

Centers for Medicare & Medicaid Services
COVID-19 Medicaid & CHIP All State Call
January 11, 2022
3:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time all participants will be on a listen-only mode until the question-and-answer session of today's call. At this time if you'd like to ask a question from the phone line, please press star 1 and record your name at the prompt. Ill now turn the call over to your host, Jackie Glaze. You may begin.

Jackie Glaze: Thank you and good afternoon everyone and welcome to today's All State Call and Webinar. We are experiencing some technical difficulties today so it will be an audio call only today. So we do apologize for that.

But we are in the process of uploading the slide deck to the appointments. So be looking for that to come across shortly. And then again we will be doing the questions by phone only today.

So well just proceed as we normally would. But we do appreciate your patience and thank you. So at this point, I'm going to turn now to Dan Tsai, our Center Director, for opening remarks. Dan?

Dan Tsai: Thanks, Jackie. Good afternoon or good morning folks, depending on where folks are. Thanks for your time as always. And as Jackie noted, sorry for the technical difficulties. I hope folks are able to access via phone and pull up the slides whenever they get posted or attached to the invite.

So we have - so this is our first state - all state call of 2022. Happy new year everybody. There's been a lot happening. We are grateful for folks partnering together and going through a lot together.

And today is no different. There's quite a bit of packed agenda. Anne Marie will go through that in a sec.

I did want to note at the outset folks probably saw the announcement today from us as Administration yesterday around some of the over-the-counter at-home testing pieces. And so we'll have a discussion around that today. We've had discussions with numerous states to understand where folks are around the requirement for Medicaid to cover at-home tests and also some of the just practical operational and other things that states have been wrestling with that we are very eager to think through in partnership together and to kind of see who is figuring out or has figured out which different components of that.

Anne Marie will walk through the rest of the agenda but I just want to continue to thank folks for both grappling with continued pieces with COVID and the pandemic and today's agenda topic will certainly hit on many of those as well as the many other pieces that we are in partnership with you all working on. So thanks for that continued engagement. And I will turn it to Anne Marie now.

Anne Marie Costello: Thanks, Dan. And hi everyone. As Dan noted, welcome to our first all state call of 2022.

We do have a packed agenda. First up, we have Melissa Harris from our Disabled and Elderly Health Programs Group. And she'll provide a refresher on the COVID-19 testing requirements under Medicaid and the Children's Health Insurance Program.

Then Nancy Kirchner, also from our Disabled and Elderly Health Programs Group, will present an overview of a state health official letter released in late December on the scope of - and payments for qualified community-based mobile crisis intervention services authorized under Section 9813 of the American Rescue Plan.

I will also say at the next all state call we will have a continuation of that discussion and look at how crisis lines like 988 may be funded with support through the Medicaid program.

After Nancy's presentation, John Coster, also from our Disabled and Elderly Health Programs Group, will provide an update on all of COVID drugs.

Finally Sara Harshman from our Center Directors Office, Nancy Kirchner and Stephanie Kaminsky from our Financial Management Group will present the number of frequently asked questions that CMS has received since the December announcement that CMS is now requiring states to cover certain Medicaid COVID-19 vaccine counseling visits in which healthcare providers talk to families about the importance of children's vaccination.

After the vaccine FAQ discussion, we will open the lines for all of your questions.

As they noted before, we do not have access to our Webinar platform right now. So all your calls will come in over the phone line and we are still working to get the slides posted and we will get a link out to everybody as soon as we can.

And with that, I'm going to turn things over to Melissa Harris to start her testing presentation. Thank you.

Melissa Harris: Thank you, Anne Marie. This is Melissa Harris in the Disabled and Elderly Health Programs Group.

And I'm going to run over a couple of the high points of the guidance we issued on August 30th, 2021, on Medicaid and CHIP coverage mandates for the coverage of COVID-19 testing.

You should be able to find the SHO letter that we issued on August 30th in which we talked about coverage mandates that were included in the American Rescue Plan for the coverage of COVID-19 testing. And we indicate in that guidance that states are required to cover without cost sharing both diagnostic and screening testing as recommended by the CDC. This includes coverage of screening testing required for return-to-school or return-to-work initiatives and travel requirements.

And of particular note, in that guidance we talked a little bit about the inclusion in this coverage mandate of at-home tests, either point of care tests or home tests that have been provided to a Medicaid or CHIP beneficiary by a qualified Medicaid or CHIP provider and totally over-the-counter tests that do not require any kind of linkage with a laboratory to read out the testing results.

And so all of those tests are part of the testing mandate in the American Rescue Plan. We know there's a wide variety of, quote, home tests. Some of them do require submission of the results to a lab or submission of the test itself to the lab for the diagnostic results and others do not. Both kinds of tests - of home tests are required as part of the coverage mandate.

And while states have the ability in the provision of COVID testing as they do in all Medicaid benefits to set clinical guidelines as part of their utilization management, we indicated in the letter that states are strongly encouraged to do that in a way that does not establish arbitrary barriers to accessing COVID-19 testing coverage but that do link the reimbursement of a COVID test to an eligible Medicaid or CHIP beneficiary.

We know that states have asked for technical assistance in how to address provisions in their state laws that require prescriptions for these types of over-the-counter tests. If a prescription is required at the state level, we note that states could issue a standing order for pharmacies to cover those tests including the over-the-counter tests as opposed to requiring a prescription per person. That's an easy way to facilitate access to an over-the-counter test while still adhering to state laws requiring a prescription.

States have also indicated a number of operational considerations and challenges that they are working through to provide coverage for at-home tests including over-the-counter tests. We are certainly available to provide technical assistance to states.

We also encourage states who have identified operational solutions to these issues to share best practices with other states.

The last thing I'll say before I hand the microphone back is a plug for a conversation that will be happening in an early February all state call.

We're going to spend some time on that call talking about the PREP Act. The PREP Act was invoked early in the public health emergency and since then the PREP Act declaration and amendments to the declaration have really set the stage for a federal statement of the scope of qualified providers that are

able to provide countermeasures such as COVID testing, COVID treatment and COVID vaccinations.

And in this all state call in a couple of weeks were going to do a deep dive in what those PREP Act declaration and amendments really mean and how those specifications federally stack up against state level definitions of who is able to administer testing, treatment and vaccine functions.

So a plug for that and we look forward to having a deeper conversation on that topic in a few weeks.

Okay, Jackie, I'm going to turn it back to you.

Jackie Glaze: Thank you, Melissa.

Next, Nancy Kirchner will provide an overview on the SHO letter on mobile crisis intervention services. So I'll turn now to you, Nancy.

Nancy Kirchner: Thank you very much, Jackie. I'm very pleased to be with everyone this afternoon.

As Anne Marie mentioned earlier, we issued a state health official letter in the end of December -- it was December 28th, 2021 -- with Medicaid guidance on the scope of and payments for qualifying community-based mobile crisis intervention services. And I'm going to go ahead and provide a high-level overview.

First in Section 9813 of the American Rescue Plan Act, it amends Title 19 of the Social Security Act to add a new section, 1947. Section 1947 authorizes a state option to provide qualifying community-based mobile crisis intervention

services for a period of up to five years. And that's during the period starting April 1, 2022, ending March 31st, 2027.

And an important take away, Section 1947 does not establish a new Medicaid benefit for mobile crisis. Mobile crisis services are currently coverable in Medicaid through the state plan and other Medicaid authorities.

States with approved coverage and reimbursement authority may receive an 85% FMAP for expenditures on qualifying community-based mobile crisis intervention services for the first 12 fiscal quarters within the five-year period provided through the state plan of Section 1915(b) waiver with corresponding authority, the Section 1915(c) waiver or of Section 1115 demonstration.

Section 1947 of the act permits states to disregard Medicaid requirements for state wideeness, comparability, free choice of provider and provider agreement requirements with every person or institution providing services under the state plan.

The qualifying services and provider qualifications for mobile crisis intervention services are defined under Section 1947(b) of the Act. And they are items and services for which medical assistance is available under the state plan or a waiver of the plan and that meet the conditions described in Section 1947(b)(1) through 1947(b)(3). And were going to go through that in a little more detail.

So under Section 1947(b)(1), services must be provided to individuals who are Medicaid eligible, either through the state plan or a waiver of such plan, experiencing a mental health or substance use disorder crisis and outside of a hospital or other facility settings.

Under Section 1947(b)(2), services must be delivered by a multidisciplinary team. This team must include one licensed behavioral health professional and other professionals or paraprofessionals including peer support specialists with expertise in behavioral healthcare.

States have options in terms of the composition of the team and we do provide a lot more detail about that in the state health official letter.

Team members must be trained in trauma informed care, de-escalation strategies and harm reduction.

The multidisciplinary teams are able to respond to crises in a timely manner and that timeliness standard is established by the state.

Teams must provide, where appropriate, screening and assessment, stabilization and de-escalation, and coordination with and referrals to health, social and other services and supports as needed and health services as needed.

The multidisciplinary team maintains relationships with relevant community partners including medical, behavioral health and primary care providers, community health centers, crisis respite centers and managed care organizations, if applicable.

Teams must maintain privacy and confidentiality of patient information consistent with federal and state requirements.

And under Section 1947(b)(3) of the act, community-based mobile crisis intervention services must be available 24/7, 24 hours a day every day of the year.

Regarding provider payment and delivery systems, mobile crisis intervention services may be provided through either fee-for-service or managed care delivery system. State plan services through a fee-for-service delivery system must have an approved attachment 4.19-B pages. And for managed care - in addition to an approved Medicaid authority, services must be specified in managed care contracts and included in corresponding managed care capitation rates.

In the statute, there are maintenance of effort requirements. Additional federal funds for qualifying community-based mobile crisis intervention services attributable to the increased FMAP must supplement and not supplant the level of state funds expended for such services in the federal fiscal year prior to April 1, 2022.

Specifically, states must not impose stricter standards for receipt of community-based mobile crisis intervention services than those in effect on September 30th, 2021, must preserve or exceed the amount, duration and scope of community based mobile crisis intervention services in effect on September 30th, 2021, and maintain community-based mobile crisis intervention services provider payments at a rate no less than those on September 30th, 2021.

Regarding increased FMAP and claiming, CMS will implement changes to the MBES/CBES to ensure that states will be able to accurately report budget estimates and expenditures related to increased FMAP for qualifying community-based mobile crisis intervention services consistent with the requirements of Section 1947.

Administrative claiming. Federal administrative match may be available for state Medicaid agency costs associated with establishing and supporting delivery of community-based mobile crisis intervention services for people with mental health conditions or substance use disorder. Allowable administrative activities could include operating state crisis access lines and dispatching mobile crisis teams as needed to assist Medicaid beneficiaries.

As (Anne Marie) mentioned earlier, there will be further detail provided in our next all state call on January 25th, 2022, regarding administrative claiming.

For Medicaid coverage, payment and service delivery system, some states may already cover mobile crisis in their state plan or under other Medicaid authorities. If states do not cover community-based mobile crisis intervention services or need to make changes to the benefit, payment or service delivery mechanism, states will need to submit necessary changes to the applicable authority.

That could be through a SPA, a 1915(c) waiver, 1915(b) waiver with corresponding authority and/or an 1115 demonstration. And states must follow the processes for the selected Medicaid authority.

And finally in the statute at Section 1947(e) of the act is a section about state planning grants that are authorized through this statute. And CMS awarded planning grants to 20 states on September 20, 2021.

And I want to reinforce for folks on the call that states did not need to apply for and/or receive a planning grant in order to provide qualifying community-based mobile crisis intervention services. That is an opportunity that is available to any states.

So with that, I finished my presentation. I'm going to go ahead and turn it back to Jackie Glaze. Thank you.

Jackie Glaze: Thank you, Nancy, for your presentation. I'll now turn to John Coster and he'll provide an oral COVID drug update. So, John?

John Coster: Thank you. In late December of 2021, the US Food and Drug Administration authorized the use of two oral medications under a procedure known as an emergency use authorization to treat COVID-19 in certain patients: These two drugs, Paxlovid, made by Pfizer and molnupiravir made by Merck. These are both oral medications.

These drugs are supposed to be available this month. In fact, we are hearing that they are available in certain places in the dispensing sites that have been designated by the states to receive them.

And these drugs help to reduce the chance of hospitalization and death from COVID for those most at risk -- most at risk for progressing to severe disease.

Now the FDA's emergency use authorization for both of these drugs only allows physicians, advanced practice registered nurses and physician assistants that are licensed or authorized under state law to prescribe the drugs if they're trained in the therapeutic class to which these drugs belong which are the anti-infective. So pharmacists were not included in the emergency use authorization in terms of ordering the drugs.

As has been widely announced, the federal government is purchasing these drugs and is entering into agreements with pharmacies and other dispensing sites that will provide these federally-purchased drugs.

The agreements will require that these drugs be dispensed consistent with the FDA's emergency use authorization and for the dispensers to maintain any records associated with the dispensing.

The federal agreement relating to dispensing will also prohibit pharmacies and other providers from charging cost sharing or any other out-of-pocket costs. And that's also consistent with the American Rescue Plan which prohibits Medicaid and CHIP cost sharing for these drugs.

Now because the drugs are being federally purchased, state Medicaid and CHIP programs will be responsible only for paying the dispensing fees. And these dispensing fees for fee-for-service are those approved under the state plan.

Medicaid managed care plans are also expected to pay the dispensing fee for the drugs, whatever fees that they're paying providers under the contract with their providers.

So at this time, there should be no Medicaid reimbursement for the drug product and no manufacturer rebates for the drugs because the drugs are not being purchased by the pharmacies and they're only approved under the emergency use authorization.

A couple of things we'd like to note for the states in terms of ways that we understand it would make it easier for pharmacies to make sure that these drugs can be available. We want to note that states should make sure that their prescription drug claims processes have deployed the NCPDP Emergency Preparedness Guidance version which is called billing for reimbursement of a free product with no - with administration fee when dispensing these oral drugs. It's a special version of the NCPDP guidance that allows for these

types of situations where there is no reimbursement for a drug but there is either an administration or dispensing fee being paid.

We also heard that the pharmacies would like the states to consider re-implementing the signature waiver for medication proof of delivery as was done during the early stages of the pandemic. We understand that some states have had these signature requirement waivers in place but some have expired.

Obviously this will allow patients to more easily obtain these medications without having to come directly to the pharmacy. We also plan on issuing further guidance on this topic in the near future.

So that's the update on oral COVID drugs.

Jackie Glaze: Thank you, John. So I wanted to let everyone know that we've now posted the slides and they are available on your appointment. So you can view those now. So just want to make everyone aware of that.

So next up the team will present on frequently asked questions that we received after the December all state call on the pediatric vaccine counseling.

So I'll turn to Sarah Harshman so she can begin that discussion. Sara?

Sara Harshman: Thank you, Jackie. Hey everybody. My name is Sara Harshman and I'm a senior policy advisor in the CMCS Office of the Center Director.

And as mentioned earlier, I'm joined by my colleague Stephanie Kaminsky with our Financial Management Group and Nancy Kirchner with our Disabled and Elderly Health Programs Group to help answer some of your most

frequently asked questions on the new pediatric vaccine counseling requirements announced on December 2nd.

In case you missed it, as Jackie mentioned, we gave an overview of this policy during the December 9th all state call and posted a corresponding slide deck on Medicaid.gov. I encourage you to take a look at that if you haven't already.

We also understand that there are likely more questions than we will be able to get to today and we plan to bring more questions to an upcoming all state call.

All right, now onto the questions. First up, we'll start on some coverage focused questions. And, Nancy, this one - the first one is for you.

Is the standalone vaccine counseling service only required for COVID-19 vaccines or can it be provided with any childhood vaccine?

Nancy Kirchner: Thank you, Sarah. Under CMS's updated interpretation of the early and periodic screening, diagnostic and treatment benefit or EPSDT, states must cover standalone vaccine counseling visits for all pediatric vaccines under EPSDT regardless of federal matching percentage. The increased 100% FMAP is only available for COVID-19 vaccines during the FMAP period from April 1, 2021, to the last day of the first quarter that begins one year after the last day of the COVID-19 emergency period.

Sara Harshman: Great, thank you. Stephanie, this next one is for you. When will the mandate for COVID counseling and the mandate to cover standalone vaccine counseling visits related to all pediatric vaccines under EPSDT go into effect? And when can states begin planning for the 100% federal match for COVID vaccine counseling?

Stephanie Kaminsky: Thanks, Sarah. The new interpretation requiring coverage of standalone vaccine counseling is effective beginning December 2nd, 2021. States already currently covering standalone pediatric COVID-19 vaccine counseling in Medicaid as part of their EPSDT will be able to retroactively adjust claims back to April 1st, 2021, to receive 100% federal match for these expenditures.

States newly-implemented Medicaid coverage of standalone pediatric COVID-19 vaccine counseling as part of EPSDT will be able to claim 100% federal match for their expenditures on this coverage beginning with the effective date of the new coverage as long as that effective date is on or after April 1st, 2021.

Sara Harshman: Great. Thank you. Just follow-up on that, to implement this new payment - any new payment rates and coverage for COVID-19 vaccine counseling, is a disaster relief SPA, which would be effective April 1st, 2021, needed as well as a permanent SPA which will be effective one day after the public health emergency ends?

Stephanie Kaminsky: States that do not currently make separate payments for pre-decisional COVID-19 vaccine counseling and decide to change their policies to pay separately for COVID-19 vaccine counseling would need to submit a state plan amendment to update their vaccine administration payment methodologies and improve the rates associated with the counseling services.

CMS is developing a streamlined template with 1135 authority for states to use for vaccine administration, testing and treatment in accordance with the new AARP benefit requirements.

Unlike the current disaster relief SPA template, however, this new template will allow states to extend their coverage after the end of the PHE through the end of the coverage period, which is one year after the quarter in which the PHE ends, without submitting a second SPA when the PHE ends.

I hope that answered the question, Sarah.

Sara Harshman: Oh, yes. Sorry. Yes. Nancy, back over to you. Is there a limit on the number of COVID-19 vaccine counseling visits that can be covered for a beneficiary?

Nancy Kirchner: No, there is no limit to the amount of times the counseling visit could be covered for a beneficiary.

Sara Harshman: Great. And can these COVID vaccine counseling services be delivered via telehealth?

Nancy Kirchner: Yes. States may deliver COVID-19 vaccine counseling via telehealth.

Sara Harshman: Great. And can pediatric COVID vaccine counseling visits be filled if delivered to a patient when the child is not present, AKA caregiver, at the time of the counseling?

Nancy Kirchner: Yes. And to clarify, delivered to a parent when the child is not present. Yes, pediatric COVID-19 vaccine counseling delivered to a parent when the child is not present at the time of the counseling is covered as a service for the direct benefit of the Medicaid eligible child.

Sara Harshman: Great. So we've also received a number of questions as to what providers are eligible to provide vaccine counseling. Besides the primary care provider, what other provider types are expected to be able to furnish standalone

vaccine counseling as part of the EPSDT benefit? Could a provider bill for vaccine counseling provided by a physician, assistant nurse or office staff? And additionally, are all places of service allowed to be billed such as schools and pharmacies?

Nancy Kirchner: Thank you, Sarah. This policy applies to the universe of practitioners that are eligible to administer COVID vaccines including those determined to be qualified via the PREP declaration amendments.

And outside of the COVID vaccine this policy will apply to all practitioners the state has determined qualified to administer the vaccine. This could apply to providers from pharmacists to school nurses.

States could also review current provider scope of practice to ensure adequate access. And this also ties into the reminder that Melissa Harris provided earlier that PREP Act requirements supersede current state scope of practice restrictions for a number of providers and any limits on ages of children to whom providers such as pharmacists may administer COVID vaccines.

Sara Harshman: Great. Thank you, Nancy.

Stephanie, I've got a few questions for you on billing and rates as it applies to the 100% FMAP.

First off, since Medicare will not be setting rates for vaccine counseling, is there guidance on a rate they should be paying for these services?

Stephanie Kaminsky: Thanks, Sarah. States actually have a wide select - have wide flexibility to set the rates for standalone vaccine counseling. States may want to pay rates similar to what they currently pay for a physician consultation visit.

Sara Harshman: Great. And are states required to reimburse vaccine counseling under EPSDT at the same rate as vaccine counseling for individuals 21 and over?

Stephanie Kaminsky: Apologies for that. No, they don't have to at the same rate. They are - states have flexibility to bill at the same rate or at different rates.

However, 100% FMAP may only be claimed for pediatric vaccine counseling under the provision of EPSDT which is for individuals under 21.

Sara Harshman: Great. Thank you. How should the state properly identify standalone vaccine counseling as a COVID-19 vaccine administration expenditure for purposes of claiming federal match at the increased 100% FMAP rate?

Also, is there any guidance on CPT or HCPCS codes that could be used to document and differentiate a COVID-19 vaccine counseling visit that occurred in order to claim 100% federal match versus codes that are built for other standalone vaccine counseling visits that are related to pediatric vaccines that are matched at the states regular federal match rate?

Stephanie Kaminsky: I'm glad you asked. States have the option to establish separate rates for pre-decisional COVID-19 vaccine counseling and may use the billing codes designed to pay providers for such counseling to Medicaid and CHIP.

The pre-decisional COVID-19 counseling services may be billed when providers counsel beneficiaries on COVID-19 vaccination regardless of whether a vaccine is administered as part of the same encounter.

States may also choose not to establish separately an associated billing code for pre-decisional COVID-19 vaccine counseling as long as the mandatory

services are otherwise paid by the state to existing payment methods such as a comprehensive office visit or encounter payment.

In such cases, states must determine the portion of payments associated with pre-decisional COVID-19 vaccine counseling that are eligible for 100% FMAP during the AARP FMAP period.

Also, I wanted to add that states may be able to use a modifier on their vaccine counseling only procedure code to distinguish pediatric vaccine counseling services which are eligible for the 100% FMAP during the AARP coverage period versus adult pre-decisional counseling which are eligible for regular FMAP.

For pediatric counseling, only visits for non COVID-19 vaccines also eligible only for regular FMAP.

For more information on the billing codes that may be used for standalone vaccine counseling, the American Academy of Pediatrics has posted information on their COVID-19 Vaccine Administration Getting Paid Web site.

Sara Harshman: Great. Thank you. Can COVID counseling be billed at the same time as other services for a child, for example, a well-child visit? Or must it be a standalone service to claim the 100% FMAP?

Stephanie Kaminsky: COVID counseling can be billed at the same time as other services for a child. When we say standalone, standalone vaccine counseling doesn't mean that no other care or services are provided. It simply means that the vaccine is not injected. Standalone counseling could be provided as a component of a

visit in which other services are also rendered including, I think as we said earlier, the administration of a vaccine.

Sara Harshman: Great. It looks like we have one more question. Could a well-child visit for an EPSDT eligible member, which includes counseling around COVID-19 vaccination and billed as an annual wellness or E&M visit, be eligible for 100% FMAP and do states have to pay a separate fee if pediatric vaccine counseling is provided as part of a medical or well-child visit?

Stephanie Kaminsky: Okay. States have flexibility regarding whether to pay a separate fee for pediatric vaccine counseling that is provided during a pediatric E&M visit. Some states may already cover and pay for pre-decisional vaccine counseling as part of routine medical exams, for example health checkups or physical exams, and may not wish to set separate pay rates for pre-decisional COVID-19 vaccine counseling services.

For claiming purposes, however, not having a separate HCPCS code or modifier will likely present significant challenges in determining the portion of payments associated with pediatric COVID-19 vaccine counseling that is eligible for 100% FMAP during the AARP FMAP period.

States that do not pay a separate fee and use a separate code for pediatric COVID-19 vaccine counseling will need to work directly with their pediatric provider communities to determine an approach that may be used to document that pre-decisional COVID-19 vaccine counseling services were provided and to identify the portion of payments that are available for the 100% FMAP.

Sara Harshman: Great. Thank you again both Stephanie and Nancy for taking the time to answer these questions. And, Jackie, with that, I'll turn it back over to you.

Jackie Glaze: Thank you, Sarah, Stephanie and Nancy. So were ready to take questions from state at this point. And as we indicated earlier, well only be taking questions by phone. So Ill now ask the operator to provide you instructions on how to register your calls and we will begin taking your calls. Operator?

Coordinator: Thank you. We will now begin the question-and-answer session. To ask a question from the phone lines, please press star 1. Ensure your phone is unmuted and record your name at the prompt. If you would like to withdraw your question, press star 2. One moment please for incoming questions. We have a question in queue. One moment please. Our first question comes from (Chris Underwood). Your line is open.

(Chris Underwood): Hello. Thanks for taking my question today. We're getting a lot of questions, press questions and provider questions based on the release yesterday. The insurance companies are going to pay for the at-home tests. And so we are trying to find some quick guidance that maybe can't wait for a future meeting about, you know, what kind of provider types other states authorized, what rates are they paying, what's the FFP rate for that and kind of what's the UM criteria?

So were kind of looking for some information we need, oh, probably today for press calls were getting. So were - hopefully you can give us a little bit more guidance or you can direct us to some states that have already set this up and we can talk to them.

Jackie Glaze: Melissa, can I - can we start with you?

Melissa Harris: Hi, (Chris). Yes, this is Melissa. You know, I also invite other states who are listening on this call and who have practiced, not so to speak, it's a two-way in, you know, from the federal perspective, you know, what we are advising

states about is the universe of practitioners that the PREP Act has made available or made - or determined to be qualified to conduct COVID testing. And that does include pharmacies and other entities like that.

We don't have our testing expert on the call today. So you're stuck with me. But I will say that, you know, the guidance that we issued in our testing SHO talks about the mandate to provide reimbursement or coverage for the at-home test including the over-the-counter tests.

To the extent you've got a question about how to make your systems work or how to enroll providers that are specified in the PREP Act as being qualified to provide testing, we are happy to have that conversation with you.

I don't know that well be able to have that today but you are certainly not alone at understanding how Medicaid lie side by side with the guidance that was released yesterday. That guidance from the commercial market is taking its cues from its own legislative direction and there was a prohibition in that legislation for the commercial market against any kind of medical management. That prohibition was not carried into Medicaid statute as its related to the authorization on the coverage of testing.

However, we do stress -- you heard me today and we've specified it in the written guidance on testing -- that any kind of utilization management that a state implements really should not be throwing up barriers to accessing tests but be done so that you can link an actual beneficiary to an actual test.

We are certainly happy to walk through the suggestion that you heard from me today to have a standing order with your pharmacies to allow them to still abide by any kind of prescription requirements that you might have for an over-the-counter COVID test. But again I also invite other states who are

finding a way to authorize reimbursement for these over-the-counter tests to weigh in.

Coordinator: Our next question comes from (Eve Likters). Oh, I'm sorry. Am I introducing the next question? My apologies.

Melissa Harris: No, sorry, this is Melissa. You know, the last thing I would say is that as we move on to the next question to the extent any state wants to hop on the question line to provide input into (Chris's) question, please do so. Thanks. And we can move forward.

Coordinator: Our next question comes from (Eve Lickers).

Your line is open.

(Eve Lickers): Good afternoon. And I have two questions. Ill piggyback on the home test question. We would love to hear any guidance from states regarding CPT codes that they may be using. We understand that NDCs are being used. But because of some of our system programming, were experiencing some difficulties there. So - especially because its - you know, because of the dispensing fee calculation. So we are looking to see what CPT codes.

Currently we are considering 87811 with a SC modifier but that is a lab code as if it were performed. So we just want to make sure that were in line with that and were open to hear. Wed love to hear, you know, what other states maybe have come up with or what CMS's guidance might be on that.

And then the second question I have I just want to be clear that were understanding this. And this is for the non-COVID vaccine counseling standalone visit. So if - and I just want to be clear that we understand that if

we have a comprehensive EPSDT visit that receives an enhanced payment if all of the requirements are met which includes immunizations and that immunization counseling that we do not have to have maybe a separate fee but it may be incorporated as part of the enhanced fee. And we just want to make sure that that is allowable. And that is non-COVID.

Stephanie Kaminsky: (Eve), this is Stephanie Kaminsky. And I think I got a little tangled in that question. So you're talking about, just to make sure I'm following, a non-COVID-19 vaccine counseling visit for somebody under 21. Is that what you're talking about?

(Eve Lickers): Yes ma'am. Yes ma'am.

Stephanie Kaminsky: And you're say - and I got - the part I got confused about is when you were talking about the enhanced match. Were you talking about - or somebody

(Eve Lickers): No.

((Crosstalk))

(Eve Lickers): No. I'm not talking about an enhanced match. We have an enhanced payment that we make to providers who complete all of the elements of a screen. And we have a listing of the items that they have to provide in order to be credited to be considered a complete screen. And the immunizations, which would include the counseling, is incorporated in that enhanced fee to the providers.

So we want to just make sure because its already accounted for that we don't have to then allow for another standalone visit for a non-COVID pediatric vaccine.

Stephanie Kaminsky: Right. I want to give it some thought but on first blush I don't think you would have to add - if its already included in there, you know, I think that you've got it already included. And so you're meeting the requirements. I think that's what you're concerned about, right? Meeting the EPSDT requirement to have vaccine counseling as part of, you know, available for somebody under 21. It sounds like you're already meeting that and you don't need to have a separate code or a separate payment for that, if that's what the question is.

(Eve Lickers): Yes ma'am, that's the question.

So we understand that, like, if they just come in like, say, for an office visit because, you know, (unintelligible) has a code and then the, you know, practitioner discusses the vaccines with them of course, then it seems to reason that they would be able to go for the standalone code because it wasn't considered to be part of what, you know, you would have normally expected to carry on the conversation for the purpose for that particular visit.

But Im just - we are just looking at the fact that we have something already kind of, you know, packaged up that we think already accounts for that. So we just wanted to be clear. But thank you very much.

Stephanie Kaminsky: Yes. Yes. I think that's fine.

Jackie Glaze: And then, (Eve), on your first question regarding the CPT codes on the home test, I'll ask Melissa if that's something we need to follow back up with you on.

(Eve Lickers): Okay, great. Thank you.

Melissa Harris: So we will not be issuing specific codes for the at-home test. We've not historically done that. But we are, you know, happy to, you know, to kind of assist you absent that information in implementing the systems linkages between the pharmacist and the sale of the test with a specific beneficiary.

(Eve Lickers): Okay, thank you.

Coordinator: And our next question comes from (Caroline Lopez).

Your line is open.

(Caroline Lopez): Hi, thank you for taking my question. I have a question about the mobile crisis intervention guidance. Some of the guidance that we got stated that if a state already covers the service and is making changes that the state should submit a SPA for those changes. If the state already covers the service but isn't making any changes, is the new SPA still needed?

Nancy Kirchner: I can take that question. This is Nancy Kirchner.

No. If there are no changes to the service required to meet the requirements in the statute in order to claim the enhanced FMAP, a state would not need to make a submission to CMS.

If, however, you may have mobile crisis service but there might be some aspect that is not comporting with the statute, then you would need to submit a SPA or some other action to bring it in line with the requirements.

So there's really like three paths. Either the state is already covering the service, the state might need to modify the service or maybe the state just

wants to newly add the service. And it's really also making sure that you meet the requirements in Section 1947. Does that answer your question?

(Caroline Lopez): Yes it does. Thanks so much. I appreciate it.

Nancy Kirchner: You're welcome.

Coordinator: We have a few more questions in the que one moment please.

Jackie Glaze: Operator are there any additional questions?

Coordinator: Our next question comes from (Jim Leonard). Your line is open.

(Jim Leonard): Good afternoon. Thank you. I just wanted to ask a quick question regarding the coverage of remdesivir given the new guidance and the study and the code that (unintelligible) for it. For paying for remdesivir in the outpatient setting, the FDA approval right now is only for inpatient use and I'm wondering if FFP would be available to the states to do add that coverage.

John Coster: So this is John Coster, Division of Pharmacy. Well the drug is being purchased by the federal government. So there would be no FFP for that. But for the administration, you know, to the extent there are costs there, yes, it would be. Is that what your question was? Whether FFP is available for the administration?

(Jim Leonard): I may be confused. I was under the understanding that the query was not such as (unintelligible).

John Coster: You're talking about - no, I think remdesivir - I mean, there were two. And I'm almost sure that remdesivir is also federally purchased. Why don't I

double check on that and, you know, get - can you send me an e-mail and Ill double check on remdesivir?

(Jim Leonard): Absolutely. Thank you.

Coordinator: Our next question comes from (Nancy Hogue). Your line is open.

(Nancy Hogue): Thank you. I have a question regarding SHO 21-006 that was issued in October of 21. And my question is about drugs used for the treatment of underlying conditions that may seriously complicate the treatment of COVID-19. Will there be any further guidance or definition

Jackie Glaze: (Nancy), you're cutting out. I may be the only one but we hear you and then we don't. So you might want to start over on your question.

(Nancy Hogue): Oh, okay. Let me try again.

My question is about SHO 21-006 that was issued in October of 21 regarding drugs used for the treatment of underlying conditions that may seriously complicate the treatment of COVID-19. Will there be any further guidance or definition of which drugs that we must eliminate the cost sharing related to that provision?

John Coster: So, (Nancy), its John. We got that question. I know you sent it in. You know, I think we're looking at it right now. I'm also going to try to provide you an answer. I don't think at this point there's any intensified additional guidance as to which drugs cover - would be covered by that. But, you know, we are looking at it.

But, you know, at this point the guidance was issued and its really up to the states to make that determination.

(Nancy Hogue): Okay. Thank you, John.

Coordinator: Once again as a reminder, to ask any questions from the phone lines, please press star 1. Unmute your phone and record your name at the prompt. Our next question comes from Arvind Goyal. Your line is open.

Arvind Goyal: Can you hear me all right? Yes, thank you. This is Arvind Goyal. I'm medical director for Illinois Medicaid program.

My question has to do with unlimited counseling visits for COVID-19 vaccine. And I would like to know what was CMSs thought behind this policy. Is it repeated counseling visits in some way setting providers to fail for a successful vaccine administration or is it keep trying and then someday you'll succeed or is it even available after the vaccine is being administered? I just would like to know the story behind the story.

Stephanie Kaminsky: Nancy, do you want to take that or do you want me to try it? This is Stephanie.

Nancy Kirchner: Yes, Stephanie, that's fine if you want to go and respond to the question. Thank you.

Stephanie Kaminsky: Oh you certainly can chime in. I mean, I think that the thinking there was that there may be folks who are hesitant and that after having, you know, counseling are still not convinced and may come for other services or may come back with additional questions and in an effort to provide, you know, sort of whatever reassurance is needed or answering questions or, you know,

information, et cetera, to help people make informed decisions, a decision was made that this is a benefit that can be administered, you know, repeatedly.

Nancy Kirchner: And thank you, Stephanie. I really don't have anything to add. That makes complete sense too.

Jackie Glaze: Thanks everyone. In closing, I want to thank you for your questions and also thank the team for their presentations today.

Looking forward, our next call will be on Tuesday, January the 25th from 3:00 to 4:00 pm, Eastern Standard Time. The topics and invitations for our next call will be forthcoming. As questions come up between calls, please feel reach out - please feel free to reach out to us, your state lead or bring your questions to the next call.

We want to thank you again for joining us today and we hope everyone has a good afternoon. Thank you.

Coordinator: That concludes today's conference. Thank you all for your participation. You may disconnect your lines at this time. Speakers please hold for post conference.

END