Centers for Medicare & Medicaid Services
COVID-19 Medicaid & CHIP All State Call
April 14, 2020
3:00 pm ET

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

Jackie Glaze: Thank you and good afternoon everyone and welcome today's all state call. I'll now turn to Calder and he would like to provide opening remarks and share the highlight for today's agenda. Calder?

Calder Lynch: Thanks Jackie. Good afternoon everyone and welcome, thank you for joining us this week. Beginning with this week's all state call we're changing up the format just a little bit and we're going to - we actually have some of our state colleagues on the line today to provide what we're lessons from the field. The goal for this is to highlight for everyone how some states have responded to the pandemic and be able to learn from each other's experiences.

Today we're very fortunate to have Amanda Cassel Kraft, the Acting Medicaid Director from Massachusetts who along with her colleague to discuss their experience with telehealth services in particular in light of COVID-19. Coming up later this week on Friday our Washington state Medicaid Director MaryAnne Lindeblad will share lessons learned from their state through the course through the tip of the spear during COVID-19. And

also on Friday we'll have James Snyder from Arizona talking about some of their experiences responding to the pandemic with a particular focus on some of their strategies to ensure access to non-emergency transportation services for some of their beneficiaries and how they've dealt with some of the specific challenges associated with public health emergency.

For today's presentation focusing on telehealth, we're going to actually begin with CMCS Division of Business and Coverage lead Kirsten Jenson who's going to set the stage for - with a brief overview of the telehealth benefits in a federal perspective, then Amanda will share some of their experiences in Massachusetts and after Amanda's presentation Julie Boughn from our Data and Systems Group will provide some information again from CMS's perspective about how states might leverage some of the IT funding support that I think Massachusetts can talk about which can be to support telehealth capacity in your state.

We're going to divide Q&A up into two sessions. So at that point we'll take a break and take your questions related to the telehealth portion of the presentation. So hold on getting into queue up and questions until you're sure you want to ask one related to telehealth. After ten minutes or so answering questions on telehealth we'll then turn to our next portion of the meeting which will provide an overview of the FAQs that we highlighted last Friday but released yesterday regarding the Medicaid CHIP provisions of the FFCRA and the CARES Act. That is now currently available on our Web site and we will answer questions on those or any other topic that states have.

Before I turn it over to the next round of speakers let me just run a couple of quick highlights. We'll continue to work with you all on a number of the waivers and SPA processing issues that we had before. We're now 50 states and territories with approved 1135 waivers, some of those not were working

around second round request. We've got 26 approved Appendix K. We're up to nine Medicaid disaster state plan amendments that have been approved. We're continuing to process those as well as CHIP disaster spas, 1115 requests, IT funding requests and of course working individually with you all in other issues as well. So that work will continue and that continues to be a priority for us. So with that I'll now hand things over to Kirsten Jensen to start us off with some information about the telehealth flexibilities available in Medicaid now. Kirsten?

Kirsten Jensen: Thank you Calder. Just wanted to talk for a brief moment about the flexibilities inherent in Medicaid telehealth and the opportunities I think that are coming out of the disruption that we've had in the healthcare system of late. And in - for Medicaid purposes in terms of telehealth states really have the flexibility to determine which services they would like to deliver using telehealth, what they would like to pay for those services. The payment rates can be the same or different for what you would pay for the same service delivered face to face.

You have the ability to determine you know, what part of the state you'd like to provide it in, what the full - do you want all physician services provided or just for example behavioral health types of services? And so states should examine what the telehealth policies are and really look at them in light of this flexibility in Medicaid. We recognize that some telehealth policies in states may be built upon rules for example, maybe in Medicare but really those rules are not ones that are inherent in the Medicaid flexibility in telehealth. And so you know, looking at policies or state rules may also be helpful in figuring out how a state may take a step back and enhance the flexibility in their own state.

State plan amendments on the - are not necessarily required for telehealth. Some states do choose to put telehealth requirements in their state

plan. Others do not. The only time that a state plan is required is if a state is paying for the service differently than they otherwise would pay for a face to face encounter. We do have the disaster relief SPA available where states can use that template to outline the telehealth policies that they would like to utilize during the period of this public health emergency and that is available as an option as well. We would like to - I would like to focus particularly on a couple of items that I think pull over in and are related to Medicaid policy. One is around the HIPAA requirements for there to be a visual contact with the patients.

Those have since been lifted by the Office of Civil Rights so telephonic communications from a HIPAA perspective is okay. We have also just heard our Medicare colleagues have also lifted that requirement as well and that can be found in the Medicare interim final rule that was just published last week. And I believe our Medicare colleagues may have talked about that a little bit last Friday. So with that I would like to turn it over to Amanda Cassel Kraft from the state of Massachusetts who will talk a little bit about how her state has made that transition from a more restrictive kind of telehealth approach to a much more expansive telehealth approach. And I'll be interested in learning about how the state did that. Amanda?

Amanda Cassel Kraft: Thanks very much Kirsten and thank you Calder. Thanks everyone for joining the call today. We appreciate being invited to talk about our telehealth policy and I have to say it feels a little bit ironic given that if you would have asked us a couple of months ago we were probably one of the last if not the last state among all the states in the nation in terms of our telehealth policy. We have had coverage for behavioral health delivered via telehealth for a little over a year but we have had no policy around telehealth beyond behavioral health at all where many if not most other states do.

And that was something that we were actively working on and in fact when COVID hit we were just about to start socializing an expanded telehealth policy with our provider and advocate community and planned to roll that out in April. But when COVID hit we kind of put that whole policy development exercise to the side and really one of the first things that we did in response to COVID was to expand telehealth coverage broadly in the MassHealth program which is our combined Medicaid and CHIP program. So we are allowing telehealth to be utilized for all services without any restriction on the types of provider or the categories of service that can be delivered via telehealth, so long as the service that would otherwise be covered if it were delivered in person and so long as the provider determines that it's clinically appropriate to deliver that service through telehealth.

We're also not imposing any restrictions on the technology that's used for telehealth during the emergency. So to the point that Kirsten mentioned at the end there we're allowing both live video and audio only or in other words telephone-based telehealth services is up to the provider to make sure that it is clinically appropriate to deliver the service in that way. But so long as they determine it's clinically appropriate and they can meet the member's need we're allowing whatever technology they need to use, whatever technology the member has access to and provider has access to to enable that.

And that's been incredibly well received by our provider and member and advocacy community that has been really crucial especially with certain populations that are particularly vulnerable to infection, including elderly - elders and other folks who may not have access or really be able to readily navigate the types of technology that one would be able to use with Zoom or other of the kinds of traditional telehealth platforms that the flexibility to be able to use a plain old telephone has been absolutely crucial in being able to continue to deliver necessary services to folks.

So that's really kind of the broad sweeping policy that we did on the MassHealth side. We're paying the same rate as we would pay for in-person services and as I said we're covering the same services that we cover already through our program. And as a result we didn't need any new federal authority to implement that broad flexibility. We do have some guard rails around it to make sure that the utilization is appropriate and that we're able to track it.

So we require that providers submit a place of service modifier on all claims that are delivered via telehealth and that they document in the patient record the technology that was used and the interaction so that it is auditable and we are able to track exactly what's going on in the field and when it's being utilized. And there are a number of other general guard rails to ensure both clinical appropriateness and appropriate documentation and protection, including working with the flexibility that's been provided by of the Office of Civil Rights around HIPAA.

We are encouraging providers to use the most appropriate available technology and to provide any necessary privacy information to patients as they - before they deliver the service or as they are delivering the service to make sure that everybody is aware of what's being provided and what's going on. So that's part 1. And we did also require all of our managed care plan to do the same thing on their side. So that is - that's across the board for all of our MassHealth members. And in fact outside of the Medicaid program in our state our Division of Insurance issued guidance to commercial plans that are regulated by the Division of ono arisa plans that they basically align their policies as well so that statewide we have as broad telehealth coverage as we can during this emergency period. That was one piece and then the second piece of our telehealth strategy, very quickly and with the help and the support

of CMS through an APD, so we ended up contacting and partnering with a company called Bolle Health to launch an online tool that triages individuals with potential COVID-19 symptoms.

So it's an app. It's an app that people can use online or on their phone and this is available to MassHealth members. It's also available to any other person in Massachusetts where folks basically go through a triage process where they click through on the app on reporting on their symptoms and risk factors and then the app provides guidance on next steps including encouraging people to call their healthcare provider when appropriate, going to the emergency room if it's a true emergency situation or simply self-isolating in their home.

And the goal of this is really to help residents understand their risk and then easily access telemedicine services when they need to so that folks can stay home, can stay out of hospitals, out of clinics, out of the public to the greatest extent possible. So what happens is folks, if they get triaged to call their health provider, they'll call their healthcare provider. They'll call their healthcare provider but if for some reason they can't reach their healthcare provider or they're not able to obtain a telehealth visit with their healthcare provider then they can actually use telehealth services through which are linked directly into the Bolle app.

So the idea that we want people to utilize their regular source of care when they can and to get in touch with their primary care provider who has their whole medical history and will have broader context. But as a backup plan if they're not able to work with their regular provider we want folks to have access to a telehealth service so that they can get some consultation and again not have to leave their home if they don't need to. So the Bolle app links directly to some telehealth only companies that we also contracted with to serve our members. So if you think of those companies like Teladoc is the

more famous ones. They're not actually one of the ones that we're utilizing for this program and mostly because they're completely tapped out.

But we have a few other companies that we're working with and partnering with to provide telehealth only services to our members when they get triaged through the app to get a telehealth visit. And we were able to build a real time interface so that they can ping up against our system and check for MassHealth eligibility before providing the service. People who have coverage who are commercial plan will get linked to the telehealth services that their commercial plan covers so there's a further triage to where you get linked to for telehealth depending on what your insurance status is. But for payment purposes and claimant purposes the telehealth vendor that we are contracted with are able to check MassHealth eligibility in real time so that they can bill us appropriately for those services.

And so we submitted an APD for that because we were - we both needed to purchase the technology and do some technology build to have the app be able to appropriately serve MassHealth members and to be able to build that eligibility interface. But CMS approved that by I can't remember the exact date but it was incredibly quickly and they were really, really, really helpful and supportive in moving that through so that we were able to stand this up really quickly and that's been really successful. So far we've now had that up and running for probably about two weeks and it's been a really, really helpful resource for folks and really successful. So those are really the two main ways in which we've approached telehealth and I think we probably would echo the sentiment of many other states that we have heard on other calls that we've been on that the situation has forced us to innovate overnight and to do things that otherwise would've taken weeks, months or years in a matter of hours. And you know, much of this is - it is temporary and it's for the duration of the emergency but we fully expect that we will learn lessons

during this emergency that will carry over into our longer term policy and I think really well puts us over the edge into that frontier where telehealth becomes a regular part of the way that we and our healthcare providers deliver care to our members.

Jackie Glaze: Thank you Amanda. We're going to move now to Julie Boughn and she's going to provide an update on the IT funding associated with the telehealth. Julie?

Julie Boughn: So thanks Jackie and yes, when we're asked by states in emergency situations we can provide enhanced match (effectee) for IT systems. The requests themselves are pretty simple. They just have to have a brief description of the equipment and services to be acquired, an estimate of the cost and a brief description of the circumstances that are behind emergency. Of course in this case we all know that we have this nationwide public health emergency and so that's the one that's driving it but FYI that sometimes like a data center flooding could be in an emergency in a particular state or something like that. We also need to have some statements around the harm that would be caused if we didn't immediately acquire or the state does not acquire that equipment. FFPs that we approved under this authority is available from the date. The state actually acquires the equipment and services. There's lots of additional information we have in regulation but the best bet if you're interested in this funding authority is to consult with your Medicaid state systems officer or email me and I can try to get you to the right person.

I just want to talk a little bit about the - how we approve these emergency requests. We do try to do it very, very quickly and within days if at all possible. And we can do it really quickly when we have three criteria associated with them. One is the amounts that are requested are really clearly and very directly related to responding to the emergency situation. In this

case obviously the COVID-19 public health emergency to the amount that is requested is really the informed amount. It's not like we need up to $10 million to fix our eligibility system or something like that. It's determined by discussions with vendors or potential vendors or there's some sort of information behind the amount that's requested and three, that it can be spent within a time period that's clearly going to help with the emergency situation. And so those three things that they're working together with us, we approved the request really quickly. What we do is we looked at them very fast.

When they come in the state officer will look at them with the management team in the Division of State System and my group. If we have all three of those things there we move it through the process to get cleared by leadership, CMCS leadership, Calder and the team, Anne Marie, et cetera and get the approval letters out to those states. If we don't have those three criteria then we're going to schedule a meeting and we're going to talk through how we can get to those three things around emergency requests. But in all cases our goal is to approve these within, get to a place where we can approve within 14 days. After we get through all this emergency we do have to get a full APD for the amount requested. We have 90 days to do that from the time we approve it so within that 90 day period your state officer will work with your teams to make sure that we get the full APD to follow up on emergency requests.

So hopefully that sort of explains to you how we do that. It's a pretty easy process and we just need to have some clear association with the emergency. So with that I think I'm turning it back to either Jackie or the moderator so that we can have a few questions on the subject.

Jackie Glaze: Thank you Julie. So for the next ten minutes we'll take your questions

specific to telehealth. So I'll ask the operator to open up the lines at this point.

Coordinator: Thank you. Once again to submit a question please press star 1, record your name and your line will be open. That's star 1. To withdraw your question please press star 2. One minute as questions queue up, please. Our first question comes from (Lisa Lee). Your line is now open.

(Lisa Lee): Hello, this is (Lisa Lee) from Kentucky. I just have a question on the funding for the IT systems related to telehealth. Could those funds be used to purchase equipment for providers in rural areas who do not - currently do not have equipment or access to provide telehealth services? And then the second question I have related to the IT funding could that be used to purchase equipment for state employees to work from home for example during this time of emergency?

Julie Boughn: Hello this is Julie. So the lens that we've put on all of the IT funding is economic and efficient operation of the program in the state. And so in both of those cases we can get to yes to help with the economic and efficient operation of the program. In the first case for the providers we can't - we couldn't fund laptops that you give to the providers but we could fund that process that the state continues to own. And again this is a nuance that we would want to work with you on in this specific request.

(Lisa Lee): Thank you.

Coordinator: Once again to submit a question or a comment please press star 1 on your phone, record your name and your line will be open. At this time we have no further questions.

Jackie Glaze: You're a little hard to hear. Did you say no more questions at this point?

Coordinator: One moment. We do have questions coming in at this time. One moment. Our next question comes from (Tom Wheat). Your line is now open.

(Tom Wheat): Thank you. This is (Tom Wheat) from Maine and I was just curious if there's anything federal guidance related to providers utilizing telehealth to satisfy supervision requirements.

Calder Lynch This is Calder. I think that that would not - supervision requirements are usually a product of state licensing laws, not federal restrictions with regard to practice acts. I think that would depend on what your own state licensing laws allow but let me check to see if my team has any additional color to add.

Kirsten Jensen: This is Kirsten. Yes I agree with Calder.

(Tom Wheat): Thank you.

Coordinator: Our next question comes from (Ernest Cunningham). Your line is now open.

(Curtis Cunningham): Hello this is (Curtis Cunningham) from Wisconsin and I'm curious. For running income issues with telehealth with our provider certification many of the providers are not Wisconsin Medicaid enrolled providers. I'm wondering if any flexibility is around that or how other states are dealing with that, for example there might be a telehealth provider that our HMOs are using but only 10 of the 100 physicians are enrolled in our Wisconsin Medicaid as a provider. Any thoughts?

Calder Lynch Yes. I think this is for some of your 1135 waiver could come into play. Jackie could you speak to that?

Jackie Glaze: Yes. So I believe within Wisconsin you did ask for a waiver where you could have providers out of state that you could use temporarily provisionally enrollment for those providers to enroll in your program to provide the care for the beneficiaries. So I believe that you have already requested that particular waiver and have been granted it but I will do a double check after this call to verify.

(Curtis Cunningham): Yes. We actually haven't submitted our 1135.

Jackie Glaze: You have one on the way though, right?

(Curtis Cunningham): Correct. So it is up to us to - we couldn't lessen the authority without the requiring of those lists to the enrolled providers.

Jackie Glaze: Yes, just make that request. You can actually use your template that you know, we have on the Medicaid.gov Web site and then you can just check those boxes that apply to the provider enrollment flexibilities.

(Curtis Cunningham): Thank you very much.

Jackie Glaze: Yes.

Coordinator: (Tariq) your line is now open.

(Tariq): Hello this is (Tariq) from the state of Michigan. Federally qualified health centers enrolled and rural health clinics receive reimbursement based upon the perspective payment system rate of reimbursement which requires a face to face visit with a professional. Now if an individual is to receive a telephonic only telemedicine service, would that generate the perspective payment

system rate payment for federally qualified health centers and rural health clinics?

(Jeremy Silanskis): Yes this is (Jeremy Silanskis). So we did issue an update on that a couple of weeks ago and the answer is yes. If a service that's covered as an FQHC in your Medicaid state plan they would pay the PPS for the alternative payment methodology rate.

Calder Lynch I will say that we recognize that that does create maybe some challenging incentives or you know, for states which regard to coverage under FQHC given the rate. But looking at the I guess current laws and regs it would require that.

Coordinator: At this time there are no further questions.

Jackie Glaze: Okay. So we're ready to move on. We have several FAQ members on our team that have information they want to share regarding the recent FAQs that we released. And so we'll begin with Melissa regarding the benefit part. Melissa?

Melissa Harris: Hello, thanks Jackie. This is Melissa Harris, Center for Disabled and Elderly Health Program group. And I first want to talk about some testing services that are available to all Medicaid beneficiaries that Family First Coronavirus Response Act made a mandatory benefit or amended the mandatory laboratory benefit to require after March 18, 2020 coverage of an in-vitro diagnostic product including the administration of such products for the detection of the virus that causes COVID-19 during the public health emergency.

The legislation directed the definition of in-vitro diagnostic product to be out of the Food and Drug Administration. And so you'll see in our FAQs that we

provide a link to that FDA definition and we also confirmed that the FDA has advised the (sterilogical) test for COVID-19 does meet the definition of an in-vitro diagnostic product for the detection of the virus that causes COVID-19. And so therefore states are expected to provide that coverage of (sterilogical) testing and what those tests do specifically are to detect the antibodies of the virus and are intended for use in the diagnosis of disease or to tell if an individual currently or in the past has had a COVID-19 infection. And so we wanted to make sure to point your attention to the fact that we have clarified in the FAQ that the antibody tests are a component of the in-vitro diagnostic product that must be provided under the new mandatory benefit.

Something else that the Families First Coronavirus Response Act did was offer states the option of covering a new optional eligibility group that received a limited benefit package. Coverage for this group is again effected no earlier than March 18, 2020 and includes those same in-vitro diagnostic products that I just talked about and COVID-19 testing related services furnished during a provider visit related to the testing for COVID during the public health emergency period. It's that same definition of the in-vitro diagnostic product that is used for the mandatory benefit. And so again there's a linkage to the FDA definition for the in-vitro diagnostic product and again the coverage of the sterilogical as part of the in-vitro diagnostic product.

The FAQs then go on to explain a little bit what a related service is for this optional group and that's items and services that are otherwise coverable under the state plan that are directly related to administration of an in-vitro diagnostic product or to the evaluation of a beneficiary to determine if there is a need for an in-vitro diagnostic product. And we provided an example of an x-ray to give you an idea of what an evaluation might look like in that case.

And then just a reminder that the COVID-19 testing related services do not include services for the actual treatment of COVID-19. That's one of the parameters of limited benefits package optional group. So I'm going to stop there. I'll be around at the end for any questions and I'm going to turn it now to Rory Howe in our financial management group, thanks.

Rory Howe: Thank you Melissa, good afternoon everyone. As we mentioned last week the new FAQs include a few clarifications on the applicability of the 6.2 percentage point of that increase to certain types of expenditures and match rates and one correction of prior FAQs. Again the corrections specify that the community first choice 1915 K expenditures are in fact eligible for the FMAP increase. The FAQs also clarify that similar to the enhanced FMAP for CHIP expenditures the match rate for money follows the person demonstration expenditures and certified community behavioral health clinic expenditures are also calculated by relying in part on that state specific FMAP that was increased by 6.2%.

So while the - while those expenditures aren't directly eligible for the 6.2 percentage point FMAP increase their match rates will receive an indirect increase because like the CHIP it has a match rate. The money follows the person match rate and the certified community behavioral health clinic match rate do rely on that underlying match rate which was increased. We also received a number of questions asking whether CHIP allotments were increased to correspond with the indirect EFF increase that I just mentioned. Although the recent legislation did not include a corresponding increase to CHIP allotments contingency funds and re-distribution funding remains available to qualifying state that might experience a CHIP shortfall to this fiscal year so if any state is concerned about a possible shortfall we encourage you to reach out to us so we can provide whatever technical assistance we can to work through that with you.

And we'd also like to note that the 6.2 percentage point FMAP increase will have an indirect impact on the Medicaid IMD DSH limits for some states. Specifically some states might receive an increase of the IMD DSH limits for fiscal year '20. We'd just like to note that that will not affect the states overall DSH allotment. We do plan to send out related information directly to states on that soon and ultimately intend to publish that information in the federal register. I do want to note that Section 6004 of the Families First Coronavirus Response Act did specify that 100% match is available for services and administrative costs related to a new optional eligibility group. For COVID-19 testing if states adopt the option and determine that they need additional funding to cover the associated costs. They can request supplemental grant awards using the standard process to do so and should reach out to your financial management contact, your state rep or any other CMS contact you have on the Medicaid side and we'll make sure to get you to the right place there.

We're also working to update MBS to accommodate CMS 64 reporting for expenditures that are eligible for 100% match and we'll have more information and training for states as soon as that's available. So with that I'd like to turn it over to Sarah Delone.

Sarah Delone: Thanks Rory and hello everybody. There are just a few questions relating to eligibility in the FAQs that I wanted to highlight. First are the questions on the new optional eligibility group that Rory was just mentioning. We discussed much of the information that's reflected in the FAQs on previous calls. So today I just want to highlight two questions which I'm not sure we have previously discussed. First is that states can accept self-attestation of uninsured status for this group and because there's no income test you don't need to correct or verify income.

So if a state does that standard third party liability clinician benefits rule would apply. So if you do know and understand the processes discover other coverage, of course that coverage would pay primary. The second thing about this group to point out is that states are not in terms of operationalizing this is that states are not required to rule out eligibility for other mandatory groups first. So individuals who may be eligible for full benefits certainly should be encouraged to apply for benefits but eligibility for another group does not have to be ruled out first in order to approve eligibility for the new optional group.

Of course if an individual is subsequently determined is eligible for another group the state would then transfer that person to that group and then do the proper claiming on the CMS 64 for benefits flowing to the full benefit group. The second area of eligibility questions are those I'm going to highlight are those - a series of questions in the FAQs on the 6008 C3 condition to continue coverage through the end of the public health emergency which states have to meet for the temporary FMAP increase. First is the overarching principle behind the answer to each of those in the different scenarios that you all have been asking about, is that individuals who are either eligible on March 18 or determined eligible after that date must remain eligible through the end of the public health emergency.

They must remain eligible for the same amount, duration and scope of services that they have been eligible for. Then a second question is what services does an actual person get and a given service would then be furnished to an individual whose coverage is being continued under 6008 C3. Then the service would then be furnished for such an individual if medically necessary and according to the state standards or in the case of home and community based services based on assessment of functional need for that individual. So

it's a two part process in determining whether a particular benefit would be covered.

Where a beneficiary becomes eligible for some other kind of coverage like an individual aging out of the adult group in an expansion state, the Medicaid coverage would continue. In that example the person probably is both eligible for Medicare, not necessarily but likely eligible for Medicare. And if eligible for Medicare also probably going to be eligible for the state's Medicare savings program benefit.

To a person who has Medicare they get that and they see that benefit to help wrap around the Medicare cross sharing and the premium and then they would have the full benefit Medicaid, meaning that the services available to in the ADP that's covered by the state for the adult group and that with Medicaid would pay secondary to Medicare. So those are the standard coordination of benefit rules again would apply. There are also some FAQs in this batch related to citizenship and immigration status. Wanted to point out on the particular related to the reasonable opportunity period and individuals who are receiving benefits during a reasonable opportunity period are considered to be enrolled for benefits in Medicaid under the statute and therefore require - there is the requirement to comply with 6008 B3 to continue products for the individual even after they are appeased over, the reasonable opportunity period is over if verification of the status is still pending.

However the limitations on FFP that exist in the statute independent of whether somebody is eligible for benefits or not continue to apply. So for example of the state is able to determine that an individual in a reasonable opportunity period who's receiving benefits during the reasonable opportunity period is not in a satisfactory immigration status as might be the case for example can actually verify somebody's illegal permanent residence and they

are subject to the five year waiting period.

So they are not in a satisfactory immigration status unless they happen to be covered under the 214 option. But let's just say you're an adult who's in that five year waiting period. They are limited to treatment of emergency services. So if the state is able to verify during the reasonable opportunity period or after the reasonable opportunity period that you have an LPR subject to the five year bare for whom FMP is limited. The only benefit for that person would be entitled to notwithstanding 6008 B3 of the Families First Act would be the emergency services.

Along a similar line there's a FAQ on beneficiaries who become an inmate of a public institution. So the eligibility for them continues in order to comply with the terms of 6008 B3 but at the same time the limitation on FFP that applies to inmates also apply to the actual only service covered while they're incarcerated would be limited to inpatient services and recognizing there may be some operational challenges to states who currently terminate as opposed to suspend eligibility. There's some discussion in the FAQs about how to make that work in regardless of whether your state that terminates or suspends eligibility at this point in time in their systems. I think that is - yes, that's all I want to do and I think Jackie now we're opening up to state questions.

Jackie Glaze: So thanks Sarah, Melissa and Rory. So we're ready to take your questions now so anything on the legislation or any general questions that you may have so the operator, you can open up the lines now.

Coordinator: Thank you. Once again to submit a question or a comment please press star 1 on your phone, record your name and your line will be open. Thank you, one moment for the first question.

Coordinator: Our first question comes from (Nicole). Your line is open.

(Nicole): Hello. I have a question around the premium restriction. Does the premium increase restriction only apply to premium amounts that are in the state plan or individual premium increases as well? For example, our workers with disabilities category is set at 5% in the state plan but if an individual reports an income increase to us during this time it'd be 5% of that new income. So it's not changing the premium or not but we have in the state plan. It's just changing that individual's requirement to pay. Is that allowed?

Sarah Delone: I want to look at the statutory language and maybe I'll try and do that while there's another question under the - my colleague (Stephanie Kiminski) can do the same to answer that. I think it's - we want to look at the exact language so either later in this call or separately we'll get back to you and add that to the list for the next FAQ if it's not completely obvious to us.

Stephanie Kiminski: You should say again who it was, who was the caller asking that question.

(Nicole Phelps): My name is (Nicole Phelps) from Pennsylvania.

Stephanie Kiminski: Thanks.

Coordinator: Our next question comes from (Rachel Hoffman). Your line is now open.

(Rachel Huffman): Hello this is (Rachel) from Ohio. I have a couple of questions actually. I know in a couple of the previous calls, I think it was Wisconsin but it may have been other states as well about whether an increase in petty or what we call patient liability or share of cost would be considered a reduction in benefits and I didn't see that included in this round of FAQs.

Sarah Delone: Yes. So that's one actually. Thanks for raising that. There were a couple of FAQs that are related to individuals who have a share of cost that petty was one group, just cost sharing, regular cost sharing and also medically needy individuals who have a share of cost and those we needed to analyze those - some more time to analyze those. So they are not in this group of FAQs. You're actually right but we expect them to be in the next - in the subsequent deck so we're still working on those.

Calder Lynch: And as soon as we land on that firm answer there we're working with our folks internally to do so. We'll share that on one of these calls even if that's before we can get the next FAQ out. We know that that's a question that needs to get answered.

(Rachel Huffman): Okay thank you. And my next question is on - I think it was March 31st call. I had a question about a verbal attestation station in place of a signature and Jessica Stevens responded about some flexibilities regarding definition of authorized rep. I didn't know if that was going to be addressed in the next round of FAQs or if that's something you should attend separately or may recover entire TTAG call if it's not something you can answer today.

Jessica Stevens: This is Jessica and yes definitely in the next set of FAQs and we can at least maybe talk through tomorrow and certainly maybe bring back on one of these calls too for the broader group.

(Rachel Huffman): Okay great. Thank you so much. And then I had a question in the FAQs - and this is my last one, I promise. The questions 28 and 29 are talking about the CHIPRA 214 option and then what we call alien emergency medical assistance. It seems like those are contradictory but maybe I'm not reading them correctly. So if you have an individual who's lawfully residing and eligible under the CHIPRA 214 and then ages out or her postpartum period

ends so if she's no longer eligible then the individual would be covered under the alien medical emergency group.

But in question 29 it seems to indicate that an individual would continue on an emergency medical category but we don't pay for services and in Ohio we only approve those after the fact and only for the specific period of time that an individual had the emergency medical condition. So it might be two days, it might be six days. Is that something we should see leaving open under the public health emergency?

Sarah Delone: We should talk with you more about that. I think this is going to be probably similar to the issue with some of the - I want to say because you asked a couple of questions in there so I guess maybe working backwards in terms of how I think your Ohio is not alone in making a non-citizen who's only eligible for treating services, not necessarily treatment of a medical condition only making them eligible for the duration of the emergency.

And so this might cycle on and off if they have multiple emergencies, if they have one they're on and they're off and that's it. So that's going to be similar I think in terms of the mechanics to where you have somebody who becomes incarcerated and some states keep them on and just have them edit in the MMIS for example to not claim for any services, not continue to pay capitation payments, et cetera and then others terminate and then put them back on if they need to have an inpatient service.

And the inmate will also say somebody's discharged. There's going - the state determines what they need - somebody is issued back to the community the states will need to have a way of tracking that and making sure that those people have their coverage restored when they leave the incarcerated status. So I think that it's a similar kind of issue so I think we should work

with you and you know, think through what the right operation of balance is to make sure that you could comply with the terms of 6008 B3 in a way that doesn't require a whole major new systems build which is not realistic so that the people get the protection that they deserve which is and are entitled to under the condition but in a way that's feasible for you.

So we'll work with you and the other states that out of the gate and then we'll also - can bring back an answer towards your group and put that into a future FAQ as well.

(Rachel Huffman): Okay great. Thank you so much.

Sarah Delone: I don't know if I answered your CHIPRA 214 question, if you had - if there was something else that was about that.

(Rachel Huffman): No. It was just a - I was a little confused reading those two together, that it seemed like we were being more lenient towards the alien emergency medical category than we would be towards the CHIPRA 214 group. I think we certainly assumed in the CHIPRA 214 group would be eligible for those protections. So we were a little surprised to see that response.

Sarah Delone: It's not that there's less - they should be treated the same. It should be the same level of protection and what the extra twist for the CHIPA 214 - people who are pregnant women or a child who's been covered through the CHIPRA 214 option is that they are currently receiving full benefits and then let's say for example, the pregnant women who is out of her postpartum period. She's been getting the full range of benefits for pregnant women in Medicaid or if she's in CHIP that she's been - that anybody else gets.

But once she's through the end of her postpartum period under 6008 B3 to

comply with that coverage for her needs to continue even though she's - as it would for any pregnant women who's now out of the postpartum period. She's been enrolled for benefits and the benefits continue. If you have a U.S. citizen or you have somebody who's unsatisfactory immigration status they're going to continue with the same level of benefits that were available to them while they were pregnant.

In the case of someone who got the full benefits only because of the CHIPRA 214 option, now the limitation on FFP for individuals who are not in the satisfactory immigration status kicks in. And so for that person she is now only going to be eligible for emergency services and then you're going to the same operation of both as you are with your other emergency services only people. You don't typically carry them in your system with this edit to make sure you only claim for the FMP for emergency services. So then you have the same operational question would apply to that same woman too. Does that make sense?

(Rachel Huffman): Yes. I think I followed all of that.

Sarah Delone: So we will work with you more. This will be helpful not only for you but also for other states and so Stephanie Kaminski and Sarah and their team can work with you more on this , how to make this work best and then we can share that with the larger group of states.

(Rachel Huffman): Okay great. Thank you.

Sarah Delone: Thanks for the question.

Coordinator: Our next question comes from (Jane Longo). Your line is now open.

(Jane Longo): Hello this is Jane from Illinois I think there you just answered my question. It was about the person in a reasonable opportunity period. Does your discussion of the CHIPRA 214 benefit package after postpartum apply - is it the same because I heard two things. Both benefit package, the duration and scope must continue and then I also heard down to emergency services but will you just go over that one more time?

Sarah Delone: Sure, sure. It's similar. It's similar. The different twist for people who are in a reasonable opportunity period is the full scope of benefits would continue past the end of the 90 day reasonable opportunity period until at whatever point. And this could be at day 45 or it could be day...635. If at any point the state is able to make a determination that actually this person is not in a satisfactory immigration status. If the attempt to verify their status is continuing and it's still an unknown the full benefit package continues to flow. But if the state makes a determination that in fact this individual is not in a satisfactory immigration status and that the clearest cut example of that I think would be - another one would be somebody who has gotten verification and say that this is a legal permanent resident. You see their entry date there within the five year waiting period.

There's no indication that an exception to the five year waiting period applies. You made that determination. Now you know you don't continue - now you know that the FFP limitation applies. And so then the coverage would be limited from that point forward to the emergency services.

(Jane Longo): And you're not violating 6008 B3.

Sarah Delone: You're not violating 6008 B3 because what we determined is that these FFP limitations whether they apply to inmates or whether they apply to non-citizens those continue to apply. They were not superseded by 6008 B3 so

you would not be in violation of 6008 B3.

(Jane Longo): Okay thank you.

Sarah Delone: You're welcome.

Coordinator: Our next question comes from (Chris Ann). Your line is now open.

(Chris Ann): Hello, yes. I just have a question about the FAQ testing related services answer. And as we're working to build edits in our system to ensure that we're covering only the services allowed using x-ray as an example and it might have just been an example but in all the coding guidance from the AMA and from CDC there's nothing about x-ray or - I'm trying to figure out if there's a document or something that has procedure codes that you're considering related services.

Melissa Harris: This is Melissa Harris. I'll take a shot and then I'll invite others to weigh in. So the short answer is no. We don't have any kind of coding document from a federal perspective the Medicaid benefit package translating into a discrete set of coding steps as sometimes a square peg, round hole kind of relationship. And a lot of that translation happens at the state and provider level. And so we don't have any...that we consulted or took our cues from in making these FAQs. And so we did provide the example of the x-ray as something that could be not - in not every case would it be medically necessary to administer an x-ray to someone. That would obviously be based on the individual's circumstances and the symptoms that they present with, et cetera.

And so it shouldn't be led as a mandate necessarily but as an example of something that could meet that second category of testing related services

which is the evaluation of a beneficiary to determine whether a test is needed. Let me stop there and see if Kirsten or any of my other benefits colleagues want to add anything to that.

Kirsten Jensen: This is Kirsten. I have nothing additional.

(Chris Ann): Okay. So we would be fairly safe. So the AMA has published DTP reporting for COVID-19 testing which encompasses all the assessment codes that the AMA determines would be used. So you feel like that would be a safe - because I mean, including all x-ray codes in the edits it may seem strange considering I haven't found any coding guidance that an x-ray would be necessary and an assessment for COVID-19 but I guess I'm just wondering if there was some sort of source that we missed.

Calder Lynch: No, I don't think that's the case. Go ahead.

Melisa Harris: And specifically the type of x-ray we were thinking about although it wasn't stated here was a chest x-ray to check for the presence of chest congestion. So certainly not all types of x-rays are created equal as it relates to sitting into this kind of category but as Calder was saying no, we did not - done in the level of coding documents and making this FAQ.

Calder Lynch: And in fact I think folks like the AMA and others would be who we would point you to in regards to the type of information on the current thinking with regard to evaluation treatment and other experts. So that sounds like you're taking the right steps.

(Chris Ann): Okay thank you.

Calder Lynch: I think we're a little over time here so I think we've reached the end of time for

questions today, appreciate everyone being (unintelligible) If you didn't get to your question please reach out directly to your state lead. Otherwise we will have a chance again to talk on Friday of this week. Again we'll have Washington MaryAnne talking about some of their experiences and hopefully we'll also save some time for questions.

I just want to provide one clarification or a little additional color to an earlier conversation that Julie Boughn was providing an overview of the ability to access emergency IT funding. We were talking about that in the context of investment to expand access to telehealth but I also want to make sure that - I think she mentioned this but just emphasize that that's also an avenue available for more states to make investments as you adapt to workforce changes.

You and employees are working from home, use my equipment to support that, also system changes you need to make to implement the requirements of the FFCRA and CARES Act. Reprogramming that needs to be done around eligibility or benefits, all of those types of activities are also available for those types of - those funding avenues to get to a more speedy approval channel. So just wanted to clarify. If you again have questions about that reach out to your state systems lead directly and she can get you contacted to the right person. All right I think that's it Jackie. Anything else to say before we wrap up?

Jackie Glaze: That's it. Thank you everyone. We appreciate your participation today. Have a good afternoon.

Calder Lynch: Thank you.

End