

**COVID-19 Frequently Asked Questions (FAQs)
for State Medicaid and Children’s Health Insurance Program (CHIP) Agencies**

A. Emergency Preparedness and Response

1. What resources are available to assist states and territories in their response to COVID-19?

Medicaid and CHIP play a critical role in helping states and territories respond to public health events, as well as natural and human-made disasters. To assist states and territories in their preparedness efforts, CMS developed a Disaster Preparedness Toolkit that is a longstanding resource that has been available to states and territories on CMS’ website, Medicaid.gov. States and territories are encouraged to be familiar with this resource as part of their emergency preparedness planning. The toolkit outlines numerous strategies available to support Medicaid and CHIP operations and enrollees in times of crisis, and serves as a comprehensive disaster preparedness resource for states and territories. Many of the flexibilities described in the toolkit will help states and territories in their response to COVID-19. The toolkit is organized by operational areas, such as eligibility and enrollment, benefits, cost-sharing and provider workforce. The toolkit also outlines the legal authorities available to effectuate various strategies, including flexibilities in current statute, Medicaid and CHIP state plan amendments, section 1915(c) waiver Appendix K, and section 1115 demonstrations. The toolkit also describes authority that may be granted through section 1135 waivers, which are only available when the President declares an emergency or natural disaster under the National Emergencies Act or Stafford Act *and* the Secretary declares a Public Health Emergency Declaration under Section 319 of the Public Health Service Act. The toolkit is available at:

<https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/index.html>.

2. How can Appendix K support a state’s response to COVID-19 for 1915(c) Home and Community-Based Services (HCBS) Waivers?

CMS developed Appendix K of the section 1915(c) waiver application for use by states during emergencies. It describes actions states can take under existing section 1915(c) HCBS waiver authority to respond to an emergency. The appendix may be approved retroactively, as needed, to the date of the event. A completed Appendix K should be submitted for each affected waiver and should be used to advise CMS of expected changes to state waiver operations. Changes may include establishing a hotline, increasing the number of individuals served under a waiver, creating an emergency person-centered service plan, expanding provider qualifications, increasing the pool of providers who can render services, instituting or expanding opportunities for self-direction, and/or permitting payment to HCBS providers when an individual is in a short-term hospital or institutional stay.

Appendix K also provides states with opportunities to:

- temporarily increase individual eligibility cost limits,
- modify service, scope, or coverage requirements,
- exceed service limitations,
- add services to the waiver,

- provide services in out-of-state settings, and/or
- permit payment for services rendered by family caregivers or legally responsible individuals.

A state or territory **may not** include changes in Appendix K that are not permitted by statute, such as the inclusion of room and board costs in non-institutional settings. CMS will work with states and territories to determine what changes may be needed and other key considerations, such as effective dates and impact to other programs.

Please see attached link for instructions and template:

<https://www.medicaid.gov/medicaid/home-community-based-services/downloads/1915c-appendix-k-instructions.pdf> and <https://www.medicaid.gov/medicaid/home-community-based-services/downloads/1915c-appendix-k-template.pdf>

3. What disaster response options do states have for separate CHIP programs?

States that anticipate needing disaster relief flexibilities in CHIP are encouraged to submit a disaster relief state plan amendment (SPA). **This may be submitted in advance of, or in response to, a disaster/public health crisis.** Through a CHIP SPA, states can add flexibilities such as waiving premiums and cost sharing, and extending timeframes for renewals. A CHIP SPA may be effective as early as the first day of the state's fiscal year as long as it is submitted by the end of a state's fiscal year. Please see the attached link for more information: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/childrens-health-insurance-program-chip/downloads/chip_disaster_relief_spa_sample_01102012.pdf

In addition to the disaster relief SPA, states may use CHIP Health Services Initiative (HSI) for additional COVID-19 related activities that are targeted to low-income children. Interested states should consult with CMS regarding the application process and parameters for HSIs.

B. Eligibility and Enrollment Flexibilities

1. Can states expand the eligibility groups for which hospitals can make presumptive eligibility (PE) determinations to include individuals who are in a hospital waiting for nursing home or long-term care placement?

Yes. Under Hospital Presumptive Eligibility (HPE), states must permit hospitals to make PE determinations for parents and caretaker relatives, children, pregnant women, and former foster care children, adults (in states that have adopted the adult group), individuals eligible for family planning services (if covered by the state), and individuals needing treatment for breast or cervical cancer (if covered by the state.) However, states have the authority to add additional Medicaid eligibility groups or populations (if covered by the state) to their HPE program. This includes eligibility groups based on being age 65 or older, having blindness or a disability, or being medically needy (ex., eligibility group for individuals in institutions eligible under a special income level). States may also permit hospitals to make PE determinations for

demonstration populations covered under section 1115 authority. Participating hospitals must meet the state's qualification requirements and comply with the procedures and standards established by the state. CMS is available to provide technical assistance on the SPA changes needed to expand HPE to these and other eligibility groups.

2. Are there any exceptions to the federal timeliness standards for processing Medicaid and CHIP applications?

Yes. States are excused from meeting the timeliness standards for processing applications due to an administrative or other emergency beyond the agency's control. This would include a public health emergency, like COVID-19, during which workforce shortages may impact the agency's ability to process applications timely and/or impacted individuals may be unable to receive or respond to notices or provide information needed to complete the application process. To exercise this flexibility, a Medicaid SPA is not needed. States relying on a timeliness standard exception on a case-by-case basis must document the reason for the delay in the individual's case record.

States seeking to invoke a timeliness standard exception for a broader cohort of cases (for example, all applications in a defined geographic area) are advised to not only document the exception in the applicant's case record, but also to obtain CMS concurrence that the exception is warranted under the circumstances.

CHIP agencies should submit a disaster relief state plan amendment to utilize flexibilities related to application processing. States that already have a disaster relief state plan amendment that includes flexibilities related to application processing will just need to notify CMS that they are activating this flexibility.

3. Are there any exceptions to the timeliness standards for processing Medicaid and CHIP renewals?

Yes. States have flexibility in meeting the timeliness standards for renewing Medicaid eligibility during an administrative or other emergency beyond the agency's control. This would include a public health emergency, like COVID-19, during which workforce shortages may impact the agency's ability to complete timely renewals and/or impacted individuals may be unable to receive or respond to notices or provide information needed to complete the renewal process. In such cases, the state must continue to furnish Medicaid to eligible beneficiaries until they are determined ineligible.

A state plan amendment for Medicaid is not needed. States relying on a timeliness standard exception on a case-by-case basis must document the reason for the delay in the individual's case record. States seeking to invoke a timeliness standard exception for a broader cohort of cases (for example, all renewals in a defined geographic area) are advised to not only document the exception in the beneficiary's case record, but also to obtain CMS concurrence that the exception is warranted under the circumstances.

CHIP agencies should submit a disaster relief state plan amendment to utilize flexibilities related to redetermination processing. States that already have a disaster relief state plan amendment that includes flexibilities related to redetermination processing will just need to notify CMS that they are activating this flexibility.

4. Can a state extend eligibility for current beneficiaries subject to an emergency or disaster so that they can continue to receive coverage beyond their renewal date, even if no longer eligible?

As described above, states have flexibility in meeting the timeliness standards for renewing Medicaid eligibility during an administrative or other emergency beyond the agency's control. Beyond those flexibilities, for eligibility groups excepted from the MAGI-based methodologies, states have the option to renew eligibility once every 12 months or more frequently than once every 12 months. States that have elected to conduct more frequent renewals for MAGI-excepted groups may submit a state plan amendment to extend the renewal period to 12 months.

Under the Medicaid state plan, states can also elect to extend coverage to certain additional individuals statewide by increasing effective income standards (and, for individuals subject to an asset test, resource standards) for some populations and/or adopt an optional eligibility group to cover other populations, when allowable under the statute. A state plan amendment would be needed to do so. However, income and resource standards and eligibility groups in the state plan may not apply narrowly to only those affected by a particular diagnosis, such as COVID-19. CMS is available to provide technical assistance to states seeking to extend coverage to additional populations during a disaster or other emergency.

CHIP agencies may extend eligibility through a disaster relief state plan amendment. States that already have a disaster relief state plan amendment that includes flexibilities related to extending eligibility will just need to notify CMS that they are activating this flexibility.

C. Benefit Flexibilities

1. How can states best provide Medicaid services and supports to beneficiaries who are quarantined?

Through a 1915(c) Appendix K, if a Medicaid beneficiary already meeting an institutional level of care is quarantined in the community, states could add *Live in Caregiver* as a service, authorizing family members as providers. Therefore, a family member in the home who is not ill can render services to the quarantined individual and be funded as a live in caregiver. Home-delivered meals, such as Meals on Wheels, could be added to provide one meal per day to the individual. Additional services, such as private duty nursing, could also be added and payment rates could be increased to account for increased health risk to providers and to solicit a larger provider pool.

Access to Medicaid services provided in an individual's private home or group residential setting should not change because the beneficiary is quarantined. However, depending on the way the state has developed the benefit and description in the state plan, a SPA may be necessary to

amend language to clarify where services may be provided. For benefits with federal requirements governing location, such as benefits that require services to be provided in a home and community based setting, CMS is available to provide technical assistance related to how states can comply with federal requirements in emergencies.

For individuals quarantined in institutional settings, regulations already require that nursing facilities (NFs) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) have an infection control policy, including policies for prevention, surveillance, and isolation. The facilities are already paid for this type of planning and care under their normal per diem rates.

Quarantine in an inpatient hospital setting could be considered an observation bed stay (for the period of observation to determine whether the individual needs an inpatient hospital stay), when covered by the state. Observation bed stays are not specifically mentioned in the federal Medicaid coverage regulations for inpatient or outpatient hospital services (42 C.F.R. §§440.2, 440.10, and 440.20), and states have discretion in whether to cover and how to pay for these services. Observation bed days of 24 hours or longer cannot be covered as an outpatient hospital service, but may be covered as an inpatient hospital stay (the Medicaid definition of outpatient described in 42 C.F.R. § 440.2 limits services to a less than 24-hour period).

If a service is tied to a specific setting, the service can be amended either through the state plan and/or through the Appendix K for 1915(c) programs.

2. What flexibilities are available to provide care via telehealth for individuals who are quarantined or self-isolated to limit risk of exposure?

States have broad flexibility to cover telehealth through Medicaid, including the methods of communication (such as telephonic, video technology commonly available on smart phones and other devices) to use. Telehealth is important not just for people who are unable to go to the doctor, but also for when it is not advisable to go in person. No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services. A SPA would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.

With regard to 1915(i) face-to-face assessments, the use of telemedicine or other information technology medium is authorized under federal regulations at 42 C.F.R. § 441.720 under certain conditions. With regard to 1915(c) waivers, the state can complete an Appendix K to allow case management to be done via telephone or other information technology medium and, where personal care services only require verbal cueing and/or instruction, the personal care service can be expanded to permit information technology medium as a resource.

3. Will CMS issue guidance on loosening prior authorization requirements for medication and supplies for medically fragile children and other populations who may be quarantined?

The answer to this question depends on whether the child receives their care through Fee-For-Service (FFS) or managed care.

FFS / Supplies: States have flexibility to establish and manage prior authorization processes without CMS approval. Given that medically fragile children are subject to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements, there should be no hard limits on services provided to these children. A SPA may be needed, depending on the state's goals.

FFS/Pharmacy: States have flexibility to establish the prior authorization process without CMS approval, including length of time and units approved. A state may need to amend their SPA for a change in quantity dispensed.

Managed Care: Under Medicaid managed care, states may develop the specific standards and criteria that best meet the needs of their program, including accelerated or relaxed requirements during times of emergency. Federal law does not prohibit or limit states from requiring managed care plans to temporarily suspend prior authorization requirements, extend prior authorizations through the termination of the emergency declaration, and expedite processing of new prior authorizations with flexibility in documentation (e.g., physician signatures).

4. Will CMS consider adding telehealth flexibilities so residents in rural communities potentially exposed to the virus do not need to visit a Rural Health Clinic (RHC)?

RHCs billing Medicare are subject to Medicare's telehealth policies. The Medicare statute authorizes RHCs to serve as originating sites for telehealth services furnished by a remotely located "distant site" health care provider, but the statute does not authorize RHCs to furnish telehealth services as distant site health care providers. A distant site is a site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system. Only physicians and certain types of non-physician practitioners are authorized to furnish telehealth services as distant site health care providers. The Secretary's waiver authority under section 1135(b) of the Act does not extend to the scope of distant site health care providers that can furnish telehealth services. The newly added paragraph at section 1135(b)(8) gives the Secretary authority only to waive the requirements of 1834(m)(4)(C), which is the definition of "originating site" for purposes of Medicare telehealth services. There is no new authority to waive who/what can serve as the "distant site practitioner."

5. Can states provide an additional month of medication to a beneficiary when their Medicaid eligibility is ending?

States have flexibility to determine the quantity of medication covered per prescription fill. Federal financial participation (FFP) is available for a prescription if the date of service falls during the individual's Medicaid eligibility period.

6. Is the test for the detection of COVID-19 coverable under Medicaid's mandatory laboratory benefit?

Yes, the test meets the criteria for a mandatory laboratory service as described at 1905(a)(3) and 42 C.F.R. § 440.30. The test must be ordered and provided by or under the direction of a physician or other licensed practitioner within the appropriate scope of practice as defined by the state, or ordered by a physician, but provided by referral laboratory. To meet this definition, the test must be provided in an office or similar facility other than a hospital outpatient department or clinic and furnished by a laboratory that meets Clinical Laboratory Improvement Amendments (CLIA) requirements at Part 493 of the Code of Federal Regulations. Tests that do not meet these criteria may still be covered under the optional diagnostic benefit described at 1905(a)(13) of the Social Security Act and 42 C.F.R. § 440.130(a).

If a state's current Medicaid cost sharing policies include cost sharing for the test for the detection of COVID-19, the state can submit a SPA to eliminate the cost sharing for that test. For CHIP, states can stop charging copayments for particular items or services through a CHIP disaster relief SPA. More information on cost sharing flexibility is found in question D.1. below.

D. Cost-Sharing Flexibilities

1. What authority is available to not charge copayments during a public health emergency?

If a state wishes to stop charging copayments for particular items or services in Medicaid (e.g., doctor visits or inpatient hospital services), the state can submit a SPA. However, exempting individuals from copayments cannot be applied narrowly to only those affected by a particular diagnosis, such as COVID-19. Rather, a copayment exemption under the state plan would need to apply to everyone who accesses a particular item or service. Alternatively, the state could request section 1115 authority to temporarily suspend copayments only for individuals needing treatment for COVID-19 infection.

States can stop charging copayments for particular items or services in CHIP through a CHIP disaster relief SPA.

E. Financing Flexibilities

1. What flexibilities are available in the event of a public health emergency impacting the availability of state Medicaid agency staff resulting in the state's inability to submit quarterly Medicaid budget estimates (Form CMS-37) 45 days before the beginning of the quarter, as required?

The state Medicaid agency should notify CMS as soon as possible that it expects a delayed Form CMS-37 submission. CMS will work with the state to ensure continued access to federal funds and uninterrupted Medicaid administrative activities and service delivery. If the state is unable to submit the form with enough time for CMS to review and process related grant awards, CMS may use the state's most recent budget estimate submission (Form CMS-37) as the basis for issuing the quarterly grant award to ensure continued availability of FFP. Additionally, states

have an opportunity at any time throughout each quarter to request additional funding from CMS as necessary to cover allowable Medicaid administrative and service costs.

2. What flexibilities are available in the event of a public health emergency impacting the availability of state Medicaid agency staff resulting in the state's inability to submit its quarterly Medicaid expenditure report (Form CMS-64) within 30 days after the end of the quarter, as required?

The state Medicaid agency should notify CMS as soon as possible that it expects a delayed Form CMS-64 submission. Although federal regulations at 42 C.F.R. § 430.30(c)(1) require states to submit the form CMS-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program) to CMS not later than 30 days following the end of each quarter, in the event of a public health emergency that impacts a state's ability to do so, CMS will work with impacted states to ensure the continued availability of FFP for allowable Medicaid services for the duration of the public health emergency. Additionally, CMS will provide technical assistance as necessary to assist the state with proper claiming of FFP and to ensure that funding provided is reconciled to actual incurred and allowable expenditures.

3. Do states need prior approval to acquire additional IT systems services and staffing?

Typically, CMS requires prior approval for most expenditures to receive enhanced FFP for state IT systems. However, when expenses are expected to fall below minimum thresholds, prior approval may not be required. The thresholds are:

1. For enhanced FFP: Approval of contracts and associated funding is not required in instances where the contract is not anticipated to exceed a total federal and state acquisition cost of \$500,000.
2. For regular FFP: Approval of contracts and associated funding is not required in instances where the contract is not anticipated to exceed a total federal and state acquisition cost of \$5,000,000.
3. For sole source contracts: Approval of contracts and associated funding is not required in instances where the contract is not anticipated to exceed a total federal and state acquisition cost of \$1,000,000.

4. What flexibilities do states have to obtain additional funding to meet technology needs in response to COVID-19?

When requested by the state, FFP for IT systems can be provided in emergencies. The FFP request should include: (1) A brief description of the equipment and/or services to be acquired and an estimate of their costs; and (2) a brief description of the circumstances driving the state's need and the harm that will be caused if the state does not immediately acquire the requested equipment and/or services. FFP approved under this authority would be available from the date the state actually acquires the equipment and services. Additional information regarding this process can be found at 45 C.F.R. § 95.624.

F. Workforce Flexibilities

1. What options are available if a state experiences a shortage of health care workers because of COVID-19?

To address provider shortages for individuals receiving 1915(c) waiver services, states can use Appendix K to expand provider qualifications (e.g., where a provider must be 21 years old, states could modify the age requirement to 18); add additional providers (including allowance of payment to family members and legally responsible relatives); add services, such as a live-in care giver; and temporarily adjust rates to entice more individuals into the workforce.

For state plan services, a SPA can increase the types of providers a state authorizes to deliver services. As always, states should be mindful of state-level requirements that might impact provider flexibility in delegation of authority.

Additionally, states have broad ability to cover telehealth through Medicaid, and no federal approval is needed for state Medicaid programs to reimburse for telehealth services in the same manner or at the same rate paid for face-to-face services, visits, or consultations. A SPA is necessary to accommodate any revisions to payment methodology to account for telehealth costs.

To address state staff shortages, the Appendix K process can also be utilized for case managers under 1915(c) to permit the use of telehealth or telephonic consultations in place of typical face-to-face requirements. Under 1915(i), existing regulatory flexibility at 42 C.F.R. § 441.720(a) permits use of telehealth in place of face-to-face assessments when certain conditions are met.

2. What precautions can states take to protect home health workers, personal care workers, and eligibility workers from contracting COVID-19?

CMS supports the Centers for Disease Control and Prevention (CDC) guidance on workforce protections; more information can be found on the CDC website: <https://www.cdc.gov/coronavirus/2019-ncov/community/index.html>. CMS has also issued relevant guidance at the following link: <https://www.cms.gov/files/document/qs0-20-17-all.pdf>. Any additional guidance will be posted to <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>. Any additional guidance will be posted to <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>.

To account for increased costs in personal protective equipment (PPE) for home care workers, a SPA or Appendix K for a 1915(c) waiver could be submitted to amend payment methodologies for impacted services.

3. What flexibility exists to allow states to utilize first responders (emergency medical technicians (EMTs), fire fighters, etc.) to administer testing for COVID-19?

Depending on the specificity in the existing Medicaid state plan, a SPA may be necessary to add first responders as testing providers. CMS notes that state laws may have implications for the

scope of providers able to perform these activities. In addition, third party liability provisions apply for services covered across the Medicaid program, and states could utilize existing mechanisms to ensure compliance.

G. Miscellaneous

1. What flexibilities will CMS provide states in the event that required deliverables cannot be submitted because of COVID-19 (i.e., SPA, waiver applications, renewals, or deliverables, etc.)?

CMS will monitor pending SPA submissions and 1915(c) waiver amendments and renewals and work closely with the state to ensure the appropriate approvals or temporary extensions are granted.

Regarding managed care reporting requirements, CMS is able to utilize enforcement discretion for managed care reporting requirements under 42 C.F.R. Part 438, with minimal exceptions (actuarial soundness, payments, and Medical Loss Ratio (MLR) requirements). The reporting requirements for MLR at 42 C.F.R. § 438.8(k) are determined by the state, as long as it is within 12 months of the end of the reporting year. CMS believes this provides states an ample window to meet MLR reporting requirements.

Regarding section 1115 demonstration deliverables or renewal requests (such as quarterly and annual monitoring or budget neutrality reports, evaluation designs, evaluation reports), states may e-mail their demonstration's CMS project officer requesting an extension to submit the deliverable/report or renewal application, along with an explanation of the rationale. As a general rule, if the state experiences challenges as a result of COVID-19, the state should notify CMS as soon as possible and CMS will work with the state to determine a reasonable timeline for compliance.

2. In the event of a public health emergency in which a healthcare facility experiences an acute critical staffing shortage, including a staffing shortage due to infectious disease, and temporarily utilizes federal health care workers (e.g., US Public Health Services Commissioned Corps Officers) in place of facility staff, may the facility continue to bill the Medicaid program for the services provided to beneficiaries?

Providers are generally prohibited from billing the Medicaid program and states may not receive FFP for practitioner services provided by federally employed health care workers. To the extent care provided by a federal employee supplants the costs of practitioner or non-practitioner services that are bundled into a rate that includes multiple service costs, the provider's payment would need to be allocated and the state's claim for FFP would need to be reduced to account for service costs associated with federally employed practitioners. For example, if a nursing facility is staffed in part by federally employed health care workers and is paid a per diem rate for Medicaid services, the state's claim of FFP for the per diem rate would need to be reduced for all care costs assumed for services provided by federal workers. In such instances, during a public emergency, the state may continue to pay the nursing facility the full per diem rate and recoup funds from the provider once data is available to properly allocate service costs. Such an

allocation may be conducted using cost data from a nursing facility's cost report or, if feasible, by reducing the per diem rates by cost factors associated with care costs assumed by the federal health care worker. The data used to allocate cost must be auditable and claimed FFP associated with the federally employed worker must be returned to CMS. CMS will work with state to ensure this process is conducted within an appropriate time frame following acceptance of federal assistance. In the interim, states may continue to pay providers in accordance with Medicaid state plan methodologies and CMS will work with the state on a case-by-case basis to ensure that a reasonable allocation method is developed in accordance with applicable cost allocation requirements.

3. What is CMS' coding guidance for laboratory testing of COVID-19 and what are the rates for testing?

CMS is working closely with the Centers for Disease Control and Prevention (CDC) to establish the appropriate coding practices related to COVID-19. CMS developed the first Healthcare Common Procedure Coding System (HCPCS) code (U0001) to pay for claims and track testing for COVID-19. This code is used specifically for CDC testing laboratories to test patients for SARS-CoV-2. CMS has since added a second HCPCS billing code (U0002) which allows laboratories to bill for non-CDC lab tests for SARS-CoV-2/2019-nCoV (COVID-19). Medicare claims processing systems will be able to accept these codes starting on April 1, 2020, for dates of service on or after February 4, 2020. These codes serve to increase more testing and improve tracking. Because these HCPCS codes allow those labs conducting the tests to bill for the specific test instead of using an unspecified code, a descriptor is not required for Health Insurance Portability and Accountability Act (HIPAA) compliance.

On February 6, 2020, CMS also gave Clinical Laboratory Improvement Amendments (CLIA)-certified laboratories information about how they can test for SARS-CoV-2. To read more about those efforts, visit: <https://www.cms.gov/medicareprovider-enrollment-and-certificationsurvey/certificationgeneralpolicy-and-memos-states-and/notification-surveyors-authorization-emergency-use-cdc-2019-novel-coronavirus-2019-ncov-real-time-rt>.

CMS's 12 local administrative contractors process and pay the fee-for-service Medicare claims for each of their respective jurisdictions. The contractors use a variety of methodologies to price new tests that will be paid at the local level, until a national price is established through CMS's annual laboratory meeting process that includes the opportunity for public feedback. CMS is actively working with the contractors in this process and will provide information in separate guidance once it is available.