

## QUICK REFERENCE GUIDE

### Submit a Standard 1135 Medicaid Waiver/Flexibility Request

Please complete the form and answer all the questions in order.

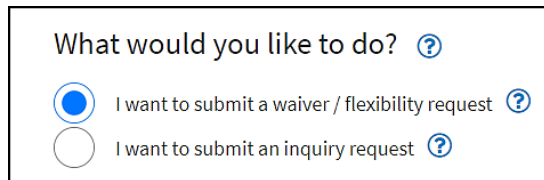
Six (6) simple steps are outlined below including several optional questions. The form is more easily processed if the optional questions are also completed. All questions are required, unless otherwise noted. A submit button only appears after all the required questions are completed.

**Important:** Before you begin, please note the system times out after thirty (30) minutes of inactivity, at which point your data will be lost. There is a five (5) minute warning after twenty-five (25) minutes have passed). If not submitted promptly.

Begin by using one of the two recommended browsers (Google Chrome or Mozilla Firefox) to navigate to the web page at [https://cmsqualitysupport.servicenow.com/cms\\_1135](https://cmsqualitysupport.servicenow.com/cms_1135)

**Note:** When working with this form, hover over the question mark (?) icon for additional information or review the ghost text in the textbox for instructions. All fields are required unless otherwise noted.

#### Step 1: Select “I want to submit a waiver/flexibility request”.



What would you like to do? ?

I want to submit a waiver / flexibility request ?

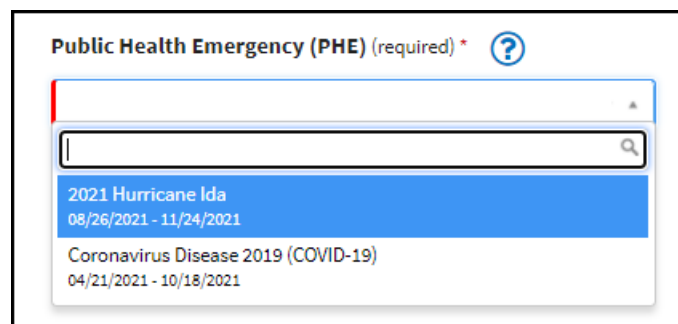
I want to submit an inquiry request ?

Figure 1

#### Step 2: Select the Public Health Emergency (PHE) that applies. This field is required.

**Note:** This portal cannot be utilized for COVID-19 PHE related Medicaid 1135 waiver submissions.

- Select from the choices in the dropdown box using the down arrow, OR
- Complete the name of the emergency in the search bar to locate it.



Public Health Emergency (PHE) (required) \*

2021 Hurricane Ida  
08/26/2021 - 11/24/2021

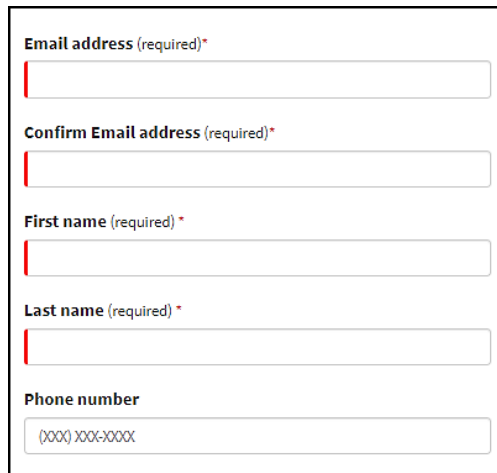
Coronavirus Disease 2019 (COVID-19)  
04/21/2021 - 10/18/2021

Figure 2

### Step 3: Complete the Contact Information.

The following fields are all required fields, except the Phone number field. After the first submission, the First name, Last name, and Organization name fields are automatically populated based on the email entered in each subsequent submission.

- Enter an **email address**.
- Type to **confirm the email address** in the Confirm Email question.
- Enter the **First name**. The First name automatically populates in subsequent submissions.
- Enter the **Last name**. The Last name automatically populates in subsequent submissions.
- Enter the **Phone number**. This field is optional. If provided, phone number may be used if there is a need for direct contact.



The form contains five input fields, each with a red vertical bar on the left side. The fields are labeled as follows:

- Email address (required)\***
- Confirm Email address (required)\***
- First name (required)\***
- Last name (required)\***
- Phone number**

The Phone number field includes a placeholder text: (XXX) XXX-XXXX.

Figure 3

**Note:** After the first submission, the First name, Last name, and Organization name fields are automatically populated based on the email entered in each subsequent submission.

### Step 4: Complete the Organization Information.

- Enter the name of the organization making the request. The **Organization Name** automatically populates in subsequent submissions, based on the email address entered. This should be the name of the State Medicaid or CHIP Agency.
- Select the **State, US Territory or Federal District** covered by this request. Start typing, and a dropdown box appears and selection may be made.
- If you accidentally enter an incorrect State/US Territory/Federal District, click on the “x” next to the name to easily remove it.

**Organization Information** ?

Who is the organization making this request?

**Organization Name** (required) \*

**State/US Territory/Federal District** (required) \* ?

Figure 4

- Select State Medicaid or CHIP Agency.

**Organization Categories** (required) \* ?

Who is the Organization making this request?

General   
  Emergency Provider/Supplier Types   
  Other

<input type="checkbox"/> Advocacy Group	<input type="checkbox"/> Association
<input type="checkbox"/> Congressional Office	<input type="checkbox"/> Corporation
<input type="checkbox"/> Department of Health and Human Services	<input type="checkbox"/> Medicare Advantage Plan
<input type="checkbox"/> Part D Prescription Plan	<input type="checkbox"/> State Government
<input checked="" type="checkbox"/> State Medicaid or CHIP Agency	<input type="checkbox"/> State Survey Agency
<input type="checkbox"/> Tribal Nation	

Figure 5

Select the type of waiver(s) you want to submit:

- Select **“I want to submit a general waiver”** if it applies to Medicare. Select the link provided for instructions on completing the [general waiver request form](#).
- Select **“I want to submit a Medicaid/CHIP waiver”** if the waiver applies to Medicaid only. Select **both** checkboxes to submit one or more of each.

**Please select all that apply**

I want to submit a general waiver

I want to submit a Medicaid waiver

Figure 6



- Identify the **Medicaid or CHIP State Contact Information (all fields are required, except where noted)**. This is the contact information that will be used for official CMS communications. This is likely the State Medicaid or CHIP Director's contact information and will be used for official CMS communications.
  - Enter the **State Official title**; for example, Director
  - Enter the **State Agency name**
  - Enter the **State Official first name**
  - Enter the **State Official last name**
  - Enter the **State Official suffix**, such as M.D., Ph.D., RN, etc. (Optional field)
  - Enter the **State Agency address**
  - Enter **Address 2**; for example, suite number (Optional field)
  - Enter **City**
  - Enter **State/US Territory/Federal District**
  - Enter **Zip code**
  - Enter **State Agency email address**
  - Confirm **State Agency email address**; You must retype the email address

**Medicaid or CHIP State Contact Information** [?](#)

This is contact information for official CMS communications

**State Official title (required)\***

**State Agency name (required)\***

**State Official first name (required)\***

**State Official last name (required)\***

**State Official suffix**

**State Agency address (required)\***

**Address 2**

**City (required)\***

**State/US Territory/Federal District (required)\***

**Zip code (required)\***

**State Agency email address (required)\***

**Confirm State Agency email address (required)\***

Figure 7

## Step 5: Describe the request.

- For **Waiver/Flexibility Request Type**, you may either select from the choices in the dropdown box, or you may type the name of the waiver/flexibility in the search bar. Please refer to Appendix A for a list of Medicaid Waiver Types.
- Select “**Click here if you do not see your Waiver Request Type**” checkbox if you do not see the needed Waiver Request Type in the dropdown list.
- Enter the desired **Waiver Request type** in the text box.
- The **Description of Waiver Request** field is pre-populated with a description based on the Waiver Request Type selected. For certain waiver request types, you may also be prompted to add additional information to your waiver request.
- If “Other” is selected, please provide a detailed summary of the request. Providing as much detail as possible, including the relevant regulation, will help facilitate CMS review of the request.

**3** Describe your 1135 Medicaid Waiver / Flexibility Request  
Select the type of request you are making. Depending on your request type, we may ask you for additional information.

**Request #1**

**Waiver/Flexibility Request Type** (required) \* ?

Clinic Facility Requirement - Allow provision of services via telehealth x ▼

Click here if you do not see your Waiver Request Type.

**Description of Waiver Request** (required) \* ?

Pursuant to section 1135 (b)(1) (B) of the Act, permits the state and clinic to temporarily designate a clinic practitioner's location as part of the clinic facility only to the extent necessary so that clinic services may be provided via telehealth when neither the patient nor practitioner is physically onsite at the clinic. Services provided via telehealth in clinic practitioners' homes (or another location) will be considered to be provided at the clinic - 42 C.F.R. § 440.90(a)

+ Add another waiver request

Figure 8

Select the **Add another waiver request** link to add multiple requests in one submission.

- Complete **Request #2** form and continue to add requests until complete.

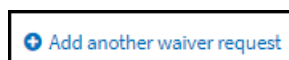





Figure 9

**3 Describe your 1135 Medicaid Waiver / Flexibility Request**  
Select the type of request you are making. Depending on your request type, we may ask you for additional information.


**Request #1**

**Request #2**

**Waiver/Flexibility Request Type** (required) \* 

Fee for Service and Eligibility Fair Hearings - Extend fair hearing request timelines  

Click here if you do not see your Waiver Request Type.

**Description of Waiver Request** (required) \* 

Pursuant to section 1135 (b)(5) of the Act, allow applicants and beneficiaries to have more than 90 days to request a fair hearing for eligibility or fee-for-service appeals by permitting extensions of the timeline to file a fair hearing request (e.g. additional time more than 90 days) – 42 C.F.R. § 431.221(d)




Figure 10

## Step 6: Submit the form.

- Click **Submit** when all required fields are complete.

**4 Submit your request**

**Submit**

Figure 11

A confirmation message appears including a Medicaid waiver case number. Please note the Case number (CSXXXXXXX) in the event further follow-up is needed.

The system also automatically sends an email notification containing additional information. **Note:** If you do not receive the email notification, check your spam folder.

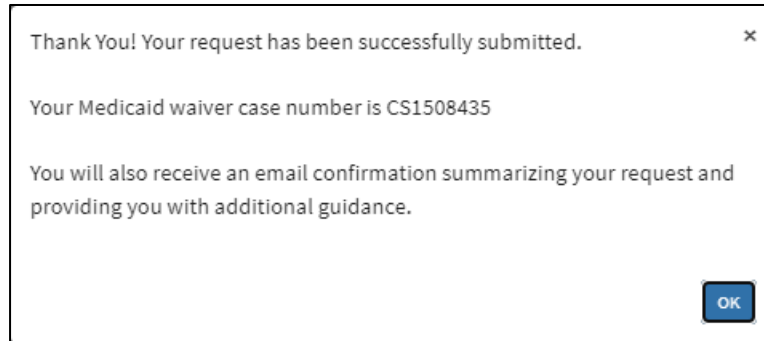


Figure 12

If both a general waiver and a Medicaid/CHIP waiver request were submitted, please note there will be two separate case numbers.

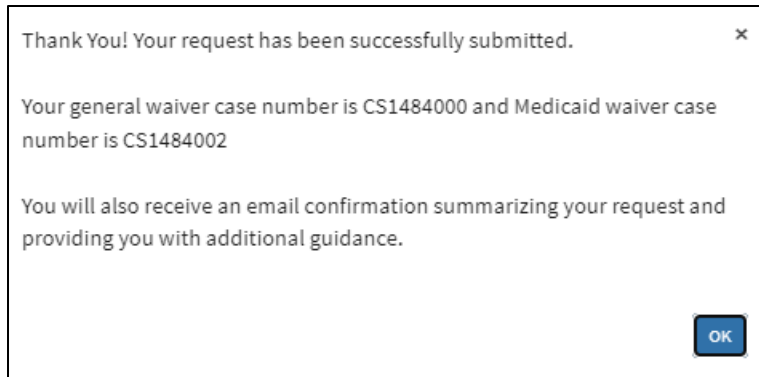


Figure 13

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*If you experience any technical issues, please contact:*  
CCSQ Service Center between 8 a.m. - 8 p.m. ET, Monday – Friday.  
Phone: (866) 288-8912\*  
TRS: 711  
Fax: (888) 329-7377  
Email: [gnetsupport@hcqis.org](mailto:gnetsupport@hcqis.org)





## Appendix A – List of Medicaid Waiver Types

1. Clinic Facility Requirement - Allow provision of clinic services in alternative settings
2. Clinic Facility Requirement - Allow provision of services via telehealth
3. Fee for Service and Eligibility Fair Hearings - Extend fair hearing request timelines
4. Fee for Service and Eligibility Fair Hearings - Extend timelines for reinstatement of benefits
5. Home Health State Plan Services Timeframe (Face-to-Face Encounters)
6. Long Term Services and Supports (LTSS) - 1915(c) Level of Care and Person-Centered Service Plan Timelines - Initial Evaluation of Need
7. Long Term Services and Supports (LTSS) - 1915(c) Level of Care and Person-Centered Service Plan Timelines - Reevaluation
8. Long Term Services and Supports (LTSS) - 1915(c) Level of Care and Person-Centered Service Plan Timelines - Review and Revision of Person-Centered Service Plan
9. Long Term Services and Supports (LTSS) - 1915(i) Evaluations, Assessments and Person-Centered Service Plans - Initial Evaluation of 1915(i) Eligibility
10. Long Term Services and Supports (LTSS) - 1915(i) Evaluations, Assessments and Person-Centered Service Plans - Initial Independent Assessment of Need
11. Long Term Services and Supports (LTSS) - 1915(i) Evaluations, Assessments and Person-Centered Service Plans - Reassessments of Need
12. Long Term Services and Supports (LTSS) - 1915(i) Evaluations, Assessments and Person-Centered Service Plans - Reevaluation of 1915(i) Eligibility
13. Long Term Services and Supports (LTSS) - 1915(i) Evaluations, Assessments and Person-Centered Service Plans - Review and Revision of the Person-Centered Service Plan
14. Long Term Services and Supports (LTSS) - 1915(j) State Plan Benefit - Annual Reviews
15. Long Term Services and Supports (LTSS) - 1915(j) State Plan Benefit - Initial Assessments
16. Long Term Services and Supports (LTSS) - 1915(j) State Plan Benefit - Use of Representatives
17. Long Term Services and Supports (LTSS) - 1915(k) State Plan Benefit - Annual Reassessments
18. Long Term Services and Supports (LTSS) - 1915(k) State Plan Benefit - Initial Assessments
19. Long Term Services and Supports (LTSS) - 1915(k) State Plan Benefit - Level of Care Determinations
20. Long Term Services and Supports (LTSS) - 1915(k) State Plan Benefit - Level of Care Redeterminations
21. Long Term Services and Supports (LTSS) - 1915(k) State Plan Benefit - Person-Center Service Plan Reviews
22. Long Term Services and Supports (LTSS) - 1915(k) State Plan Benefit - Use of Representatives
23. Long Term Services and Supports (LTSS) - Conflict of Interest Requirements - 1915(c)
24. Long Term Services and Supports (LTSS) - Conflict of Interest Requirements - 1915(i)
25. Long Term Services and Supports (LTSS) - Conflict of Interest Requirements - 1915(k)
26. Long Term Services and Supports (LTSS) - Conflict of Interest Requirements - HCBS services in approved 1115 Demonstration
27. Long Term Services and Supports (LTSS) - HCBS Settings Requirements - 1915(c)
28. Long Term Services and Supports (LTSS) - HCBS Settings Requirements - 1915(i)
29. Long Term Services and Supports (LTSS) - HCBS Settings Requirements - 1915(k)
30. Long Term Services and Supports (LTSS) - HCBS Settings Requirements - HCBS services in approved 1115 Demonstration
31. Long Term Services and Supports (LTSS) - PASRR
32. Long Term Services and Supports (LTSS) - Person Centered Plan Beneficiary and Provider Signatures - 1915(c)
33. Long Term Services and Supports (LTSS) - Person Centered Plan Beneficiary and Provider Signatures - 1915(i)



34. Long Term Services and Supports (LTSS) - Person Centered Plan Beneficiary and Provider Signatures - 1915(k)
35. Long Term Services and Supports (LTSS) - Person Centered Plan Beneficiary and Provider Signatures - HCBS services in approved 1115 Demonstration
36. Managed Care Appeals, Fair Hearings, and Continuation of Benefits - Modify adverse benefit appeals filing timelines
37. Managed Care Appeals, Fair Hearings, and Continuation of Benefits - Modify authorization decision timelines
38. Managed Care Appeals, Fair Hearings, and Continuation of Benefits - Modify continuation of benefits timelines
39. Managed Care Appeals, Fair Hearings, and Continuation of Benefits - Modify standard appeals timelines
40. Managed Care Appeals, Fair Hearings, and Continuation of Benefits - Modify state fair hearings timelines
41. Managed Care Appeals, Fair Hearings, and Continuation of Benefits - Modify timelines to resolve appeals
42. Physician Direction - Allow clinic services to be directed by other licensed professionals
43. Physician Direction - Allow inpatient psychiatric services for under 21 to be directed by other licensed professionals
44. Private Duty Nursing - Modify practitioner requirements
45. Private Duty Nursing - Modify supervision requirements
46. Provider Enrollment - Allow out-of-state provider reimbursement
47. Provider Enrollment - Pause revalidation deadlines
48. Provider Enrollment - Waive application fees
49. Provider Enrollment - Waive criminal background checks
50. Provider Enrollment - Waive licensing requirements
51. Provider Enrollment - Waive site visits
52. Targeted Case Management Timeline – Monitoring and Follow-up Activities
53. Use of Legally Responsible Individuals to Render Personal Care Services