Centers for Medicare & Medicaid Services
COVID-19 All State Call: Frequently Asked Questions
April 7, 2020
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Coordinator: Good afternoon and thank you all for standing by. At this time I would like to inform all participants that your lines will be placed on a listen-only mode until the question and answer session of today's conference. Today's conference is also being recorded. If you have any objections you may disconnect at this time. Thank you, you may begin.

(Jackie Glaze): Good afternoon, everyone. This is (Jackie Glaze) and I'd like to welcome you to today's all-state call. Our discussion today will focus mainly on the FAQs that were released last week, and (Calder) will begin by providing opening remarks and then we have a few speakers that will share a few of the frequently asked questions, and then we will move on to the open session for you to ask the questions. So (Calder), I'll turn it to you.

(Calder Lynch): Thank you, (Jackie). Good afternoon, everyone, apologize that we're a few minutes late starting just due to some technical difficulties here with the conference line. So again I want to welcome you all. Before I begin, I did want to recognize a new member of the team who's joined us, effective yesterday. (Courtney Miller) has joined the CMCS leadership team as the director of the Medicaid and CHIP operations group.

So she's listening today. I just want to before I begin, just again express my such deep appreciation for (Jackie) and her leadership through the recent integration of the team and of course in helping us organize and stand up our response to COVID-19 and just all the work she's done. I think her and (Courtney) are going to make a fantastic leadership team for MCOG and I'm really looking forward to that continued partnership with the state.

Today we're going to be discussing highlights from the third set of COVID-19 FAQs that we released last week as well as work that we're doing to continue to update our FAQ documents and questions that we're receiving from states. We'll probably dedicate the majority of time today to taking questions as we continue to know that there's continued issues and things that folks are needing to address.

We are still working quite hard to produce a second set of FAQs in response to the brief congressional actions which we will likely have out and be able to discuss prior to our next call. As a reminder we had previously released a set of FAQs related to the Medicaid and CHIP revisions of the family first coronavirus response act, or the FFCRA with much of the focus being on the enhanced FMAP and the conditions applied to it.

This second set of FAQs will be focused on updates based on changes and additional considerations that Congress made as part of the CARES act. We've been working to make sure that this FAQ is as complete as possible. We know there's a lot of very detailed questions about how some of those provisions are operationally playing out.

So it's taking us just a bit longer to work through some of those complex legal and operational issues, but we're very close, and again I expect that we'll be diving into those all next call. One question that will be addressed in those FAQs that I know has come up a good bit over the last few days and that I can address now is regarding the impact of the forthcoming $1200 stimulus checks on Medicaid eligibility.

We've been working very closely with our partners at the IRS and the Department of Treasury, and I think confirmed that those additional payments

will not count toward neither MAGI or non-MAGI eligibility for purposes of Medicaid eligibility. Also it is not counted as a resource in non-MAGI eligibility determination as long as the funds are spent within 12 months of receipt.

So for all intents and purposes those additional payments would not be counted in the financial eligibility determinations for anyone, and that's the same as any of the additional payments that are available to individuals to the unemployment fund, the additional payments that are being made available under the CARES act would not count as well. Those – there was a specific provisional law that discounted those extra payments from counting toward eligibility.

But we know that question's come up, and so we wanted to clarify that. You'll see that answered in a little bit more detail in the FAQs that are released shortly. The – another update I wanted to provide is just where we are with some of the waivers and SPAs and flexibility that we've been working on. We have now received and approved 1135 requests from nearly every state.

I think it's at this point today we only have one outstanding state that came in on Sunday night that we're working through. We know there's a handful of states that are either coming in with a second round of requests under 1135 authority, or maybe are just beginning that process and will be working those as quickly as possible. Those are being – those initial approvals at least are being approved in an average of less than five business – five calendar days.

Much of the work though I think is turning to sort of the next set of authorities and flexibilities with of course there being a lot of focus on the disaster state plan amendment, the disaster SPA, and the Medicaid and CHIP Medicaid – I'm sorry, and the CHIP disaster SPAs as well. We've now approved three of

the disaster SPA templates for Medicaid, and I believe we'll have the first CHIP disaster SPA in light of COVID-19 approved today as well.

Also as of last night we've now approved about 21 appendix K's for your 1915C waivers. And so we're continuing to process those as well as some of the 1115 requests, and the IT funding requests that have come in, and we're also responding to states just to affirm some of the flexibilities that they have in their existing regulatory authorities. And we encourage you to reach out to your state lead if you want to confirm what other options may already be available to you under the current regs.

I know a topic that continues to be a focus area for many states and for this – for NAMD as well has been the ability to address issues in provider solvency through the ability to make some types of retainer payments, or additional payments to providers in light of COVID-19, and ensuring that we're able to continue access to care through and beyond the public health emergency.

This is something we're looking at I think broadly across both CMS and HHS as a whole. As you may know, Medicare has been working to accelerate advanced payments out to providers which are a type of loan, what they're able to provide for several months of payments in advance, I think they've injected nearly $70 billion in additional reimbursement out to providers through those advance payments that have been accelerated over the last 10 days or so.

And then the department, HHS, will be providing very soon more detail regarding how the additional $100 billion that was appropriated through the CARES act is going to be disbursed into the provider community with much of that funding being prioritized for quick allocation into cash out to providers, and then we'll have follow-on discussions about feature

investments of those funds and how – and certainly we'll be communicating that to states in terms of its relevancy to Medicaid providers, which are certainly an important part of our provider community.

Right now through our existing authorities we've been working with states on of course a number of opportunities for these types of payments through for HCBS providers through the appendix K authorities. Also we're beginning to work with states through the disaster SPA process which allows for temporary rate enhancements or rate methodology changes that we may be – we believe may be able to address some of these needs.

And as we develop more experience with states there, we'll provide more guidance and examples of how those options are being used. And even beyond that we know that there's ongoing asks, and we're continuing to assess the needs of Medicaid providers and states as we receive those requests, and we'll continue to work on additional steps that may be necessary as we see more how the needs of states are playing out and of providers in light of all the things I've just discussed.

So that's going to be a continued set of work for us with you all. So with that I'm going to turn it back over to (Jackie) I think to introduce our next speakers, who are going to dive a little bit into the FAQ batch three that was released recently and then of course as I mentioned we'll spend the balance of the time on your questions.

(Jackie Glaze): Thank you, (Calder). So now we'll move to (Alissa Deboy), and she's going to address several of the managed care questions in the FAQ batch #3, so (Melissa)?

(Alissa Deboy): Great, thank you, (Jackie). Hopefully you can hear me okay. Good afternoon, everybody. On behalf of the disabled and elderly health programs group, we have a few questions in batch three, the question set recently posted. They range from pharmacy, third party liability, and managed care. The most significant of these questions though relates to managed care and I wanted to briefly highlight it for you all this afternoon.

The question concerns the impact of the COVID-19 pandemic on state level managed care plan performance and quality measurement efforts. We note in the FAQ that CMS recognizes that the current COVID pandemic is likely to affect clinical practices as well as the timely and accurate reporting of quality data. And as a result states may need or want to revise their managed care contractual rule quality measurement requirement.

So we list some examples. For example, states may have contractual requirements surrounding withhold arrangements in which a portion of the capitation rate is withheld from the managed care plan, and which payment is linked to quality performance. Similarly other states may have contractual incentive arrangements, in which an amount over and above the capitation rate is paid to managed care plans for meeting targets specified in the contract.

In addition to these arrangements, states may also have approved directed payment proposals that can issue payment to providers upon the performance of specific quality measures. Or states may have general contract requirements that impose penalties on plans for failing to meet certain performance levels. States as we note in the FAQ, states may want to reexamine these payment arrangements to determine if contractual changes are necessary in light of the COVID emergency.

Depending upon the needs of the change, the contract amendment may be needed as well as a rate cert amendment if changes are expected to have a material impact on the rates. So if that is a directed payment change, a revised rate cert will likely need to be submitted as well. As we've noted before, CMS is working to prioritize and expedite these reviews and we have a dedicated mailbox where these actions should be submitted, and it's the identification of which is in the FAQ.

I also want to note that we have a special call this Friday to discuss managed care rate implications in light of the COVID pandemic. Our colleagues from the office of the actuary will be presenting some considerations for states, focusing on flexibilities available under state authority. We'll discuss these options in terms of complexity and timing of various approaches.

We think that you'll find that very informative and encourage states and their actuaries to participate. So with that I'll turn it back to (Jackie). Thanks, (Jackie).

(Jackie Glaze): Thank so much, (Alissa). So next up is (Jeremy Silanskis), and he'll talk about the payment and financing, so (Jeremy)?

(Jeremy Silanskis): Hi, thank you. So some of our questions are more procedural in nature. We have a few questions here about flexibilities available in the event of a public health emergency impacting state Medicaid agency staff and their inability to submit quarterly budget estimates or on form CMS-37 45 days before the beginning of the quarter.

So what we see there is that that's fine. You should notify CMS that the form 37's going to be delayed, and we'll work with you on what that will look like.

And the same applies to CMS-64 reporting too. You should notify us and we'll work with you on timelines there.

We do have some guidance about telephonic services provided by QECs and how that would work and whether FFP is available and we do clarify that yes, FFP is available for telephonic services provided by FQECs. We're getting that fairly frequently, so we did want to clarify that. And then also how – whether the PPS rate must be paid for telephonic services that are provided by FQECs or HCs as they would be paid for in-person services.

And so we clarify that, that you don't need to submit a state plan if you're going to pay the same way as you would for at least each encounter, and that yes, if states do provide FQEC services telephonically, then they should be paid at the PPS rate.

(Jackie Glaze): Is there anything else, (Jeremy)?

(Jeremy Silanskis): Yes, one more.

(Jackie Glaze): Okay.

(Jeremy Silanskis): Just some clarifying information around retainer payments and how that will work. Unfortunately we don't have flexibility in a state plan to make retainer payments, but we do have the ability for states to offer higher payment rates to providers to offset losses that they might incur in providing services. There is some guidance in the section 1115 template on how states might make some retainer payments to certain providers.

And there also is the option through appendix K to make those payments. So we are getting that very frequently and I just did want to clarify that, and I think that's our most frequently asked questions, (Jackie), so back to you.

(Jackie Glaze): Thank you, (Jeremy). And so next up is (Sarah Delone), and she's going to share some information about eligibility and related issues, so (Sarah)?

(Sarah Delone): Actually, it's (Sarah Spector), in our division of Medicaid eligibility policy is going to present. Thanks, (Jackie).

(Jackie Glaze): Thank you.

(Sarah Spector): Hi, all. Thanks so much. So there are three areas that we just want to flag for state that we were able to provide additional guidance in the most recently published FAQs as it relates to eligibility and enrollment. The first is additional flexibility for verification processes as it relates to their asset verification system, so for verification of resources.

And that is that while the AVS systems need to continue to be used, they can be conducted post-enrollment, so that a state could take self-attestation initially, and then conduct and use the AVS system post-enrollment. The second is related to – the question we're getting from a number of states, which is how to handle the office closures and staffing problems that are happening in some states.

And there is an FAQ that gives some extensive discussion to sort of the different options that states may have, utilizing contractors that they may already have available, whether that's call centers to handle applications, expanding those kind of call center capacity, or out-station resources that already are in place.

Additionally many states have contractors that can perform lots of administrative functions and as long as appropriate oversight functions are – continue to be in place, that would be appropriate to maybe think about those relationships that seem to already have in play, and may be able to shift and utilize some of those resources while you're addressing the staffing and office closures.

The last piece I want to address today is related to fair hearings. We've gotten a number of questions around flexibility for fair hearings, and a number of different pieces of flexibilities states can put in place without any waiver or even state plan amendments. So some examples of those are delays in issuing and holding fair hearings, or issuing fair hearing decisions can be done under our existing regulations.

Moving to telephonic fair hearings and putting in place processes that would allow for submission of evidence and holding of hearings telephonically instead of having in person hearings, those are all things that states can do without a waiver, and without any state plan amendments. We would ask that states come in and request that and we would provide a concurrence so that we can help to document those delays and also that they would be documented in individuals' case records.

There is one particular flexibility for fair hearings that's available through an 1135 waiver, and that is if a state wanted to extend, wanted to grant additional time to an individual to request a fair hearing, beyond the otherwise permissible 90 days for fee for service and eligibility fair hearings or 120 days for managed care appeals.

States can permit individuals to have additional time to request a fair hearing, and that would be through an 1135 waiver. So there's more detail about all those issues in the FAQs and I think I'll turn it back to you, (Jackie).

(Jackie Glaze): Great, thank you, (Sarah). So that concludes our formal comments, so (Christie), we're ready to take questions from the audience, so can you open up the mike at this point?

Coordinator: Thank you. If you would like to ask a question, please press star one on your phone. Please make sure that your phone is unmuted and state your name clearly when prompted. Again, please press star one on your phone. If you wish to withdraw your question, please press star two. One moment while we wait for questions to come in. Our first question comes from (Nicole Soap). Ma'am, your line is open.

(Nicole Soap): Hi, good afternoon, everybody. I had a question about hospice care for long term care facilities (unintelligible). Are we – are they able to increase the cost of care during the present emergency? We know that copays and things like that can be increased, but is that an allowable increase if we get information that would increase the risk of this cost of care?

(Sarah Delone): Are you – this is (Sarah Delone). Just to confirm, are you referring to the post-eligibility treatment of income cost of care?

(Nicole Soap): Yes.

(Sarah Delone): So that is something that would be addressed in the FAQs that (Calder) mentioned, so hopefully they will be out shortly.

(Nicole Soap): All right. Thank you.

Coordinator: Thank you. Next question comes from (Renee Mallo). Your line is open.

(Renee Mallo): Hello. Thanks so much for the call today. I do have one quick question, back to (Sarah) on the eligibility and using the self-attestation for verification of resources. I just want to also make sure that with the post-enrollment verification of the AVS systems, if we do find that someone is in fact not eligible given the provisions under COVID and the statutes, we would maintain those individuals' ineligibility and coverage I mean?

(Sarah Delone): That's correct, to comply with – if it – it would be a determination based on the self-attested information, so they would then get the protection that you would need to comply – to maintain their coverage to qualify for the increased FMAP. Yes.

(Renee Mallo): Okay. Okay. Okay, thanks. And hi, (Sarah).

(Sarah Delone): Hi, (Renee). Hello, everybody.

Coordinator: Our next question comes from (Colin Loughlin). Sir, your line is open.

(Colin Loughlin): Hi, thank you. I appreciate all the hard work that everyone's doing. I had two questions in particular related to facility-based care. The first one is mentioned earlier that state fund services were not available for retention payments could be able to receive supplemental or enhanced payments, in particular for nursing facilities or intermediate care facilities. Is that something that should be submitted through the 1115 or the 1135?

We keep getting direction that's kind of moving back and forth, and so hoping to get some clarity there. And then secondarily, has there been any

consideration of allowing states to utilize several monetary penalty funds for in particular I think off the top of my head COVID related issues, in terms of outbreaks within specific facilities or potentially even looking at enhanced or supplemental payments for some facilities to keep them open if there have been positive COVID results from those areas?

(Calder Lynch): Hey, this is (Calder). In terms of your first question on enhanced or supplemental payments for facilities, I think we'd probably first look to the state plan authority. (Jeremy), do you want to talk about that in terms of the disaster SPA there?

(Jeremy Silanskis): Sure. So the disaster SPA actually has a place where you can describe those payments, so if you want to make new or additional supplemental payments to facility providers, you can do so in that template. You do have to factor in upper payment limit room, so that is a consideration there.

But I think we're also recognizing that there could be – and this is covered in the FAQs that we released, there could be an additional cost or there likely will be additional costs during the public health emergency period that aren't factored into your UPL calculations. And so we can work with you on language that would keep you within those limits, but also give you the flexibility to make payments that you need to make today. So that's an option there.

(Calder Lynch): And then in terms of the CMP, who – I'm not sure who on my team is best positioned to answer that. Let me check.

(Jeremy Silanskis): I think to the extent that you would intend to use those for the non-federal share of payments, that would be us, (Calder). And I don't think that's permissible. We can certainly take that back and investigate that more with

our legal counsel, but you are somewhat limited in what you can use to serve as the non-federal share. We'll take that question back though.

(Calder Lynch): Or do you just mean using them for these purposes, generally?

(Colin Loughlin): Okay. Yes, so I think I mean, the understanding and the intent of the fund is to – in terms of how we're getting our brands into – in Colorado improved quality of care, slice of life in facilities, provide a safety net in the event there's a closure or an emergency situation, and so wondering in regards to in particular I think you extrapolate that, incentivizing people to still show up to facilities who may have a COVID outbreak. Is that something that we could use those funds for an enhanced payment mechanism?

(Calder Lynch): I see. Okay, we'll – let us take that back and run that down a little bit. Thank you.

(Colin Loughlin): Okay, thanks.

Coordinator: Thank you. Our next question comes from (John LePhilips). Sir, your line is open.

(John LePhilips): Hi, thank you. I was wondering with the state of Wisconsin, and we were wondering if it would be permissible under the MOE for children to have their eligibility changed from Medicaid to CHIP, since our benefits are identical under both programs, it's not like they're losing any benefits.

(Sarah Delone): So (John), let us take that back. I think we actually addressed that in one of the earlier MOEs that was – there was a similar question that came up with either the ARA or the ACA MOEs and I – let us check so we're – and see how we

resolved this then, and I think the same answer would apply now. So we'll get back to you.

(John LePhilips): Thanks.

Coordinator: Thank you. Our next question comes from (Jane Jackson). Your line is open.

(Jane Jackson): Oh, hi. Good afternoon. I'm fairly new to the game here, so fun times for me. My question is probably very basic, but I'm wondering where I can find guidance on or to try to verify whether or not I can use the enhanced 6.2 FMAP money to supplant any non-federal or state funding, general funds? Has there been guidance issued on that?

(Calder Lynch): Sure. So I'll start and then (Jeremy) can probably color in a little bit of the details. So to the extent that the enhanced FMAP frees up state funding that you no longer have to contribute as much state share to the cost of the program since the FMAP is higher there are no restrictions on what you – how you repurpose those funds within your budget.

You know, you're of course always – there are always limitations on what you can use as non-federal share and Medicaid, but in terms of repurposing those dollars elsewhere for state needs, there's no limitation with regard to that. But and then we do have guidance and FAQs out on what services and populations specifically qualify for the enhanced FMAP in terms of being able to understand which of those will receive the extra funding. (Jeremy), did you want to add anything to that?

(Jeremy Silanskis): No, I think that's the right answer.

(Calder Lynch): Did that answer your question?

(Jane Jackson): Okay, thank you very much. Yes, thank you so much.

(Calder Lynch): No problem.

Coordinator: Thank you. Our next question comes from (Bill Snyder). Sir, your line is open.

(Bill Snyder): Good afternoon. I've got a question related to state's option to cover COVID testing and related services with 100% FMAP. My question is, as we look and think about the programming and administrative costs that it might require to get this benefit online for potentially small number of people, especially in a small state, my question is might there be flexibility for states to report and claim those expenses outside of the MIS and outside of formal enrollment in the program?

(Calder Lynch): That may be something we want to think about and explore a little bit more with you in terms of what flexibility might be available. (Sarah Delone), I don't know if you have any additional thoughts, but that might be something we want to take offline and discuss. I think there's definitely merit to your idea, but we just need to explore what kind of statute would provide for.

(Sarah Delone): Yes, I think that's right, (Calder). I don't have anything off the cuff. I think it would make sense for us to take that back and think it through. And maybe talk to the state to see what we were – yes.

(Calder Lynch): Yes, if we could get some more – maybe work with you offline and get more details what you're thinking about, that might help us think through that.

(Bill Snyder): Appreciate that. Who should I work with?

(Calder Lynch): Work with your state lead – or go ahead, (Sarah).

(Sarah Delone): Yes. No, no, no, sorry, go ahead, (Calder). State lead makes sense.

(Calder Lynch): Yes, because they're logging everything. We can track – they'll get it up to (Sarah) and our team to look at.

(Bill Snyder): Thank you, appreciate it.

Coordinator: Thank you, our next question comes from (Anna Erkes). Ma'am, your line is open.

(Anna Erkes): Hi, thank you. I'm from Pennsylvania, and I think that this has been already discussed in previous calls, but I just wanted to confirm, telephone only services for telehealth are appropriate for services and reimbursement in Medicaid program as long as – and without any kind of SPA, as long as the service is provided in the same way it would have been as if it was face to face. Is that correct?

(Kirsten Jensen): Yes, this is (Kirsten Jensen) from benefits and coverage. Yes, telephonic services are okay, and the only – there are two circumstances where you would need a SPA. One is if for a state plan on the coverage pages has any restrictions about what services telehealth can be used for or in what circumstances you would need a SPA, even if it's a disaster SPA to – for the period of the disaster be more flexible with telehealth in your state then.

The other circumstance is if you are paying for the service differently than you would for a face to face, and you don't have that already in your state plan, then you would need a SPA for that as well.

(Anna Erkes): Okay, great, thank you. Yes, there has been some stakeholder guidance that has gone out saying the opposite, and I just wanted to confirm for us that we are good with the telephone only as long as we follow the guidance for the SPAs if needed.

(Kirsten Jensen): There's been some confusion and – not confusion, but the telephonic piece, I think there were some HIPAA requirements that were in place that our office of civil rights have lifted for the period of the emergency to allow for telephonic consultation. There is also it seems to be some notion that Medicaid telehealth policy is dependent on Medicare telehealth policy, and that's not true.

(Anna Erkes): Okay.

(Kirsten Jensen): So there may be some nuances to what's floating around hopefully, and not just conflation.

(Anna Erkes): Well, I appreciate the confirmation that we were on the right track. I do have one more question if possible. The requirements for ordering, referring, and providing, or ordering, rendering, and providing or prescribing providers being enrolled in our Medicaid program, is that something that can be waived for like out of state ORP providers in order to be able for the – our state to pay for those benefits?

(Calder Lynch): The – this is (Calder). I think the short answer is yes. I believe that's one of the flexibilities available through the 1135 waiver, but let me make sure I'm confirming that correctly. (Jackie) or someone else want to weigh in on that?

(Jackie Glaze): I'm sorry, (Calder), could you repeat that question?

(Calder Lynch): I'll let the questioner ask or repeat it back.

(Anna Erkes): Sure, yes. Is the requirement that an ordering, rendering, prescribing provider be enrolled in the state's Medicaid program able to be waived in order for us to pay for a benefit for a Medicaid beneficiary? Like I have some providers out of state and prescribes a benefit?

(Jackie Glaze): Well, I'll have to follow back up with you on that question. Thank you.

(Anna Erkes): Okay, all right. Great, thank you very much. Thanks.

Coordinator: Thank you. Our next question comes from (Kimberly Quinn). Your line is open.

(Kimberly Quinn): Okay, thank you. Are states required to continue coverage for individuals who are eligible for Medicaid only through emergency Medicaid coverage for undocumented citizens or aliens in order to qualify for the FMAP?

(Sarah Delone): So again we have a series (unintelligible) and we have a series of questions and answers, frequently asked questions that are coming out on that, and that question is in that batch. And so hang tight for a couple more days and you should have your answer.

(Kimberly Quinn): Perfect, thank you.

Coordinator: Thank you. Our next question comes from (Suzanne Beerman). Your line is open.

(Suzanne Beerman): Hi, good afternoon. My question is also related to the maintenance of effort requirements for the 6.2 enhanced FMAP. So I saw in the FAQs that there is a limitation on – or actually a requirement for benefits related to COVID-19 specifically. My question was, does the MOE have any other sort of coverage or benefit requirements specifically if a state wanted to make changes to some of its optional benefits, would that be prohibited under the MOE?

(Jackie Glaze): So this may be a tag team between sort of the eligibility piece and the benefits folks, so I will give a response from my perspective, and then invite obviously (Calder) and (Alissa) and (Kirsten) to weigh in. But the maintenance of effort, so there's four different conditions, and the maintenance of effort one, the one that's sort of classically labeled maintenance of effort is in 6008-B1 and that's for not imposing standards or methodologies or procedures that are more restrictive.

That's very – that's a common maintenance of effort language that has appeared in other statutes. (John LePhilips) had asked about this earlier, but the CHIP to Medicaid, right? So there was a maintenance of effort requirement, same language, and the recovery act in 2008, there was the same language in the affordable care act, and there was the same I think in the healthy kids it was extended further for kids.

That really refers – that's the classic maintenance of effort, and that's about not imposing more restrictive eligibility standards or charging higher premiums to make it where we're changing your processes in any way that's going to make it more difficult for people to obtain or retain coverage or make it more restrictive for them, more strict standards.

The COVID requirement around COVID testing and treatment services is in 6008-B4 of the families first act, and that's really just around one of the services that has to be required for your Medicaid beneficiaries across all of them in order for you to receive the increased FMAP so that your maintenance of effort in B1 does not pertain to coverage of benefits. That's around eligibility for coverage. So I think the answer to that is no. But I want to defer to my colleagues in DEHPG if they have anything to add.

(Melissa Harris): Hi, this is (Melissa Harris), deputy director in DEHPG. I'll also flag that in our – some upcoming FAQs we're going to look a little deeper into what it means to satisfy the conditions required for NCAMP, FMAP and one of those is looking at what it means to provide a comparable level of benefits, and that's where I've got the language verbatim from the statute.

But it's going to be addressed in some of our upcoming FAQs, so this – that's kind of a coming attraction of what's going to be included there. We know this is a pretty big topic of interest, so appreciate your patience on that.

(Kimberly Quinn): Thank you.

Coordinator: Thank you. Our next question comes from (Dana Petmeier). Ma'am, your line is open.

(Dana Petmeier): Good afternoon. I'm from Wyoming Medicaid, and I had two questions. The first question is, if the client is currently on a Medicaid waiver program and they get specialized services and Medicaid services, do we – is it required that we cover both types of services with this requirement?

(Sarah Delone): Could you say a little bit more about your question?

(Dana Petmeier): Yes, if a client is currently on a Medicaid waiver program and for some reason they – let's say they go over resources or their income exceeds the standard or for some reason they're not eligible, are we required to cover both the medical services and the reimbursed services to continue this program?

(Sarah Delone): So you're – this is somebody who's in a like a 1915-C home and community-based waiver program?

(Dana Petmeier): Yes.

(Sarah Delone): Yes, so I think that's also a question that will be addressed in the upcoming FAQs.

(Dana Petmeier): Okay.

(Calder Lynch): Yes, although – this is (Calder). I'll broadly say that in general while you can't take away eligibility for certain types of benefits and scope of benefits, you'll see that reflected in the FAQ, particularly in the 1915-C, services are always so they need to be based on the individual needs and assessments, right? And so that will continue – those types of procedures and processes would be able to continue to apply. And that will be more detailed in the FAQ.

(Dana Petmeier): Okay, and my next question is if someone that's currently on Medicaid and they entered a public institution, and so they were going to lose eligibility in April, is that an exception to continuing them on Medicaid?

(Calder Lynch): It is not, and this will be detailed in the FAQ, though. I mean, and it'll give some circumstances why states have in the past suspended eligibility because of the – there's an FFP exclusion, a federal funding exclusion in the statute,

that would not allow federal funding to flow while they're in a public institution.

That's a separate part of the statute and would continue to apply even if they – you are not able to technically remove their eligibility. But again how those interact will be detailed a little bit more in the FAQ, and it will be hopefully forthcoming in the next day or two.

(Dana Petmeier): Okay, thank you.

Coordinator: Thank you. Our next question comes from (Amy Dobbins). Your line is open.

(Amy Dobbins): Thank you. I'm calling from Washington state. And it sounds like maybe you'll cover this in the FAQ that's coming out in the context of continued coverage under the response act. We're just wanting to know if moving somebody from an alternative benefits plan to categorically needy is considered a reduction in services, so similar to other questions.

(Calder Lynch): Yes, I think those types of examples are, and I think it's really going to depend on the specifics of the change in whether or not the – what category they'd be moving into provides for the same amount, duration, scope of benefits as what they're currently in, or if there is a reduction. But again, that will be detailed a little bit more in the FAQs. (Sarah), you want to add?

(Sarah Delone): No, I think that's right. I think that that particular scenario is not one that the FAQs exactly are addressing, so if you are unclear about the answer once you read the FAQs that are there, then certainly please reach out through your state lead so we can clarify the answer for you in that particular scenario.

(Amy Dobbins): Sounds good, thank you.

Coordinator: Thank you. Again, if you would like to ask a question, please press star one on your phone. Please make sure that your phone is unmuted and state your name clearly when prompted. Our next question comes from (Esta Stacey). Your line is open.

(Esta Stacey): Good afternoon. I'm from Arkansas, and I just had a clarification that I needed for the stimulus. The unemployment stimulus payments, how are those going to be counted for Medicaid, or will they?

(Calder Lynch): The additional payments that were appropriated as part of the recent congressional action are to be specifically disregarded from income under the statute. It is important and it does not mean that the base unemployment payment that someone's receiving as a matter of course, those old rules would need to apply there. But I think there was a specific provision, (Sarah), correct me if I'm wrong, that disregarded the additional payments that were recently appropriated.

(Sarah Delone): That's correct, (Calder), and then so whether you – and then (Calder) had talked in the beginning of there's two sort of payments that are at issue. One is the $600 increase, weekly increase in unemployment compensation which (Calder) has talked about, and then the tax rebate that up to $1200 that's sort of like a tax rebate, tax credit. That is also separate, right? And that also is not counted as a practical matter for MAGI or non-MAGI determinations.

(Esta Stacey): Thank you so much.

Coordinator: Thank you. Our next question comes from (Nicole Silk). Your line is open.

(Nicole Silk): So sorry, I tried to eliminate my questions, somebody already asked it. Thank you.

Coordinator: Thank you. Our next question will come from (Pam Winsell). Your line is open.

(Pam Winsell): Hi. I – my question was answered already and I couldn't – I don't remember how you said to cancel that, so I apologize.

Coordinator: Thank you. Again if you would like to ask a question, please press star one on your phone. Please make sure that your phone is unmuted and state your name clearly when prompted. If your question has been asked, please press star two to remove yourself. Our next question will come from (Steve Constantino). Sir, your line is open.

(Steve Constantino): Thank you. Thank you for this. And this is probably a confirmation because I haven't been on the previous calls, but just curious on the enhanced FMAP. Is it going to be based by – I think I understand it's not being based by date of service, but based on when the expenditure happens. Is that accurate?

(Jeremy Silanskis): That's correct, it's date of payment.

(Steve Constantino): Okay, so just some scenarios, many states are going through a process where they potentially may have a cash flow problem. So just theoretically and hypothetically, if a state just delayed say an MCO payment into July rather than doing it in June, that would not be eligible for the FMAP. Is that a correct assessment?

(Jeremy Silanskis): That is correct, yes.

(Steve Constantino): Thank you very much.

(Calder Lynch): And of course we don't know yet when the enhanced FMAP will end, right, because it's going to…

((Crosstalk))

(Calder Lynch): Emergency.

(Steve Constantino): Right, right. Exactly, yes. I just needed that confirmation. Thank you.

Coordinator: Thank you. At this time I'm showing no further questions.

(Calder Lynch): Okay, folks.

(Jackie Glaze): Thank you. So – go ahead, (Calder).

(Calder Lynch): No, I was just going to say thanks, everyone, for joining us. Appreciate the time this afternoon, we'll do this again on Friday and hopefully we'll be able to dive more deeply into some of these questions with more additional detail on that on the FAQs.

So again continue to reach out to your state leads if you have any follow-up questions or need any additional guidance or further TA, and we'll of course continue to make sure that you're checking our Web site for updates as those are released.

(Jackie Glaze): Thank you, everyone, and just as a reminder as (Alissa) indicated that we will have the managed care rates and flexibilities discussed on Friday. We will also have the office of the actuary within CMS on the line as well, so we

encourage the states to invite your actuaries as well to the call on Friday. So hope everyone has a good afternoon and thanks again for your participation today.

Coordinator: Thank you. That does conclude today's conference. You may disconnect at this time. Thank you and have a good day.

End