Centers for Medicare & Medicaid Services

COVID-19 Medicaid & CHIP All State Call

April 21, 2020
3:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time all participants are in listen-only mode. During the question-and-answer session of today's call if you would like to ask a question please press star 1 on your phone. 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 to today's All state call. I will turn to Calder now and he will provide opening remarks and introduce our speaker today. So Calder.

Calder Lynch: Thank you Jackie and thank you all for joining us today. Today we are lucky we have a special guest joining us from the CMS Office of the Administrator. Dr. Marion Couch who is the Senior Medical Advisor to Administrator Verma is with us to talk about the guidance that was released by CMS over the weekend regarding steps to reopen the healthcare system and areas of low incidents of COVID-19.

You know that you as Medicaid agency and some of the largest payers in your states begin to think about the process of reopening your healthcare system. There is a lot to consider and CMS wants to make sure that you have the information you need to do safely and effectively.

So the guidance that Marion will be discussing today updates some earlier

guidance that has been provided by CMS that have limited non-essential surgeries and medical procedures during the pandemic.

We know that these recommendations are not meant to be implemented uniformly at the same time by every state, county or city at this time. And it is really up to governors and local leaders to make the decisions about what is appropriate for your own communities.

But these recommendations are targeted to the communities that are in Phase 1 of the guidelines for opening up America again. With low incidents or relatively low and stable incidents of COVID-19 cases.

After Marion's discussion, CMCS staff will share observations and feedback designed to help states as you continue to work with us in some of the COVID related flexibilities. And we have got a number of subject matter experts on the line to answer any other questions that you may have.

We are continuing to work with you all on a number of approvals. You know of course you know we had a few additional 1135s approved this week. Thirty five states now have their Appendix K approvals for up to 16 states with disaster state plan amendment approvals. So we know that we are continuing to work with you on a number of those fronts and we will continue processing those expeditiously as we can.

With that though, I will stop and hand things over to Dr. Marion Couch who will be discussing the reopening guidance.

Marion Couch: Thank you Calder and thank you for letting me join your call today. I am happy to review document that is on our Web site called, Opening Up America Again. CMS recommendations, reopening facilities to provide non-

emergent, non-COVID-19 healthcare. And again as Calder alluded to. This is for Phase 1.

And I would like to reiterate our gratitude for all the people across the United States who limited non-essential surgeries, procedures and care so that we could best prepare for possible surge across the country. This set of recommendations was issued on March 18. And I think people heeded that advice.

We now find ourselves in a situation as Calder mentioned where we have areas that have low incidence or low incidence and stable, relatively stable COVID-19 incidents. So these areas might be able to in conjunction with their local and state public health officials consider opening up the care that everyone needs such as planned surgeries procedures, chronic care disease and ultimately preventive care.

We understand that there is a backlog and patients are having care deferred and therefore we think it is appropriate in certain areas of the country to consider opening up based on the gating criteria that was announced on April 16th at the White House by Admiral Deborah Birx.

And the guidelines for Opening Up America Again can be found at the White House Web site. But there are gating criteria. And once states and regions go through and achieve those gating criteria they can proceed to Phase 1.

And that is what this document talks about. We will have subsequent documents that will talk about Phase 2 and Phase 3. But no one is past Phase 1 right now. So we are just ramping up to think about Phase 1.

I would like to also point out that we still think maximal use of telehealth

modalities ought to be used. Care that can't be accomplished virtually should then be considered for this reopening Phase 1 effort.

We have a set of general recommendations. And if you don't mind I would like to spend a few minutes going over them and then I will be happy to answer any questions you might have. I can't say it enough. It is really important that is done in coordination with state and local public health officials. Folks need to evaluate the incidents and trends for COVID-19 positivity in the area where they are considering restarting in-person care.

This is also an important point. Our recommendations are that you evaluate the necessity of the care based on clinical needs. Providers should prioritize surgical and procedural care and high complexity chronic disease management.

But as I stated earlier, we also understand that preventive services might be highly necessary. For instance, we think vaccinations ought to be happening. We don't want to have a problem down the road where we have resurgence of other diseases.

Another concept that is part of our recommendations is to consider establishing non-COVID care zones. And in these zones staff would routinely screened and patients, all patients would be screened as well for symptoms of COVID-19 including temperature checks.

Folks who were working, staff who are working in this area would not be working in other areas. You wouldn't for instance as a physician work in a non-COVID care area and then go round on your patients in a hospital with COVID positive patients there.

We also make the point that you want to have sufficient resources so that you can take care of your patients across all cares of the - all aspects of the care journey. Making sure that you have adequate preoperative care for instance and post-operative rehabilitative services. You need to have your ancillary staff that might include radiologists, pathologists and certainly nurses and medical assistants as well.

And at all times make sure that you could handle a surge if it came and you would have a healthy workforce to participate in that surge. Bottom line is we are really thinking about reopening to stay open and as the Administrator pointed out. This would be a sunrise not a turning on of the switch, light switch.

In the recommendations we talk about personal protective equipment what we commonly refer to as PPE. We recommend that we follow CDC recommendations for universal source control. And therefore healthcare providers and staff would probably wear surgical face masks. And patients would wear a cloth face mask to again reduce the incidents of transmission. We also acknowledge that we need to conserve PPE as often as possible.

We make a point that you ought to ensure that you have an established plan for thorough cleaning and disinfection prior to opening up these spaces and facilities. As an example, if you were going to have surgeries and procedures and you use anesthesia machines for COVID positive patients. You would want to make sure that you followed CDC guidelines for decontamination.

Supplies and adequate medications have to be factored into this. And at all times this area that opens up for Phase 1 has to be sure they have adequate supplies, staff, PPE in case there is a surge.

Testing is a big issue. And what we said is that all patients should be screened for potential symptoms of COVID-19 prior to entering a non-COVID care facility. And staff ought to be routinely screened. When adequate testing capabilities are established patients should be screened by laboratory testing before care. And staff working in those facilities should be regularly screened by laboratory testing as well.

Our hope is that by following these recommendations we have given people flexibility to allow safe opening of in-person non-emergent, non-COVID-19 care in select communities and facilities. And Calder I am happy to answer any questions folks may have.

Calder Lynch: Thanks so much Marion. Operator I think we will pause there and we will ask if folks have any questions for Dr. Couch on that topic. And then we will move onto the rest of the meeting after that. So if we can go ahead and open up for questions.

Coordinator: Thank you. If you have a question or a comment please press star 1 on your phone and your line will be open. That is star 1. Record your name and your line will be open. Thank you.

One moment as questions queue up please. At this time there are no questions in queue.

Jackie Glaze: Before we move onto the next segment. Do we have any questions from the CMCS team? Okay so Dr. Couch we thank you for your presentation. We will move onto the next part of our agenda. We have a number of our CMS team that will provide some overview and some key messaging on some of the templates and checklists that we have provided.

So we will begin with Judith Cash. Are you ready Judith to discuss the overview on the 1115 demos?

Judith Cash: I am thanks Jackie and good afternoon everyone. Nice to have the opportunity to talk with you this afternoon. As many of you know, CMS issued a couple of weeks ago a template for the Section 1115 emergency demonstration which offered a list of potential flexibilities in a template form.

We have received from many states, 1115 proposal applications that we are working through. And what we have found is that in many cases there are a number of flexibilities that states are requesting in those 1115 proposals. Which actually can be accomplished through other authorities.

And so we are working with states as well with our subject matter experts and our colleagues here at CMS to identify those available flexibilities. Many of which can be achieved through a state plan amendment for example. Or through the use of the Appendix K for your 1915s related services.

And really then getting to those flexibilities that are only available through the authority that is provided to us through Section 1115 of the Act. So we are working through those. I can tell you that we are very close to approving our first 1115 demonstration and then we will have a few come behind that.

So we appreciate the work that all of you have done on those 1115 proposals and engaging with us to really understand clearly what it is the state is proposing so that we can find the best way to help you achieve those goals with the right authority.

There are a number of requests that states have made that are still under consideration. And those are under consideration really in light of a number of

other activities that are happening at the federal level. So I am sure you are aware and we had the opportunity to share with you information about some of the provisions in the CARES Act and other funding sourcing available.

So we are looking to states to use those available funding sources. And may not at this time be approving Medicaid expenditure authorities for some things including housing for example or additional nutrition services as those may be able to be achieved through some of the other funding sources that are available.

So we are continuing to work with states on those and to look at that. And we appreciate the work that you all have done with my team as well as with our other subject matter experts to help you achieve the goals that you have got for your COVID response. In using what is the right authorities. So we look forward to continuing for that and to approve some of the 1115 demonstration requests over the next several weeks.

Jackie Glaze: Thank you Judith. So moving onto the next topic. We have Sophie Hinojosa, Stephanie Kaminsky and Jessica Stevens and they are going to provide some updates on the Medicaid disaster relief SPAs. So Sophia are you first up?

Sophia Hinojosa: Yes thanks Jackie. Good afternoon everyone. We have received a number of Medicaid Disaster Relief SPAs since we released the templates in mid-March. We have been able to approve 16 of those Medicaid Disaster Relief SPAs as Calder mentioned earlier in the call.

As all of you know, we are trying to process and approve these urgent time limited state fund amendments as quickly as possible. And we wanted to share some reminders with states today of process and items which would allow us to process these state plan amendments quicker. As it is our goal so that states

are able to have the flexibilities you need to address COVID response work immediately.

And first I am going to share some general state plan amendment reminders. And then we are going to turn it over to our experts to share specific requests. The first one is that we always here to provide technical assistance as we do for all SPAs.

The state would like to share a copy of a draft file before states officially submit it to CMS. We are always here to do that. You can contact your state lead if you would like for CMS to review a draft of Disaster Relief SPA.

Additionally we do want to request we need a state plan amendment number when the states submit the SPA to our mailbox. We have received a few Disaster Relief SPA without fund numbers so that creates a little bit of delay. So we wanted to share that reminder with states today.

And the same with the 179 form. We are requesting for states to include the 179 form with their Medicaid Disaster Relief SPA. We did add hyperlinks to that form right under Medicaid Disaster Relief template on Medicaid.gov.

And it is usually the case. We ask for the state to include a statutory reference if it is possible. You can just put a general title 19 for example under Section 6 for legal citation. And if the state is able to provide an estimated budget impact under Section 7. That is also very helpful.

We wanted to also share with states that you definitely have the ability to submit more than one Medicaid Disaster Relief SPA. So you do not have to figure out all the potential flexibilities you might need right away. You will see we are of course publishing all our Medicaid Disaster Relief SPAs and if

you see on our Web site for the 16 SPAs we have approved, a number are for the same SPAs.

So you can definitely submit many Disaster Relief SPAs and we are flexible. We work with the states in terms of whether you want to supersede previous Medicaid Disaster Relief SPAs or whether you want them to just be approved on top of one another. So we are offering as much flexibility to states as possible.

And then a quick reminder. As you know, with the Medicaid Disaster Relief template you are able to selection 1135 flexibility that might be needed for that amendment. Including a retroactive effective date back to March 1st. Waiver of public notice is applicable. And modifications to tribal consultation requirements. So we just request for the state if you need those 1135 flexibility so to please check those in the actual state plan amendment page.

Then finally I believe most states are aware of this right now but for the new eligibility group for individuals to cover COVID testing. The effective date of that would be March 18th not March 1st. So you have (unintelligible) you will see that CMS is requesting a March 18th effective date and we are not able to go back to March 1st for that particular group.

And then even Disaster Relief SPA includes payment provisions which you can find in Section 8. And we also ask for the state to please include responses to the Medicaid standard funding questions. And of course you can find those on Medicaid.gov as well.

So with that I am now going to turn it over to Stephanie Kaminsky to share some reminders applicable to eligibility spots. Stephanie.

Stephanie Kaminsky: Thank you Sophia. Hello everybody. Yes so Sophia that was a great overview. I was going to start with the COVID-19 group but you beat me to the punch.

We do have a limitation in that we can't approve it any earlier than March 18, 2020 as Sophia said since that was the date that Congress authorized the actual eligibility group. That is when it came into existence. And retroactive eligibility can only go back as far as that date as well.

And I want to just repeat one other piece that Sophia actually laid out for you which is that if a state wants to come in with numerous or several iterations of Disaster SPAs. Sophia said they can supersede each other but they can also be additive.

So a state if they want to just add a new piece to their Disaster SPA should not repeat in the second SPA any of the provisions they put into the first SPA. We have a way through denoting what is superseding. What to allow a state to be able to do this additive process. So just wanted shortcut - short circuit that back and forth for the state if you want to just put a new provision in place. Please don't resubmit anything that has already been approved.

In addition to the tips that Sophia gave I want to mention that if a state would like to use a less restrictive financial methodologies for any of its non-MAGI eligibility groups. We need the state to identify the actual eligibility groups to which it would like to apply the 1902r2 authority.

So we can work with you but states should look at their existing either Mac Pro or Attachment 2.2A of their Medicaid state plan to identify the eligibility groups to which they would like to attach less restrictive methodologies.

In addition we have had some states come in and look to utilize the flexibility around the reasonable opportunity period for non-citizens. Allowing for a longer ROP period in certain situations.

If in fact a state wants to do that that is fine. But if they already have that authority in their current state plan we would like to point out that there is no need to actually select that option in the disaster template. Indeed we recommend that they don't select it if they already have that authority in existence.

In addition as you are probably well aware and as we have discussed on previous calls. There are some requirements for cost sharing exemptions in the Families First Coronavirus Act. And also some options for cost sharing exemptions for states that are looking to claim 6.2% FMAP bump.

We have developed some model language that we would recommend states utilize for the cost sharing section of the Disaster SPA and the model language for the premium section as well. Again to bring states into compliance with the FFCRA, the Families First Coronavirus Act and the CARES Act requirements.

You can obtain that model language from your state leads. They will have that and we recommend that you use that if you currently have cost sharing in your state plan that you need to modify during the period of the disaster and/or if you are charging premiums in your state plan that you need to modify during the disaster or at least not terminate people because of those premiums and certainly not raise them.

So those are some of the overarching tips that I wanted to give. I think that my colleague Jessica Stevens will be able to walk you through a few more in the

areas of presumptive eligibility and hospital presumptive eligibility.

Jessica Stevens: Thanks Stephanie. Yes we know that many states are seeking and many have already submitted state plan amendments seeking expanded use of presumptive eligibility. So just wanted to take a couple of minutes to highlight the specific requests that can be made through the SPA and address a couple of questions that we have received through the process.

So the disaster relief state plan amendment in Section B includes three sections on presumptive eligibility. The first one focuses on hospital presumptive eligibility and that allows states to add new groups through their existing hospital presumptive eligibility SPAs including use of PE to determine eligibility for non-MAGI populations.

That includes the uninsured testing group which we just talked about. It also allows states to make adjustments to the standards that are already included in the state's hospital presumptive eligibility SPA.

The second Section B2 allows states to designate - allows the state to designate itself as a qualified entity for purposes for making presumptive eligibility determinations. This is something that a number of states already do. And it really is primarily used to help streamline determinations and enrollments for some or all MAGI groups in the state plan.

I will note that presumptive eligibility separate from hospital presumptive eligibility is not an option for non-MAGI groups including the uninsured testing group. So states that are seeking to expand the use of presumptive eligibility here and in the next example that I will talk about. Can do so only for MAGI populations elected in the state plan.

And so the third option in B3 is to add qualified entities or additional MAGI populations to allow states to use presumptive eligibility for those groups.

I will note that for all three of these the SPA template requires that states specify what reasonable limits on the number of presumptive eligibility periods the state will provide for the limited time. And we are available to provide any additional technical assistance that states may need on that. And we will pause there and turn it back to you Jackie.

Jackie Glaze: Thanks Jessica, Stephanie and Sophia. So we will move now to Julie Boughn and she will provide an update on the IT spending process.

Julie Boughn: Thanks Jackie appreciate it. Yes just wanted to mention a couple of things about the IT funding, the emergency IT funding authority that is available. The first is like all the usual regulations around what things we can fund and not fund apply here. But with that said there is a wide variety of things that we can approve, you know, based on the economic and efficient operation of the program.

So just to give you some examples of things that we have requested and we have already approved. It is obviously some of the things that you heard our colleagues from Massachusetts talk about last week around COVID screening tool, connections to telehealth vendors.

But we also have approved requests for emergency changes to eligibility systems and MMIS systems. Additional equipment and software capabilities for states that want to advance their telework capabilities.

A really good way to think about the emergency IT funding is that it is not so much emergency funding as it is an expedited approval right? As I said last

week we have to follow up the approval of the emergency IT funding within 90 days with an actual APD.

That does appropriately cost allocates to Medicaid and does all the other things that APDs usually do. But it is a way to get at approval more quickly than sort of the usual APD processes.

A couple of criteria to think about with the emergency IT funding request. The first is we should be clearly tied to the emergency. In this case of course the public health emergency. We like to look at the money being spendable if you would. Like you can get it out, get it on contractor whatever within 60 to 90 days give or take. Within the length of time to help with the emergency is what we are really looking at.

And your cost estimates should be based on something, you know, grounded in reality. Like it could be an estimate from a potential vendor or an existing vendor. Those are the types of things that we could actually tie the expenditure to. It shouldn't be like I need to spend up to X million dollars.

And probably the most aspect of the funding request is that they need to describe the consequences that would accrue if the expedited approval was not given.

So the best sort of way to begin the process if you think you would like to have some access to emergency, an emergency approval of IT funding is to work with your Medicaid system state officer. And they can advise you on both the contents of the request as well as potentially whether you actually even need to do a request for this.

So I think those are the major dos and don'ts I wanted to go over. Some things

that we are seeing that cause more conversation. For example, a two year plan to advance health information exchange capabilities around surveillance and the public health system.

That is a little bit harder to sort of get our arms around in this natural emergency right now. But with that said maybe I need to accelerate some aspects of that. And emergency funding, emergency approval of funding would help with that. So we are happy to approve those things.

And so those are the major points that I wanted to make and I think I will turn it back to Jackie now.

Jackie Glaze: Thank you Julie. So thank you all of the presenters. So we are ready to take questions now from the audience. So operator can you open the lines please?

Calder Lynch: Jackie?

Jackie Glaze: Yes.

Calder Glaze: Jackie real quickly before we have the operator open the lines. I just wanted to one follow on comment. I know a number of you have perhaps received outreach from your state nursing home and long term care provider associations about providing data or information to support their request for funding as allocated under the CARES Act provider of funds.

We are working to greater clarity on what may or may not be needed there and what data can or cannot be shared and to whom. But to get everyone we are working with our colleagues at HHS who are administering that process. Make sure that those lines of communication are clear and we are communicating out of our normal channels with states.

I know that a number of you have reached out to me to NAMD about that. And we are working to try to get greater clarity there to provide to you. So I just wanted to say that.

Jackie Glazer: Thanks Calder. So operator we are ready to open up the lines and take questions at this point.

Coordinator: Okay thank you. Once again if you would like to submit a question or comment please press star 1 on your phone and record your name and your line will be open. Once again that is star 1. To withdraw your question you may press star 2.

One moment as questions queue up. Our first question comes from (Allison) your line is now open.

(Allison): Hi yes this is (Allison) from Massachusetts. Just want to follow up on the discussion about the state plan amendment. I think the speaker said that we can't request expansion of hospital presumptive eligibility to non-MAGI through the state plan. Is that correct? Does that mean we would need to include that in 1115 request?

Jessica Steven: This is Jessica again and no. Let me clarify. In hospital presumptive eligibility can be requested through a state plan amendment for non-MAGI population. It is just presumptive eligibility through other qualified entities that cannot be done for other non-MAGI populations.

(Allison): Perfect great thank you for clarifying.

Jessica Stevens: Sure.

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

Woman: Hi I have a question about the emergency period. In the last FAQ that was posted in 4/13 it clarified that the emergency period was for 90 days beginning on January 27th. So we are nearing the end of the emergency period.

I was curious if there was any discussion as to an extension of that? Or when we would become aware of that? Because they are making policies and changes that would be affected by the end of the emergency period.

Calder Lynch: Hi this is Calder. So yes we are coordinating closely with the folks at the department and elsewhere on that. We have not received any indication that there would not be further, you know, renewals of that given the ongoing, you know, the ongoing emergency situation.

So as soon as we have more, you know, detail we will share it. But we are not anticipating, you know, anything ending in the very, very near future. As we learn more we will certainly share that. But we are continuing to plan as if we are continuing under this authority for the time being.

Woman: Thank you.

Coordinator: Our next question comes from (Louis) - I am sorry, (Louis Johnson) Your line is now open. Mr. (Johnson)?

(Ruth Johnson): This is (Ruth Johnson)

Coordinator: Oh sorry.

(Ruth Johnson): That is okay.

Calder Lynch: Hey (Ruth)

(Ruth Johnson): Hey Calder. Thank you so much for addressing that. A follow up question is and I know you had spoken about this on a previous call. Will additional information be available to states on who receives payments as we look at requests that are coming to us for rate increases for Medicaid. We would like to cross reference that to funding that is available through the CARES Act.

Calder Lynch: Yes we have gotten word from HHS that there will be more granular data available about the distribution of those dollars. Right now, you know, they published it at an aggregate state level but I know there is interest in drilling down further.

I don't have a timeline yet. I know that part of the process is that once those dollars are made available to providers there is an attestation process where they have to confirm that they are accepting the conditions that come with it. And so that process needs to play out before they can sort of finalize for sure how much they are getting.

But once we know that information is available we will make sure to share it because I know there is a lot of interest from states on that front.

(Ruth Johnson): And one last question. The guidance is going to go to providers that is being worked on as far as accessing the additional CARE dollars for the Medicaid population. Will that also be posted on you all's Web site so we can get to that?

Calder Lynch: We will make sure to link to it and to share it out with folks. It will probably be on the HHS Web site. They set up a Web site for the CARES Act funding. And just, you know, to share a little bit. So there was the initial $30 billion right that was first distributed out based on Medicare fee for service volume.

The department has been working with I know a number of providers for part of that initial distribution but who maybe did not have a high amount of Medicare fee for service volume, you know, because they are high Medicare advantage or they are primarily Medicaid provider, children's hospital.

There is a process in place now to sort of true up those providers and reflect our overall revenue. And more information and more news about that as the week goes on. And beyond that though there is an additional tranche funding for a more targeted distribution.

And part of that will include a focus on Medicaid providers who did not receive funds out of that first, you know, more sort of Medicare focus distribution. So as we get more information about that we will share it and we will make sure that folks are aware of it.

(Ruth Johnson): Thank you so much.

Coordinator: Our next question comes from (John La Phillip). Your line is now open.

(John La Phillip): Thank you. (John La Phillip) from Wisconsin. Question for probably for Stephanie or Jessica. I was just wondering when this (unintelligible) last week there was some mention of an addendum coming out for the - it was either the Disaster SPA or maybe the verification plan.

I was just wondering about when that might be happening? And when might

the next FAQs be coming out? Talking about (unintelligible)

Jessica Stevens: This is Jessica. I will take the first part. And it is already out. It is posted on Medicaid.gov. It is the addendum to the verification plan which states can use to notify CMS of changes that are being made to MAGI based verification policy just for the duration of the emergency.

(John) we can send the direct link to you. But for all other states wanted to note that it is available on Medicaid.gov at this time.

Stephanie Kaminsky: Although Jessica this is Stephanie and I found that it is not on our COVID page. It is on our eligibility page right?

Jessica Stevens: Correct.

Stephanie Kaminsky: I think it is on the eligibility page so you might have to search around a little bit for that. And we are excited that you are an avid subscriber to our FAQs. I think that others (unintelligible) but hoping that the next batch will be coming out this week. I think that is what we are all really aiming hard for.

(John La Phillip): Okay great. Because we have those pending questions about petty and cost share and co-payments all that.

Stephanie Kaminsky: Got it yes.

Calder Lynch: I think we are getting a little closer on that. We can probably provide a little bit more color Sarah Delone if you want to respond.

Sarah Delone: Sure. Happy to yes. I think we are expecting those to be in the next batch. I think the general theme there will be that you know the amount of medical

assistance is also something that is protected by 6008 B3 in terms of needing to comply with that to get the increased bump.

So that anything that would reduce the amount of medical assistance like increasing cost sharing would not be consistent with the conditions to receive the increased FMAP bump. So that is the, you know, sort of that is the principle and the FAQs that will be released should reflect that.

(John La Phillip): Cost sharing as in including co-payments?

Sarah Delone: Cost sharing including co-payments and also like a post-eligibility treatment of income cost sharing. So you know once somebody is already receiving - if you have a current beneficiary and they are subject to a post-eligibility treatment of income rules. Then to reduce their personals needs allowance would essentially decrease the amount of medical assistance that would be provided to them.

And so that would be a violation of - or that would not be consistent with the condition in B3, 6008 B3 to continue to furnish the same level of, you know, of medical assistance.

Calder Lynch: Yes and this is Calder. Let me say you know we will have more detail, you know, in the final FAQs when they are released. But I know folks are anxious for direction on this.

We been trying to work with our counsel to get - to get a clear read on the statute and this is kind of the direction we are getting and we are now reflecting that into the FAQ. So just wanted to get folks kind of a sense of where they are landing. But we will have more details in the final FAQs once they are issued.

(John La Phillip): Thank you.

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

(Anna Arks): Hi good afternoon. This is (Anna) from Pennsylvania. And I think my question is more about the - again with the COVID testing eligibility group. I understand that that is authorized for just during public health emergency and however long that is extended.

But is there any discussion or consideration for continuing that group after the public health emergency ends to allow for continued testing and tracing in case there is a resurgence come the fall or later?

Calder Lynch: Well I believe, I mean I think that is a statutory issue. Is it not Sarah in terms of what the authorization (unintelligible).

Sarah Delone: Yes, yes.

Calder Lynch: Yes we can certainly take that back and think about what other options may exist. I think there is definitely an understanding that there is going to be a continued need around surveillance and testing. So we can think more about that.

(Anna Arks): Okay and then so I guess if we were - a state were to elect to increase eligibility to this group and go through the process of establishing the systems needed to do it. How should we authorize - I mean do we only authorize it for a period of three months or does it sort of have a termination date as soon as the health emergency ends?

Sarah Delone: I mean I think the answer is basically you sort of yes you would need to terminate coverage under the group at the end of the public health emergency or really to be compliant with the 6008 B3 at the end of the month in which the public health emergency ends which is, you know, going to be consistent with most states doing full month eligibility.

But I think you may be acting a little bit more of a practical question. And there are a number of operational implementation issues with this group that we are working through with states now. And I think you are highlighting another one which is, you know, it is sort of appropriate anticipation of the group coming to the authority to keep providing the coverage under this group coming to an end.

And then what do you need to do to prepare for that and provide proper notice? And that kind of thing. So I think we should add that to our list of issues that we are working through you all in terms of how to effectively operationalize this group.

Jessica Stevens: And if I could just add. This is Jessica. Because I know it is a question that we have received from a few other states that is related. I think the other thing that we will be providing additional guidance on is the potential need to redetermine eligibility for these individuals prior to just terminating.

As another Medicaid eligibility group it may not be appropriate to just terminate eligibility for these individuals. And we can provide additional clarity on that as well.

(Anna Arks): Great thank you very much. I appreciate it.

Calder Lynch: And I will say generally too that we are you know beginning to think about -

there are a number of things (unintelligible) to the eventual end of the public health emergency and that we will need to properly provide some guidance around. You know the steps that will be necessarily related to a number of these different authorities.

So appreciate folks flagging those so that they could help inform some of the thinking there and we will be working with states through (unintelligible) otherwise on that.

Coordinator: At this time there are no further questions in queue.

Jackie Glaze: Calder is anything else from you before we adjourn for today?

Calder Lynch: No I think we covered everything. I appreciate everyone's time this afternoon. Hopefully it is a good sign that we are getting through without using the full hour. And we will continue information as we get it available.

Jackie Glaze: Thanks Calder and thanks everyone for your participation today and we appreciate your time. And we will be meeting with you again on Friday. So I hope you all have a good afternoon.

Coordinator: Thank you. That concludes our conference for today. Speakers please remain on the line.

End