

**Centers for Medicare & Medicaid Services  
COVID-19 Medicaid & CHIP All State Call  
May 5, 2020  
3:00 p.m. ET**

Coordinator: Thank you for standing by. At this time all guest lines will remain on listen-only mode until the question and answer session held at the end of today's conference. If you'd like to ask a question you may press star then 1.

This call 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, ma'am. You may begin.

Jackie Glaze: Thank you and welcome and thank you, everyone, for joining our call today. We have a very late-breaking release of a long-awaited fourth set of FAQs. That will be the focus of our discussion today. We just posted those to the web about an hour ago so you should see them shortly.

At the end of the call today, Calder Lynch will provide an update on the provider release fund and after his remarks, we'll open it up for the state questions. For the FAQ discussion today, I'll let my colleagues give you more details but wanted to call your attention to a couple of changes of the format of the FAQs. In response to your feedback, we've done some reformatting of the FAQ document to make it easier to navigate now that we have so many FAQs for your review. The reformatting FAQs will still be in the same link that we've used in the past. Only the format has changed.

The separate legislation focused FAQ document is now incorporated into the

new document. But we're also releasing a secondary document with only the new FAQs from this release. They are also incorporated into a larger reformatted document as well but we wanted folks to be able to have the opportunity to see only the new FAQs readily available.

So now we're going to begin our discussion on the latest use of the FAQs. We do have multiple speakers so we'll begin with the Children and Adult Health Program Group Section and Jessica, Stephanie, and (Karen) will provide overviews of their section.

So Jessica Stephens will begin the discussion on the enrollment. Jessica, are you ready?

Jessica Stephens: I am ready. Thanks, Jackie, and hello everyone. I will start off by just sharing a few updates that you will find in the FAQs. We have a number of new questions related to some application and enrollment questions that a number of you have been asking.

Specifically in three areas on safe use of presumptive eligibility and hospital presumptive eligibility including some questions related to oversight of hospitals and processes that are available for states to conduct presumptive eligibility including by phone and through online portals.

The second area that we have in here relates to verification, policies, and flexibilities including conditions under which states can accept self-attestation, timing of any post-enrollment verification that may be required, and excessive state processes for documenting changes to verification policies.

I know we provided before that there is a verification plan addendum now

available to document changes to MAGI based verification policies. There's a link to that in the FAQs along with more information about how to document various changes.

And third, I want to note that the long-awaited question that many of you have been asking related to obtaining and retaining applicant signatures is included in this batch of questions. And that includes use of third parties and collection of signatures when individuals may be receiving assistance by phone during this emergency.

I will turn it over to Stephanie Kaminsky to talk a little bit more about some of the other eligibility. Thank you.

Stephanie Kaminsky: Thank you, Jessica, and hello everybody. This is Stephanie Kaminsky.

And I would like to talk to you a little bit more about some of the eligibility FAQs that were just published. In particular, with respect to hospital presumptive eligibility, we're pleased to share that we found some flexibility and have articulated that in the FAQs regarding the transfer of asset rules and post-eligibility treatment of income.

States have the - states don't have to apply the transfer of asset rules against institutionalized individuals who are receiving services during the hospital PE period if they have not yet submitted a Medicaid application.

And similarly, states have the option whether or not to apply PETI rules during the presumptive eligibility period. So we're hoping that that will help facilitate some expedited presumptive eligibility determinations.

In addition, we have a couple of FAQs about self-attestation. One of them refers to the medically needed spend down. States can permit individuals to

self-attest to the amounts of their incurred medical expenses. That's both for medically needed and for 209(b) state spend down. States can permit this on a temporary basis through the end of the public health emergency.

And we would expect that states would document this in their internal policies and procedures. In addition, states can also permit self-attestation of the level of care required but just for the Katie Beckett Group. Other level of care attestations or level of care designations for example for the 217 or the 219 Groups have other regulations outside of the scope of Medicaid eligibility that would come into play, some of those being the home and community-based services regulation.

But we did want to share that at least for the Katie Beckett Group states can accept self-attestation for the level of care requirement.

And finally, the long-awaited questions about the interaction of the Family First Coronavirus Response Act 6008(b)(3) with cost-sharing and PETI, we want to announce that in both cases for cost-sharing and for PETI states cannot - would not be eligible for the increased FMAP if they increase liability for PETI or for cost-sharing during the public health emergency period.

So this is, yes, so I'm just going to quote exactly. Increasing a beneficiary's liability reduces the amount of medical assistance for which an individual was eligible and therefore inconsistent with 6008(b)(3) of the FFCRA.

We have a few other questions I didn't get to related to the definition of disability whether or not somebody who has COVID-19 is incapacitated and also some questions on residency with respect to AIAN individuals and what states can do under their state plan.

So I think those are the ones I wanted to cover today. So I think that's it for myself right now. Thanks.

Karen Matsuoka: Hi everyone. This is Karen Matsuoka. I'm the Director of the Division of Quality and Health Outcomes, also the Chief Quality Officer of Medicaid and CHIP.

Just wanted to very quickly say that also included in this latest batch of FAQs in the section called Data Recording are three new sites of questions and answer on CARES on how the public health emergency is expected to affect a variety of different quality reporting and provision.

The first is on the Childs and Adult Core Set and covers things like how states can approach measures and surveys that call for approaches that are inadvisable at this time such as onsite medical cut review and in-person experience of care measure, how to handle things like data trending and how CMS expects to handle things like data trending of data reported to us from states as well as reporting timelines for the Federal Fiscal Year '20 Child and Adult Core Sets.

The second set of Q&A Cares is on EPSDT reporting through the Form CMS 416. And addresses questions around things like timely data submission as well as how to account for telehealth in well-child visits which is permitted on CMS 416 provided certain conditions are met.

And third is a set on managed care quality reporting such as things like submission deadline for quality strategies and external quality review and how states can think about addressing the public comment and have a consultation requirement for managed care quality strategy.

As Jackie said these FAQs have only recently been released. And so probably a lot more questions will arrive. All three topic areas do include contact information should questions arise once you've had a chance to kind of read them and digest them.

Finally, outside of the Data Reporting Section, I just wanted to note that there is an additional FAQ on dental coverage and specifically it's on telehealth on dentistry.

And with that, I will turn it back over to Jackie.

Jackie Glaze: Thank you, Karen. So now we'll move to the Financing Management Group, Jeremy and (Amber). I'll turn to you.

Jeremy Silanskis: Great. Thanks, Jackie. Good afternoon everyone. This is Jeremy Silanskis from the Financial Management Group.

And in this round, we presented quite a few Medicaid financing and reimbursement FAQs that we thought would be useful for states. As states request guidance on how to update and modify upper payment limit demonstrations for 2020 Fiscal Year and particularly for demonstrations that have already been submitted to CMS for approval we provide guidance on updating EPL for COVID-19 and utilization costs and payments during the public health emergency. And we also clarify that states may submit updates to EPL to refresh data based on changes in services during periods of PHE.

We clarify that states are not expected to submit EPL demonstrations along with Medicaid disaster relief SPA templates. However, though we are not expecting states to submit at the time that they submit their SPAs they are still

held to the EPLs for the applicable services for payment increases.

We've had many states come in and ask what they can do with the SPA template. And so we provide some guidance on example for changes that they can make to their payment methodologies through the template including additional cost incurred to the provision of Medicaid services to COVID-19 patients, increase in payment rates to recognize additional costs incurred in delivering Medicaid services including additional scale cost and PPE, adjusting payments to providers to account for decreases in new service utilization by increasing cost per unit due to allocation of fixed cost or increasing payments for Medicaid services delivered via telehealth which is really important at this point in time.

We also clarify that states may target payment increases within geographic regions to address outbreaks and make supplemental payments to take the providers beyond hospitals and nursing facilities.

And then finally, we provide some additional guidance to clarify the mechanics of the SPA template submission process that will both help expedite our review and alleviate the concern. And that includes things like submitting the CMS 179 Form and the standard funding questions, just a reminder to submit both of those. That will help expedite the process.

And then a clarification on the sunset of the C Plan already and concerns of access to care that some of the states have raised are related to the sunsets.

So that's part of what we clarified in these FAQs and I'll turn it back over to Jackie.

Jackie Glaze: Thank you, Jeremy. So now we'll move to the Disabled and Elderly Health

Programs Group. And Kirsten Jensen.

Kirsten Jensen: Thank you, Jackie. Wanted to draw attention to a couple of benefits related questions in the question set. The first is we had recent statutory changes that make mandatory under the Medicaid lab and x-ray benefit that tests for the detection of SARS, CoV-2, or diagnosis of the virus that causes COVID-19 are now mandatory under the lab benefits of the period of the public health emergency. This coverage must include the in vitro diagnostic product that are defined by the FDA and the administration of that product.

States may continue to cover these services, these tests and administration of the tests post the public health emergency period under the lab and x-ray benefit. There's nothing precluding them from doing that. And this particular guidance replaces a Q&A that we had issued back in mid-March, early April, and prior to the statute coming into play so I'd just like to make note of that.

We also highlight in this question (unintelligible) the previously issued interim final rule which we discussed in detail last Friday that importantly the flexibility that we provided are not rural well health in terms of being able to offer parking lot testing and also self-collected tests where the beneficiary may be at home collecting the sample. They're sending the test into a lab for reading.

We also have a question here about Alternative Benefit Plans and this relates to the new mandatory or relates to the 6.2% FMAP increase. Neither piece of statute that was passed recently expressly required the coverage of these services in Section 1937 which is the Alternative Benefit Plan. And we want - I wanted to talk through a few mechanics about that.

For the moment, for states that have Alternative Benefit Plans that aligns with



their state plan the coverage for COVID-19 testing is automatically incorporated into your benefits because of what I just talked about. For states that are not aligned with the state plan you may need - you will need to add this testing to your ABP if it's not otherwise covered. And we are available for technical assistance if you should be a state that's in that position.

And I'll turn it back over to Jackie.

Jackie Glaze: Thank you, Kirsten. So we'll move now to (Jen). (Jen) would you like to talk about the MSP Program?

(Jen Bowdin): I'd be happy to. Hi everyone.

Jackie Glaze: Thank you.

(Jen Bowdin): This is (Jen Bowdin). So we have received a number of questions related to the public health emergency from MSP Program. The FAQs get into additional detail.

But I wanted to hit on a few highlights, first, we have received questions from MSP grantees about making temporary programmatic changes during the public health emergency such as using alternative communication methods such as phone calls or video chat for transition activities that would normally be conducted in-person or extending the 180-day billing period for transition coordination activities prior to community transition.

The short answer to both of those examples is yes. States can use alternative communication methods such as video chat or telephone calls in place of in-person activities. Grantees can also extend the 180-day period for transition coordination activities that occur prior to transition to the community.

In addition, as we note in the FAQs, we have provided a letter to MSP grantees. It was sent through Grant Note on April 8th.

And in this letter, we indicated that states do not need to receive CMS approval, prior approval before implementing programmatic changes to their MSP Program operational protocols if those changes are directly related to the response to COVID-19 and otherwise allowable under the grant.

We do ask however that grantees notify their MSP Project Officer as soon as possible if they are making any programmatic changes as part of their response to COVID-19.

Grantees have also asked about purchasing personal protective equipment or other supplies to protect MSP transition to members, direct service workers, and other professionals and they're working with MSP grantees. We have implemented an expedited budget review process including brief budget forms in order to quickly review and approve new budget requests to use grant funds for supplies and other equipment including PPE.

Grantees also have flexibility to transfer up to 10% of their MSP funds between budget line items for previously approved activities as long as the use of the funds directly supports the goals and intent of the MSP Program and complies with grant regulations and the terms and conditions of the grant award.

There are more details in the MSP letter to grantees on April 8th. And of course, grantees can reach out to their MSP Project Officer and the Grant Management Specialist if they have additional questions related to those budget processes.

We have received some questions from MSP grantees about modifying statutory requirements of the program including expanding the type of residence that people can transition to, reducing the institutional state requirement, and providing post-transition services under MSP for more than 12 months. And unfortunately, we cannot modify statutory requirements of the program.

However, grantees should contact the MSP Project Officer to explore other options and considerations for increasing some assistance to the community and addressing other concerns related to COVID-19.

And lastly, I just wanted to note that Section 3811 of the CARES Act provides a short-term funding extension for the MSP demonstration including increasing Fiscal Year 2020 MSP funding to \$337.5 million. This is an increase from \$176 million that was previously appropriated. This provision does support continued MSP Program operations for continued grantees but it doesn't make any other additions to the program.

As a result, grantees do not need to make changes to the 2020 Budget and we have not implemented any changes to the MSP budget process for this year. We will be following up separately with MSP grantees over the next several months to talk about funding for 2021 and in future years.

And with that, I will turn it back over to Jackie.

Jackie Glaze: Thank you (Jen) and now I'll turn to Julie Boughn, the Director of the Data Systems Group. Julie.

Julie Boughn: Thank you, Jackie. All that heavy-duty policy work you just heard about, the

IT additions this week are in this batch of questions is a little bit lighter. We have sort of three major headlines that I wanted to draw your attention to in the new question. The one is we've gotten a number of questions from states around waiving timely claims, processing, and timely claims submission.

And we're - for basically the conversation that we had last week on Friday on the importance of data, we think it's important to keep the data and the money moving through the system. So we're not going to generally waive those. We're happy to have individual conversations about specific situations in states if need be as we go forward in the emergency.

We also included a batch of questions around telework largely signaling that you know, we're supportive of states adopting more capabilities around telework and remote work to help with the resiliency for the Medicaid Programs and the Medicaid agencies and CHIP agencies in the state so that's a set of questions there.

But probably the major headline from an IT perspective is a question around our T-MSIS data quality work. And most of you are aware that we've been going through this process the last couple years in particular where we kind of up the ante on how the level of quality of the T-MSIS data that's submitted. And we will take potentially compliance actions for states that are not there.

We're not going to be - although we are still going to measure and report on T-MSIS data quality, going forward we're not going to be - we're going to be basically pausing our compliance program for the duration of the public health emergency and probably for some period of time afterwards as well.

So that's a summary of our IT stuff Jackie so I'll turn it back over to you.

Jackie Glaze: Thank you, Julie, very much. So I'm going to circle back to Stephanie Kaminsky who had a couple more minutes she needed to spend with you and then we'll move on with the rest of the agenda. So Stephanie.

Stephanie Kaminsky: Yes, thanks so much, Jackie. I just wanted to flag one more question that I had intended to share which is that we have an FAQ that describes the interaction of the 6008(b)3 provision with the medically needy population in general especially those who become eligible during the public health emergency and who might otherwise need to meet a spend-down requirement for a new budget period. But for whom the state would need to keep eligibility intact.

So just another 6008 interaction with eligibility question that states might want to look at with respect to medically needed. Thanks.

Jackie Glaze: Thank you, Stephanie. And thank you the rest of the speakers for your highlights on the batch four the FAQs. So now we're going to move onto Calder Lynch. And he's going to provide some updates on the most recent request on the provider relief funding data. So Calder.

Calder Lynch: Thanks, Jackie. I know we have been in conversation with many states with regard to the needs of your providers. I shared with Medicaid Directors in a separate conversation on Friday that, you know, the department has released another tranche of funding focused around rural providers as well as the hotspots geographic zone.

And more information about those distributions including some county-level information is available at [hhs.gov/providerrelief](https://hhs.gov/providerrelief) which is really where all the information can be found with regard to those funds as they're - as it's made available.

But, you know, we know that there's a continued conversation with regard to the needs of Medicaid providers whose needs may not have been met in the general distribution methodology, you know, that was - they included providers that had had Medicare fee-for-service revenue over a certain time period.

Two, so to support recommendations around how best to address that we have asked states to provide us with summarized provider revenue data for calendar years 2018 and 2019. I know many of you have been feverishly working with your health plans and other vendors to compile that information. And we received and have been responding to a number of questions from over the weekend since we began that process on Friday.

So I want to share some of the questions and answers that we've been providing which will be providing I think the right follow-up as well if we haven't already out to all the states and then, you know, then we're going to have Julie come on and talk about actual data submission.

So first, one of the questions that we've been getting is what needs to be captured with regard to the amount of payment revenue that's going out to providers, what's included in that?

And what we've been advising states is that those should be all the payments that are made to a provider consolidated to their NPI or if they don't have an NPI the taxpayer ID number level across both fee-for-service, any managed care payments that are made by managed care plan to those providers, a supplemental payment, DSH payment, pay for performance payment or in some cases PMPM payments that are made to providers such as those who operate a medical center - a patient-centered medical home or for care

coordination services as well as in cost settlement payments.

It should not include any capitation payments made to the actual managed care organization but rather the payments that are made to the providers themselves.

We realize that our specialists may not have specifically address the need to include payments to CHIP providers or providers who are serving CHIP beneficiaries in their data submissions. We recognize that some states have separate CHIP Programs that are operated by a different agency which they may need to coordinate to include that information. We'll be updating our instructions to reflect this and are also doing special outreaches to the states in which that may be an issue that we need to address.

Another question that's come up is how should states handle self-directed providers. These are self-directed direct care providers. We recognize that these are important providers of Medicaid funding and (HCBS) in many states. But there are some data reporting challenges for states that submit revenue and patient information with self-directed providers. We are currently exploring several different options to address these challenges and we'll follow-up.

And until then we're asking for states to not include self-directed providers in the file that they're submitting to CMS and again additional guidance will be forthcoming on that.

Another question that's come up regarding whether states should include PACE payments. PACE organizations do create some additional complexities because they are both providers of services as well as manage their own provider networks unless they make payments. So we're going to be following

up with some more detail how to address those nuances. And in the meantime, we ask states to exclude any capitation payments made to PACE organizations from your data submission.

Another question that's come up is, you know, what if states don't have all of the data that we have reflected or all the fields of data that may be available. We recognize that states cannot submit information they do not have. We are asking that you work with your health plans and other vendors to make the files as complete as possible and certainly work with us individually if you've got any individual concerns. But ultimately if there's information that you don't have, you know, to leave those associated fields blank.

We know that we asked for a very quick turnaround on this data. And we appreciate the efforts that many states have made to meet that. A number of states have reached out to let us know that they're going to need additional time and we recognize that and we're here to support those efforts.

And we're happy to work with you to make sure that you're able to submit as complete a file as quickly as possible. It seems like, you know, the vast majority of states are getting their data submissions, you know, this week and we're working with states to make that happen.

And then the last question is, of course, how do I actually submit this data to you? We wanted to make sure that we had a secure transition channel for states that have completed their data and one that you're familiar with.

So I'm actually going to turn it over to Julie Boughn who's going to describe the instructions that we'll be providing the states for the actual data submission.



Julie Boughn: Thanks, Calder. Yes. We have an email all but ready to hit Send on to go out to state Medicaid Directors. We're also going to post this information on the - our T-MSIS, kind of technical pages as well.

The email is going to clarify I think some of the things that you just heard Calder describe. It's going to also include the document that we sent on Friday that basically gives you the specifics for the files that we want to have you send in to us.

And then there's going to be another attachment that's going to describe how to send it. And the - we're going to take advantage of the fact that we've been working so many years with all of you on T-MSIS. And we're going to basically use the same infrastructure and processes that we used for you guys to transmit T-MSIS data to us for these files as well.

And that way we can ensure a similar level of security while the files are in transit and actually where they ran here at CMS. So I don't want to get into the technical details and nits and nats about what the file will be named. But it's going to be basically the exact same process that we used for T-MSIS files to send to us.

So I think with that I'll turn it back over to you Calder.

Calder Lynch: Thank you, Julie. And again more that information and detail will be going out as Julie said shortly in an email.

Lastly, before we transition back to Jackie to help facilitate our Q&A, I just wanted to issue a general reminder that we know that this pandemic has been a learning experience for all of us and the needs of states and your providers and your beneficiaries has continued to evolve.

And as such, we just want to remind everyone that, you know, perhaps when you first assess the various authorities that we outlined around, you know, 1135, Appendix K, disaster SPA response and funding, etcetera that you may not have thought you needed at the time and maybe that's changed.

So just, you know, please continue to feel free to avail yourselves of those flexibilities and authorities. We're happy to work with you to determine if you're not sure what the best authority is to achieve your policy goal, to help you identify that and we'll walk you through that process.

You know if another approval of the state SPA or funding request has given you, you know, an idea that you didn't think you could pursue and now you are interested please, you know, raise your hand. Reach out to your state lead. Medicaid Directors certainly will - are certainly welcome to reach out to me directly, you know if you need to. Because we're continuing to work with you and process those as quickly as we can.

So with that, I think Jackie I'm handing it back to you to get us rolling on the Q&A.

Jackie Glaze: Thank you, Calder. And so we're ready to take your questions now. So Operator, can you open up the phone lines and we can begin taking questions?

Coordinator: Thank you. At this time if you'd like to ask a question please press star then 1 and record your first and last name clearly when prompted. Again, please press star then 1 at this time if you'd like to ask a question. One moment please for a question.

Our first question comes from (Cat Curtis). Ma'am your line is now open.

(Cat Curtis): Yes. This is a question regarding the emergency period. I know this - I haven't had a chance to look at all your FAQs but there was a charge. And we had asked this I think about a week ago. The public health emergency started I believe on January 27th and was to last for 90 days which I believe ended on April 29th or 30th.

And has that been officially renewed and does that affect only the Appendix K processes as the chart indicates? The chart indicates it's only for Appendix K. I just wanted you to confirm that that's all that the public health emergency addresses.

Calder Lynch: So the public health emergency has been renewed by the Secretary for an additional 90 days so I think that takes us out...

(Cat Curtis): Okay.

Calder Lynch: ...yes, until sometime in July. And I'll check with others. I know there's certainly implications for some of the requirements under FFCRA and CARES, right, with regard to, you know, your requirements for continuous eligibility and whatnot that are implicated by that. But let me check to see if the 1135, the thought process is impacted by that.

(Cat Curtis): Okay. Thank you.

Anne Marie Costello: So Calder this is Anne Marie Costello. And for sure any state that submitted and had approved a disaster relief Medicaid SPA under the template, those flexibilities are only in effect until the end of the public health emergency.

In particular, if you used any authority using 1135 to either modify the submission timeline to state plan amendment, to raise public notice requirements, and to modify tribal consultation. But certainly for the Medicaid disaster SPA template that is only through the duration of the public health emergency.

(Cat Curtis): Thank you (unintelligible).

Jackie Glaze: As a reminder.

(Alissa Deboy): Go ahead, Jackie.

Jackie Glaze: I was going to say that that also applies to 1135 for flexibilities as well but those are effective through the end of the public health emergency.

(Alissa Deboy): Right. And this is (Alissa Deboy) and I just wanted to clarify about Appendix K. There is some additional flexibility. Those Appendix Ks will terminate either January 26, 2021, or any earlier date elected by the state and that's what's clarified in this new batch of FAQs. Thanks.

Anne Marie Costello: Right. And this is Anne Marie Costello again. Question 7 starting on Page 5 of the new document has a table that lays out by authority the duration, the effective date, and then the termination date.

Calder Lynch: Okay, we can take the next question.

Coordinator: Thank you. And as a reminder, if you'd like to ask a question please press star then 1. Our next question comes from (Alice White), State of (unintelligible).

(Alice White): Hi there. Good afternoon. I actually have two questions if that's okay. My first

question is do we need to make SPA changes for the CARES changes that were in announcement last week regarding testing and setting or do they go into effect automatically? So should we be expected to fill out and submit a disaster SPA to effectuate the requirements under the CARES Act?

Sarah Delone: (Alice) can you say a little bit more about what exactly the CARES Act requirement is that you're talking about?

Calder Lynch: I think you're meaning like the flexibility around the location or laboratory testing with the, you know, the parking lot...

(Alice White): Right.

Calder Lynch: ...lot. Yes.

(Alice White): Yes, the setting requirements and also the new availability of the testing - of the reimbursement for the testing at higher rates and different types of (unintelligible).

Calder Lynch: Right. So this would be a benefits and coverage question. I don't know if (DE), Kirsten, or (Melissa) is the one.

Kirsten Jensen: Yes. This is Kirsten. I think of - if you are affording yourself the flexibilities, then yes, we would like a state plan amendment to be submitted.

And in that you would - if you're adding reimbursement or changing while you're reimbursing for those services we would need to - that specified on the disaster SPA as well.

And FMG you can correct me if I'm not stating that correctly.

Jeremy Silanskis: No, that's it. Thank you.

(Alice White): Great. Okay, my second question relates to eligibility. So we are getting questions about the application for the reasonable opportunity period. So if we are trying to verify citizenship and immigration status during the public health emergency and someone's citizenship or immigration status is not formally verified and we're giving them the opportunity to provide additional documentation if they're attesting to being a citizen or having eligible immigration status we have to afford them the 90-day reasonable opportunity period.

And the question is if at the end of the 90 days they fail to provide us with that information do we have the flexibility to terminate that individual or does the termination - is the termination barred under the maintenance of effort requirements under the FFCRA?

(Sarah Delone): So there's actually (Alice), this is (Sarah), there's an FAQ on that. I forget. I think it was the second batch of legislation FAQs that they are okay. That once an individual is enrolled that if somebody in the RFP period who's attested to satisfactory immigration status or to U.S. citizenship, they're enrolled for benefits.

And the coverage is protected under the 6008(b)(3) (unintelligible) In order to receive the increased FMAP. You know even beyond the 90 days. The exception would be if you actually make a determination that they do not meet the, you know, the citizenship or a satisfactory immigration status. You know let's say for example you determine that they are an LPR subject to the five-year bar. And there's not a CHIPRA or 214 situations.

So then that case then they remain eligible but the (FMAP) is limited to emergency services only. But the 6008(b)(3) does provide, you know, yes, they can continue to provide coverage beyond the 90 days even if you otherwise would terminate. Again unless you determine that they are not eligible, you know, they are not in a satisfactory status.

(Alice White): Okay, and that's helpful. Thank you. Sorry if I missed that.

(Sarah Delone): No. You know it's a little bit of a needle in a haystack sometimes. That's why hopefully some of these reorganizations will be helpful to you.

Coordinator: Thank you. Our next question comes from Julius Covington. Your line is now open.

Julius Covington: Hi. The question about the post-eligibility treatment of income. This is on Page 15. It talks - it says that states cannot modify the rules such as changing the personal use allowance. And I think that's pretty much misunderstood. I think the clarification we've been waiting on deals more with responding to changes in a person's income that may increase the amount they paid to the facility itself. And I think that's a clarification we're really facing.

(Sarah Delone): So this is (Sarah Delone). Thank you. We've gotten a couple of other additional questions for a clarification and that being one of them when somebody's income increases.

And I think we can pretty confidently say although we will get another FAQ out that in that situation also that the liability, a person's liability shouldn't change. More complicated are when somebody changes setting. And we actually are working. So I know a number of you have raised that question.

And we're working through some additional, a bunch of additional scenarios in which the sort of the application of the state's principle that we've published in this FAQ is not so readily apparent. And so we'll be looking to publish similar FAQs as soon as we're able to go through those issues.

Julius Covington: Okay. As a follow-on to that, so we also noted still the protected income, you know, the person (unintelligible) setting, their income is protected so they pay zero liability for the facility. And the next month they're responsible for the cost of care. But that means that the protected income period would be extended through the emergency period.

(Sarah Delone): I think we should - can I get your name and we can get that. I think we should probably - I'm not familiar with the protected income and I have a feeling that we're going to need to have a cross-section of us that discussed it. So can I get your name again?

Julius Covington: Yes ma'am. Julius J-U-L-I-U-S Covington, C-O-V-I-N-G-T-O-N, and I'm in South Carolina.

(Saran Delone): And what state are you from? South Carolina. Great.

Julius Covington: South Carolina.

(Sarah Delone): We will circle back with you and find a little bit more particular so we can make sure to get that question (unintelligible) as well.

Julius Covington: Okay thank you.

(Sarah Delone): Thank you.



Coordinator: Thank you. As a reminder, please press star then 1 if you'd like to ask a question. Our next question comes from (Beverly Luna). Ma'am your line is open.

(Beverly Luna): Hi. I'm from Texas. This is a question regarding the continued eligibility and the 6.2 percentage FMAP.

We're supposed to continue the same amount duration and scope of benefits. However, we only have to continue those services that are medically necessary, correct? For instance, if someone is getting five days of physical therapy a week, it doesn't mean that during the course of the disaster we could never reduce that down. Is that correct?

Sarah Delone: That's correct.

(Beverly Luna): Okay thank you.

Coordinator: Thank you. Our next question comes from (Tony). Sir, your line is now open. Again, our next question comes from (Tony). Sir, your line is now open.

(Tony): Hi.

Coordinator: Please check your mute.

(Tony): Can you hear me?

Calder Lynch: Yes, we can.

(Tony): Okay great. I had a question. The provider release data request that it encompasses bank account information and that type of thing and it's pretty

sensitive. And I'm kind of curious as to the authority that is being utilized here to provide this information to you. Could you help us out with that?

Calder Lynch: Sure. A few states have asked about that and we've been consulting with our general counsel. And they're supplying us with some information to share, which should be coming shortly around the authority that allows us to collect that information. So just, we're just waiting for us to get that, you know, file right up and then we'll be getting that out to states.

But we understand a couple states have raised questions about that so we'll be getting that answer out as soon as possible.

(Tony): Thank you.

Coordinator: Thank you. Our next question comes from (Jane Longo). Ma'am your line is now open.

(Jane Longo): Hi. I'm from Illinois. And I'm sorry I was a little late to the call. But did Jessica, could you discuss the requirements for a signature for the uninsured testing program and how coverage of uninsured testing and Medicaid interacts with HRSA?

Jessica Stephens: So I did flag the first question. And that is in the batch of FAQs which is not specific to the uninsured testing group. But more broadly deals with flexibilities availability to the states for collection of signatures and that would apply in the context of the uninsured testing group but even more broadly. You know we've also gotten a number of questions about challenges obtaining signatures in the context of individuals who are seeking assistance by phone.

And so we've laid out a number of options including the ability for an

individual to provide verbal delegation of an individual to be an authorized representative to allow them to sign for the individual and provide that verbal designation along with the application submission.

(Jane Longo): And (Jane). And that could be by phone or in-person, the verbal authority to be - authorize that.

Jessica Stephens: Correct. Correct. And certainly, you can take a closer look at that question which has a little bit more detail about the parameters, and certainly available for any follow-up questions that you may have after you take a look at that.

Sorry, your second question.

(Jane Longo): How Medicaid coverage of uninsured testing interacts with HRSA coverage of testing for the uninsured.

Jessica Stephens: So we did not go (as deep) in that in any detail today. But let me check with any others if there's more to provide on that. I know we have some additional guidance coming around the uninsured testing group.

Kirsten Jensen: Right. I think we are looking into that issue. A similar question was raised last Friday. And sort of the interaction for that and also with respect to question on third party liability and how Medicaid, you know, interacts with HRSA, you know, provider, you know, funds in this area.

So we are looking at that. And I expect that you know, we'll have a future FAQ in this area.

(Jane Longo): Do you have any sense of timing? And I don't want to be pushy but we're getting lots of questions on that from providers. Is that something you think

might be this week or would it be next week?

Calder Lynch: We may be able to provide a more verbal update. And we'll circle back. I think we'll elevate that on the priority list. It sounds like there's - that's a burning issue.

(Jane Longo): Thank you so much. Much appreciated.

Coordinator: Thank you. Our next question comes from (Desiree Bital). Ma'am your line is now open.

(Desiree Bital): Yes. In regards to the data request on the provider relief fund if - we are waiting for guidance from your general counsel. And will that like further I guess delay payments to providers if we're waiting for that information and then a possible extension request?

Calder Lynch: So we still have a few steps between now and anything to providers. At this point, we're still just, you know, gathering data. Although we do want to move as quickly as possible. And we should have the guidance very shortly on the legal authority on the banking information.

So hopefully that won't delay, you know, getting submitted. I think it's significant time, your ability to submit that to us. So but we'll follow-up then after when we know more in terms of timing on payments.

(Desiree Bital): Okay thank you.

Coordinator: Thank you. As a reminder please press star then 1 if you'd like to ask a question. Our next question comes from (John) (unintelligible). Sir, your line is now open.

(John): Hi. I'm from Wisconsin. And have a repeat question. I asked (Sarah) this a while back. If there's been a decision made about whether it's okay for us to have our kids change over from Medicaid to CHIP eligibility since we're providing the same benefit for them under both programs.

(Sarah Delone): So (John) I will - let me move back with our team. And I know that we were working internally to figure that out. And I will be perfectly honest saying I don't know where that is right now. It may be into with our counsel but I'm not sure. So I will pledge to get back to you if not today, tomorrow with the status.

(John): Okay thanks (Sarah).

(Sarah Delone): Sure. Thanks for the reminder.

Coordinator: Thank you. Our next question comes from (Nicole). Ma'am your line is now open.

(Nicole): Hi. This is (Nicole) (unintelligible), New Mexico. We tossed this question over an email but since you all are all together, we thought we'd try again. On the FAQs for the testing eligibility group there's an indication that we need a Social Security Number.

We know that there are some nonqualified or sorry, some qualifying noncitizen statuses who do not have an SSN. We just wanted to verify with you all if they would be eligible to be covered as part of that testing group without an SSN and how you'd like us to capture that or if they're not eligible.

Jessica Stephens: Hey (Nicole). It's - this is Jessica again. So we've gotten a similar question

from a number of states. And the requirements to obtain a signature for the uninsured testing group are the same as they would apply for any other group. So for individuals who are not eligible to have an SSN so the same processes that you would use for another application would apply in those circumstances. Similarly, the requirements to assist any individual in obtaining an SSN would apply for an individual who'd be eligible to receive one but does not have one.

Does that answer your question?

(Nicole): Okay, yes. Thank you.

Jessica Stephens: You're welcome.

Coordinator: Thank you. There are no further questions at this time.

Calder Lynch: Okay well thank you all for joining us this afternoon. I believe we're going to continue our next All-State call on Friday where we'll have representatives from Advancing States, the organization formerly known as NASUAD to discuss a new web site that they've helped launch that's designed to help with staffing needs of long-term care providers and linking them with healthcare professionals seeking employment in the field.

And they, of course, represent the state and territorial agencies that manage the Aging and Disabilities and (LTFS) Directors and Programs.

So because there will be a digital component to this, we will be using the same webinar platform that we used last Friday and we'll send out information and login details shortly.

In this one, we are looking to begin transitioning the frequency of this call to weekly probably beginning next week. Although, of course, we can ramp back up at any time if we feel that that's necessary. But we want to be responsive to everyone's needs and times as best we can. So appreciate any feedback on that if folks feel strongly but that's the plan I think moving forward. And as we have more details, we'll share those with folks.

So with that again, just thank everyone for joining us and have a good rest of the day.

Coordinator: Thank you. This concludes today's conference. You may all disconnect at this time.

End