

Centers for Medicare & Medicaid Services
COVID-19 Medicaid & CHIP All State Call
April 17, 2020
4:00 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 conference. At that time, you may press Star-1 on your phone to ask a question.

I would like to inform all parties that today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the conference over to (Jackie Glaze). Thank you; you may begin.

(Jackie Glaze): Hi. Good afternoon, everyone, and welcome to today's All-State call. I'd like to turn to Calder Lynch, and he's going to highlight today's conversation, and will also provide opening remarks and introduce our speakers for today. So, Calder?

Calder Lynch: Thank you, (Jackie). Good afternoon, everyone. Thank you for joining us today. We are today continuing with our new format that we launched this week, which will feature some lessons from the field.

The goal of this is really to highlight some of the work that you're doing out on the frontlines and working with your own Provider communities and health plans and other partners to respond to the pandemic so that we and your fellow States can learn from these experiences.

Today we are very fortunate to have both Jami Snyder from Arizona and Jason McGill from Washington State with us on today's call. Most of you, of course, know Jami, as she is the Director of Arizona's Health Care Cost

Containment System, or AHCCCS.

And Jason McGill is the Assistant Director for Medicaid Operations and Program Integrity for Washington State's Health Care Authority. Jason is graciously filling in for MaryAnne Lindeblad, who was pulled into a last-minute meeting. We are very lucky to have them both with us today.

Jason will be sharing lessons from Washington's experiences, including insights that were included in a recently-published Millbank article, which I think most of us have probably had a chance to at least see by now.

And then Jami Snyder will be discussing Arizona's work in ensuring non-emergency medical transportation during the public health emergency. I know that's been a challenge and a hot topic amongst not just States, but Providers and even our own partners internally at CMS and Medicare as we are to make sure patients are getting the critical services like dialysis. So, they have done some creative things and we wanted a chance for her to share that with you all.

We'll then we taking questions for Jami and Jason during that portion of the call today. And then, finally, as always, we'll use the remaining time to answer any general questions that you may have, as we're continuing to work through all of the different issues. And then we'll continue to talk about some of the things that are I'm sure raised earlier this week.

Just a few quick updates. We are now at nearly every State and Territory, with at least an (initial) approval of some of the 1135 where (flexibilities) are up to 52. We have approved 30 Appendix Ks for your HCBS waivers. We're now up to 11 Disaster State Plan Amendments that have been approved, and 6 Emergency IT Funding Requests.

So, those, you know, in particular, those State Plan Amendments that we want to make sure folks are aware of, because they may give ideas some of the things that you may be considering in terms of temporary benefits, reimbursements or eligibility changes that you wish to make. We're continuing to all process remaining requests, including CHIP Disaster SPAs, 1115 requests and other requests from States.

One question I know that I've been fielding this week from a few folks is with regard to more in-detail on the ongoing distributions of the Provider relief funds that was appropriated by the CARES Act. We're certainly working closely with the Department, who has the lead on those efforts. And I know that they plan to provide more granular data with regard to the distribution of those funds and which Providers are receiving it, as I know that's come up at the State level as you've been working with your own Providers around some of those needs. And so, we'll certainly be pushing that information out as it becomes available to States.

Right now, I know that they have published that at a State level, but I know that folks are looking for that at a greater detail. So, we'll share that once that's available.

So, with that, I'm now happy to hand it over to Jason to discuss some of the lessons that they've learned out there in Washington. Jason?

Jason McGill: Great. Thank you, Calder. Good day, everybody.

Our COVID-19 response is much quite like, I'm sure, many of yours. It's just been extraordinary and requiring participation from all levels, everybody. We have a State Emergency Operation Center led by the Governor. We have a

COVID-19 Czar, which we were fortunate to hire former Rear Admiral Raquel Bono, who Dr. Bono formerly served with the National Military Department to help run a military hospital and health care system. So, we have a great resource in that regard.

We have - it's a bit of a Cabinet structure, an Incident Command, Emergency Management structure, and it's important to keep the level of communication strong. So, it starts there for us and has from Day 1. And of course, we were the first case here in the nation, and unfortunately the first death.

I think the good news is, our health care system is strong and we are seeing the curve flattened for us. We have still some very critical issues with regard to testing and PPE and now, of course, unemployment and expansion state here, so our health benefit exchange and our system in terms of eligibility is strong. So, we're prepared for that but must plan for that.

I think Agency preparation is important. So, not only taking the lead from an Incident Command structure, but our Agency Director is at the small table with regard to that Incident Command structure, and she reports in often twice daily to the Executive Team at Medicaid and the Health Care Authority, which also runs the Employee Health Care Program for the State and School employees for our State.

So, that's been important in terms of communication. We have strong project management. Leads cross - Division Leads, from a clinical perspective from a Medicaid Ops and Managed Care perspective, from a Coding and Payment System involvement, all sectors at the table for daily meetings, and we're seriously on the phone all day long, working on these issues.

Of course, leading to our waivers and SPAs and requests along those lines,

which have been challenging, but thank you to the CMS team for all of your assistance on working through those many requests.

So, it's important to coordinate. It's also important to coordinate cross-agencies. So, with the other State Health Divisions, so our Public Health Division, our State psychiatric hospitals, our Long-Term Care and Developmental Disabilities Administration, and our Department of Children, Youth and Families.

So, we have a strong Health and Human Service Connection. We have a sub-Cabinet structure in place there, and working again cross-lines.

We're also working with our Military Department and local governments. Working with FEMA and setting up isolation quarantine facilities and with locals in terms of trying to help them with their options along those lines.

Again, important to have strong communications with the Governor's Office and the State Budget Office and strong communications with Legislative Leadership. So, many, many meetings and updates along those lines.

Clearly, telehealth has been - it's been a complete sea change for us, and we feel proud to really be a leader, I think, in the nation with regard to scaling up and really doing the how-to for telehealth among any, all types of Providers.

Our FAQs online for the various types of Providers - Behavioral Health Providers. It's extraordinary work, and our staff has done that. We have taken the time to do the how-tos, the FAQs, working on Webinars and trying to get the word out, and trying to get how-to out to Providers so we keep doors open and keep our Providers viable.

It's been challenging. And we need laptops and cellphones and HIPAA-compliant Webinar conference capability, which we have all brokered those items. Just this week, 1000 Apple cellphones donated and distributed to our Medicaid Members.

Assistance to Providers has been just an extraordinary effort. We have had some initial State dollars that we have been able to push out to Providers. We are working now with CMS on other Provider viability options - directed payments, retainer fund agreements, and looking forward to options along those lines.

We are working with our Managed Care Plans, who do have some flexibility to change up different payment methods that they could agree to Providers. So, they are working, starting with Providers most reliant on Medicaid, our Behavior Health Providers. They're small, most of them are small and reliant on Medicaid.

Our Managed Care Plans are stepping up and working with us to do so in an organized fashion, so we can identify those Providers most in need and try to get them alternative financial arrangements to help them in the short term.

These are advanced agreements, advanced payments, prospective capitation arrangements, and even small grant programs that might be a bridge program to get your telehealth up and running or to get to either the directed payments or retainer funds that may be coming or other Congressional dollars.

Considerable work with regard to communication with Providers. We have a weekly Webinar with Providers that I think about 1000 Providers join, and it's well-organized. A lot of time available for Q&A. We have our experts to talk about telehealth coding, which of course is a major part of that weekly

Webinar. A lot of questions about financing and financial options come up there.

Quite a bit of hospital discharge coordination amongst the Agencies. Not only our State hospitals, our public and private, our State psychiatric hospitals are also challenged with regard to staffing and resources. So, we need to move people who do not need to be in hospitals out.

That has put a special challenge on our Long-Term Care system. That is also challenged at this time with regard to COVID-19 cases. So, incredible coordination, and just now in the last week, we have to release a number of folks from our Corrections -our State Corrections System as well. So, we need to coordinate on that.

Future planning here, we're planning for the new normal using our cross-Agency structures and our Governor-led, Cabinet-led Incident Command structure, thinking about what is necessary for the next phase for our new normal.

What does the testing look like? The tracing, surveillance, and isolation quarantine. How can we go back to work? How can we open schools up in the fall and how soon we can do that. Do we have enough PPE for the system to operate? Do we have the technology that's necessary?

So, it may be an opportunity to consider how to transform our IT infrastructure and our health information exchange. So, we're looking at that. We're looking at a focus on Primary care, Pediatrics care, Behavioral Health care, and linking that to our public health needs for testing and surveillance.

This is - you know, it really may sound cliché, but to me, it is like wartime

efforts to transform the system altogether. And we are seriously looking into extraordinary options with regard to technology and care delivery along those lines, including social determinant support. And just extraordinary collaboration across all sectors.

So, anyway, covered that very quickly. Calder, folks, I'll leave it at that and happy to stand for questions when you're ready.

Calder Lynch: Thank you so much.

((Crosstalk))

Jackie Glaze: We're going to turn to Jami, now. Sorry about that, Calder. Jami, are you ready?

Jami Snyder: Sure, thanks, (Jackie). And thanks for offering us the opportunity to provide a brief overview of Arizona's NEMT solution during the pandemic.

So, early on, I would say as early as the beginning of March, it became evident that we needed to develop a strategy to prevent the unnecessary use of ambulance transport, and particularly for those members that were obtaining routine services, such as dialysis or chemotherapy treatment, who were even COVID-positive or could potentially have the virus.

So, essentially, the strategy required the establishment of an enhanced rate for NEMT, really to cover the cost of hazard pay for drivers and the cost of the additional expenses incurred by the NEMT brokers, which included things like the provision of PPE, car cleaning, training, and plastic shields that are in each of the specialized driver cadre, each of their cars, that separates them from the Member.

So, AHCCCS decided to work on an agreement with the two NEMT brokers that the MCOs contract within Arizona and they include Veyo and MTBA. I'm sure many of you are familiar with them.

And the focus was on establishing a specialized fleet of drivers that were willing to provide transportation to Members who are COVID-positive or deemed a person under investigation - a PUI.

So, we established an add-on rate of \$93 per trip for qualifying NEMT transport using one of three HCPC codes and a special modifier to designate that the trip was made - or involved the transport of a Member who is either COVID-positive or presumptive-positive.

And so, to give you kind of a frame of reference there, our current base rate for transport runs just over a dollar and \$11, and our add-on, again, is \$93.

But when you compare that to the cost of transport using an ambulance that cost runs between just over \$500 to over \$1000. So, we're still saving in the end by preventing the unnecessary use of ambulance transport, and more importantly, freeing up those ambulances to transport Members who have a critical need.

So, it's important, too, to let you all know that the enhanced rate pertains only to the base rate established for NEMT services, not the per-mile rate. And we did require that the MCOs apply 100% of the dollar value of the add-on payment for each qualifying transport.

We are limiting the use of the enhanced rate to the period of the declared emergency, but we did indicate in our guidance to both the brokers and MCOs

that we do reserve the right to eliminate the add-on rate before or after the declared emergency is ended.

We're requiring also that the MCOs work directly with the NEMT brokers to proactively identify Members that meet the criteria - either COVID-positive or more importantly, presumptive-positive.

And in Arizona, it's interesting, half of our MCOs contract with one of the brokers and the other half contract with the other broker.

So we did, in the course of the discussion around this enhanced rate, we really encouraged the MCOs to form single-case agreements or other temporary contracting arrangements to work with the other broker that they aren't contracted with currently to ensure that necessary transport is available for those specific Members.

Both brokers are implementing the specialized fleet option, but primarily in urban areas, currently, and to some degree in rural areas, but as you can imagine, it's much more challenging in rural areas to find drivers that are willing to transport individuals who have tested positive or presumptive positive.

And a kind of final note on the fee schedule is the existing fee schedule has not been adjusted or changed for other NEMT rides for individuals who do not have that diagnosis or a presumptive-positive diagnosis.

Correspondingly with the efforts that we engaged in to offer that enhanced rate, both of the brokers worked quickly to develop protocols that would ensure the safety of their drivers and members, and ensure that they had the proper information and resources that they needed to provide trips to the

designated population.

So, that included the establishment of driver qualifications - for instance, the driver cannot be a smoker, pregnant, must be under the age of 50, not immunocompromised. They also established a driver consent form indicating that the driver understands the risk posed by transporting this particular population and that both of the brokers are providing PPE.

Or initially, that was a real challenge. At least one of the brokers was really struggling to obtain PPE. We were able to link them to a couple of resources, and now they're up and running and are able to provide that PPE.

And that includes things like surgical masks, disposable gloves, medical scrubs, foot protection, eye protection, hand sanitizer and a disposal bag, once they're done with their shift, so they can dispose of the gloves and masks.

They also are offering or requiring, rather, training for individuals that are serving this population. And so they have enhanced training. They also have some requirements around vehicle configuration.

Again, and requiring that that plastic shield be in place between the driver and the passenger, that drop cloths be on the rear seat, and that the ventilation in the vehicle is on external - or exterior air only, rather than recirculation, as you can imagine.

And they also have established passenger qualifications saying that the passenger must be in stable health condition with no respiratory distress, able to ambulate without assistance, and so forth.

And then, finally, they've established some pretty robust vehicle cleaning

protocols, where they're sterilizing the interior passenger section of the vehicle using a dry steam mechanism and disinfecting all surfaces in the back seat of the car as well.

And you can imagine, the brokers - there's a little bit of variability in how the brokers are using the enhanced rates or the add-on rates. Clearly they're offering a portion of it to drivers, but it's also being used for those cleaning fees. The car cleaning facility rental, and in some cases in the provision of PPE.

But they've been very creative in the process. We worked closely over the course of the last six weeks to develop the protocol on our side as well as support the work that the brokers were doing on their end.

It's really taken the work of brokers, the Agency and our Managed Care Organizations. They've been directly involved in the process of negotiating the protocols that we've developed at the Agency level, and certainly the protocols that the brokers have implemented.

So, with that, I'd be happy to take any questions.

Jackie Glaze: Thank you, Jami, and thank you, Jason, very much for sharing your perspective and just your - the way you have had to deal with the COVID-19.

So, right now, for the next 15 minutes, we'll take questions from the audience specific to Jason and Jami's presentations. So, if we could focus on discussion with them over the next 15 minutes if the Operator can open up the lines at this point.

Coordinator: Thank you. We will now begin the question-and-answer session. If you would

like to ask a question, please press Star-1, unmute your phone, and record your name clearly. Your name is required to introduce your question. If you need to withdraw your question, press Star-2.

Again, to ask a question, please press Star-1. It will take a few moments for the questions to come through. Please stand by.

Our first question comes from (Lee). Your line is now open.

(Lee): Thank you. This is for Arizona and your NEMT. It sounds like you all have done a great job with it, by the way. Are all of your Members in Managed Care Organizations, therefore all of the NEMT is provided or administered by the Managed Care Organizations?

Jami Snyder: Yes, only a small portion of our Membership is actually Fee for Service. It's around I think 125,000 enrollees.

The remainder of the population, which totals 1.9 million individuals, is (on ten) Managed Care. And the Managed Care Organizations are responsible for contracting with the brokers directly. So, we have it carved into their contract.

((Crosstalk))

(Lee): You don't provide any NEMT for your Fee for Service?

Jami Snyder: We do. We do. And that's a really good question. To date, we've only worked with the brokers around this add-on rate. And we'd had some discussion about that, actually, really recently because we certainly do have NEMT Providers in that Fee for Service space, even though it's a small population.

But when it came down to it, this enhanced rate, or the add-on rate, was really to support both the hazard pay for the driver as well as all the additional investment that NEMT brokers are able to make.

And by and large, the NEMT Providers within our Fee for Service system are independent drivers, not established brokers with the ability to offer the types of resources that are really necessary in this situation, like the provision of PPE, the additional training, cleaning of vehicles, so on and so forth.

So, at this point, we've only been able to extend that add-on to those that can offer that additional resource and support to drivers that are providing rides to the population.

(Lee): Thank you.

Coordinator: Our next question comes from (Justin Owens). Your line is now open.

(Justin Owens): Hey guys. I just had a question on the HCPC (with the) special modifier that you all created. You said you all were using one of three. Are you able to provide those three HCPC codes and the modifier you're currently using?

Jami Snyder: Yes, I can. So, it's A-zero-1-zero-zero, A-zero-1-2-zero, and A-zero-1-3-zero. And the modifier is T as in Tom-U. T-U.

(Justin Owens): All right. Thank you, guys.

Jami Snyder: Yes.

Coordinator: I'm showing no further questions at this time.

Jackie Glaze: Thank you. So, at this time, we'll just open it up...

(Anne-Marie Costello): (Jackie), (Jackie), may I ask a question?

Jackie Glaze: Sure, sure.

(Anne-Marie Costello): This is (Anne-Marie Costello). And my question is for Jason McGill. Jason, can you say a little bit more about the work that you all did on telehealth? I heard you mention that you had phones donated. So, can you share a little bit more about the work Washington's done on telehealth?

Jason McGill: Sure. Hi, (Anne-Marie). We have done - we have just done extraordinary work. We sort of started with thinking about what codes and what services need to be opened. Fortunately, in Washington, we already sort of had parity in terms of payment, so that's a starting point. Take a look at that.

We looked at telephone, because at the time, we didn't really have any authority from sort of from the Feds in terms of HIPAA and our State in terms of other sort of in-person requirements, so that was an initial challenge. And of course, most of that has now been resolved. So, allowing us to streamline through regulations along those lines.

But we opened up telephonic codes, and we paid for telephone visits. And again, parity with those sort of (ENM) codes for just regular visits.

And then we needed to get FAQs out, and it sort of started just generally. And then one type of Provider (asked). So, a physical therapist, a - certainly Behavioral Health has been an incredible type of service. We are now doing Zoom group therapy. And it's working well. We are doing involuntary commitment over the telehealth.

And so each one of those sort of needs its own protocol. And we have those developed. And all this is on Washington Health Care Authority COVID. Google that, you'll see our Web page and all the various FAQs associated with telehealth, and the type of Provider and so forth. The Behavioral Health one, alone, is incredible.

(Anne-Marie), you mentioned just some of the services. So, we have - the first thing we did was try to broker a license option for Providers to use. And we did some amazing work over a period of a weekend with almost, you know, all of the big players who offer some sort of telehealth-based Webinar service -conference service.

And we went with Zoom in our State, and we actually bought licenses for Providers who we could deploy quickly. And so, we have that available.

And then, you know, soon realized we may need some laptops for more complicated provision of care, so we offered some laptop services for people - for Providers.

And finally, our Managed Care Plans do a good job offering cellphone services for Members, but you know, we still have a large Fee for Service population as well. And some of the Plans, some of the cellphone Plans may not offer an incredible amount of data and minutes per month.

So, we asked and worked with the cellphone companies to expand data and minutes available, and in fact, actually, through that work, got a couple thousand donated to the State. So, we have now cellphones that are fully loaded and ready to go that we can get out to individual Members who may not have a phone.

So, just incredible work along those lines.

(Anne-Marie Costello): Thank you very much.

Jackie Glaze: So, now I think we'll transition to the general questions, and also if you think of other questions that you have for either Jason or Jami, you can ask those as well. So, we'll just open it up for the general questions or what other questions you may have at this time.

So, again, thank you, Jami and Jason, for your presentations. So, we'll take the additional questions. Operator, we're ready anytime.

Coordinator: As a reminder, if you have a question, please press Star-1.

Our first question comes from (Anna). Your line is now open.

(Anna): Hi. This is (Anna) from Pennsylvania and I have two questions.

The first is regarding Home Health Services that was in the intermediate or the Interim Final Rule. Can you just confirm that the recent changes in there that allows non-physicians to prescribe and order Home Health? Is it limited to the Public Health Emergency period, or does it extend beyond that?

(Kirsten Jensen): This is (Kirsten Jensen). It's limited to the Public Health Emergency.

(Anna): Okay.

Calder Lynch: But I will say - I'll add - this is Calder, I'm sorry - but (Kirsten), correct me if I'm wrong, but CARES Act did include a provision that would allow for more

permanent change, and we're working on some follow-on, you know, changes to implement that. So, you'll see more coming from us with regards to that.

But for now, the Interim Rule is limited to the period of the Public Health Emergency.

(Anna): Okay, great. And are States - should we include that provision in our Disaster State Plan Amendment? Or do we not need to include that if it's not - if there is no provisions around prescribing Home Health in our current State Plan?

(Kirsten Jensen): This is (Kirsten). You don't need to include it. We are, you know, you don't need to include it if there's nothing in your underlying State Plan. If you would like to include it so that we have a record of it, then that's fine. But there's no requirement that it be there.

(Anna): Okay, great. And I do have one more question, I'm sorry.

About the maintaining the level of benefits for an individual; specifically, an individual that ages out of a category, like somebody that turns 21. In our State, we extend the EPSDT benefits to 21.

Once if that person ages out and is transitioning to another benefit category that doesn't include the level of benefits that EPSDT covers, do we have to include - to keep them in EPSDT level of benefits until the end of the Public Health Emergency, or can we transition them to a standard State Plan benefit?

(Sarah Delone): Hi, there is (Sarah). Calder; I can take that if you want. You should, you would need to maintain to comply with the requirements for the Temporary FMAP Increase requires the same sort of, the same level of benefits, so you would need to continue to provide the EPSDT benefit.

(Anna): Okay, so, okay, great.

Sarah Delone: Through the end of the Public Health, you know, the month in which the Emergency ends.

(Anna): Right. Okay. Perfect. Thank you, that clears that up for me. Thank you very much.

Sarah Delone: You're welcome.

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

(Leah): Hi. We have a question about people who no longer need a nursing facility or ICS or hospital back-up unit level of care. Specifically, should those beds be handled as a State Plan benefit that should be stopped once they are no longer medically necessary?

Or rather, would we handle them like an HCBS waiver where eligibility is maintained? This obviously relates to the enhanced FMAP. And of course, our concern is that part of these - some of these folks may not have somewhere to go if they lose their institutional bed.

Sarah Delone: So, I feel like we probably over there want to take it back, because I think that the - probably intersection of different, you know, different policies.

The - it's similar I think to the Home and Community-based Services questions that were in the last set of FAQ. States are not required to continue to furnish benefits that aren't medically necessary for an individual.

However, you have a little bit of a conundrum because there's no other place to put this person that's safe. So, I think we - I feel like - (Alissa) and (Ralph), unless you guys feel like you can answer, I think we should take that back and talk it through.

(Leah): Okay. Thank you.

Sarah Delone: Thanks. Great question.

(Leah): Thank you.

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

(David): Thank you very much. You have mentioned that there were some emergency IT funding requests granted. Are those posted anywhere online?

Calder Lynch: Do we have (Julie) on?

(David): Excuse me?

Calder Lynch: I was asking if we had (Julie) on. But (Anne-Marie), do you know, or does anyone know, if there's a posting?

(Anne-Marie): If I could have this question, I'm going to look at Medicaid's.gov. And maybe we could give that answer before the end of the call.

Calder Lynch: Okay. We'll check. Either way, we can follow up with you. Which State, I'm sorry?

(David): New York OPWDD.

Calder Lynch: Got it. Okay. We'll see what we can find out, and if we get it before on the call, we'll share it. Otherwise, we'll follow up with you individually.

Did you have any other questions?

(David): No. Thank you very much.

Calder Lynch: All right. Thank you.

Coordinator: Our next question comes from Kelly Cunningham. Your line is now open.

Kelly Cunningham: Hi. Good afternoon. This is Kelly Cunningham from Illinois Medicaid. Just a quick question and a comment.

My comment was I really appreciated hearing, Calder, your saying at the beginning of the call that CMS would be pushing forward to release information to States on those Medicare allotments to specific Providers.

We're anxious to get that information, as it's going to help us to plan financially how we want to and are able to support Medicaid. So, we're anxious to see those Medicare allotments by Provider type for our State when that's available.

And then just a quick question. Has CMS approved any 1115 waivers for the corona COVID emergency? We've been unable to locate any on your Web site but wanted to ask.

Calder Lynch: Sure. This is Calder. So, first, to your first question, I just want to clarify. So, what I was mentioning is the Department will be releasing more granular

detail on the CARES Act funding distribution, which is just sort of direct relief grants that are being provided to States - the \$100 billion that was appropriated.

And there's going to be further rounds of that funding that will be distributed, including some that will be focused on Medicaid Providers and other sorts of hot spot needs. And as more information about that is available, we'll push that out to States.

Were you speaking to the - so in addition to that, and Medicare has also been making advance payments out available to Providers - almost \$100 billion worth, I believe, actually, has been distributed so far. And I think those are more like loans that Providers will have to repay.

Were you asking about those? Or about the CARES Act dollars...

((Crosstalk))

Kelly Cunningham: Actually, thanks for clarifying. The CARES Act, generally, so thank you very much.

Calder Lynch: Got it. Oh, no problem. And then, on the second, we have not, but we actually are very, very close on the 1st, which will then, I think we have several subsequent following it in close order. So, over the next few days, just keep an eye out. We'll certainly be pushing out over our listserv any updates on approval of (1115 waivers) related to COVID.

Kelly Cunningham: Great. Thanks so much.

Coordinator: I am showing no further questions at this time.

(Anne-Marie Costello): So, this is (Anne-Marie). And it appears we have some technical difficulty. (Julie Brown) is on the line, but she can't be heard, so I'll share that we do not post the IT approvals.

So, if there is some information that you would like, we could connect you. You could connect in your States with either your State Lead or with your State IT Project Officer. And they could help you with some technical assistance around what could be done through the Emergency IT Funding.

Calder Lynch: Yes. And I'll add to that if you weren't tuned in, was it on Tuesdays, or last Friday's call, (Anne-Marie), where (Julie), she kind of gave a little bit more detail on the types of things that States could apply for there. Either way, those recordings are posted online. If you (unintelligible), all right?

(Anne-Marie Costello): It was Tuesday's call.

Calder Lynch: Tuesday's call, yes. So, you can go check that out. But certainly, yes, reach out to your State Funding Officer. You know, it could be anything really ranging from, you know, somebody invests and sees States want to make, and helping boost telehealth capacity in their State.

You know, Massachusetts talked about an app that was developed about, you know, building some connections for - others, it does have to relate back to Medicaid beneficiaries of course, and there's some rules and restrictions around that.

It's of course what the States may want to do, or need to do, to either comply with the requirements under the CARES Act around benefits or eligibility changes that you would need to program into your system.

Or capacity you need to build or buy around, moving toward a more remote workforce - all those types of things can be eligible for enhanced funding through the Emergency IT Process, which usually results in approval in a matter of just a few days.

Operator, did we get any last-minute questions coming in while we were talking there?

Coordinator: Yes. We have a question from (Christy Garland). Your line is now open.

(Christy Garland): Yes, I have a question about, thank you, this is (Christy Garland) from Oregon. I have a question about how to handle increases to costs of care.

So, with post-eligibility treatment of income - (PEDI) income - can you give us any advice on how to treat (PEDI) for individuals paying cost of care for long-term care services?

Calder Lynch: Yes. We have been working on an FAQ there that we should have out shortly and be able to give you more information, hopefully, next week. But (Sarah), did you want to add anything?

Sarah Delone: No, I was going to make sure that we were talking about the (6008b) (unintelligible). So, yes. Nothing to add.

Calder Lynch: So, I don't have any answer on that. We're working on it. That one's a little tricky, but we're close, and should have guidance out. Hopefully, we'll talk about it on one of next week's calls.

(Christy Garland): Okay, thank you.

And then I have another question if nobody else is on the line also.

Calder Lynch: Sure, go ahead.

(Christy Garland): Okay. So, in the instance where we have an individual who is receiving emergency services over Medicaid, and they become eligible for a Medicare Savings Program - specifically, it's a QI1 and SLMB Program.

Would we need to keep that person eligible for the Emergency Medical Services Program as well as allow them to transition to one of those Medicare Savings Programs?

Sarah Delone: I was going to say most likely. I mean, interesting situation. So, I want to make sure I understand the scenario, and I'll give you the one potential caveat that we're still working through to the answer.

So, you've got somebody who is not in a satisfactory immigration status for purposes of full Medicaid benefits? So, they may be a legal permanent resident subject to the five-year waiting period, or in some other immigrant category that doesn't confer them, you know, full benefits.

And that person is therefore eligible only for Emergency Services under Medicaid. And now they turn 65 and they are actually eligible for Medicare?

(Christy Garland): Yes. And actually, I'm sorry, I forgot to add a caveat. They - we understand this is a small - this is probably a small population of people. It just does matter for how we're programming our system or the other things, or manually, how we have to look at it.

But so, yes, so they are - that's a great example, LPR under five years. So,

they meet their five-year bar at the same time they become Medicare-eligible. Also, though, they become no longer eligible for a Medicaid Program. So, Emergency Services or otherwise.

Sarah Delone: I mean, so what I can say is, so, the safest at this point is to certainly not make the programming change that would shift them out of Medicaid completely.

Of course, to the extent to which the Emergency Service that they require is covered by Medicare, you know, they'll get the - they would shift them to get either the QI or SLMB benefit that they're eligible for through your Medicare Savings Program or whatever level of Medicare premium or cost sharing support they would, you know, that they would be entitled to once they, you know...

I don't entirely understand how you somehow have somebody who's subject to the five-year bar or any one of those categories only gets Emergency Medicaid and then is eligible also for the QI or the SLMB, Special Level Medical Benefit - Medicare Benefit Share, I think that's what that stands for - Group.

So, that's not totally resonating with me, so I would want to loop back with our immigrant eligibility and our (LPR) eligibility experts to make sure that (by tell us) the situation arising. But the general principle is right, that the Medical Assistance has to continue, whatever level of benefit that is.

In this case, probably Medicare is going to be the first, the primary payer. It's likely to be covered. And so there probably not much left for Medicaid, but maybe a little bit.

The possible caveat to that, and this is a question we're trying to, we're

working on also. So, this is an FAQ that will be upcoming when we can figure out the answer, that way, is what is shifting of a Medicaid beneficiary from one Program to another at the same level of benefits is provided. Same operation and scope, same to the extent of medical assistance is provided in the other program. Is that okay?

We've had one state asking about things shifting from Medicaid to CHIP. Is it exactly the same? This is a sort of a similar kind of situation. We're trying to get that question answered. But this particular scenario seems strange. So, can I get your name and office so we can sort of - couple different people we need to check in with and we can follow up with you?

(Christy Garland): (Christy Garland). It's (Christy Garland). I will say though, I get this is like a perfect storm, and so I understand conceptually that we need to keep them at the same level of benefits and also give them the Medicare. And that was actually one of the questions.

It wasn't about them - it didn't start with an Emergency Services Medicaid, but in the FAQ, this was addressed to some degree that we keep them at the same level of benefits and then give them MFB Program if they're also eligible for it.

I think this population is even smaller because you have a perfect storm of somebody meeting their immigration status requirements at the same time they become Medicare-eligible, and then also - like, let's say they go over income for any of the full Medicaid programs, right?

So, it's like the perfect storm that - I'm not sure what happens. So, I think that we, I don't know that you need to follow up, because I think your answer actually gave us enough information to understand what we need to be doing.

(Sarah): Okay. That's great.

(Christy Garland): Okay. Thank you.

Coordinator: I'm showing no further questions at this time.

Calder Lynch: Okay. Well, thank you all for joining us this afternoon. Appreciate your time today. We'll pick this back up on our next call, I think, on Tuesday. I look forward to talking to you all then.

Coordinator: That concludes today's conference. Thank you for participating. You may disconnect at this time.

End