Centers for Medicare & Medicaid Services
COVID-19 Medicaid & CHIP All State Call
Friday, March 20, 2020
Moderator: Jackie Glaze
1:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time all participants are on a listen only mode until the question and answer session of today's conference. At that time, to ask a question, press star and the number 1 on your phone and record your name at the prompt. This call is being recorded. If you have any objections you may disconnect at this time. I will now turn the call over to Ms. Jackie Glaze. Thank you. You may begin.

Jackie Glaze: Thank you (Jennifer) and good day everyone. This is Jackie Glaze. I'm the Acting Director for the Medicaid and CHIP Operations Group. I would like to thank you and welcome you to today's call. We will focus a lot on the state benefits flexibilities including tele-health and pharmacy. So we had a really great turnout earlier this week. We had over 980 participants so we're really pleased that it is beneficial to you.

So before we turn it over to the discussion, I would like to introduce Calder Lynch. He is our Director for CMCS and he would like to provide a few opening remarks. So Calder?

Calder Lynch: Thank you Jackie and thank you all for joining us. Good afternoon and good morning to those of you on the West Coast. I appreciate everyone taking time to join us today. I know we're all working very hard and are very busy and most of us doing so from makeshift home offices. And we're all working to make sure that the Medicaid program continues to effectively serve our beneficiaries across all of our programs.

I know that like us, many of you are finding new solutions every day but also uncovering new challenges. And we're all working through this dynamic and unprecedented situation together. I want to quickly recap some of this week's activity, talk about some of the things that are in the coming soon category. And then preview a little bit of today's call before I hand it back to the team.

Many of you I believe probably joined us earlier this week for our all state call. If you did miss it, a recording of that call is now posted on our Web site at Medicaid.gov on the COVID-19 related resource page. You'll also find through that link, recordings of other national stakeholder calls that CMS is holding with the broader healthcare community that are being posted as well, on our Web site, along with transcripts.

The transcript for the state call will be available soon and as soon as it is we'll also be posting that on the Web site. I also want to note that we issued our second batch of frequently asked questions, FAQs earlier this week, which I believe, you know, we're going to be able to talk a little bit more today or answer questions about today if needed.

You know, that set of FAQs was updated and released and attached to the original set. So there's one updated document you can now access. We've also begun moving freight on the 1135 waiver requests that have been coming in from the states with the approvals of the Florida and Washington requests this week. I know we have quite a few more that have come in the door since then.

We've been working to get a process in place internally so that those can move as quickly as possible. And we also have some new tools coming that will help expedite that, that I'll talk more about in a moment. Many of you

have also been engaging with our team around the flexibilities in the 1915(c) home and community based waivers, so the Appendix K process.

We've also begun turning around approvals on those. We've issued approvals in Washington, Pennsylvania and West Virginia so far. And I think those states that have come in first I think, you know, our experiences together will help us continue to improve and streamline that process.

At a broader level I also want to be sure to draw your attention to some of the other actions that CMS has taken this week. Yesterday the agency issued guidance and recommendations regarding delaying effective - elective, non-essential healthcare services during this response period. That went out to the broader healthcare provider community that you may want to familiarize yourself with.

We also - the agency also issued COVID-19 specific guidance to PACE organizations that I want to draw your attention to because I know we work with them collectively. And all of this as well as any other updates that are provided from the larger CMS, you know, work that we're doing will be posted to CMS.gov on the COVID-19 landing page.

Turning to the what is - to the coming soon category, we are working to release very shortly, some additional tools that we believe will help facilitate the 1135 waiver request and the Appendix K approvals which we also expect will help streamline this process. I'm hoping you'll have these as we head into the weekend and we're planning to dedicate some time on Tuesday's call to discuss it.

But that is definitely going to be coming soon. We're also going to be providing some additional tools to help facilitate your ability to access state

plan authority as well as 1115 authority as it relates to response to COVID-19, which we also expect will have some discussion on the Tuesday call, so be looking for that as well.

For states that have already submitted requests to CMS under these authorities, we're going to continue to process those. But please, as we release these additional tool, reach out to your state leads that they provide additional questions or additional ideas for what you may want to pursue.

And I also know that many of you probably have questions about the legislation passed by Congress this week, including how the (FMAP) increase will work and the new option for states to cover testing for the uninsured. We are working furiously with our legislative teams and our legal counsel to try and turn around some solid guidance to you all on that, as well as to begin to operationalize those provisions as quickly as possible.

We are particularly sensitive to the fact that we want to make sure that those financing channels get opened up as quickly as possible. We probably won't be able to answer all of your questions today about that as we're still working through some of those details. But I expect we'll also dedicate a portion of Tuesday's call to that topic as well.

So with that, we'll proceed with our agenda. I believe we're planning to have a deeper dive into some of the benefit questions that we've been receiving, with a focus on tele-health and pharmacy issues as Jackie mentioned. Then I also want to make sure we have plenty of time at the end of the call for any state questions that we have. And again, if we don't get to all of the questions that you have, please do continue just to reach out to your state lead. We are tracking all of those and we'll continue to post updates to our FAQs as we resolve those issues.

So with that, I'll hand it back over to you Jackie, to introduce our next speaker.

Jackie Glaze: Thank you Calder. And so next is Michael Tankersley. And he will provide an overview of the lab and the diagnostic benefits in tele-health. So (Michael), are you ready?

Michael Tankersley: Sure. Thank you Jackie. And hi everyone. My name is Michael Tankersley. I'm a technical director in the Division of Benefits and Coverage. And we just want to spend a few minutes talking about Medicaid coverage for the tests for the detection of COVID-19.

As I'm sure you've seen we discussed this in the first batch of FAQs. And we confirmed in those FAQs that Medicaid coverage of the test is available and under the mandatory laboratory services benefit. Like I said, this is a mandatory benefit so all states will have coverage for it.

The requirements for this benefit are described in 1905(a)(3) and 42 CFR 44030. I'll briefly go over them. There are basically two requirement for this benefit. One, the first requirement is the laboratory tests must be ordered or provided by or under the direction of a physician or other licensed practitioner when the - within the appropriate scope of practice as defined by the state.

Or it needs to be ordered by a physician but provided by a referral laboratory. The second requirement is 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 the clinical laboratory improvement amendments requirements at Part 493 of the CFR. So that's the first area.

And like I said, since that's a mandatory benefit, it should be available in your state. However, if the tests do not meet that requirement there is potential for the test to be covered under the optional diagnostic services benefit. This benefit is described in 1905(a)(13) and 42 CFR 44130(a). And I'll quickly go over the requirements for that benefit as well.

And so the diagnostic services benefit includes any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts when the scope of their practice under state law enable the practitioner to identify the existence, nature or extent of illness, injury or other health deviation in the beneficiary.

Like I said, this - all this information was included in the first batch of FAQs that CMS released. I also want to draw your attention to the latest batch of FAQs where we've had states reach out - states and stakeholders reach out about potentially utilizing first responders or additional providers to administer the tests for COVID-19.

So you'll see in there that there is an FAQ that addresses this. You know, these types of questions - it's really going to be state specific based on what's in your state plan. Also based on current state laws. And so, you know, if you're interested in adding practitioners to administer the test I think what I would encourage you to reach out to us directly. This is, you know, really a sort of a weedy issue and I think it would be - that will - I'll have to talk to you about that probably one on one to see if there's - if we can add those additional practitioners.

Also there is - there is also an FAQ in there about coding guidance, the laboratory testing for COVID-19 and the rates. So we provide some

additional information. Then I know my colleagues within CMS are continuing to work on this and we'll provide further guidance as needed.

So that's just a quick overview of how and where the tests for the COVID-19 would be covered under the Medicaid program. The second issue I wanted to talk about is Medicaid, tele-medicine and tele-health policy. I would say from a benefits perspective, we've probably received maybe the most questions about Medicaid, tele-medicine and tele-health policy.

And so we thought we'd spend a few moments talking about this. The FAQS also address specific questions about when coverage is available, what type of flexibility states have. There's also a one pager on the CMCS Web site that talks about some of these flexibilities. But we thought given the number of questions from both states and stakeholders, we thought we'd spend a few moments going over the requirements.

I think, you know, as I said, we've received a number of questions which is understandable given some of the access challenges due to the COVID-19 public health emergency. And I just want to say that, you know, this administration as well as us at CMCS, you know, we're committed to working with states to expand the use of tele-health and tele-medicine in the Medicaid program.

We've also heard from stakeholders that are understandably concerned about access challenges. We've particularly heard from folks that are concerned about access to behavioral health services, dental services. And so we just want to clarify that those types of services can be delivered through tele-medicine and tele-health under the Medicaid program.

So let's talk a minute about what the requirements are. And I think there's been some confusion because the Medicare policy and the Medicaid policy aren't the same and so we've had some questions from states and stakeholders about, you know, which policy is required. So I'd like to make clear first that the Medicaid policy in this area is not dependent upon Medicare rules.

States - we know that states may have established policies that linked Medicaid tele-medicine policy to Medicare rules, but there are no federal requirements to do so. So, you know, I would encourage you when you are looking at ways to expand use of tele-medicine, tele-health and Medicaid, please keep this in mind. States already have significant flexibility under the Medicaid program.

As I just said you have - states have significant flexibility to cover Medicaid services provided via tele-health. States have flexibility to determine whether or not to cover tele-medicine, what types of tele-medicine, where in the state can be covered, what services, what practitioners. So you already have an enormous amount of flexibility in the Medicaid program to deliver services via tele-medicine and tele-health.

Now as I said, you have a lot of flexibility and a state plan is - federal approval is not required to cover services via tele-health. However, we know that some states do have tele-health language in the coverage pages of their state plans that limits services that can be provided for the means of communications that can be used.

And so if you're one of those states that have this type of language that limits the use of tele-health, tele-medicine under your state plan and you wish to expand the use, you know, there are options to doing so. You can obviously amend your state plan to remove this language. You can also - I think we

were working on the (SPA) template for this emergency that could be used to amend your state plan as well.

Also, so states - as I mentioned, states - you don't have to - you don't need federal approval to provide the service via tele-medicine and tele-health. But this assume that you're paying the same rate for the services as you would for a face to face visit. And so if you would like to use a different methodology to pay for services via tele-medicine and tele-health, then a state plan amendment would be required.

Finally, I wanted to make you aware of recent guidance that was published by our federal colleagues in the HHS Office of Civil Rights and the Office of the Inspector General. HHS Office of Civil Rights announced their intention to exercise their enforcement discretion to not impose penalties for noncompliance with the regulatory requirements under HIPAA rules.

I know I've talked to a few states that still have some questions about that announcement and I can confirm that our colleagues at OCR are working on some FAQs related to that announcement. The OIG as I said, also issued a policy statement notifying physicians and other practitioners that they will not be subject to administrative sanctions for reducing or waiving call sharing obligations.

So with that, I just want to reiterate what Calder and what Jackie have said. You know, as you have questions about benefit policy, you know, please reach out. We're obviously here to help you as best we can. And I will turn it back over to Jackie.

Jackie Glaze: Thank you Michael. So up next is (John Coster) and he will provide an overview of the flexibilities that are available to states and territories, with

providing pharmacy services through the fee for service and managed care program. So (John), are you ready.

(John Coster): Sure. Thanks Jackie.

Jackie Glaze: Thanks.

(John Coster): Well similar to what Michael said, the states have - generally have a significant amount of flexibility in operating their pharmacy benefits. Let me talk a little bit about the groups and buckets of questions that we've been getting. Some of these we've already put information out on the - the first big bucket of questions we've been getting relates to adjusting base supplies or quantity limits.

Can a state dispense either - authorize a dispensing of a larger quantity or an earlier refill or synchronized refills so that a patient can get all of their medications either pickup or delivered at the same time? And the answer to that is yes. There's really no federal limits other than for controlled substances, which I'll speak about in a minute, in terms of the amount of drug that you can dispense.

Most states have limits now in place, obviously, for, you know, just prudent purchasing and fraud waste and abuse purposes. But the state agency can allow for larger quantities of certain medications to be dispensed at a time so that there's social separation. And those can be for any categories of drugs that you so choose.

One thing I would urge you to do is look at your state plan, your current approved state plan. Certain states do have limits in there. A few states have limits on the number of prescriptions that a person could get. Few states, if

any, have actual quantities in their state plans. But if you do that's where you might need to make a change, you know, to your state plan.

So quantity limits, early refills, larger quantities, those are all permissible. Again, the one caution is on controlled substances, schedule 2 controlled substances are not refillable. Those are only allowed to be dispensed 90 day supply. Schedule 3-5 are refillable but you should also check with your state board in terms of what they would permit with respect to any modifications from DEA requirements with dispensing of controlled substances.

The other set of questions we're getting is on prior approval. Again, we generally at CMS don't review a state's prior approval. Processes - there are federal requirements in terms of the time to have a prior approval process, but we don't review the individual states' prior approval criteria for individual drugs, the clinical criteria.

So unless there's something in your state plan relating to prior authorization that, you know, how it would have to be modified or changed, we've gotten questions about removing requirements for the clinical review from the dispensing of a drug or extending prior authorization requirements that have already been approved. And you - states use either approach. Again, unless there is something in your state plan that's different than that which again, you'd have to have changed.

Preferred drug lists, the same thing. We don't really review the state's preferred drug list for the medications that you have on the PDL. So and unless there's something specific in your state plan we've gotten question about, you know, if a state has a certain drug preferred on their state plan, like a generic, and that generic happens to be in short supply for some reason, can they switch that to the (innovative) brand?

You know, again we don't review those types of things at the federal level. So, you know, you can do that in terms of flexibility in establishing your preferred drug list exceptions. So again, on the quantity limits, higher quantities can be dispensed. Earlier refills, synchronization can occur; prior approval both requirements for clinical review or allowing for an existing prior authorization to continue can also occur.

Preferred drug lists - again, we don't review those. If you do at some point want to extend coverage to - for example, certain of the excludable drugs like nonprescription drugs, those - in some states they've indicated that - whether they cover those or not. So again, I would encourage you to check your state plan and see whether or not you cover or don’t cover any of the excludable categories of drugs and whether you want to make changes to those.

We've gotten questions about signature requirements and counseling requirements. So most times you go to pick up a prescription whether it's for a commercial plan or a federal plan like Medicare or Medicaid, you sign at the pharmacy in order to indicate that it was picked up. Most third parties require that in order to pay the pharmacist for the prescription.

And there's no federal Medicaid requirement that a signature be obtained by the patient. Sometimes the states will have these confirmation requirements in their provider manuals. So again, we're getting all the questions from pharmacists about the issue of, you know, patient doesn't want to come to the pharmacy, can we home deliver it; or even through the mail?

First, I would check whatever state requirements you have, provider manuals or not, but we don't have any federal requirements. You know, you could use other options like asking the patient to just call you if they've received the

prescription if it's delivered or text you or email or some other form of confirmation.

We've gotten questions about counseling requirements. Most states require counseling on medications. You know, that can happen telephonically if it's on a new prescription. So that's a relatively new question that we've received that we're developing an answer to. But those - that's our initial response to those types of questions in terms of signature confirmation requirements.

You might also want to check with your state program integrity unit and see how to coordinate any changes with them. We've gotten questions also on dispensing fees. There are requests for payment of additional - additional payments to pharmacists for home delivery. You know, most states just went through changes in their dispensing fee requirements with respect to cost of dispensing.

There is, you know, opportunity for the states to provide an additional temporary supplemental payment to the approved professional dispensing fee for the cost of delivering a medication to the beneficiary's residents or where the beneficiary might be located at that particular time, if they're not in their residence for some reason.

So we'd like - if the state wants to do that we'd ask them to submit documentation that they're going to do that and, you know, what their approximate additional payment is going to be for the additional services they're providing in order for the prescription to be delivered. And then finally, we've gotten some questions about shortages. We're monitoring shortages.

We - every week we monitor what we're hearing in the market. We're not seeing any shortages yet, at least that we know of. And there have also been questions about whether drugs that are not - that could become in short supply whether FFP would be available for those. There are some opportunities for drugs to potentially get (FMAP) if they're not covered outpatient drugs.

But that would be on a situation by situation basis. So, you know, more on that as it comes along, but right now we're not hearing of any major shortages of either brand or generic drugs but again, we're early on into this. So I'll leave it there and see if there are any questions later on.

Jackie Glaze: Thank you (John). (Jennifer), we're ready now to take questions from the audience. Can you open the mic?

Coordinator: Absolutely. To ask a question from the phone please press star followed by the number 1. Please make sure to unmute your phone and record your name at the prompt. Again that is star 1 for any questions. One moment please while questions come through.

I believe this is from (Tom) from the State of Maine. Your line is open.

(Tom): Hi. Thank you. I was just curious about retroactive state plan amendments during the emergency period.

Calder Lynch: Thank you (Tom). This is Calder. So we actually talked a little bit about this on Tuesday's call. We have been working and we can allow for retroactive approvals of state plan amendments using 1135 authority, 1135 waiver authority. And as I mentioned, we'll have additional tools coming out and this will spell that out a little bit more in detail.

But that will allow states to go back beyond the first day of the quarter in which the state plan amendment was submitted in those cases. Jackie, is there anything to add - or (Ann Marie), is there anything to add there?

(Ann Marie): I think Calder the one thing that I would add is that if the state plan that would be submitted, also requires - would normally require public notice we have the ability to waive the public notice requirement associated with changes in payment methodology, cost sharing and changes in benefit packages for their alternative benefit plan.

And there's also some flexibility around modifying private consultation timelines. And all of that will be specified in the disaster relief state plan template we'll be putting out.

Coordinator: The next question comes from (Jack). Your line is open.

(Jack): Yes. The 6.2% (FMAP) enhancement mentioned in the federal legislation, does that apply to CHIP or is that exclusively for Medicaid? Thank you.

Calder Lynch: So I think we're still working through that with the team internally. I think our initial read is that it applies to the state's regular match funded services. But again, we're still working through that and expect to have guidance out in the next couple of days.

Coordinator: The next question comes from (Henry). Your line is open.

(Henry): Thank you. I appreciate these calls greater Calder. With the respect to Medicaid schools is there any guidance coming out with respect to schools being delivered - services being delivered remotely in many places, how any

effect on that program or those services, would be affected by things here in terms of do we have to make any adjustments to relate to that?

Are there any additional flexibilities that are available to keep services going to children who otherwise would be getting them in the physical presence at the school?

Calder Lynch: That is an excellent question. I'm, you know, I'm not sure if we've - we tackled that one specifically. I'll ask the team. There may be some opportunity under 1135 authority I'm thinking because it does provide some ability to do alternative settings. But let me ask folks maybe from DE, if they - is that something they've thought about yet?

(Henry): Thank you. I know you're going to come out a little bit further on the (FMAP) change, but are you able to give an effective date yet or is that still open to interpretation?

Calder Lynch: Again I don't - we're working through that. I think we're thinking that's going to go back to the beginning of the quarter. But there are still just some final details to work through there, which would be January 1st. But yes, I don't want to do anything formal until we can, you know, work through those final details.

(Henry): And lastly, in the same section, the no redetermination period, could you just give your read of that or if you're going to give the read of that future in terms of how to interpret that section a little bit more on a…

Calder Lynch: I think I want to defer that until I can probably have a little bit more detailed conversation here, because we want to be really careful about what we say and

make sure that we're interpreting that correctly so that we can give you good guidance. I don't want to get too far ahead of that.

(Henry): Thank you. I'll let someone else have a chance. I appreciate it.

(Kiersten Jensen): And this is (Kiersten Jensen) from the Division of Benefits and Coverage. We can certainly take back the school's question and think about it a little bit more thoroughly. But, you know, tele-health might be a useful tool in - for those providers as well if the state wishes to set up tele-health as a delivery mechanism for services provided by the providers in the school, say the school psychologists and counselors and those sorts of things. I think that would be available to the state.

Coordinator: The next question comes from…

Calder Lynch: We can think about that in more detail (Henry) because that's a really good point to raise given it looks like schools are going to be closed for the foreseeable future. So we'll take that offline as well.

Coordinator: The next question comes from (Julie). Your line is open.

(Julie): Good morning. Thank you for the opportunity to ask this question. Can you please provide information related to the (SPA) submission process and whether states are going to be allowed to do one comprehensive (SPA) of all of the proposed changes or if we'll be required to open separate (SPA)s for each COE? And then whether we'll be submitting via macro or any other means?

Calder Lynch: So thank you for that question. We'll - this kind of alludes to I think some of what I mentioned and what (Anne Marie) mentioned that we've been working

on a more consolidated (SPA) template for this sort of - for this situation that would allow you to do it in one (SPA) and have that be effective for the duration of this time. That's coming very, very soon, I'm hoping by the end of the day.

And we're going to plan to dedicate some time on a call next week to talk through that. (Anne Marie), did you want to talk about the submission process?

(Anne Marie): Sure. And maybe I'll just say we've built into the template sections related to eligibility, related to enrollment, related to benefits, payment methodologies, post eligibility treatment of income, along with a catchall other section. This template is for use during the duration of the public health emergency. So it is meant to be a place we could try to do everything at one time so we could try to apply as much flexibility to it as possible.

It will be a good old fashioned paper state plan amendment. So you'll be able to fill it out and submit it through your (SPA) mailbox. But when we put it out we'll share on Tuesday, some additional instructions for submission. But we wanted to make it as simple as possible and so we thought doing the paper state plan process which states still use for many of your state plan amendments and submitting it to the regular (SPA) mailbox.

(Sarah Delone): (Anne Marie), this is (Sarah). Can I just add just to remind folks that for states that have a separate CHIP that there already is a CHIP disaster state plan template. We are looking at possibly making some updates to that but it already exists. It's in use and that's available for states to make the one CHIP state plan amendment for this disaster.

(Julie): Thank you.

Coordinator: The next question comes from (Vicky). Your line is open.

(Vicky): My question was answered by as previous question. So thank you.

Coordinator: Just a reminder, if you'd like to ask a question it is star 1. If you need to withdraw your question you may press star 2. The next question comes from (Penny). Your line is open.

(Penny): We just had a question - I'm hoping you know now and it won't take until Tuesday, about the Family First legislation and maintaining Medicaid eligibility. We need to know when that actually begins. If we need to go back to March 1st and reevaluate our forced eligibility for individuals who may have already been closed for not completing renewals and things like that.

Can you give us a timeframe on when we'll know exactly when that begins?

Calder Lynch: Thank you. Yes. I hope to get guidance out before Tuesday on that, but I also want to make sure that we understand, you know, what our options are to give you, you know, the best guidance we can because we understand that given the effective date of the legislation we that could pose some challenges from a retroactive perspective. So we want to understand that.

We're working through that now. So if you could just give us maybe a day or two to work through that we'll have more information coming.

(Penny): Thank you.

Coordinator: The next question comes from (Anne). Your line is open. (Anne), please check your mute button. We're getting no response.

(Pam): This is (Pam) from Illinois.

Coordinator: Yes, I'm sorry. (Pam), go ahead.

(Pam): Okay. That's okay. Thank you. I have two questions. First, where do we - and this is off the topic of today, but following up from the call last week. Where do we submit our Appendix K amendment?

Jackie Glaze: You can submit your Appendix K submissions through your state lead.

((Crosstalk))

Ralph Lollar: …to clarify.

(Pam): Excuse me?

((Crosstalk))

Woman: Go ahead.

Ralph Lollar: They go into the (SPA) mailbox just like a (SPA) would.

(Pam): Okay.

Calder Lynch: And if you're working on a K right now, let me just say that is also one of the tools that we're looking to get out, you know, again hopefully before we head into the weekend, is a sort of prepopulated K so that may be helpful if you're working through that now. That is on its way too, soon.

Ralph Lollar: But Calder if I can, I'd like to take the chance in respect to this question, to let states know, you can submit a single application 1915(k) for all of the waivers in your state or any number of waivers in your state by identifying the waivers in the title, their respective control numbers and then delineating any differences between them in the text boxes. I hope that helps.

(Pam): Yes, thank you. My second question is - I've been on a couple of different calls and I just want to just clarify that we have to have CMS approval of our Appendix K before we can implement, but we can request a retroactive date. But we still have to have that approval prior to implementing any changes?

Ralph Lollar: That is accurate. You have to have a retroactive date up to January 27, 2020 which was the date of the Secretary announced effective.

Calder Lynch: But let me also say, this is Calder, that we recognize that these are somewhat extraordinary times and folks are working as hard as they can to make sure they're responding to the needs on the ground. So to the extent that you've seen the types of flexibility that we're approving and that are going to be included in this prepopulated template and you need to, you know, move forward while we work through the paperwork, you know, we understand that and we're going to get right on the paperwork and make sure that everything gets approved.

But recognize that you also need to be, you know, nimble on the ground. So there's not going to be, you know, us coming in and quibbling over a couple of days between implementation and approval. They will be retroactive.

(Pam): Okay. Okay, thank you.

Coordinator: The next question comes from (Aaron). Your line is open.

(Aaron Butler): Yes. Thank you Calder. Thank you team, for these calls. We appreciate it. This is (Aaron Butler) from Tennessee. I just wanted to underscore and emphasize what (Julie) said, that states looking at the families first Corona response bill, law now, really need guidance in a very time sensitive way about the 6.2 enhanced (FMAP) and it's conditionality on non-termination of members and when that starts, and what to do in situations where we may be looking at people who have been determined presumptively eligible and haven't filled out an application, what to do with people who have been determined ineligible in a previous period, that may still be receiving benefits on a continuation of benefits status while they're on appeal, when people die. That doesn't seem to be contemplated in the law.

But if the (FMAP) is going to be conditioned on our compliance with this non-termination, we just need guidance as soon as possible. So just raise that for your team's consideration.

Calder Lynch: Thank you. We definitely understand that and that is one of our top priorities right now, because we recognize there's a lot of anxiety. And just, you know, the need to know, you know, quickly if there needs to be operational changes. I will say that, you know, the questions you're posing are helpful. We're trying to think through all of those different types of scenarios or questions. But if you want to - it would be helpful if you share those with us in real time so that we can make sure that was we're thinking through the implications we've thought about, you know, all of the different possible scenarios.

We probably won't think of all of them and this may be something we have to revisit. But we want to try to provide as much of the best guidance upfront at least as possible.

(Aaron Butler): Thanks. I really appreciate it.

Coordinator: Just a reminder, if you need to withdraw your question please press star 2. If you need to ask a question in the queue please press star 1. Again, star 2 to withdraw; star 1 to ask. And the next question comes from (Siobhan). Your line is open.

(Siobhan): Hi. Good afternoon. First, let me say thank you for everything that you guys are doing. You have been super responsive. I'm calling from Florida, Florida Medicaid. And so I know you can't - or would you prefer to defer questions on the federal legislation, but I just want to put out a couple of questions that when you issue your guidance if you could cover, it would be great. Or if you can answer it today that would be even better.

So specifically related to the (FMAP) increase, if you could clarify whether it's any for state plan services or if home and community based services authorized for you in 1915(c) or services in 1115 that are not covered in the state plan, if those would also be eligible.

And then secondly, what would a state need to do to request consideration for the (FMAP) since its conditional? Do we need to submit something or how would the approval process go so it could be covered? And then last but not least, would payment made through (DSH) or low income who will be eligible for the increase as well? That's it. Thank you.

Calder Lynch: Thank you. We're writing those down and we'll follow up. I don't think we're quite in the position to answer all of that today. But those are exactly the questions we are working to answer as quickly as possible.

(Siobhan): Thank you Calder.

Coordinator: The next question comes from (Tanya). Your line is open.

(Tanya Helga): Good morning. Yes. This is (Tanya Helga) from Utah Medicaid. And we had a question regarding whether there will be some additional guidance related to (PASRR) requirements. And, you know, how they could potentially cause a barrier to moving people out of hospitals on a rapid basis. And just wondered what if any guidance we should be expecting around (PASRR) as it relates to COVID.

((Crosstalk))

Alissa Deboy: Oh, I'm sorry.

Calder Lynch: No, I was just going to ask - yes, I was going to ask someone to jump in there because there is some opportunity I believe under the 1135 waivers, to get some flexibility there. But go ahead.

Ralph Lollar: Sure this…

Alissa Deboy: Go ahead (Ralph).

Ralph Lollar: This is (Ralph). There are - take a look at the regs again and we've sent out some clarifying information. For instance, transfer from a nursing facility to another nursing facility. The level 1 and level 2 from the first facility stand you don't have to repeat them. The level 2s are trapped on an average number of days to conducting the evaluation which is 7 to 9 days.

So the timing here if you run a little late, may not run afoul on average. In addition to that, there is no prohibition in the regulation about - against

conducting level 1s or level 2s remotely through electronic means, telephone, Facetime, etc. But if you wish to extend the timeframe to begin a level 1 for instance, you would need the 1135 to authorize that type of extension beyond what the regulation permits. Did that address your issue?

(Tanya Helga): Yes. That's great. Thank you. I appreciate it.

Ralph Lollar: Okay. Yes. There's a lot of flexibility inside already, so I wanted to make sure we got that out in front of what you would need the 1135 for. Thank you.

Coordinator: The next question comes from (Anna). Your line is open.

(Anna Delorgan): Hi. This is (Anna Delorgan). Can you hear me?

Calder Lynch: Go ahead.

Ralph Lollar: Yes.

(Anna Delorgan): Yes. So I know in your considerations you may not have guidance today, but we are curious to know how and if this is going to enhance (FMAP) if (FMAP) will applied to 1915(k) options.

Calder Lynch Yes. And I know everyone is very anxious for guidance on the applicability of the enhanced (FMAP), but I don't want to speculate too much until we're able to get things solid on our end, which we are meaning to try to do today and get that out as quickly as possible. So please just hold tight a little bit and we'll get that guidance out.

(Anne Delorgan): Excellent. Thank you.

Coordinator: The next question comes from (John). Your line is open.

(John): Hi. This is (John) with Utah Medicaid. I wonder if there will be any flexibility in UPLs. Two fronts there - one, if the deadline for UPL submissions of June 30th might be extended but more importantly as we look to perhaps increase reimbursements to providers, will UPL caps be suspended during this time period? Thank you.

Calder Lynch: Thank you. I know we are looking across the board at a number of our sort of administrative, you know, reporting deadlines both from a financial perspective as well as other administrative requirements, to see where it's appropriate for us and where we have that authority to provide some relief, given we know that we're all consumed, you know, and also it has depleted resources with which to conduct some of this work.

So that is work that's underway and we'll, you know, as we identify those opportunities we'll be sharing them out. Although it's helpful for us to hear, you know, where states feel the most pressure with regard to being able to meet some of those requirements.

To your second question, that is not something I don't know if we have considered yet, but we can certainly take that back and think about that and think about what, you know, authorities we would have there or what, you know, what that need would look like. And of course, you know, as we work through this together, we're also identifying needs. I think we'll continue to see some Congressional action here so it's helpful to hear where there may need to be some additional, you know, relief that we can work with Congress on. So we'll take that back and follow up with you on that.

Coordinator: the next question comes from (Julie). Your line is open.

(Julie): Thank you. For the requirements that the state wishes to change which require CMS concurrence, are those reviews being looked at as quickly as the waivers or is there a different timeline that those are following? Any guidance on that you could provide would be very helpful.

Calder Lynch: Yes. (Anne Marie) or (Sarah), is that one you all can take?

Sarah Delone: (Anne Marie), do you want to go or I can go?

(Anne Marie): No, go ahead (Sarah). Go ahead.

Sarah Delone: So we are - I mean I think across the board we're looking at all of the - doing everything as quickly as possible. So there's no prioritization and it's often different teams that work on different issues. Sometimes it's the same team. And there are, you know, and there - I know some of the areas there's just concurrence. There may be - so I don't have in mind. I think I would reiterate though what typically the areas that you need CMS clear concurrence on are things for which you don't need express approval of, right?

You don't need CMS to give you authority but we have highly recommended getting CMS concurrence for audit and, you know, PERM review kinds of purposes. And we still encourage that as being very important. Similar though to what Calder said around where you know there is - that have been approved for other states or there's flexibilities that are clearly identified in the disaster inventory that's on Medicaid.gov.

You should do what you - you know, you should respond to the crisis and implement the tools that you need and we will work with you as quickly as possible. But after the fact it's easy to get the paperwork in order.

Calder Lynch: And I'll add too that, you know, we'll flag, you know, pretty quickly if we see something problematic. And I think we - the ones I've see come through, those have resulted in pretty quick conversations and understandings of, you know, whether there was any concerns or not. So it seems like everything we're working as rapidly as we can and hopefully some of the tools that we're going to release today are going to help streamline some of that and make it a little bit easier.

(Julie): We definitely appreciate that and I had one additional question to your last statement about administration and reporting and what CMS is looking as far as the release they can provide states. Is CMS also working with other sister agencies or other federal regulatory authorities in related to audits that the states are currently undergoing and there may be some flexibility there?

Calder Lynch: We are in active discussions with our friends over in CPI as well as the OIG, you know, on that very issue. So we all understand I think that the world has changed and, you know, we need to figure out how we're going to respond accordingly. So those conversations are ongoing. So I don't have anything yet to share but we're definitely aware of and are working on some resolutions.

(Julie): Thank you. WE do very much appreciate that.

Coordinator: The next question comes from (Teresa). Your line is open.

(Teresa): So we've had some providers who do our presumptive eligibility applications, ask a question about if they can do those over the phone. And what about the signatures for the applications? Do you have - the presumptive eligibility applications. Do you have any guidance on that?

(Jessica): I can jump in on this particular - so this is (Jessica). And there are - so as you said that we are in the process of - I know this question has come from a number of states and hopefully will be included in a future round of FAQs. But I wanted to just clarify that under existing requirements for presumptive eligibility, that information can already be taken - information for presumptive eligibility can already be taken verbally by phone, or in person.

And there are existing FAQs on this that we can point states to that would not - that you can take that signature either electronically or you are able to collect the information without obtaining a signature from the individual as long as in the context of HPE for example, the hospital attests to collecting all of the appropriate information.

(Teresa): Great. Thank you.

(Jessica): You're welcome.

Coordinator: Just a reminder, it is star 1 if you'd like to ask a question. The next question comes from (Anna). Your line is open.

(Anna): Hi, yes. I think I'm at just adding some more questions to the (FMAP) guidance that would - in the discussions you guys are having. I'm really curious about whether or not that will apply to any of the different rates that each state has, especially the newly eligible population, administrative cost and (family) planning services.

Calder Lynch: Thank you. We'll make sure that's addressed when we provide the guidance.

(Anna): Great. Thank you very much.

Coordinator: The next question comes from (Tyler). Your line is open.

(Tyler Gynas): Hi there. (Tyler Gynas) from Wyoming Medicaid. Just a quick question about MDS Section Q referrals. And similar to (PASRR) will we be able to have some flexibilities in referring those Section Q referrals to the local contact agencies for those who have indicated a desire to return to the community? And would we ask for that flexibility in an 1135 as well?

Calder Lynch: I'll pitch that one over maybe. Is that (Ralph)? Is that for you to take?

Ralph Lollar: Yes. Can you repeat the question again? It's about Section Q? Go ahead.

(Tyler Gynas): Yes. So for the Section Q referrals to local contact agencies for individuals who would like to return to the community, do we have the same flexibilities in delaying those or referring those at a later date when those local contact agencies will be able to, you know, visit the facilities?

Ralph Lollar: Let me dig a little deeper on that and get back to you with a complete answer on that Section Q is under another division's purview. But I don't see that there will be a problem with that. But I'll discuss it with them. You want to amend the timeline for the referral, right?

(Tyler Gynas): Yes. Thank you.

Ralph Lollar: Yes.

(Tyler Gynas): Okay, great.

Coordinator: The next question comes from (Siobhan). Your line is open.

(Siobhan): Hi. Just one more question on retainer payments. I know that CMS is working on flexibilities on considering additional flexibilities related to other types of providers in the home and community base setting. So I just want to inquire about state plan services. We do have some of our providers that are particularly worried and we just want to know if that's on CMS's radar and if you anticipate any guidance in that regard.

Calder Lynch: It definitely is on our radar. You know, when - we've talked a little bit about the disaster state plan amendment template today, you'll see in there, you know, within the optional state plan authority some options and possibilities that states can think about in terms of adjusting rates and methodologies temporarily.

You know, we're also looking at that in the context of the rest of the work that is happening to provide relief to the healthcare system as well as, you know, other businesses or organizations impacted by the virus. So that's going to be ongoing. I don't think this is going to be a one and done. So once we kind of understand more what that looks like we may come back and revisit, you know, potentially 1115 authority there if necessary. But certainly it is remaining on our radar and we're working through that.

And you will see I think some options at least under the state plan authority to make adjustments in rates and payment methodologies to address part of the issue.

(Siobhan): Okay. Thank you.

Coordinator: I am showing no other questions in the queue at this time. It is star 1 if you would like to ask a question.

Jackie Glaze: (Jennifer), no further questions?

Coordinator: No questions at this time.

Jackie Glaze: Okay. I think we can just wrap up a few minutes early but we'd like to thank everyone for all of your questions that you've asked us today. It really helps us to think about policies and guidance that we need to further think about. So continue to ask the questions that you're asking. We would also want to remind you that we will have two all-state calls next week on Tuesday and Friday.

And as Calder indicated, we will be talking more about managed care and eligibility. So we look forward to you joining us at that time. So we thank you and hope you all have a good day. Thank you.

Coordinator: That does conclude today's call. Thank you for participating. You may disconnect at this time.

End