

Centers for Medicare & Medicaid Services  
COVID-19 Call: Eligibility in Managed Care  
Friday, March 27, 2020  
Moderator: Jackie Glaze  
3:00 p.m. ET

Coordinator: Welcome. Thanks for standing by. Participants are in a listen-only mode. (Unintelligible) question-and-answer session of today's event (unintelligible). Today's conference is being recorded. If you have any objections, you may disconnect. And I very much would like to turn it over to your host, Ms. (Jackie Glaze). Thank you, ma'am, you may begin.

(Jackie Glaze): Thank you and hi everyone and welcome to today's Allstate meeting. We would like to begin by sharing our topics on the COVID eligibility in managed care. And we will also take 20 minutes to take some questions at the end of the session. So, we appreciate your attendance. And I would first like to turn it over to (Calder Lynch). He does have some opening remarks. So, (Calder), are you ready?

(Calder Lynch): Yes, I am. Thanks (Jackie). Good afternoon. Welcome everyone. Thank you for joining us again for this Friday's afternoon All State call. There's been quite a bit of activity since we last had a chance to talk on Tuesday. I'm sure folks are following the activities that are happening on Capitol Hill. On Wednesday the Senate approved a bi-partisan stimulus package that advanced through the House and I just got a newsletter a while ago that that's been approved and is now on its way to the President, and I expect he'll sign it shortly.

We, of course, are still digesting a lot of the provisions of that bill - will work to provide information and guidance to states. As we do so, I will note, though, that there is quite a lot of funding appropriated through that bill for a

variety of purposes, including, you know, reimbursement to healthcare providers, funding for, you know, housing, for, you know, meals and nutrition services. So, lots of things that we have already begun engaging with states around - and particularly some of the things folks have asked for -- signature authority and some of the pending 1115 waivers that we have before us.

So, we'll be working to make sure we understand what all Congress is appropriated there to make sure that we can share that information with you, and move forward with those other requests, you know, in the context of what's now been, you know, appropriated or what will soon be passed into law -- you know, as part of the broader COVID response efforts.

Also, we have been continuing to work with states on your individual requests. You know, we have tried to fast track approvals of 1135 waiver request where we've got clear, sort of, policy and language around knowing what we can do under 1135 that was part of that template that we released over the weekend. I think now we're up to 34 states. Of those, 32 were approved this week. Know that many of you have other requests that were a part of those initial letters that we're continuing to work with you on, and expect to have any individual conversations about whether there's opportunities under 1135 or whether we need to seek other authorities as best we can to accommodate those requests.

We've also approved six appendix Ks this week to provide additional flexibility in your community-based services programs. And then we did get those FMAP FAQs out shortly after we completed the call on Tuesday. So, I hope that those have been helpful. If they spark additional questions than I believe they already have, then, you know, please make sure you're getting those up to us because we will probably need to update those depending on what further actions Congress took in the Bill that we expect to be signing into

law shortly. We also expect to have a third batch of more general FAQs posted early next week based on further questions that we have been receiving.

On our agenda today we're going to be discussing updates of some of the eligibility needs, including those that were included in the Family's First Coronavirus Response Act - as well as some further information on the managed care plan amendment and flexibilities that we know some states have been interested in and asking about.

But before we jump into today's agenda, I just want to share some information about some steps we're taking now to provide some administrative relief for states. We recognize that many of us are all strained to continue to carry out our routine operations as best we can -- relying on, you know, less staff capacity in case of staff working remotely. And that's continuing to place a strain on our resources. So, in recognition of that, we will be temporarily suspending other audits that draws staff time away from critical pandemic functions, including the Medicaid eligibility quality controller MEQC program and the payment error rate measurement audit -- the perm audit.

Specifically, we'll be pausing those audit operations that request documentation from providers and state staff -- recognizing that many of you in audit position could be able to fulfill those functions with staff working remotely or otherwise engaged in pandemic efforts -- as well as activities related to state corrected action plans. We want to enable to make sure everyone is able to focus their full efforts and resources on the COVID-19 response efforts.

More details about what this means in longer terms will be released soon. And I believe we also have some of the relevant staff online today to be able

to answer questions on these topics, but I just wanted to share that information with you today. So, with that, I'm happy to now turn it back to (Jackie) who's going to bring us to the rest of our agenda.

(Jackie Glaze): Thank you (Calder). So, next we have the eligibility team and they would like to share with you some of the flexibilities that are available to states and territories. And so, I'll turn it over to the team now.

(Stephanie Comizkie): Thank you (Jackie). This is (Stephanie Comizkie), Division Director of the Division of Eligibility Policy. And I wanted to start by noting as we did in the last meeting we had that the Family First Coronavirus Response Act did add a new eligibility group -- an optional eligibility group -- which is for uninsured individuals as defined by that act and modified by the new piece of legislation that (Calder) just mentioned. And states already are using our disaster master template to submit spas to indicate the coverage for this uninsured optional eligibility group -- the Coronavirus 23 group.

States are also welcomed to come in through the disaster template to expand coverage for other optional groups. Some, for example, have explored using the 20 group to expand coverage possibly linking it to the coronavirus through 1115 authority. So, those disaster templates are coming in now and we are happy to provide TA on any expansion related or additional optional eligibility group coverage that states would like to add to their state plans.

With respect to cost sharing and premiums -- as you know from our conversation a few days ago, states can waive the public notice requirement for new cost sharing spas. And there are some new spas that states are in the midst of submitting to us -- mostly to implement the Family First Corona Response Act requirement for the new mandatory cautionary exemption for all individuals as well as the cautionary exemption that's required for the

(unintelligible). We are working with states to streamline the language that they should use when they submit those spas because some of the language in the FFCR -- the Family First bill -- was not completely aligned. We think that if states use the language that is related to the FMAP bump they will be covered for the mandatory benefit as well, and we're happy to work with you on that.

I wanted to also mention that there are other cost sharing and flexibilities. Some states are choosing to -- during the period of this emergency -- suspend all cost sharing. And, of course, that's certainly something states can do through the state plan process, and the disaster template allows that to really be a temporary suspension if that's all that's intended.

In addition, there already is state plan authority -- a regulatory authority I should say to give individuals hardship exemptions from premium payments. And so, to the extent that there are any premium payments still being collected right now, that is something that states can avail themselves of by documenting that request for hardship exemption and individual case records. And, you know, assuming they have that authority already indicated in their state plan. If they don't have it in their state plan already, they certainly can request that as well. And this is a broad-based hardship exemption. It could be used for many different eligibility groups.

I wanted to mention especially though that our team has been working really diligently over the last couple of weeks to explore strategies to help expedite enrollment for ADD applicants. We have been working with our enrollment colleagues on coming up with ways that states might be able to do -- and hospital presumption eligibility -- state plan amendment change where they would be applying hospital presumption eligibility to disabled individuals. We are exploring ways that states may be able to take self-attestation around

disability determination and possibly have medical documentation subsequent to the initial determination.

We are helping states explore whether or not they can temporarily postpone petty collections; whether they can increase personal (unintelligible) allowance variances regarding - so that there would be lower petty obligations. And we are advising states that there are no real timeframes associated with the regulatory and statutory requirements to do asset transfer scope of benefit reviews. So, those can be done after eligibility is determined.

Just a couple of more things. We're looking also at self-attestation. We're exploring self-attestation for Medicaid needy spend down and we're also looking at self-attestation followed by subsequent paying of an AVS in order to really expedite those eligibility determinations. I know that states are already well familiar with a lot of the flexibilities that are in our tool kit around fair hearings, around residency, around reasonable opportunity period, extension for non-citizens. And again, some of those are really documented in the template that we went through last week.

So, I think that's very high-level overview. My colleagues have a lot of other pieces of the puzzle to fill in around eligibility and other areas and I look forward to questions at the end.

(Jessica Stevens): Great. Maybe I'll pick up - sorry, go ahead (Jackie).

(Jackie Glaze): No, go right ahead...

((Crosstalk))

(Jessica Stevens): ... (Stephanie). This is (Jessica Stevens) - and talk a little bit more about some of the Medicaid enrollment flexibilities that are available to states -- some of which I know we've talked about on prior calls. There are a number of enrollment, retention and other related flexibilities that states can implement through a number of different authorities including just state plan authority. And these may be really helpful to states -- particularly given some of the challenges that we know all of you are facing related to workforce capacity -- workers not being in the office and just inability to sort of keep pace with some of the regular work that needs to be done.

I think the first bucket includes flexibilities that are available to states under the state plan without any specific additional authority. That includes the fact that under state plan authority right now, states are excused from meeting timeliness standards for application or renewal processing and acting on changes and circumstances when in the context of an emergency. And we've determined that this particular emergency certainly counts. The expectation there is just that states document the reasons for the delay in an individual's account. I know that we received a number of questions about challenges -- doing it for each individual -- in an individual's account. So, it's also permissible under these circumstances to document that information in our -- sort of broadly as long as you identify cohortative states to which it applies.

I'll note specifically to that -- for that we have strongly recommended to states that you seek CMS concurrence -- even though this is something that can be done under state plan authority right now just by a simple email, short letter, just indicating to us what specific flexibilities you choose to implement -- and CMS will just provide some currents and that can also serve as documentation.

I'll note that similarly as it relates to provisions around enrollment that ensured continued coverage just somewhat relates to the bill language -- which I know we talked a little bit about on Tuesday -- that under the Family's First Coronavirus Response Act gave as a condition a receipt of the increased FMAP that's provided there, states may not terminate eligibility for individuals who are enrolled as of March 18 when the bill was enacted through the end of the month when the emergency period ended.

I know there have been a number of questions about that and certainly happy to answer more here. But I think both for that and for the renewal and change of circumstance flexibilities, I wanted to address just one question that I know that we've gotten repeatedly from a number of states which is, the timeline for catching up. And I think we recognize that, you know, all of these are tied specifically to the emergency period. So, we're not at this time granting six-month, twelve-month delays, for example, but we will be working with states on a -- to identify appropriate timelines for catching up at the end of the emergency that are reasonable and achievable by states.

I wanted to fly to that there are flexibilities that exist for verification and (Stephanie) just talked about some of them. There are also, you know, existing changes that states can make to reasonable compatibility standards to use self-attestation of certain information when documentation is not reasonably available to suspend periodic data matches. All of those can be done with simple updates to the verification plan and we are working on a simplified template that states can use. In the meantime, if you have specific questions, you should feel free to reach out to us. In the disaster spot template that was released on Sunday there are also a number of specific flexibilities that states maybe interested in implementing related to enrollment. There is presumption eligibility, as well as (unintelligible) hospital presumption eligibility.

And as (Stephanie) just noted hospital presumption eligibility under current state plan authority is available to individuals enrolled in a non-MAGI group. And we have tools and guides and resources for states that are interested in pursuing that. And I know we've already received a number of spas from states that are interested in expanding hospital presumptive eligibility to non-MAGI populations and are available to provide technical assistance on that. States I know are also exploring continuous eligibility, use of simplified applications and implementing 12-month renewals for adults in the event that states don't currently have that policy in place.

Lastly, I know that - I just want to note that we are continuing to be available to talk through any other state's specific enrollment and retention options that might be available to states and some of you have already come to us with some ideas including things like accepting assessments of determination from the FFE. But if there are questions, I'd be happy to answer those at the end as well. I'll turn it to (Meg).

(Jackie Glaze): Thank you (Jessica) and thank you (Stephanie). So, we are going to move on to the managed care agenda items. So, I'll turn it to the managed care team...

((Crosstalk))

Sarah Delone: (Jackie), (Meg Barry) was going to take a couple of minutes to talk about the CHIP.

(Jackie Glaze): Yes, just a couple of minutes; thanks.

(Meg Barry): I'll be quick. So many of the enrollment and cost sharing flexibilities that (Stephanie) and (Jessica) talked about are also available to the chip disaster

state plan amendment. So, things like the laying renewals and changes and circumstances and suspending verification rules. You know, things around waiving premiums and the premium lock-out period and cost sharing. That's not an exhaustive list but if you have more questions, you can talk to your chip project officer.

I also know that some of you have questions about what to do about children who are aging out of chip and we're working on an option for those individuals. And we hope to be able to share it soon.

I also just wanted to flag one other question we've been getting from a lot of states about maintenance of effort in separate chips. I did want to clarify that the maintenance of effort requirement in the Family's First Act don't apply to separate chips. So that's a little different for chip than Medicaid. So, I'll turn it back to you (Jackie).

(Jackie Glaze): Thank you (Meg), appreciate it. So now we'll move on to the managed care. So, (Alexa).

(Kerry Smith): Actually (Kerry)'s going to kick it off.

(Jackie Glaze): (Kerry), great -- thank you.

(Kerry Smith): Yes, sure. So, this is (Kerry Smith). I'm the Deputy Group Director for the Disabled and Elderly Health Programs Group and the Division of Managed Care Policy is in our group. And I wanted to start off by just expressing the same message for managed care that has already been emphasized for other authorities -- and that is, meeting the needs of the beneficiaries in the states is the top priority.

So, we are committed to our partnership with states in review of Medicaid managed contracts and associated capitation rates to ensure that states and plans are able to respond to the COVID-19 pandemic and protect Medicaid beneficiaries and providers. Today we will go over the process we put in place to ensure expeditious review and approval of amendments to contracts, rates and state directed payments. In addition, we'll go over a few of the frequently asked questions as well as flexibilities offered through the 1135 authority for managed care.

So, first I want to start off by saying that, in general, it's really important to know that states may already have sufficient flexibility in their existing contract with plans in order to accomplish the activities necessary to address COVID-19. If in reviewing their contracts, states find that something is not currently addressed appropriately, it should submit an amendment to the contract for CMS review and approval. We also understand that there may need to be changes to previously approved rates due to changes in assumptions and utilization related to COVID-19. And we are committed to providing technical assistance and expeditious review and approval of these rate amendments.

So, as far as process goes, I wanted to let you know that the CMS team is working in close collaboration with our Office of the Actuary on COVID-19 submissions to ensure that all pieces of this submission are reviewed and approved. And as you may seen in a list serve earlier this week, CMS is requesting that states submit all COVID-19 related managed care action items to the following mailbox: So, it's [cmcsmanagedcarecovid19@cms.hhs.gov](mailto:cmcsmanagedcarecovid19@cms.hhs.gov). And we would like you to send all COVID related contract amendments, rate amendments and state directed payment pre prints to this mailbox. We request that states identify COVID-19 in the subject line of the submission

and identify the type of action included in the email. States should continue to cc their field office managed care analysts on their submissions.

And I wanted to make clear that all COVID-19 questions including those related to managed care should still channel through the state leads. They should not submit them to the COVID-19 managed care mailbox. This mailbox is just for action. We want to keep that separate -- the questions and the actions separate. And reassure you that CMS will prioritize COVID-19 actions above all other actions. I also want to clarify - we've been getting some questions that states will still need to submit pre-prints for state directed payments for any purpose other than COVID-19 through the normal process, but any state directed payment pre-prints that relate to COVID-19 should be submitted to the mailbox that I just mentioned.

Next, I'll move on to cover the frequently asked questions on managed care flexibility. First, you had a lot of questions about telehealth and payment and managed care. So, as previously been discussed on state calls, states have broad flexibility to cover telehealth through Medicaid including the methods of communications to use. No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or the same rate that states pay for face-to-face. A fee for service -- a SPA would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs. But for managed care -- if a benefit is covered under the state plan, Medicaid waiver or demonstration, CMS encourages states to amend managed care contracts -- if it's not already included in the contract -- to extend the same telehealth flexibilities authorized under their state plan labor demonstration for services covered under the contract.

Absent coverage under the state plan or otherwise authorized through a Medicaid waiver demonstration services furnished under telehealth through

managed care could also be provided as in lieu of services or value-added services. So, under the regulations in lieu of services would be alternate services or services furnished in an alternate -- alternative -- setting covered by managed care plan or entity in lieu of state plan coverage services. But they must be authorized by the state as being a medically appropriate and cost effective substitute for the covered service we're setting under the state plan and they have to be authorized and identified in the managed care contract and not required to be used by the enrollee in lieu of the state plan covered service.

In addition, there are specific rates development rules used on a managed care contract authorizes the use of in lieu of services. So, the other option of valued added services are additional services beyond those in the contract voluntarily provided by managed care plans. The no-contract amendment is needed. However, the cost of the value-added services cannot be included when determining the capitation rates. So another common question that we're getting is, how can states collaborate with managed care plan partners and community based organizations including home delivery services to provide non-medical support such as meals and over-the-counter medications to Medicaid and chip beneficiaries quarantined or self-quarantined in their homes.

And so, as long as the benefit is covered under the state plan or waiver, states can add services to managed care contracts via contract amendment.

Managed care plans also have flexibility to voluntarily provide additional services beyond those in the contract which would be the value-added services that I just mentioned. Again, no contract amendment is needed for value-added services. However, the cost of such services cannot be included when determining the capitation rate. So, we're also getting questions about payment for testing as a non-risk payment outside of the capitation payment. There are multiple approaches in which states can permit payment for

COVID-19 testing in managed care programs to the extent that health plans are responsible for providing laboratory services, they must cover the COVID-19 test. However, in the event the approved rates are not sufficient to cover the costs of these tests, states may wish to address this through extra actuarially sound rate adjustments.

States could amend their rates to include an adjustment for those costs if such an adjustment is actuarially sound and a state determines that to be necessary. States could also create a chip payment consistent with actuarially sound requirements for managed care plans to cover the tests which would require a contract amendment and rate certification. Another option is states could pay for the tests outside of managed care capitation payments as a non-risk payment either as a separate non-risk contract with its managed care plans or as an amendment to its existing managed care plan contracts to include a non-risk payment. If the state chooses to amend its existing contract to include a non-risk payment, the state will need to comply with the upper payment limits consistent with the requirements for non-risk contracts.

For chip states could follow the same approach of paying for the test outside of managed care capitation payments as a non-risk payment. The states also have another option to pay for the test under their Medicaid and chip fee for service programs and carve this benefit out of the managed care program and contracts. In general, we advise states to review their managed care contracts and rates carefully to identify any existing flexibilities to determine whether managed care contracts or rate amendments are needed.

So, next I want to talk about medication supply in Medicaid managed care. A (unintelligible) managed care plan permit 90-day supplies of medication at retail and mail order pharmacies in situations where 90-day medication supplies are clinically appropriate as well as waivers of early refill

requirement. The state should review their state plans and managed care contracts to ensure they have no state restrictions in place. In general, states have flexibility to establish Medicaid and chip fee for service prior authorizations and drug utilization review processes but encompasses extended dates, supplies and early refills for emergency situations without CMS' approval.

Some states may need to modify their state plans. Under CMS managed care regulations, the need for a contract amendment related to prior authorization -- extended dates -- supply of medication and early refills will be dependent upon the detail included in the state's existing managed care contract. The existing managed care contract specifically do not allow for 90-day supply of medications or early refills. States will need to submit a contract amendment. And again, CMS will prioritize our review and approval of these COVID-19 related state plan or contract amendments.

So, this goes along with -- the last topic I'll cover -- that's prior authorization for medication and supply. So, we've been getting questions about this as well. And under Medicaid managed care states may develop the specific standards and criteria that best meets the needs of their program including accelerated or relaxed requirements during times of emergencies. And federal law does not prohibit or limit states from requiring managed care plans to temporarily suspend prior authorization requirements, extend prior authorizations through termination of the declaration and expedite processing of new prior authorizations with flexibility and documentation. We have been asked a lot about this whether there's a 1135 authority needed for prior authorization for managed care since there's no federal law regarding prior authorization for managed care, there's no need for a waiver.

So, that's a good Segway for me to turn it over to (Alexis Gibson) who's going to talk a little bit more about the 1135 authority for managed care.

(Alexis Gibson): Hi, good afternoon. States will need to submit - sorry. CMS recommends that if a state requires a flexibility and fee for service and then managed care, that the state specifically call out both in their 1135 request. There are several flexibilities approvable under the 1135 waiver authority that can be applied to fee service and managed care service providers. And the approval letter from CMS will provide clear approval for both.

Approval flexibility under 1135 waiver does not require contract amendment. Contract amendments will depend on specific details in the contract. For example, if the contract provides more details over the state plan on prior authorizations, then the state may need to amend the contract to help the managed care organizations meet the needs of beneficiaries during the COVID crisis. In another example, a state may need to amend a contract and rates if they decided to include a new state direct payment that is COVID related. And CMS is happy to talk to states about contract amendments, rate amendments and about state directed payments related to COVID. The most frequent use of the 1135 for managed care related to appeal timings. Within the 1135 waiver, CMS cannot waive parts of 42 CFR 438 sub-part F as they relate to appeals of adverse benefit determinations which occur before fair hearings for Medicaid managed care enrollees.

However, CMS is able to modify the timeframes associated with the appeals. And CMS has previously approved the following modifications. First, modification of the timeframe for managed care entities to resolve appeals under 42 CFR 438.408 F1 before an enrollee may request a state fair hearing down to one day. Another day would be a modification to the timeframe under 42 CFR 438.408 F2 for enrollees to exercise their appeal rights to allow

an additional 120 days to request a fair hearing when the initial 120 day deadline for an enrollee occurred during the authorized period of the section 1135 waiver. Thanks (Kerry).

(Kerry Smith): Thanks (Alexis). So, (Jackie), we're good. We can answer - we'll be happy to answer any managed care questions that come up.

(Jackie Glaze): Great. Well, thank you (Kerry). Thank you (Alexis). So now we're going to open up the mics. So, moderator, can you do that so that we can take the questions from the audience.

Coordinator: Thank you. At this time if you would like to ask a question, you may press star 1. Please unmute your phone and state your first and last name when prompted. Again, that is star 1 for any questions. (Alice Whice), you may go ahead.

(Alice Whice): Sorry, I was on mute. So, I have two questions. The first question relates to the guidance that CMS provided regarding reductions in service. So specifically, regarding the language about whether - I know a state can't determine eligibility under the Family's First Coronavirus Response Act - but the question has to do with whether the state could - is redetermining eligibility for an individual - make a determination whereby the individual might receive a reduction and service - or whether the language in the frequently asked questions document was referring more generally to the state's authority to reduce benefits for beneficiaries generally.

This is coming up for us in the context of our EPD waiver program or home and community-based services program. And we're curious if we erroneously determine someone eligible because we've waived some requirements, do we

have the flexibility to redetermine them eligible just for the aging, blind and disabled program for example?

(Jessica Stevens): This is (Jessica). (Alice), I missed the very last portion of your question. I did want to address. I did want to address the first part and then ask you for follow-up on the second. You're right that this question was addressed in the FMAP FAQs that were released earlier this week. And in those we clarify that in conducting we determined nation of eligibility, states may not reduce benefits for any beneficiary enrolled under the act. So, to answer your question very specifically, that's correct that we were referring to that specific provision and not just more generally the MOE. Can you - do you mind clarifying the latter part of your question.

(Alice Whice): So, for example, would that - thank you (Jessica) for that one. So, for example, with respect to the - if I have a beneficiary in my program who I've determined eligible for home and community-based services and then I determine later on that it was inappropriate to put them in that category based on the level of care assessment that I do later, can I reclassify that individual into benefit category that does not provide them with home and community-based services. Would that be considered a reduction in service for that beneficiary under the guidance?

(Stephanie Comizkie): (Jessica), this is....

(Jessica Smith): Go ahead.

(Stephanie Comizkie): No, I think that would be likely (Alice). I'd like to try to take that back and double check myself. But my understanding is that could be considered a reduction in benefits that is not permissible with the MOE requirement. So,

let me just confirm my thinking on that and we'll circle back after the call with you directly to let you know that one.

(Alice White): That's great. Actually, my second question had to do with the extent to which I know you've explained - and (Jessica), I think you did a great job of summarizing the flexibilities regarding extensions of eligibility. One issue that's come up for us is in our state we have a special needs program for children. And we have the aging out date is when they turn 26. We've received a request to allow for an extension for those individuals upon turning 26 during this emergency period. Is that the sort of thing that CMS might consider, and if so, would we need to request that under an 1135 or could that just be considered an extension of eligibility?

(Jessica Smith): So, for the children in this group who are currently enrolled in Medicaid -- for the purposes of the -- well, it's actually until the end of the month when the emergency period ends -- those children enrolled in Medicaid should not be terminated from coverage as a condition of receipt of the increased FMAP. As (Meg) noted, it's different from chip. But yes, after that point, I think we recognize that not all states are going to be able to, you know, re determine eligibility as appropriate, terminate eligibility as appropriate - you know, as of that day. And so, those are the types of circumstances that we would like to talk to states on a case-by-case basis and likely issue additional guidance later on to help.

(Alice White): Okay. So, for the purposes of this provision, what you mean is that a child under the age of 26 could be retained in that category even if they turn 27 during the emergency period?

(Jessica Smith): Correct.

(Alice Whice): Great. Thank you.

(Stephanie Comizkie): (Jessica), can I - I just want to chime. Is the 26-year-old mark is that a D.C. related requirement. I'm just - it's not registering with me as a particular eligibility group.

Anne Marie Costelle: Why don't we just take that (Stephanie) offline and maybe we can move onto other questions.

(Stephanie Comizkie): Absolutely.

Anne Marie Costelle: I'm looking at the clock, so.

(Stephanie Comizkie): Yes, sure.

Coordinator: Thank you. Our next question from (Bill Ward). Your line is open sir.

(Bill Ward): Thank you. Really quick. I do want to make sure I heard correctly that all perm audits -- they will be suspended. So that means perm audit - it's coming up here in July of this year - and so we are not going to resume any perm audits for the next perm cycle which is July. Is that correct? Is that - (Calder Lynch) said that.

((Crosstalk))

(Calder Lynch): Sorry. All the folks I think on the line know the answer. So, the activities are paused for now. We'll come back soon on what the longer-term plans are. So, I don't think (Bill) what I'm talking about probably stems all the way out to July at this point. But there are states who are currently engaged with regards to document requests and work and those activities will pause for near

term and we'll have further guidance soon on the longer-term activities over the next few months.

(Bill Ward): Oh, I see. Okay.

((Crosstalk)):

(Calder Lynch): ...add anything.

Anne Marie Costelle: So, (Christy Fallar) is with us. (Christy), do you want to jump in?

(Christy Fallar): No, I totally support what (Calder) just said. It's just for the short-term. More information will be coming out for long-term activities as far as...

(Bill Ward): Very well.

Woman: Hello?

(Calder Lynch): Yes, hi. Couldn't hear you.

Woman: Oh, I'm sorry. Didn't fully hear my name. Sorry about that. I just have a quick question about MCO credentialing. I know that federal state says - requested that waivers - and I haven't seen any granted. I don't know if 1135 waiver is the right way to ask for a waiver of the MCO credentialing of providers or if there's another mechanism we should be using.

(Alexis Gibson): Hi, this is (Alexis). So, the 1135 should be the way to go. And then one of those times where you would specifically call out fee for service and managed care so we can write it clearly in the letter for you. They essentially waive the

same parts of 45 -- 42 CFR 45 sub part B and sub part E. So, the 1135 would be the way you go.

Woman: Okay, thank you.

(Calder Lynch): Operator, next question.

Coordinator: Thank you. (Lia), your line is open now. You can ask your question.

(Lia): Hi, my question is already asked by I believe the person who earlier asked about reductions in waiver benefits and waiver enrollment. If you could get that response after confirming it to all of us and not just the questioner, I think we'd all be grateful for that. Thank you.

(Calder Lynch): Absolutely. We'll add them into our general FAQ we're updating regularly.

Coordinator: As a reminder, if you have a question, please record your name. I have several with no names and I want to get your line right if I could. (Erin Black), your line is open now. You may ask your question.

(Erin Black): Thank you. I have a couple of quick questions here. Related to - so, is our Medicare savings program groups covered by the non-termination piece of the 6.2% enhanced match requirement. And if not, would states be okay not terminating buy-in for them?

((Crosstalk))

Woman: The provisions apply to all Medicaid groups.

(Erin Black): Okay. And then, can you clarify - so, we've been having some discussions about the start and end dates for the 1135 via appendix K and the spa -- disaster relief spa. So, we've seen - I think a couple of them referred to the public health emergency. And a couple of the other ones or there might be a duplication related to the national emergency. And so, we just want to clarify the timeframes for those in terms of the end dates. And then, if the states would be able to submit maybe - if the states are going to need to submit a 1115 to potentially address timing issues -- federal versus state. And then any potential transition time based on the ending of those authorities.

((Crosstalk))

(Calder Lynch): Yes, I was going to ask (Jackie) if she could walk through that because I know some - because of the specific authorities go back to the beginning the PHE others are tied more specifically with the national declaration.

(Jackie Glaze): Yes, and so, the - it is through the duration of the public health emergency. So, it was declared that it would begin on March 1st of this year and then the public health emergency is 60 days. And so, the Secretary does have the authority to extend it. So, there could be extensions based on the one that we have. And so, as far as the spa -- the disaster spa -- that would be affected with March the 1st. I will refer to (Ralph Lollar) on the appendix K for the HCBS.

(Ralph Lollar): Can you repeat the portion regarding the portion regarding the ....

(Calder Lynch): (Ralph), the question is -- what is the early effective date of the appendix K. So does it go back to the beginning of the PHE or the national declaration?

(Ralph Lollar): You can go to January 27th -- (unintelligible).

- (Erin Black): And then it would end with the public health emergency ending or to the national declaration?
- (Ralph Lollar): With regard to the appendix K, you can go for up to a year. So, it would be January 27 of 2020 to January 26 of 2021 if you want to be that expansive.
- (Erin Black): Okay. So, the spa and 1135 both end 60 days from the public health emergency unless there's an extension. And then, if a state wanted to address, could the state -- if there was an issue between timing for the state and the federal end time -- would there be a potential for maybe doing a 1115 waiver to address the variance and/or transition time for going back to normal?
- (Calder Lynch): Yes, we can certainly work with you on that. The 1115 template that we put out over the weekend contemplates those demonstrations lasting until 60 days after the end of the PHE the public health emergency. But if there's some other needs, you know, regarding transitions that would extend beyond that, we can, you know, work with you to see what that would look like. You're raising a good question. I think it's probably pointing to a need for us to, you know, just provide a clear chart of the effective dates of the different authorities. So, folks have that because there is a little bit of inconsistency based on the -- sort of statutory, regulatory authorities. But we can certainly work with you on that.
- (Erin Black): Okay. And then really quickly -- the Family's First, the testing services and treatment that are required without cost sharing -- I thought I heard the same. We were thinking maybe we didn't need to submit authority changes related to that because it's required by the Family's first legislation but it sounded like -- from what was said today -- that maybe we need to submit some

change to our authorities through a state plan or other -- if it just for that group that's tested positive for those services?

(Stephanie Comizkie): This is (Stephanie Comizkie). And I would say that if you have currently a state plan cost sharing authority that would create cost sharing for the services that I mentioned earlier, then the state should come in and exempt through the disaster template during this temporary period, if you will, the required mandatory exemptions.

(Erin Black): Okay, thank you.

(Anne Marie Costello): And I also think that we'll take a look at - to see if there's any additional flexibilities there. So, we'll take that one back as well.

(Erin Black): All right. Thank you very much for your help.

Coordinator: Next question from (Debra Kinsey). Ma'am, your line is open.

(Debra Kinsey): Thank you. As far as the recording that's going to have for this call, is that going to be posted on the CMS COVID-19 web page?

(Calder Lynch): Yes, it will be. And the past calls have begun to be posted as well and then transcripts too once they're available.

(Debra Kinsey): Very good. Thank you.

Coordinator: Our next question now from (John Lasiwit). Sir, your line is open.

(John Lasiwit): Thank you. Yes, I'm with the state of Wisconsin and we're wondering if the MOE requirements for the enhanced FMAP includes increases in any kind of

co-payments or in cost share or personal liabilities (unintelligible) petty for nursing home and community waiver folks?

(Stephanie Comizkie): This is (Stephanie Comizkie) and I want to try and quickly pull up the legislation so I don't trip on myself because, you know, typically I think of cost sharing not as condition of eligibility but it is a scope of coverage kind-of thing. And to the extent that maintenance (unintelligible) language is covering scope of coverage as well, I would say that - you know, it's sort of like that reduction in benefits scope of coverage. So - sorry, I'm just trying to quickly look at it. My inclination is to the extent that scope of coverage generally is not supposed to be reduced. And so, that's the same for petty and cost sharing. Does that make sense (John)?

(Calder Lynch): We'll take that back and make sure that we can get you a solid answer on that. We'll take that back.

(Judith Cash): Yes, and this is (Judith). And I'm aware that Wisconsin has some issues related to its 1115 demonstration that we're working with the state on so we can follow up with you on that as well.

(John Lasiwit): Great, thank you. There is one other question, and that was -- what authorities should be operating under for ignoring persons aging out and other kind of terminations? Is that something we'd ask for in a disaster spa or would that require 1115 waiver request?

(Calder Lynch): Yes, we're working through that now to try to find the simplest solution to that question -- and you know, working with folks on the hill as far as whether there can be further clarifications provided to avoid the need for that -- but we'll hopefully have further guidance on that very shortly.

(John Lasiwit): Thank you.

Coordinator: Our next question from (Shavon Harris). Ma'am, your line is open.

(Shavon Harris): Thank you and good afternoon. Hopefully these are two easy questions. So, related to the Family's First Act, in terms of the enhanced FMAP. We just want to know for the medically needy population, are those individuals required to maintain their Medicaid eligibility as well, because as you know month-after-month they have to meet their share of cost or spend down before they are determined Medicaid eligible? And then I have one other question?

(Jessica Stevens): Yes to that question because all Medicaid groups are included as part of that -- as a condition of increase.

(Shavon Harris): Okay, great. And then for the SSR population - so, are we to just override - so, in our system we kind-of rely upon the feed from Social Security Administration and information that they share. Are we to just override all of that and just keep those individuals eligible or are you guys doing anything at the federal level for that population?

(Jessica Stevens): I think we can look into whether there's something that could be done but those individuals too are included. I think we included them -- noted a specific example of them in our FAQs as well that they too should remain enrolled.

(Shavon Harris): Okay, so we should just override. Okay, all right. Thank you. That's it.

(Jessica Stevens): You're welcome.

Coordinator: Our next question from (Christy Garland). Your line is open.

(Christy Garland): Hello. Thank you. I have a couple of questions, and a few of them are kind of lumped in the same regards. I believe I just heard further guidance is coming. So, I'll ask again and if it (unintelligible) let me know. But I'm wondering about people who - like we legitimately know are not eligible for the program they are receiving, and I understand they have to stay open. My question really is what -- will allowances be given if they're kept in the program we know they're not eligible for or should we move them to a different program. For example, individuals who are receiving the adult programs for individuals 19 or 65 are under 133%. Let's say the individual starts receiving Medicare or turns 65 and we know they're not eligible for that program anymore they're receiving, we're not going to close them, but should we keep them in that program or should we move them to one of the ABD programs -- you know, so there's that.

And another example is a non-service citizen who turned 19 becomes an adult, they - this would be for a reduction they were receiving - you know, like the full Medicaid benefit and now they would only be eligible for emergency based on their immigration status and not meeting the non-citizen requirement. We're processing reductions. So, would we - we would then move them to an adult program and keep them at that plus level until the emergency period. And I had another general question about income too but first there's that one.

(Sarah Delone): Sure. So, this is (Sarah Dalone). I can jump in and try. And I think one of them we're going to - it's a great question. They're both great questions, but the latter one around the non-citizens I think who are sort of aging out of the option that states have to cover lawfully present individuals -- it sounds like children that's the issue you are concerned with. So, I think we need to take that back. I think with the first scenario that you mentioned in terms of - and

again, I think all of these questions are great and we should circle back. I think what (Calder) has said where we haven't done the written guidance on it, we should circle back just to confirm in written guidance.

But, I think we're - what we think this is the approach that would be expected by the legislation is that you would keep the adult who's the individual who's turned 65 or narrowly would be terminated from the adult group. In that group -- because as (Jessica) mentioned earlier -- you can't -- the law requires that you do not reduce benefits that somebody's getting at the time, you know, it's sort of in this magic window period. But at the same time, that person is also entitled to the, you know, if they're moving into a Medicaid savings plan categories where they typically would go. They are eligible for that assistance with their Medicare cost sharing and premiums. And so, you would want to add those benefits also.

And I think in terms of the - if there's some operational issues in terms of getting those - we have our two groups -- (Stephanie Comizkie)'s group -- the eligibility policy and (Jessica Stevens) with the enrollment policy -- (unintelligible) was sort of thinking through that a little bit and we can be available to provide some assistance with that -- sort of thinking through how that's going to be feasible if that's an issue for your state.

(Christy Garland): Okay thank you and you can add to that like a child who turns 19 who was receiving benefits under 133% and now is eligible. I know there is an option in the state plan that was sent out for this emergency period that there is an option to cover adults over 133% -- but if we wanted to only apply that to current recipients and not to new applicants coming in that would be a question. But you can put that on there.

So, the other question is about income. Do we have an answer about whether or not the stimulus would count? And also, will there be other - is there anything they worked on for other income allowances, if any that will be given? And will that guidance be coming out? Because we've seen some changes related to like self-employment and just other things that were wondering about (unintelligible) income and (unintelligible).

(Calder Lynch): So, with regards to any additional income that states the individual to receive stimulus and there was a provision regarding that's applicability the public assistance programs in the draft of the bill. I haven't had a chance to review whether -- you know, what stayed in the final. I think we'll need to go back and look and provide follow-up guidance on that specifically but I know that they were looking to address that so it wouldn't result in folks losing eligibility. And then someone else may want to jump in on the second part.

Sarah Delone: Can you repeat the second part.

(Christy Garland): I'm just wondering - the stimulus is the first -- will that count. And the second is, are there going to be other allowances to income on things that might be considered taxable that we wouldn't consider for MAGI or changes? If something is changed that they may say, "Okay, this X type of income is now not going to be taxable because of the emergency period. Would we receive guidance on that?" Or do you know of any already that that you're preparing guidance for.

(Stephanie Comizkie): This is (Stephanie Comizkie) and I would say this is - the answer to that is really the same as what (Calder) just said to the extent that any of those types of, you know, changes to tax requirements, etcetera, are in the midst of being legislated. We certainly will study those and get out guidance quickly

as possible. We've been tracking that very closely and understand how important it is for you to have that information asap.

(Calder Lynch): Yes, I think, you know, generally for anyone who's eligible under MAGI, you know, it's going to require Congress to be explicit to exclude that income from that formula where it will have more discretion but on that MAGIs group (unintelligible) which is included in the disaster spa will be able to add additional (unintelligible) to that. But, I think, for MAGI it's going to require Congress to be explicit about that.

(Calder Lynch): I think we had some really great questions today. We got into a lot of detail on that (unintelligible). We probably did not get to everyone's question and I apologize for that. Please do make sure that if you have a question that was not answered today that you provide that to your state lead. We do have another set of FAQs that will be out - our hope is very early next week. But we're allowing these additional questions to make sure that they get incorporated as well. And of course, we'll be studying the bill that was passed today. As they get signed into law providing further guidance by the applicability to Medicaid as well.

Again, want to thank everyone for joining us this afternoon. Appreciate all of the work that everyone is doing I know under very difficult circumstances. Appreciate the partnership with states and all the work that you're doing to serve our beneficiaries. Thank you and have a great weekend.

End