Centers for Medicare & Medicaid Services
COVID-19 Medicaid & CHIP All State Call
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Operator: Welcome. Thank you for standing by. Guests are in a listen-only mode until the question and answer session of today's event. At that time you may press star 1 on your touchtone phone if you care to ask a question.

Today's conference is being recorded. If you have any objections please disconnect.

Now I'd like to turn it over to your host Ms. Jackie Glaze. And thank you so much, ma'am. You may begin.

Jackie Glaze: Thank you. And good afternoon everyone. And welcome to today's All State call.

I'll turn to (Calder) now and he will share the highlights for today's discussion. (Calder).

Calder Lynch: Thanks, Jackie. Welcome everyone, thank you for joining us today. We are going to be continuing some of our lessons from the Field Series as well as of course having time to be able to answer any questions that folks may have.

But today, the topic area for us is going to be around remote work. With the implementation of school closures, social distancing practices and stay at home orders, just like the rest of the U.S. economy our HHS and Human Service agencies have been confronted with the challenge of how to maintain operations amidst this new normal.

Many Human Service agencies had to move very quickly to implement telework programs to their staff and to help provide accommodations for

employees who could not come into the office or in some cases implement full office closures.

Some states already had telework capabilities across their various operations while others may be needed to stand up new operations or protocols and for some this might've included procuring laptops, setting up VPN or secure connections to agency systems, distributing equipment and masks, expanding their Call Center and other vendor capacity, developing new training, developing new operational state operating procedures.

And so we're pleased today to have Stephanie Muth from Texas join us to discuss how the Lone Star State has handled this situation and has moved to a much heavier reliance on telework in a very short period of time. Stephanie, of course, is the Deputy Executive Commissioner of the Texas Department of Health and Human Services where she oversees Medicaid and Children's Health Insurance Program. She and I will be discussing how Texas has moved its workforce to telework where possible in the early days of the public health emergency.

And after Stephanie's discussion, Julie Boughn will join the conversation to share some more information about how states can use IT funding to add telework capabilities for its workforce.

After Julie, we'll open up the line for questions on that topic for our speakers. And as well as actually any other topics that you may want to ask us about.

Before we move into the conversation I also wanted to briefly draw folks' attention to the telehealth toolkit that was released by CMS last week, the Medicaid and CHIP telehealth toolkit. We all recognize the importance of telehealth services in this time in which we are encouraging America to stay at home and to avoid unnecessary and nonessential trips outside of their homes and telehealth can be important toward helping folks avoid clinical settings or, you know, stay safe.

And so there's been a lot of sort of across the entire agency to expand access to telehealth including in Medicare as well as in Medicaid. And so the Administrator in addition to releasing the toolkit also sent an accompanying letter to the nation's governors encouraging them to use the toolkit to assess barriers in your individual states from full utilization of telehealth services whether they be in your own Medicaid coverage policies or in broader scope of practice and licensing requirements. So we encourage states to make use of that toolkit as a way to assess those opportunities, to expand access to telehealth services, and where necessary, you know, seek changes in policies, state plans, or other operational protocols.

Now to return to our conversation, we will begin with Stephanie. Stephanie, I'm wondering if you could just begin by telling us how much telework you were doing in Texas before COVID-19.

Stephanie Muth: Sure. Thank you (Calder), and thank you for the opportunity to be here today to share with you the Texas experience which I'm sure is similar to what many other states have gone through in the past six weeks or so. I would say that Texas as an agency, we were definitely utilizing telework. I think my analogy would be like we had our feet in the water but we very quickly had to dive headfirst into having a very expanded approach on telework. We were accustomed to doing it. We had policies and procedures and training for staff. We understood the technology needs. We had proper security controls.

But I don't think culturally it was very widely embraced. So a little bit about Texas. Eligibility, we have an integrated eligibility system with about 5000 eligibility workers across 254 offices. That sits outside of my division but we work very closely in partnership with them. So I'm going to talk a little bit about both areas.

But for my staff who we do all of the once you're enrolled in Medicaid the receipt of benefits and all of the operations and policy around that, we had about 10% of our staff that were teleworking on some level. It might just be a couple days a week.

And then in the eligibility space, they also had around 9% to 10% of their staff. Most of that was we have some dedicated units that do escalation from our Call Center. So those teams are 100% telework.

But for our regular local office staff, we had done some pilots and had the ability to telework but it was not broadly being utilized.

Calder Lynch: And so when you realized you were going to have to scale this up really quickly, what were some of the first steps that you took?

Stephanie Muth: So the biggest challenge for us, as I said, you know, we sort of had a lot of the basics covered. We had some training in place. We knew what security controls needed to happen.

But our biggest constraint was we did not have enough laptops. So the first thing we had to do was inventory who, you know, we knew who had the laptops but who didn't have them.

And then our other solution was to have people who had computers at home that they could utilize for work to use. A Go to My PC account which is less ideal but also it allows you to do your work and then also if you could just get into your email.

So since we had to flip so quickly into a telework environment we were utilizing whatever we had in place. And then inventorying who had a gap and really prioritizing those folks that were mission-critical to make sure that they received the technology support that they needed to help them telework first and prioritizing that across a very large agency.

And then, of course, you know, this handling the distribution of equipment. Much easier for our central office staff, gets more challenging if you're going out into those eligibility offices all across the state.

So our IT Department worked like vigorously to schedule distribution days and work to get the equipment out to staff.

Calder Lynch: And so do you do this kind of all at once or did you have to stage it over a period of time?

Stephanie Muth: It had to be staged. I'd say it happened pretty quickly for getting the equipment out for some of the central office staff. There's still a few folks who, you know, were lower on the priority that we're working on. And for eligibility staff very few of those staff had laptops. Like for me, for my team, about 65% of our staff already had the basic equipment that they needed or licenses that they needed to telework. The number was much lower on the eligibility side.

So they are working their way up and we have reached a saturation point of about 74% of those eligibility staff can now telework due to the equipment needs being met.

Calder Lynch: Wow, that's a big achievement. But in addition to getting the equipment out there, how did you handle their ability to access, you know, casework files, eligibility system, data sources to do verification activities?

Stephanie Muth: And I think that was where the work that we had already done in terms of already having some staff that were doing this we had that capability in place where you could access the information remotely, that capability.

And the way that we even assign and distribute our work is done on a statewide basis. It doesn't matter if you're in an eligibility office or working remotely.

So from that perspective, we were ready to move to a more telework environment.

Calder Lynch: Does this change how you interacted with beneficiaries at all or what you

need to communicate to them around eligibility operation?

Stephanie Muth: Yes. Well, I think this was interesting because I was contemplating, previous to serving in my current role, I oversaw our integrated eligibility operations at the time that we were implementing the Affordable Care Act changes into our IT system.

And when we did that we took advantage and really were very strategic about moving things to online versus paper. Texas had already made some strides in that area. But most of our applications were still coming in on paper.

But we started really shifting the way that we interacted with our clients to reinforce that there's no need for you to come into the eligibility office. We deployed a mobile App that lets people provide any missing documentation from wherever they are.

So really our communication message was the same. You can access everything you need. You can check the status of your application. You can get basic information about your account without ever going to an eligibility office. You can go online. You can call 211 and get the information you need about your case without coming to the office.

So it was really the same message but it just gave us the opportunity to reinforce that.

Calder Lynch: And as you begin thinking about, you know, obviously, there's a lot of conversation about, you know, getting back to a new normal and reopening, you know, states and economies, have you begun planning for a transition back? Do you see telework being a bigger presence in your work moving forward?

Stephanie Muth: Absolutely. I think we are starting to plan for at least a phased-in return to work and what that might look like and when that might occur.

But I think there won't be - there's definitely - the normal post-COVID will not look like it did pre-COVID. And there are two things in my mind that we've established through this. One, we've created an appetite for staff to be able to work remotely. I think we've proven we can be effective in working remotely.

And there has not been a significant impact to productivity. It's provided additional flexibility. I think those needs and that desire is going to continue into the future. I mean I will say we also have some staff who are very eager to get back to the office and return to working.

But I think that appetite for telework is there. And we proven that it's a effective way to do our work. And obviously, we wouldn't want to do it exactly like we're doing it now out of necessity. But I think that it will change some of the culture within the agency and supervisors' comfort with supervising in a remote environment.

So while, you know, we're definitely thinking about the phased-in approach and how to safely return workers to the office, there will be no doubt about it, more demand for telework once we return to our new normal.

Calder Lynch: You mentioned two things that I want to touch on a little bit. So one is productivity which I think is something we hear a lot about in terms of, you know, moving workforce to different settings. And how, you know, how are you measuring that? What have you've been really observing in terms of, you know, productivity among staff? What metrics have you found really helpful?

And then the other thing you mentioned is supervision which is another issue that comes up a lot. And just wondering if you've got any tools or practices that you have found to be particularly effective in helping managers supervise the remote workforce.

Stephanie Muth: So I'll address the question about metrics first. And I think in the eligibility world it's very metric-driven.

So part of the transformation that we've been having in eligibility was to move more to an environment where we are measuring an individual worker's activities and having those concrete metrics.

So it doesn't matter if you have your eyes on what's happening. You have the data to manage and see whether someone is working effectively remotely or if their productivity has changed.

So from the eligibility perspective, you have hard and fast metrics about the number of patients that you're processing, how long it takes. You know how long someone is even working because you can tell from their production. It's similar to what happens in a Call Center environment.

So metrics from eligibility has not been a challenge because we established that and it's true whether you're in an office or working remotely. I think for some of the other things that we do, policy development, other things that are more nebulous it's you don't have a concrete deliverable. It's a little bit harder to have a solid metric.

But what we've seen is in this environment we have had to quickly respond to stakeholder requests, do analysis, make requests to you all for federal flexibilities. There's state flexibilities that we requested. Our volume of work has increased tremendously. And our ability to do that has not been negatively affected. So I think you can still see that productivity and it's not as concrete.

From a supervision perspective, I think a lot of it is communication. And one of the things that getting feedback from the teams and the supervisors is really using that video technology so that you actually have face-to-face conversations through video teleconferencing versus just telephone makes a huge difference. We've encouraged our supervisors to check in regularly with their team.

And we do have a supervisor toolkit and training that's available. Training for

both the teleworker and supervisor that we already had in place and is online. So as we've moved more to telework that's something that is an available resource for staff.

Calder Lynch: That's great. So, Stephanie, it sounds like you had a tremendous amount of success in a short period of time but I'm sure along the way you came across some barriers that made it more difficult.

What were they? And are there any things that we can be thinking about or doing at the federal level to help make this an easier transition for states?

Stephanie Muth: I think our biggest barrier and challenge was just supply chain because everybody in the country if you're already not supporting a telework environment you're moving to do that. So the state was fortunate in that we had ordered a number of laptops because we were already planning to transition some folks from desktops to laptops.

But there was also the disasters in Tennessee that impacted the Dell warehouse there that impacted our order coming in. So we just had supply chain issues in order to get the number of laptops that we needed. That's been our biggest challenge. I talked to my team. I could not think of any federal barriers. I think again a lot of the work that we've done with electronic signatures and the ability to work remotely has set us up nicely for success in this environment.

We did discover though that there were a number of processes that we had in place where it involved routing paper still and identifying those things and responding. We figured out several ways already that we can be more efficient and move away from paper and more to digital signature that all of those things are going to continue with us whether or not we're working remotely or back in the office. So that's been a good benefit as well.

Calder Lynch: Great. Well, my last question is really just what's the best advice you can share for fellow states in terms of folks that maybe aren't as far along as you

are in this transition?

Stephanie Muth: I think that there's the need to be flexible with your staff especially in this environment where we have a lot of people who are teaching and parenting at the same time that they're trying to do their work.

And what we've seen is offering that flexibility so in addition to having people work remotely but allowing them to flex their schedule has been a necessity. And that just being flexible and open most - we've had very few issues. People have risen to the challenge. I do think there's some jobs that just aren't conducive to - aren't as conducive to telework. And those folks that we still have going to the office are people who have to do things like process some mail that we receive and other activities like that that we just have not been able to work remotely with. But it's just be flexible and be willing to adjust the approach when something is not working. And that's the best advice.

And I'm sure that's what every state has had to do as they've responded to this unprecedented situation.

Calder Lynch: Indeed. Well, thank you, Stephanie, for joining us. I'm going to keep you on the speaker line in case if you're able to stay, in case folks have any specific questions that you can help us answer.

But I think with that we're going to maybe transition over to Julie Boughn. Julie, Stephanie talked a lot about the need to kind of get equipment in place. And make sure folks had systems' access. And that's an area where we can help support states with some enhanced funding opportunities.

So I think you're going to tell us a little bit more about that.

Julie Boughn: Yes, thanks (Calder). And what was also interesting about that conversation that you just had with Stephanie was how, you know, it's totally obvious that telework is not just a technology issue. It's a culture issue, a training issue, policies, procedures, is what cognitively that goes into thinking about

becoming a teleworking organization.

But what we can help is the technology expenditures and just sort of to refresh people's memories because I've talked about this a number of times on these calls is, you know, the way to think about the Emergency IT funding is as an expedited approval of funding. We still will have to have follow-up with an ACD and things like that. The first lens that we provide any IT Funding Request is to help the efficient and effective operation of the program in the state. And of course the closer it's tied to the, what's referred to in the law as the Mechanized Claims Processing and Information Retrieval System the easier it is for us to do the approval. That should be any systems that you might have in data warehouses. But it can sort of stretch out, you know, from there.

The three kind of lenses that we put on the Emergency IT Funding Request just to refresh everyone is that it has to be clearly tied to the emergency and reacting to the emergency, number one. Number two that the money can be spent within a reasonable timeframe which we think of 90-ish days that it has to get spent kind of and the capability has to be in place within that timeframe to really be able to help with the emergency.

And the third thing is that the cost estimates or the amount that you're asking us to approve in an expedited way is tied to something or some actual cost estimate behind it. It's not just I need to spend up to $10 million fixing my eligibility system, to do the maintenance of effort requirements.

So and the fastest way to sort of build-out requesting and getting the discussion started about your funding is to talk to your Medicaid Enterprise System State Officer.

So with that, I think I'm going to turn it back over to Jackie who can help us with questions.

Jackie Glaze: Thank you Julie, and thank you Stephanie, for your assistance with the

telework. So we'll take your questions now so we'll just open it up Operator, and just for the audience to ask any questions that they may have for us.

Operator: Thank you so much for that. So if you do have a question, please press star 1. If you muted your phone please unmute and record your name clearly when prompted. Your name is needed so you know when your line is open. So please star 1 and record your name. One moment, please.

Thank you, one moment. I have one question. (Lauren Wrigley), ma'am, your line is open now.

(Lauren Wrigley): Hi. This is (Lauren Wrigley) from Colorado. And we recently saw that HRSA opened a portal for providers to submit claims for COVID testing and treatment for the uninsured. And we were just wondering how this impacts and relates of the Medicaid coverage of uninsured testing. And we know that this would be paid through Medicare.

Calder Lynch: So yes. So I think we did share the news release that came out from HRSA that they've opened a portal for the CARES Act. There's two I think funding streams that were made available. One, first under the first bill, the Family First Act which was $1 billion for testing. And then as part of the $100 billion that was allocated under the CARES Act the department has allocated funding to reimburse for recruitment of uninsured patients and those claims are being paid through a portal that HRSA has operationalized and there's information online about that at hhs.gov/providerrelief.

So that would be largely for individuals who would be, you know, uninsured and then face that, likely haven't opted to cover at least for the testing, the testing group. But beyond that could also include, you know, for treatment of the individuals, you know, who would be in any state that's uninsured.

But Sarah Delone maybe you can speak to the intersection more specifically.

(Sarah Delone): Sure. Thanks (Calder). I mean I think the main point I think as (Calder)'s

indicating there, that really there are two separate funding streams in terms of the funding that's available for testing for uninsured individuals. So one funding stream would come through the Medicaid Program. And those would be for states that adopt the optional COVID testing group. And then somebody is, you know, enrolled in that group. And the claims would be paid through the Medicaid Program.

And we know that and I think as (Jessica) and (Steven) and Julie and Rory talked about on the last call, we understand there's some, you know, operational challenges to states in standing up that group and getting claims paid and then doing the claims.

And so we're working on, you know, some strategies to help, you know, jerry-rig that I think was the (loose) term to enable that to happen without sort of the usual - all of the usual bells and whistles would usually accompany adopting a new eligibility group. So that's one funding stream that would come through the Medicaid Program.

The other funding stream, the $1 billion that's for testing that's not - is a separate pot of money and that would be for uninsured individuals including those who are not enrolled in Medicaid, right. And so that would be funding that would not come through the Medicaid Program but that providers would be making a separate claim for.

And that's, I think that's also HRSA. HRSA administers, is that right (Calder) and so that - it's just...

Calder Lynch: Yes.

(Sarah Delone):   ...a separate funding stream. And it goes directly to the providers, not mediated through the states.

And I think as we get more information about that, how that funding is flowing and working we can share that with states so you can think about how

these two funding streams maybe coordinate at the state level and the choices that you want to make.

Operator: Thank you. At this time I have no further questions over the phone lines. To ask a question, press star 1.

((Crosstalk))

Jackie Glaze: Thank you (unintelligible).

Calder Lynch: Let's just give folks a second to see if any come in.

Operator: Yes. Thank you for that. I do have one more. (Jane Rango). Ma'am your line is open.

(Jane Rango): Hi. Can you hear me?

Calder Lynch: Yes.

(Jane Rango): Hello?

Calder Lynch: Yes. We can hear you.

(Jane Rango): Oh I'm sorry. Okay good. So and I may have missed the end of that conversation but is Medicaid the payer of last resort when we consider the HRSA money and the Medicaid money for this group? How does that work?

(Sarah Delone): And...

(Jane Rango): And how would we make sure that these claims that we receive, you know, the tests that we're paying for in Medicaid were not previously paid for by HRSA?

(Sarah Delone): So I think I mean somebody asked on the last call I think. (Calder), I think I

can take a stab if you want. I think in terms of the - I mean in terms of the Medicaid as the last, you know, payer of last resort, I think we want to take that back to confirm.

But and I would welcome, you know, the third party liability DHPG colleagues to weigh-in. But I don't think this would be - this is not - I don't think this would fit into that usual hierarchy. It's not - it requires the provider - just let us take that back. I think it's going to be Medicaid at first.

(Jane Rango):   Okay.

(Sarah Delone):   But and not the fund that's sort of the limited pot of money. It's $1 billion which seems like a lot but might dry up, depends on if the providers who get through the hoops that they have get through. My guess is that it doesn't - Medicaid would come first there but let me take that back...

Anne Marie Costello: And (Sarah) can I add?

Alissa Deboy   Yes. I agree with you (Sarah). This is Alissa Deboy. I can tell you like the rationale. But we need to check on that. Thanks.

Anne Marie Costello: And maybe we can just - this is Anne Marie Costello. And maybe just if someone enrolls in the uninsured group that the state has adopted the new 23 Group they would then be a Medicaid beneficiary, right, and would then even if we call it that insured group would have insurance and Medicaid would be paying, right. I think separately if someone goes through the funds they have no means of insurance, right, whether that be Medicaid or private insurance or marketplace or any other method of payment, right.

So if someone is in Medicaid you would be paying the bill to the people enrolled in Medicaid including this new group is this state elects to adopt that group.

So I think - I know we want to think about third party liability. But I think

when you think about who is uninsured and who could get paid through the fund, those are people that are uninsured so would not be Medicaid enrolled individuals.

Calder Lynch: Yes.

(Jane Rango): And if I could just add, if it was initially paid for by the fund and then comes to us is what the scenario I was thinking of, comes to us for an application.

Calder Lynch: I think it would depend on when the individual is enrolled in the new group and whether they're...

Anne Marie Costello: Yes.

Calder Lynch: And whether their coverage was effective on that date or not.

Anne Marie Costello: Right.

(Jane Rango): Okay.

Calder Lynch: But clearly that's, you know, so we've gotten a couple questions on this. It sounds like we probably need to develop a little bit more guidance that we can provide in writing on some of those interactions. So we will take that back and work on that with folks...

(Jane Rango): Thank you.

Calder Lynch: ...from the department.

Operator: Again if you have a question please press star 1, take a moment to record your name. My next is from (Pat Curtis). Ma'am your line is open.

(Pat Curtis): Yes. This is just a quick question about the FAQs. I don't know if you issued them. I haven't seen them. But from the call from last week, is there a target

date for issuing those?

Calder Lynch: We're on track to get those out this week. Hopefully, before the end of the week and as part of releasing these additional FAQs you'll also see us updating the broader FAQ document to hopefully make it a little bit more user-friendly and easier to navigate. But we are working to get those out in the next couple of days. We're very close.

(Pat Curtis): Thank you.

Operator: And my last question at this time anyway is from Molly. Your line is open ma'am.

Molly Slotznik: Hi. This is Molly Slotznik from the State of Maine. I have another question on the uninsured piece, a little bit different. In the FAQs we've seen that the 100% match applies of course to the claims, to medical claims themselves for requesting testing related services and then also to administrative costs. That's what the FAQ said.

And I was wondering if you could define administrative costs a little bit more. Would those only be costs for which we currently get the 50% match rate or does that also include for example if we're making changes to our (MMIS) where we already get an enhanced match rate till we get 100% match on those claims into the (MMIS)? Thank you.

Rory Howe: Hi. This is Rory Howe. I think that's a question that we'll have to take back and something that we can look to provide more guidance on. And to the extent that you're interested in working through which costs will be available, we're happy to provide direct TA to you to the extent that you need to modify your cost allocation plans or your admin planning plans. But we will take that question back as well and get more information out as soon as possible.

Molly Slotznik: Okay, thanks very much.

Rory Howe: Sure.

Operator: At this time, I have no further questions. Again please star 1. Thank you. Now I have nothing coming through the queue.

Calder Lynch: All right, well thank you all for joining us today. I think we will continue our conversation on Friday with a focus of the conversation being something I think folks are probably looking at your state level as well which is around, you know, understanding what the data is telling us about COVID-19 so looking at data and analytics and dash boarding, you know, looking at claims data. Hopefully being able to share with some of what we were doing at the department around Medicare and hopefully being able to make sure that we're looking at that consistently with states as well.

So we'll have folks on the line to talk through that and look forward to that conversation as well as of course time and for questions you have which will hopefully include any questions that may be sparked by the additional FAQs that we send and release this week.

So with that, we'll give folks a little bit of time back on their calendar and I hope you have a good afternoon. Thank you.

Operator: Again, thank you for your participation. As the conference is over please go ahead and disconnect. Thank you very much.

End