum Payment Disruption (CHOPD) accelerated and advance payments.<sup>7</sup>

In addition, recognizing the unprecedented disruption to states' claiming processes, CMS will provide PERM flexibilities, within our authority, to impacted states during the Change Healthcare cybersecurity incident, consistent with flexibilities offered previously when states experienced disruptions to their claims processes.

### **Conclusion**

We understand that the SPA and future reconciliation process for interim payments approved under the flexibilities discussed in this CIB could present challenges for some states. CMS staff are available to assist. Please contact [MedicaidFinancialFlexibilities@cms.hhs.gov](mailto:MedicaidFinancialFlexibilities@cms.hhs.gov) to request technical assistance. While this CIB primarily describes flexibilities and authorities for Medicaid, if states have questions regarding CHIP related to the Change Healthcare cybersecurity incident, they should contact their CHIP Project Officers.

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<sup>7</sup> <https://www.cms.gov/newsroom/fact-sheets/change-healthcare/optum-payment-disruption-chopd-accelerated-payments-part-providers-and-advance>