Centers for Medicare & Medicaid Services

COVID-19 Medicaid & CHIP All State Call

June 23, 2020

3:00 pm ET

Operator: Greetings and welcome to the CMCS All-State Medicaid & CHIP Call webinar. During the presentation all participants will be in a 'listen only' mode. Afterwards, we'll conduct a question and answer session. If you have a question, please press the 1 followed by the 4 on your telephone at any time during the presentation. At that time, your line will be briefly accessed from the conference to obtain information. You may also submit a written question using the chat feature located in the lower left corner of your screen. If at any time during the conference you need to reach an operator, please press *0. As a reminder, this conference is being recorded, Tuesday June 23rd, 2020. I would now like to turn the conference over to Jackie Glaze. Please, go ahead.

Jackie Glaze: Thank you. Good afternoon and welcome everyone to today's All-State Call. Calder will begin by making opening remarks and he will also provide an introduction of the topics that we will be sharing today. Calder?

Calder Lynch: Thanks, Jackie. Good afternoon, everyone. Thanks for joining us again. Today we're going to be continuing the conversation that we began last week about the process for how states can unwind and in some cases sustain flexibilities and authorities that were adopted during this public health emergency (PHE). Today's call will be similar to last week's, but we are focusing of the CHIP program. We'll have Meg Barry, this Director of the Division of State Coverage Programs, who will review the steps that states need to take if they want to retain some of the CHIP state plan flexibilities adopted during the PHE.

After Meg's presentation, we'll open up the lines for your questions on this topic. After we spend a little time there, we're going to invite John Coster, the Director of our Division of Pharmacy, to actually spend a little bit of time on a non-COVID related topic for a change. But John will be providing a few highlights of a recently released proposed rule related to Medicaid best price and pharmacy value based purchasing that was released last week. We just want to make sure we draw your attention to it and give you a little bit of a high-level overview of what's contained in that notice of proposed rule-making. It itself relates, as I mentioned, to the Medicaid Drug Rebate program. And if the goal of the rule is to permit more flexibilities for payers and drug manufacturers to negotiate value based contracting arrangements for new drug therapies, among other proposed changes in the Medicaid Pharmacy Program. And that proposed rule is open for a 30-day public comment period. Again, John will provide more specifics when we get to that portion of the meeting.

After that presentation, we'll pause again to take any questions on the pharmacy rule. And then finally, Julie Boughn, the Director of the Data Systems group, will join us again to discuss two issues. First, she will share information from our colleagues in Health Resources and Services Administration (HRSA) related to the Medicaid and CHIP provider distribution of the Provider Relief Fund. And then the second issue she'll be discussing is plans around the use of T-MSIS data for COVID analytics. We'll then turn to your questions for Julie, as well as any other general questions that you might have for us today.

I do have just a couple of notes that I wanted to mention before I turn the call over. On the topic of the Provider Relief Fund, I would like to call your attention to the HRSA webinars that are being held this week for Medicaid and CHIP providers. HRSA is hosting two webinars. The first one was actually held about an hour ago from 2:00 to 3:00 PM, and the next one will be this Thursday from 2:00 to 3:00 PM. Both of those times are Eastern Time Zone. We did send this information out to the Medicaid and CHIP directors last week in order for you to be able to share with your provider colleagues in your state. We've also distributed that out to the relevant national provider associations to make sure we have as wide a reach as possible. But did want to make sure that your attention was drawn to that, as we have one more webinar opportunity later this week.

I'll now hand things over to Meg to begin our conversation with regard to the CHIP program. Meg?

Meg Barry: Thanks, Calder. As Calder mentioned, last week my colleagues told you how you can retain Medicaid authorities after the Public Health Emergency ends. And this week, I'll be focusing on CHIP. Just like last week, I'll walk through things that you should be considering as you think about submitting a CHIP state plan amendment (SPA) to extend your flexibilities: things like whether you need public notice, whether you need tribal consultation, what the effective date of your SPA would be. And for CHIP, you're also going to need to think about whether you need more authority or whether actually you already have what you need. So more on that in a minute.

The first consideration is really public notice. Here, CHIP is different than Medicaid. For CHIP, public notice is only required for CHIP SPAs that restrict eligibility or benefits. For the types of SPAs that we're talking about today, there will not be a federal public notice requirement. But I'll always encourage you to take a look at our regulations at 42 CFR 45765 for a full description of the public notice requirements in CHIP.

The next thing that you'll need to consider is tribal consultation. CHIP has the same tribal consultation requirements as Medicaid. If there's an Indian Health Program or Urban Indian Organization that furnishes healthcare services, the state must conduct tribal consultation prior to the submission of any state plan amendments likely to have a direct effect on Indians, Indian Health Programs, or

Urban Indian Organizations in accordance to your state's tribal consultation policy.

Here's where you should think about whether you even need more authority to extend your CHIP flexibilities. Some states use 1135 authority to delay tribal consultation on your CHIP disaster SPAs, and if you did that, your CHIP flexibilities will only go to the end of the Federal Public Health Emergency. But other states either don't have a tribal consultation requirement because there are not Indian Health Programs or Urban Indian Organizations that furnish healthcare services, or because the state did tribal notice prior to submitting their CHIP disaster SPA, or because your states had existing CHIP disaster flexibility in place. Those states generally already have the authority to extend their flexibilities to the end of the state's declared emergency to the extent that that emergency goes longer than the federal emergency. So if you're not sure about the duration of your CHIP disaster provisions, please check in with your CMS CHIP Project Officer. They'll be able to point you in the right direction.

The third general consideration is the effective date of your CHIP SPA. This is another place that CHIP is different than Medicaid. For most CHIP SPAs, the state has until the end of the state fiscal year in which the SPA becomes effective to submit the SPA to CMS. If the SPA has an effective date of August 1st, 2020, you have until the end of the state fiscal year to submit it to CMS. For most of you, that would be June 30, 2021. Here, I'll just put in a quick plug for the states that I know are planning to submit a disaster SPA for the current PHE but haven't done yet. The end of most of your fiscal years is next week, so those SPAs are going to be due to us in one week on June 30th.

If you are considering a restrictive SPA, and remember that the SPAs we're talking about are not restrictive, those can't be in effect longer than 60 days prior to submission to CMS. But I'll remind you that although the Families First Coronavirus Response Act (FFCRA) Maintenance of Effort did not apply to CHIP, we still have the long-standing Maintenance of Effort provisions that apply to all children in Medicaid and CHIP. So if you're considering a restrictive SPA, please get in touch with your CMS CHIP Project Officer as soon as possible so we can guide you through that.

Now I'll turn to the list of each authority that we have provided during the Public Health Emergency and walk through how you can retain it following the PHE if needed. I'll note that in the table, we have laid out each flexibility and what you would need to do if you wanted to retain it temporarily, or if applicable, how you would retain it permanently. Again, I'll note that none of these SPAs are restrictive, so none of them would require public notice, so I'll skip that column when I'm taking through these.

If you wanted to continue extending the reasonable opportunity period, that goes in section 4.3 of your CHIP state plan and gets submitted to the CHIP SPA mailbox. If you would like to continue suspending your waiting period to the

extent your state has a waiting period, those changes go in section 8.7 and goes to the CHIP SPA mailbox. However, if you wanted to make a permanent change to your waiting period, that would go in template CS20 and get submitted to the MMDL system. Changes to presumptive eligibility would go in section 4.3 of the CHIP state plan and get submitted to the CHIP SPA mailbox. Again, if you wanted to make a permanent change, that would go in template CS28 and get submitted to Medicaid Model Data Lab (MMDL). Changes to continuous eligibility also go in section 4.3 and go to the CHIP SPA mailbox. If you would like to make a permanent change to your continuous eligibility policy, that would go in template CS27 and get submitted to the MMDL system. Changes to your changes in circumstance policy go in section 4.3 and get submitted to the CHIP SPA mailbox.

This next slide focuses on changes to CHIP premiums and cost sharing. If you would like to continue suspending premiums and cost sharing in CHIP, those changes go in section 8.2 and get submitted to the CHIP SPA mailbox. I'll note that that is for both temporary and permanent changes to your premium and cost sharing policy. If you would like to continue waiving the premium lock-out period, those changes go in section 8.7 and go to the CHIP SPA mailbox. But permanent changes would go in the CS21 template and get submitted to MMDL. If you'd like to extend your premium deadlines, those changes go in either section 8.2.1 or 8.7 and go to the CHIP SPA mailbox. The final policy I'll talk about is changes to CHIP benefits. I don't think we have had many states that have made changes to their CHIP benefits through this Public Health Emergency. If that's something you have done and you're interested in retaining it, that goes in section 6 of the CHIP state plan and goes to the CHIP SPA mailbox.

Jackie, I think that's it for me. I'll turn it back to you for questions.

Jackie Glaze: Thank you, Meg. We're ready now to take your questions for Meg on retaining the CHIP flexibilities. We'll follow the format that we've used in the past by allowing those that would like to use the chat function first, and then we'll follow with the phone calls. Operator, can you provide instructions on how to submit their questions through the chat?

Operator: Of course. If you'd like to submit a written question using the chat function, it's located in the lower left corner of your screen. And if you would like to register for a phone question, you can press the 1 followed by the 4 on your telephone.

Barbara Richards: Jackie, we don't have questions in the chat at the moment, so maybe we should start with the phone.

Jackie Glaze: Yes, yes. Operator, will you please open up the phone lines at this time?

Operator: Of course. If you'd like to register a question, please press the 1 followed by the 4 on your telephone. You will hear a three-tone prompt to acknowledge your request. Your line will then be accessed from the conference to obtain

information. If your question has been answered and you would like to withdraw your registration, please press the 1 followed by the 3. Once again, to register for a question, please press the 1 followed by the 4.

Our first question comes from the line of Diane Mazuera. Please go ahead.

Diane Mazuera: Good afternoon. I wanted to just clarify about the deactivation of the Public Health Emergency Disaster Relief SPA. I want to find out when the Public Health Emergency ends, do we need to notify our CHIP contact that we are deactivating the... If we're not going to continue our Public Health Emergency flexibilities, do we need to do something proactively to state that we're ceasing this as of the end of the Public Health Emergency, or is it assumed that they will end?

Jackie Glaze: Are you asking specifically about the Disaster Relief SPA or did you just want to know in general?

Diane Mazuera: So, Pennsylvania submitted a Disaster Relief SPA. We have it approved. It's in effect. My understanding of the process was at the end of our Public Health Emergency here in Pennsylvania, we would then issue a letter stating that we are no longer utilizing the flexibilities in our Disaster Relief SPA. This call made me question perhaps that letter was not necessary.

Jackie Glaze: Can I ask someone on the line that can speak directly to the Disaster Relief SPA on when the flexibilities end and what the next steps would be?

Diane Mazuera: Is Meg Barry still on?

Meg Barry: I'm still on. It is my understanding that that does just come to a natural end at the end of the Public Health Emergency.

Diane Mazuera: Okay, thank you so much.

Operator: And we have no further questions at this time.

Jackie Glaze: Thank you. So we will move on to our next speaker, and that's John Coster. He will provide some updates on the Pharmacy NPRM. John, are you ready?

John Coster: I am. Good afternoon everybody. This is John Coster. I'm the Director of the Division of Pharmacy. And as Calder said, we published last Friday in the Federal Register a notice of proposed rule-making. The comment period ends July 20th, so it's a very quick turnaround. But we think it makes some important landmark changes in the Medicaid Drug Rebate program, especially around the ability of state Medicaid programs and other payers to engage in value based contracting arrangements.

I divide the rule into three major sections. And if it's okay, I'll take each section one at a time. First are the proposed changes we make in the Medicaid Drug Rebate program to encourage both Medicaid programs and commercial payers to engage in value based contracting around drugs. The second major area of changes relates to minimum standards for Drug Utilization Review, especially as it relates to the use of opioids in the Medicaid population in response to changes made in law by the Support Act. And the third group of changes relate to program administration, program integrity being made in response to those changes that have occurred in law over the past few years.

First, I'll be brief, but let me talk about value based contracting. Over the last several years, it's become apparent to us that there is more interest among payers in negotiating with drug manufacturers. States and payers negotiating with drug manufacturers around high-cost drugs, gene therapy type drugs, regarding outcomes. Manufacturers have been interested in working with payers in offering additional rebates or discounts if the therapies don't work or don't work as intended, which is good for Medicaid and good for payers, because it gives manufacturers some vested interest in making sure their drugs work. But we've also heard that some of the rules around Medicaid, especially as it relates to best price, have been creating disincentives for manufacturers and commercial payers to enter into these arrangements, which affects Medicaid because Medicaid programs are entitled by law to get the best price that manufacturers offer to any commercial payer in the market.

Traditionally, manufacturers can only report one best price per drug per quarter, and that best price is used to calculate the rebates that state Medicaid programs get every quarter. And best price has been very beneficial to states. It's helped save states billions of dollars in terms of bringing in revenues. But we think it's time to modernize the definition of best price to allow for value based purchasing arrangements, which oftentimes have multiple outcomes depending upon how the patient does. One of the major things the proposed rule does is it first of all defines value based contracting, and it offers a definition relating to evidence-based outcomes and outcomes... Two types of outcomes: evidence-based outcomes and outcomes-based outcomes. What I mean by that is that manufacturers can offer evidence-based measures, which link the cost of the drug to existing evidence of effectiveness, or outcomes-based measures, which link payments for the drug to how the drug actually performs in the patient. These are two proposed definitions of value based contracting.

If a manufacturer is engaging in value based contracting, it could then offer multiple best prices for that particular drug based on outcomes. So again, previously, a manufacturer could only offer one best price per drug. Now, we can offer multiple best prices per drug based on outcomes. And it can offer this to either a commercial payer, or it can offer this to a state Medicaid program. And if it does offer it to a commercial payer, then a state Medicaid program, if it so chooses, could take advantage of the outcomes-based measures. It could either choose to just take the best price for that quarter or that particular drug, or it

could choose to engage with the manufacturer offering that program and take the multiple best prices. So it could link the price it gets for that particular patient to the particular outcome for that patient.

And that's because what was happening as manufacturers... if they were offering these programs and if a patient failed on the drug and there was a huge rebate or discount that the manufacturer had to give, then that would reset the best price for all of Medicaid. Now what will happen, at least in one example of this, is that a manufacturer could offer multiple best prices for the drug. And depending upon that individual patient's outcomes, the state would get -- in addition to the best price it got in the quarter in which the drug was administered -- it could get additional rebates depending upon the patient's outcomes. So you have to sit down and kind of draw it out and think about it a little bit, but we think this will be a great opportunity for states to take advantage of a new flexibility being offered in the marketplace to allow manufacturers to offer multiple best prices for a particular drug based on some value based purchasing arrangements. That's the big piece of what we're doing in the proposed rule.

We also make several other changes around value based contracting in addition to defining it and also proposing a definition and also proposing multiple best prices. We allow for a manufacturer to use a bundled sale as a performance requirement. This would be more likely for a drug that had a larger patient population, so that a value based contracting arrangement could be considered a performance requirement under a bundled sale approach. And that would allow the manufacturer to distribute the value of any discounts in a value based arrangement across all the patients, so that one patient's failure doesn't necessarily reap that best price.

We also lengthened the period of time that manufacturers can adjust their pricing metrics to accommodate value based contracting, because value based contracting often occurs outside the current three-year permissible window. Currently, manufacturers can only adjust their AMPs, their Manufacturer's Prices and best prices, within a three-year window. And they can only do it in certain limited circumstances outside the three-year window. This would allow them to adjust outside the three-year window for value based contracting arrangements if, for example, an adjustment needs to be made as a result of a patient's failure. That will also benefit states.

The last thing we do in value based contracting is we ask states that do engage in value based contracting to report to us at the end of each quarter on a certain limited number of variables so that it will help us and the state assess the benefits of the value based contracting program. So the cost of the program as well as the savings that are generated from the program.

If you look at the rule, you see the heart of it is the changes we make in value based contracting, defining what a value based contract is, allowing manufacturers to offer multiple best prices in order to accommodate different

patient outcomes, defining performance requirements, value-based payment (VBP) is a performance requirement under bundled sales, allow for a three-year reporting window to accommodate value based contracting arrangements that are longer than three years, and have some reporting requirements on states with respect to value based contracting.

The other major group of changes that we make relate to Drug Utilization Review (DUR). What we basically do is we codify the Support Act requirements relating to opioids. Starting last October, states had to initiate some new specific DUR edits, both prospective and retrospective, with the use of opioids. The states have already put those in place, both in their Fee for Service and Managed Care plans. This proposed rule will codify those changes, and it will also propose two new standards: one relating to the use of opioids in a person who was just recently prescribed medication-assisted treatment. Obviously, the concern there that if a patient's on MAT and all of a sudden getting an opioid, that should send up a red flag. And another is the encouraging co-prescribing of Naloxone for individuals who are taking opioids, which many states are already doing.

We also include in here conforming language from MCOs. The MCOs have to have a DUR program in place that's consistent with the Fee for Service program, so there's language in here that amends current MCO rules to put that in place. Again, the MCOs are supposed to be doing this already based on state contracts with the MCOs, but we're just codifying it.

And then finally on DUR, we're proposing that the MCO reports that you send to us from your MCOs will be posted for individual for MCOs. Previously, for the last year, we had just posted a summer report.

Last set of changes that we make relate to program oversight and administration, and I'll just flag three of them. One is we codified changes that were made by statute with respect to the reporting of how manufacturers calculate their average manufacturer's price for authorized generic drugs. These are manufacturers who have a brand-name drug but also allow a generic version to be sold. Previously, the manufacturers were able to blend the sales, which would lead to the AMP for the brand being driven down, reducing the rebates that states get. Now, we're codifying that. That no longer can happen. The manufacturers must report a separate AMP for the brand and for the authorized generic.

We have a requirement here around state reporting of Drug Utilization Review data. States do report to us at the end of every quarter their state Drug Utilization Review data, just not state Drug Utilization... This is not the DUR reports that we just talked about. This is the actual data that we report for us on spending and rebates. We're clarifying the information that you need to report. And there's also a certification requirement in there for the states with respect to the data that they report to us, because it's important that the program data that we get from the states... We use that for many different purposes, for example, calculating the prescription drug tax.

And then finally, we create a definition of line extensions to help implement the penalty that was included in the Affordable Care Act that penalized manufacturers for creating line extension drugs that they tried to avoid paying inflation penalty rebates on older drugs.

Sorry I took a few minutes longer, but we're very excited about this rule. We encourage states to look at it carefully and comment on it, and we hope to get it finalized sometime before the end of this year. Thank you for the attention.

Jackie Glaze: Thank you, John. We're ready to take your questions now on the pharmacy rule. We'll begin with the chat function, so you may submit your questions through the function now.

Anne Marie Costello: And John, this is Anne Marie Costello. While we're waiting for the questions to come in, can you just remind the audience that you'll be presenting to the pharmacy directors?

John Coster: Sure, we have a call tomorrow in the afternoon at 1:00 PM Eastern with the state Medicaid pharmacy directors to go more in depth about the regulation, to see what questions they have and to also touch on some other relevant pharmacy issues. That's from 1:00 to 2:30 tomorrow afternoon.

Jackie Glaze: I'm not seeing any questions through the chat function. So again, if you'd like to send your questions through the chat function, please do so, and then we'll wait another minute and then we'll open up the phone lines.

Okay, Operator, will you open up the... We do have one question.

Barbara Richards: The question is for John. Can we have information on how to join the call with state pharmacies? And they may have meant state pharmacy directors.

John Coster: Sure. We can get that out in whatever way makes most sense. So yeah, I will say yes.

Barbara Richards: Great, thanks, John. I think, Jackie, maybe we should open up to the phone line now.

Jackie Glaze: I agree. Operator, please open up the phone lines.

Operator: If you would like to register a question over the phone lines, please press the 1 followed by the 4 at this time.

Our question comes from the line of Chad Hope. Please go ahead.

Chad Hope: Good afternoon. This is Chad Hope with Minnesota Department of Human Services. Question for John Coster on the value based purchasing URAs. If a

manufacturer is able to report multiple best prices, conceivably there's going to be multiple unit rebate amounts for each drug in each quarter. What sort of changes are you anticipating CMS is going to need to make to the URA file layout? Or is it anticipated there would be no change, and states won't have system development costs to accommodate the change?

John Coster: Hi, Chad. That's an excellent question. You know, I think we are anticipating that we're trying to accommodate these changes in our new system that we're building. But I don't have a complete answer for you about whether that will be done in time or how those will be transmitted. I suppose it's possible that for an interim period, there might have to be separate files sent out to the states if they're interested in participating and there's a manufacturer that wants to report multiple best prices to us. But that's part of the operational issues we're still trying to work through when we implement a multiple best price approach.

Chad Hope: Thank you.

Operator: And we have no further questions at this time.

Jackie Glaze: Thank you. So now we'll transition to Julie Boughn, and she'll provide an update on the Provider Relief Fund and the T-MSIS COVID analytics. Julie?

Julie Boughn: Thank you, Jackie. As Calder mentioned at the beginning of the call, our colleagues at HRSA are working on the process for making payments to providers who do Medicaid providers in the Provider Relief Fund. First of all, I thank all of you and the states who sent us your files. Those have been incredibly helpful to this whole process. An important step in the process of determining who should payments is making sure that the people are Medicaid providers. And so the way the process is working is that HRSA will take the people who apply relief funds, they'll compare them against those state files that you all sent in along with an augmented version of the file that we gave them from T-MSIS to see if they can just validate the entity, or their organization or the entity that's applying is a Medicaid provider.

Assuming they find them there, then the rest of the process can continue on. The issue becomes when we're not able to find the people on those files. And there can be a lot of reasons why that is. We all produce this data really quickly. There's a whole set of providers that we think are probably not on those lists. But we want to have HRSA work with all of you in states to validate whether or not providers who apply for the funds are Medicaid providers. So we're still working out some technical details on this whole thing, whether it will be a secure email, or whether it will sort of a file upload download kind of process. But the way it's basically going to work is we at CMS will give you a heads-up that files are coming, and then HRSA will make the files available through one of those technical mechanisms, and states will then get five business days to review those and then send the files back to HRSA, again through the technical method that they set up to respond yes or no on the providers.

We're going to have more details about this process in an email that will go out to all of you hopefully, maybe today, but more likely tomorrow or Wednesday or Thursday on how it will exactly work. And just FYI that one of the things that we're going to do is we're going to give HRSA contacts that they should be reaching out to in the states for sending the files back and forth. The contact that we intend to give is the T-MSIS contact that we have unless you tell us that it should be somebody different. But we thought that that would be the most efficient list to get that.

And just one note. There's a handful of states that send us separate CHIP files for T-MSIS. Those states will get the file, the state providers that can't be identified. The same file will go to both agencies in the state, because we have no way of knowing when somebody applies whether they're a CHIP provider or a Medicaid provider or maybe even both. And so that will happen in terms of validating, and HRSA will be able to sort all that out on the backend.

So that's how that process is going to work. Right now, there are close to 2,000 providers who have applied for funds across the country who have not been... We can't verify that they're for sure Medicaid or CHIP providers. That just sort of gives you a sense of the volume there. Of course, it will be divided out amongst states and territories.

I think that's it on the Provider Relief Fund. Moving on to the data topic, there's actually two mildly related subjects I wanted to touch on the call today. The first is that most of you know that we did a per-capita expenditure calculation for last year's scorecard. We're updating that for this year's scorecard, and we'll be sending emails out to individual states with your results the week of July the 6th. Tomorrow, there's a webinar specifically on the per-capita expenditure methodology and how we went about doing. There was some changes this year from last year based on what we learned from last year. Anyway, states will get the state-specific results the week of July 6th.

But on the T-MSIS subject, I'm sure many of you saw yesterday that CMS did a press release on Medicare and COVID essentially and some of the analysis that's happened with the early Medicare data that's been coming into CMS. Again, I need to thank you all, because in early June we processed the T-MSIS data files that you sent us in May, and we actually do have COVID specific information in those files. We have diagnoses and we also have certain procedures that have been going on. The volume is kind of low right now, but we obviously anticipate that as Claims Run Out happens, that will go up. We are providing that data to our colleagues in the Office of External Data and Analytics, and the Medicaid data will be reported as part of the regular CMS releases going forward, Medicaid and COVID. This is really a plea to continue to make sure your systems are updated and able T-MSIS data to us with COVID information.

We've also been seeing a little bit of inconsistencies in some of the procedures and the way that the claims are reported on the T-MSIS file segments. I don't

want to get into a ton of technical detail, but we are going to be doing some way more specific technical guidance to states in the next week or so about how those things should be coded appropriately when you're doing your T-MSIS data files. Again, thank you for the provider files, thank you for the T-MSIS data. We're pretty excited to be able to analysis Medicaid and CHIP data at the national level this quickly in the process. It's an ongoing thing, but it was just really just... This is really just to give you a heads-up that the data's going to be starting to be made public within the next few weeks. I think that's it, Jackie. I'll turn it back over to you.

Jackie Glaze: Great. Thank you, Julie. Appreciate your updates. We're ready now to take questions, any kind of general questions you may have or any of the questions you may have on the topics we discussed today. We'll start again with the chat function. Those of you that would like to do that, go ahead and submit your questions at this point. And then we will then open up the phone lines. So, we'll wait for your questions through the chat line at this time.

Barbara Richards: Jackie, we have a couple questions in the chat. The first one if John Coster is still on the phone... The question is why is CMS allowing 30 days for public review and comment? Only 30 days for public review and comment?

John Coster: Well, I think -

Calder Lynch: I can answer that, John, if you'd like.

John Coster: Okay. Sure, Calder. Of course.

Calder Lynch: Based on the economic impact analysis that was done, this rule was not determined to be a major rule, and therefore the minimum public comment time under the APA is 30 days. Given the tailored focus of the rule's subject matter, we felt that that would be sufficient in order to allow us to get this finalized, in order to for these types of VBP arrangements to begin being put into place. We recognize that it is a short period of time, and that's why we wanted to make sure we flagged that it was a 30-day comment period. But comments will need to be submitted by July 20th to be considered.

Barbara Richards: Great, thanks, Calder. The next question is I think for our colleagues in Disabled and Elderly, and possibly Calder as well. Unrelated to today's topic, can someone comment on when we will see further guidance on when we will see pharmacy COVID testing?

Alissa Deboy: This Alissa DeBoy. We are actively working on that guidance and hope that will be out soon. I know it's important. It's actively in development. Thank you.

Barbara Richards: Great, thanks, Alyssa. And Calder, this may be a question for you and possibly Julie. It's really more a person is conveying a concern, but I thought we should

just share that. It's related to the Provider Relief Fund and the Medicaid and CHIP distributions. One concern we have heard from providers is that they have received a de minimis payment from the first round, sometimes as low as one dollar, which has made them ineligible for payments from this distribution despite being unhelpful with actual impacts from COVID. I think the person is sharing the concern from providers who have received the de minimis amount of as low as a dollar.

Calder Lynch: This is Calder again. We have heard those concerns as well, and we have shared them with our colleagues in HRSA and at HHS, who I know have been looking at the matter. For providers that qualified under the initial general distribution round because they had maybe even just one Medicare Fee for Service claim during the time period that was pulled, they would have received a de minimis payment, but they would have also had the opportunity at that time to go into the portal and submit information including their total revenue... total gross revenues... and would have received a second payment that would have brought them up to the same 2% of gross revenue threshold that they would have qualified for under that round, which is the same amount that the Medicaid-only providers qualify for in this round.

I think the department's looking to understand why those providers maybe didn't take advantage of that opportunity then and to understand what other opportunities may be available, but we don't have any new information. And at this point, they would not qualify under the Medicaid-only round, because they would have been able to do that in the initial distribution. But we have flagged that issue for them, and I expect when we have more information we can share it if there's going to be further opportunities.

Barbara Richards: Great. Thanks, Calder. I think this next question is for our colleagues in CAP around eligibility. It's a general question regarding post-PHE eligibility determinations. When states restart Medicaid eligibility determinations for individuals whose eligibility has been extended due to COVID, any redeterminations of eligibility will be prospective from the date of redetermination. Correct? This state has received a question about whether CMS expects states to update eligibility back to the date of renewals when they were supposed to occur. Can you clarify expectations?

Sarah deLone: This is Sarah deLone. I'll restate what I understand the question to be, which is if a beneficiary had come up for their regular renewal during the period of time during the Public Health Emergency -- let's say it was a June renewal. And let's assume also that the Public Health Emergency comes to an end at the end of July, and then the state needs to complete the renewal process for that individual. The termination would be prospective from when the renewal process is actually completed. The advanced notice of termination is provided. It would not get back-dated to the June renewal date when the person initially would have been processed. So I think the assumption of the questioner is correct. It will be a prospective termination at that point.

Barbara Richards: Great. Thanks, Sarah. And at this point, Jackie, I think we should just open up the phone lines.

Jackie Glaze: Yes. Operator, would you open up the phone lines at this point?

Operator: Of course. If you would like to register a question, please press the 1 followed by the 4 on your telephone. And it's just going to be a moment as we gather the information.

Our first question comes from the line of Krisann Bacon. Please go ahead.

Krisann Bacon: Yeah, hi. This is just a general question about 1135 waivers. We received informal feedback on our 1135 waiver request that indicated many of the blanket waivers for Medicare were applicable to Medicaid and CHIP, but we can't find that published anywhere. So I'm wondering if you can direct us to that, or if there's some place that we can direct providers to.

Jackie Glaze: Hi, this is Jackie. And yes, we have received clarification from the Center for Clinical Standards and Quality and the Center for Medicare that the blanket waivers through Medicare do apply to Medicaid and CHIP. I will have to follow up to get the actual citation, but that is correct that those waivers do apply to Medicaid and CHIP as well. I believe I have your name, and I can certainly follow up with the citation for you. But we did include that in our approval letters as well.

Krisann Bacon: Thank you.

Calder Lynch: Are you looking just in terms of where those are posted and where you can find information about the individual waivers themselves?

Krisann Bacon: Yeah, no. So it wasn't in the letter that we got back on our final approval, but we did get informal feedback for the other requests that stated that. And we had some audits. And we wanted to point to that language, and we just couldn't find it published anywhere.

Calder Lynch: Got it. Okay. So Jackie can follow up with you on that.

Jackie Glaze: Yes. And are with Pennsylvania, did you say?

Krisann Bacon: Utah.

Jackie Glaze: Utah. Okay, okay. We'll certainly follow up. Thank you.

Krisann Bacon: Thank you.

Operator: Our next question comes from the line of Tara LeBlanc. Please go ahead.

Tara LeBlanc: Hi, this is Tara LeBlanc from Louisiana. I believe it was on last week's CMS call. This is in regards to after the PHE is ended. CMS stated that if we start post-eligibility now, that we could use recent data sources and data points to determine eligibility. Can they define recent? Is it 30 days, 60 days, 90 days that we can start working on some of the backlog now?

Sarah deLone: This is Sarah deLone. I think there's, Anne Marie, were you trying to get in?

Jessica Stephens: This is Jessica, but go ahead Sarah. I'll add on.

Sarah deLone: Oh, go ahead Jessica. No, go ahead.

Jessica Stephens: I think you're referring to conducting any verifications for any individual who would need to have their eligibility verified because you enrolled them based on self-attestation. And so when we refer to recent information, there would be no different in the time period and the recency of information used now compared to what your practice was prior to the Public Health Emergency. So for example, for an individual whose income, for example, you're verifying at this point, you would use the most recent income information available to the state that is based on information you have now and not necessarily the information in the data source at the time that the individual applied if, for example, they applied in March.

Tara LeBlanc Okay. I have a follow-up question to that. So if we start post-eligibility in the month of June and we're using our current data, and we determine an individual is ineligible based off of income, and the PHE is extended for another 90 days, at the end of the PHE in 90 days, would we have to go back and re-run eligibility on that individual again because now it's another 90 days? We could have more current data?

Jessica Stephens: Good question. We are in the process of developing more specific guidance to states to outline both in the context of verification and redetermination, the cases in which states may need to conduct another redetermination for individuals and where they don't. I don't think we have that specific answer for you right now, but it's definitely something that we're considering and we'll put out in guidance in the near future.

Tara LeBlanc: Thank you.

Jessica Stephens: You're welcome.

Operator: And our last question in the queue in the moment comes from the line of Eve Lickers. Please go ahead.

Eve Lickers: Hi, good afternoon. I have two questions, and pretty much it's still kind of a follow-up to some previous questions that I've asked. One is there any further

information about a possible delay for Electronic Visit Verification (EVV), and is there any update on the guidance related to the FFCRA Maintenance of Effort requirement that is going to be coming out soon?

Calder Lynch: Yep. This is Calder. I don't know if I've seen anything really recent on a potential EVV delay. I know that's something that had been talked about. It would require Congressional action. If we see something along those lines come through, we'll certainly share it. But I have not heard anything recent. I can check with our Office of Legislation staff between now and next week to see if they're aware of anything that we can share. But on the second, yes, we do have the updated guidance that we're working on the MoE requirements. They were planning to release that on a stand-alone guidance rather than our normal integration into the batches of FAQs so that we can get that out as soon as it's cleared. That process is underway, and I hope to have it out soon. I know that's not a satisfying timeline, but we are working on it.

Eve Lickers: Okay. Thank you, Calder. I think I heard somebody else had asked about guidance related to the pharmacists as well, and you're anticipating that to come out soon related to the COVID-19 testing?

Calder Lynch: Yeah, we're going to begin pushing out more information on testing as we have it. We're working on some guidance specifically around the pharmacist question and the requirements around Medicaid. We're also going to make sure folks see, if they haven't already, the guidance that was released Friday night from Medicare around their coverage and payment policies for testing in nursing facilities, because we think that could be illustrative for states as they consider some of these issues. But now that we have that guidance as well as some updated guidance from the CDC on testing more at-large, that's helping inform the guidance that we're working on specifically for states. And so now that we have that, we're able to move forward, and we're working on getting that out as quickly as we can.

Eve Lickers: Okay. Thank you very much. I appreciate it.

Barbara Richards: And Calder, while we're in the neighborhood of releasing guidance soon, there's a question about is there any update information on retainer payments?

Calder Lynch: Not as of right now, but that is something we're hoping to address in the next batch of FAQs, which we had hoped to have out before this call, but we just didn't get across the finish line there. We're still working on it. That one's probably closer to the top of the list in terms of timelines hopefully, but we'll definitely follow up once we know, once we have that. We know that continues to be a hot topic.

Barbara Richards: Great. Thanks, Calder. We've got another question that's for our friends in CAP on eligibility. Will renewal packets need to be sent, or can eligibility be run based on the information that is in the system? For example, a household returned a

renewal packet on June 1st. They were ineligible but kept open. At the end of the emergency, do we need to get new info out, or just re-run and close based on what is in the system?

Jessica Stephens: This is Jessica again. And I think this is another example of the type of situation that... I'm forgetting exactly which state we just discussed related to verification. I think that guidance applies both to renewals and redeterminations and verifications, where there may be some instances in which we would expect that a state would re-do a redetermination for individuals who were determined during the public health emergency but not terminated. But we're in the process of putting together some more concrete guidance to states to help to identify the actions that are needed after the end of the Public Health Emergency.

Barbara Richards: Great. Thanks, Jessica. And we have another question for our eligibility colleagues. A question was submitted regarding changes to recurring income for Post-Elibility Treatment of Income (PETI) after the call on May 5th or so, and we have not seen any follow-up on that question yet, nor have the FAQs been updated. Will additional guidance be forthcoming?

Stephanie Kaminsky: This is Stephanie Kaminsky, and yes, that guidance is forthcoming. It's included in the 6008 guidance that folks have referenced during this call. There are parts of that guidance that will address some of the questions we've had about PETI and the implications vis-a-vis 6008 B3.

Barbara Richards: Great. Thank you. And we've also received in the chat box a couple of comments and/or questions about the blanket waivers. First, a comment that I think all states need that blanket waiver citation for audit purposes, so a request to share it broadly. And then also, Arizona Medicaid would also like the citation regarding the Medicare blanket waivers implications.

Jackie Glaze: Yes. We understand that everyone needs the language, so we'll make sure that we get that information out to everyone. And what was the question for Arizona?

Barbara Richards: They were just reiterating it.

Jackie Glaze: Okay, great. Great, thank you. We'll definitely get that together for everyone. Did we want to take one more question, Barb? Or do we want to turn it over for Calder, because he has a few closing remarks?

Barbara Richards: Yeah, I think we should turn it back to Calder. Thank you, Jackie.

Jackie Glaze: Okay, Calder?

Calder Lynch: Thanks, everyone, for joining us. I know that folks are very anxious to have the updated guidance we referenced, and I know it's taking us a little longer than we hoped to get that cleared and out to you. But it is still at the top of our priority

list, and we're working really hard to try to get that out because I know it's important for your operational planning efforts. We will continue next week on next Tuesday. The topic and invitation will be forthcoming. And of course, between now and then, please feel free to reach out to your state leads. We're here to help and assist you on trying to work through some of these issues. Again, thank you all for joining us today. I want to just continue to express my appreciation for all that you're doing on behalf of our beneficiaries and all the work that your teams are doing and the hours that are being worked. I know it's sometimes less than ideal circumstances, so appreciate all of that. Have a good afternoon, and we'll speak again next week.

Operator: That does conclude today's webinar. We thank you for your participation and ask that you please disconnect your lines.