

Centers for Medicare & Medicaid Services
COVID-19 All State Call
August 25, 2020
2:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time, all participants' lines are in listen-only mode until the question and answer of today's session. At that time, you may press Star 1 on your phone to ask a question. This conference is also being recorded. If you have any objections, please disconnect your line at this time. I would now like to turn the conference over to Jackie Glaze. Thank you. You may begin.

Jackie Glaze: Thank you and good afternoon and welcome, everyone, to today's Allstate call. I'll now turn to Anne Marie Costello -- our acting Center Director -- and she'll introduce our guest speakers and share highlights for today's discussion. Anne Marie.

Anne Marie Costello: Thank you very much, Jackie, and welcome to everyone, and thank you for joining us today. I'd like to take a moment and acknowledge the leadership transition happening here at CMCS. As Calder mentioned a few weeks ago, he is now the acting Chief of Staff to Administrator Seema Verma.

And as of today, I am the -- I'm sorry -- as of yesterday, I'm the acting Director for CMCS. I'm really very excited about this opportunity and especially my ability to continue to work with you as we work together to collaboratively run the Medicaid and CHIP program.

But now, turning to our call today, we're joined by Steve Ferraina -- the Deputy Group Director and CMS's Center for Program Integrity -- so we'll discuss their plans to resume MEQC and PERM's corrective action plan

related activity.

We'll also hear from CMCS staff about an informational bulletin released yesterday that describes reimbursement strategies available to states that want to implement specific infection control practices by designating a quarantine or isolation wing for COVID-19 patients in nursing facilities. This is critically important giving how we know nursing facilities were particularly vulnerable to the prevalence and spread of COVID-19.

Before those presentations, we'll hear from Will Chang, Brenna Jenny, and Laura Schattschneider from the HHS Office of the General Counsel. Will serves as the Deputy General Counsel. Brenna also serves as Deputy General Counsel and Chief Legal Officer to CMS, and Laura is an attorney in our General Counsel's office. Our OGC colleagues will provide an overview of an amendment to the PREP Act declaration that allows pharmacists to administer vaccines to children.

As you may have seen immunization data from the CDC show that routine pediatric vaccinations has dropped off considerably during the public health emergency related to COVID-19. There are a number of reasons that potentially explain this decline, including changes in healthcare access, as a result of temporary practice closures, social distancing, concerns about virus exposure during well-child visits, and other COVID-19 mitigation strategies.

In order to ensure that all children can receive necessary vaccinations to prevent outbreaks of childhood illnesses, eligible state-licensed pharmacists and pharmacy interns have been given authority to administer vaccines to children ages 3 through 18, as long as specific requirements have been met.

We understand that after listening to this overview, you will likely have

operational questions specific to Medicaid and CHIP. We are working on developing some FAQs related to Medicaid and CHIP provider enrollment requirements, requirements related to the vaccines for children programs, and implications to states with managed care. We welcome your questions today but may need to follow up further in a future All State call with additional information.

Before turning things over to OGC, I also wanted to take a moment to highlight that August is also National Immunization Awareness Month. This is especially timely to spread awareness about the importance of pediatric vaccines because of the drop in routine pediatric immunizations that I just noted. It is critical that children continue to be immunized during the public health emergency so that there are no increases in preventable childhood diseases.

The HHS Office of the Assistant Secretary for Health, the Census for Disease Control, and the National HPV Roundtable have just released toolkits focusing on the importance of pediatric vaccines, as well as National Immunization Awareness Month. We'll be sending out an email tomorrow to share these resources with you.

I also want to take an opportunity to note that as the United States continues to fight COVID-19, it is particularly important to be protected from flu by getting the seasonal flu vaccine. We encourage states to start thinking earlier about their flu vaccination campaign. HHS will soon be releasing additional information focusing on the importance of the flu vaccine. We'll highlight those materials for you as they become available. With that, I'd like to turn the call over to Will Chang to start OGC's presentation. Will.

Will Chang: Thank you, Anne Marie, and congratulations on your promotion, and thank

you all on the call for this opportunity to talk with you about the Secretary's most recent amendment to the Declaration under Public Readiness and Emergency Preparedness Act, also known as the PREP Act. As many of you know, the PREP Act is a federal statute that allows the Secretary to confer broad liability immunity to designated persons who use designated medical countermeasures. Examples of such countermeasures include COVID-19 tests that the FDA has approved, licensed, or authorized, similarly, therapeutics and other FDA approved devices.

Now, the PREP Act preempts any state legal requirements that differ from or are in conflict with the Secretary's declaration. So what that means is that the Secretary -- under the PREP Act -- may authorize persons to use and administer covered countermeasures, even if state law does not allow such persons to perform those services. Now, the Secretary has previously used this authority on a topic that we've discussed with this group and that involved licensed pharmacists ordering and administering FDA authorized COVID-19 tests.

And for the reasons that Anne Maria already discussed, the Secretary recently amended his PREP Act declaration to authorize state-licensed pharmacists and pharmacy interns -- who are licensed or registered with the State Board of Pharmacy and operating under the supervision of a state-licensed pharmacist - - to administer certain vaccines to children ages 3 through 18. So the pharmacist can order and administer such vaccines and the pharmacy interns may administer those vaccinations, acting under the supervision of the pharmacist.

There are conditions attached to the authorization. The vaccine must be approved or licensed by the Food and Drug Administration. The vaccination must be ordered and administered according to CDC's Advisory Committee

on Immunization Practices immunization schedules. The licensed pharmacist must complete a practical training program of at least 20 hours that is approved by the Accreditation Council for Pharmacy Education (ACPE).

This training program must include hands-on injection technique, clinical evaluation indications and contra-indications of vaccines, and the recognition of treatment of emergency reactions to vaccines. The licensed or registered pharmacy intern must complete a practical training program that is approved by the ACPE. This training program must include hands-on injection technique, clinical evaluation of indications and contra-indications of vaccines, the recognition of treatment of emergency reactions to vaccines.

Both the licensed pharmacist and the licensed or registered pharmacy intern must have a current certificate in basic cardiopulmonary resuscitation. The licensed pharmacist must complete a minimum of two hours of ACPE approved immunization-related continuing pharmacy education, during each state licensing period.

The licensed pharmacist must comply to record-keeping and reporting requirements of the jurisdiction where he or she administers vaccines. And that includes, informing the patient's primary care provider when available, submitting the required immunization information to state or local immunization information system -- ultimately the vaccine registry -- complying with requirements with respect to reporting outbreak-events, and complying with requirements whereby the person administering the vaccine must review the vaccine registry or other vaccination records, before administering the vaccine.

Now, the licensed pharmacist to receive that coverage, the licensed pharmacist must also inform his or her childhood vaccination patients and the adult

caregivers, accompanying the children of the importance of a well-child visit with a pediatrician or other licensed primary care provider and refer patients, as appropriate.

In his amendment to his PREP Act Declaration, the Secretary again reemphasizes the importance of making these well-child visits with a pediatrician and primary care physician and highlights all the stats that (unintelligible) are taking during the COVID-19 pandemic can ensure a safe environment for children to meet the well-child visits. Laura.

Laura Schattschneider: Thanks, Will. So, I'm going to speak a little bit to what all of this means for purposes of Medicaid reimbursement. So, as I'm sure you're all aware, states are required to cover administration of vaccines for most Medicaid eligible children in the age group that is covered by this recent amendment to the PREP Act Declaration under the early and periodic screening diagnostic and treatment, or EPSDT benefit. Additionally, states are required to ensure that Medicaid beneficiaries can receive Medicaid covered services from the qualified and willing provider of their choice.

So the PREP Act Declaration Amendment makes pharmacists and pharmacy interns -- who meet all the conditions in the declaration that Will just summarized -- qualified to administer vaccines to children age 3 through 18, and it does so regardless of any state law to the contrary. So accordingly, HHS will expect state Medicaid programs to reimburse pharmacies if their qualified staff pharmacists order and administer and if their pharmacy interns administer, childhood vaccines to Medicaid eligible children consistent with the amended declaration.

And HHS and CMS expect this even if -- absent the amended declaration -- state or local scope of practice laws would not permit the pharmacist or the

pharmacy intern to carry out these tasks. States still must meet all other applicable federal requirements, such as reimbursing only those providers that are enrolled as Medicaid providers.

Nothing in this recent amendment to the PREP Act Declaration affects the federal requirements in 42 CFR part 455 subpart E, regarding the screening and enrollment of Medicaid providers. So that is the top-line upshot for Medicaid reimbursement.

Jackie Glaze: Thank you, Laura, and thank you, Will. Are you finished with your presentation or are we ready to take questions?

Laura Schattschneider: We are.

Jackie Glaze: Okay, great. Okay, so we'll now open up the phone lines so that the audience can ask questions of Will, Laura, and Brenna. And so, Operator, please open up the phone lines.

Coordinator: Thank you. We will now begin the question and answer session. If you would like to ask a question, please press Star 1, unmute your phone, and record your name clearly. Your name is required to introduce your question. If you need to withdraw your question, press Star 2. Again, to ask a question, please press Star 1. It will take a few moments for questions to come through. Please stand by.

I am currently showing no questions. Again, as a reminder, if you would like to ask a question, please press Star 1. Stand by a moment. Our first question comes from John Ross. John, your line is open.

John Ross: Hi. I'm John Ross, Indiana Medicaid. You know, similar to a question I've

asked in the past, with regard to the pharmacists, will the pharmacist need to be enrolled as an individual provider or will the pharmacy's MPI and enrollment be sufficient?

Laura Schattschneider: So, this is Laura. Jackie, did you want to take that, or?

Jackie Glaze: Laura, you can certainly answer the question.

Laura Schattschneider: So, I think this is one of the areas that you should expect to see some additional guidance or direction on from CMS unless there are others on this call who would like to discuss it.

Amy Lutzky: Laura, this is Amy Lutzky. So, that's right. We are working on FAQs that are going to focus more on these operational considerations, knowing that, you know, states will want some more specifics regarding enrolling pharmacists or pharmacies.

John Ross: Thank you.

Amy Lutzky: Thank you, John, for that question. It's very helpful as we develop the FAQs.

John Ross: Thank you.

Coordinator: Our next question comes from Jessica Dresner. Jessica, your line is now open.

Jessica Dresner: Thank you. I'm calling from MO HealthNet -- the state Medicaid agency in Missouri -- and I apologize I really just have this one question as John, it's just a little bit more fluid and I was speaking with the Operator, so I may have missed part of the discussion around this. But my question was A, same as John's -Can we, you know, pay the pharmacy if they're the enrolled

practitioner, does the individual pharmacist needs to be enrolled? Part B to that is just about the FAQs, if you could help us out with just a little bit more to that, would it be sufficient if the pharmacy is enrolled, that the pharmacist is the performing provider, understanding if that is the expectation , he or she would have to still be enrolled? But would it be alright for the pharmacy to be the billing provider and the pharmacist to be the performing provider?

And then just back to the original question. Can we just have the pharmacy be performing and billing provider (unintelligible) without the pharmacist being enrolled? So look forward to those FAQs. Thank you for that.

((Crosstalk))

Coordinator: Next question comes from Judy Mohr Peterson. Your line is now open.

Judy Mohr Peterson: Hi. Thank you so much for this information. It's very helpful. My questions are regarding the timing of this. If we can enroll, or if we can have the pharmacist enrolled, a lot of times we have -- I know in our systems -- we have it set up so that only certain types of claims can come in from that and we would only pay the provider for certain kinds of claims and that's in our system, but then being a managed care state, we also have to have, you know, get this information out to all the medical plans, et cetera. So my questions are around timing and then the timing of the type-up of the FAQs, et cetera, and how we'll be able to make this happen? And is this only for the time of the emergency or is it related to just in general? And I apologize. You probably said that and I just missed it.

Will Chang: Yeah, so, (Laura), let me take the first two parts of that question, and thank you for those questions, Judy. They're very important. You did not miss it. This authorization is effective so long as the PREP Act is effective, which

boiled down is so long as there is an emergency - public health emergency - as discussed.

And to your second question on timing, which I cannot answer the operational nuances, that's not my wheelhouse, but this PREP Act Declaration amended -- from a legal perspective -- all the legal authority that we just discussed are effective, as of today.

Judy Mohr Peterson: Thank you.

Will Chang: I defer to others on the operational questions.

Jackie Glaze: And Judy, we do have your questions and we will continue to work through those because we understand it's important that you get some feedback very quickly. So we have your questions and we will certainly follow up as quickly as possible.

Judy Mohr Peterson: Thanks so much. Appreciate it.

Coordinator: The final question we have in queue comes from Eve Lickers. Eve, your line is open.

Eve Lickers: Hi, good afternoon. Thank you for this information on the pharmacists. Our question, kind of also I think lends itself to the last inquire, in the fact that, you know, pharmacists currently in Pennsylvania can administer vaccines and it's not just limited to these that are for the children, and we're looking to add these to the state plans, and so currently right now, when we talk about pharmacies, when we talk about prescribed drugs, that's the category of service that is identified. So obviously, that's where we're identifying payment to the pharmacies. So we're looking at how would we actually identify this in

the plan and how, you know, what is CMS's recommendation? And also, how would this be reported on the CMS-64?

Kirsten Jensen: This is Kirsten Jensen from CMS and we will take those questions back as well and work on getting guidance out on those topics.

Eve Lickers: Great. Thank you very much.

Jackie Glaze: We can take one additional question and then we'll move onto our next speaker. Do we have any questions still in the queue?

Coordinator: That was the last question we had in queue.

Jackie Glaze: Okay, great. Thank you. And I, again, want to thank Will and Laura for your presentations and answering the questions that we had from the audience. So now we'll move onto Steve Ferraina and he's going to provide an update on CPI's resumption of the MEQC and PERM CAP. So, Steve?

Steve Ferraina: Great. Thank you, Jackie. Good afternoon, everyone. My name is Steve Ferraina and I'm the Deputy Group Director in the Center for Program Integrity. I wanted to just give a brief overview of two recent announcements that we've made regarding the PERM and the MEQC programs.

Many of you are probably very familiar with these programs already, but just by way of level setting, the PERM program estimates Medicaid and CHIP improper payment rates both nationally and at a state level. And it also identifies the drivers of errors and the related corrective actions. And the MEQC program operates during states off-cycle PERM years to help states address beneficiary eligibility errors in particular that were identified during the PERM review.

So starting with the PERM program, a few weeks ago my colleagues in the Office of Financial Management provided an update to you all about their resumption of the PERM measurement activity, so we in the Center for Program Integrity have also resumed our PERM corrective action plan work with the states.

We've already been in contact with each of the cycles of states, but I just wanted to give a quick summary of the current status and each of their PERM test updates. So for Cycles 1 and 3 from their most recent PERM review years, we reengaged reviews of those submitted tasks from earlier this year and our goals to work with those states to get them finalized in the near future. And then our routine oversight work of those tasks will continue going forward until the next PERM review.

And for Cycle 2 -- which will have their improper payment rates recorded this November -- we understand the significant impact that COVID-19 has had on state operations, so we're providing some flexibilities for Cycle 2 states specifically as they develop their tests. So the biggest flexibility for Cycle 2 states is that we're implementing a summary level CAP requirement that will cover the main drivers of the national PERM rate instead of the state-specific PERM rates, and we're going to be holding a kickoff call with Cycle 2 states in November to go over these flexibilities in greater detail.

In terms of the MEQC program, we announced last week that we're implementing various COVID flexibilities for Cycles 1 and 2 that I just wanted to draw your attention to. So just by way of background, Cycle 1 states under MEQC were conducting their reviews during 2019 and were set to report the results of their reviews this summer.

And Cycle 2 states are conducting their MEQC reviews this year and are set to report their results next year. So for both Cycles 1 and 2, we're implementing reduced reporting requirements for their case level reports and corrective action plans, so states will only have to report high level, summary level information for their case level reports, and their corrective action plans.

We're also providing an extension for submitting these documents. We're extending the deadlines to November 1 of this year for Cycle 1 and November 1 of next year for Cycle 2. And finally, we're also not requiring either Cycles 1 or 2 to conduct the payment reviews that they would normally have conducted to identify and return overpayments as a result of the MEQC pilots. So in addition to those flexibilities, for Cycle 2 only, we're also reducing their sample size from 800 cases to 200 cases, to provide some additional flexibility.

So I'm happy to answer any questions you all have about these changes at the end of this call or you can also reach out to your PERM CAP and MEQC points of contact here at CMS. And so with that, I'll turn it over to my colleague, Amy Lutzky, to cover the next topic.

Amy Lutzky: Thanks so much, Steve. Good afternoon, everybody. I'm Amy Lutzky and I'm the acting Deputy Director in the Children and Adult Health Programs group. We have been working in partnership with Steve and other colleagues in the Center for Program Integrity to develop a webinar discussing Program Integrity strategies for Medicaid and eligibility.

This webinar on Program Integrity is scheduled for next week on Monday, August 31 from 2:00 to 3:30 pm. This is actually part of the CMCS Coverage Learning Collaborative (LC) that many of you on today's call are already probably familiar with. The Coverage LC provides a forum for CMS and

states to examine eligibility and enrollment requirements and develop tools and guidance to support state efforts.

The webinar this Monday will cover specifically, Medicaid and Program Integrity basics, the relationship between Program Integrity and eligibility processes, the CMCS informational bulletin that was put out last year on oversight of state claiming and Program Integrity expectations, as well as ensuring accurate eligibility determinations and claiming of FMAP, program oversight monitoring, and will also feature examples of highly effective Program Integrity practices in states.

Accurate eligibility determination may not traditionally be considered Program Integrity, but it is a vital aspect of a Program Integrity strategy. So this webinar will really focus on accurate eligibility determinations as being a front line for strengthened Program Integrity efforts.

Invitations were sent last week to All State Medicaid directors, CHIP directors, and state Program Integrity officials. Please register and encourage your eligibility staff to register, as well. If this email sounds vaguely familiar but you're thinking it might be buried in your inbox, we are also planning to send out another email through the CMCS LISTSERV very soon. So please be on the lookout for that. Thank you. I think that's back to you, Jackie.

Jackie Glaze: Thank you, Amy, and thank you, Steve. We're now moving onto (Amber Picaro) and she's going to provide an update of the nursing home informational bulletin. Amber?

(Amber Picaro): Hi, thank you, Jackie. Yesterday, we released a CMCS Informational Bulletin (CIB) to remind states of the available flexibilities that can be used to enhance Medicaid payments to nursing facilities during this public health emergency in

order to support the facilities' ability to safely care for its residents.

Through the CIB, we're encouraging states to use these flexibilities to support any necessary actions to slow the further spread of COVID-19 in nursing homes, such as isolation or quarantine of residents. As everyone is now very familiar with the Medicaid Disaster Relief SPA template that was released early in March, one of the key authorities that we have approved through this SPA template has been to increase Medicaid payments to nursing facilities.

The CIB highlights a variety of ways that the states can use or have used the Disaster Relief SPA in order to increase Medicaid payments to nursing facilities, including the recognition of additional Medicaid costs associated with increased staffing and personal protective equipment needed, and also targeting payment increases to nursing facilities that are either treating residents diagnosed with COVID-19 or to nursing facilities that are located in geographic areas that have experienced an outbreak.

The CIB also highlights initiatives that have already been implemented by three states -- Ohio, Michigan, and Iowa -- to improve care and mitigate the spread of COVID-19. We are going to have a more in-depth presentation on some of those initiatives on a later call, so I'm just going to, for now share a high-level overview.

Excuse me. Ohio provides tiered Medicaid payments to certain nursing facilities based on an individual resident's need for isolation or quarantine. The payments differ based on whether quarantine or isolation is necessary and it's also based on patient acuity. Instead of designating certain nursing homes as COVID only, Ohio allows nursing facilities to designate specific sections of the facilities for quarantine or isolation, which enables residents to remain in their home facility.

Michigan increased Medicaid payment rates for certain nursing facilities that the state has designated as a COVID-19 regional hub. These facilities are solely dedicated to serving COVID-19 patients. The facilities received an upfront payment of \$5,000 per bed in the first month to address staffing needs and infrastructure changes necessary. After that first month, the nursing facilities received an additional payment of \$200 per resident per day.

In Iowa, the state is providing special COVID-19 relief rate payments to nursing facilities that either have a designated isolation unit for COVID-19 treatment or that has been designated as a COVID-19 only facility. These payments are an add-on payment of \$300 per day to eligible nursing facilities for each resident in one of the designated units (unintelligible), discharged hospitals of the nursing facility and is COVID-19 positive or who has a COVID-19 test result pending.

The CIB also includes a reminder about the funds that are available through the Coronavirus Aid Relief and Economic Securities -- the CARES Act -- and the Paycheck Protection Program and Health Care Enhancement Act in which the federal government validated \$175 billion in payments to be distributed through the Provider Relief Funds to support healthcare-related expenses or loss revenue that are attributable to the COVID-19 pandemic.

These payments need to be repaid to the government of the providers comply with the terms and conditions of receiving those payments. And with that, I'm going to turn the mic over to John Giles who will briefly discuss some of the payment flexibilities that are available to states with managed care delivery systems.

John Giles: Thanks, (Amber), and good afternoon, everyone. In states that have a

managed care delivery system and are interested in enhancing specific payments for nursing facilities, states can direct specific payments made by managed care plans to providers through a state-directed payment. As we provided previously on other All state calls, states can include contractual requirements for their managed care plans to pay a specific minimum fee schedule or a specific uniform dollar or percentage increase for a class of providers, including for nursing facilities.

We published guidance previously on May 14 that was intended to help states comply with the regulatory requirements for state-directed payments in response to COVID-19 and provided a framework that will help states design these payment arrangements and facilitate CMS's review and approval process, including an example preprint template.

For states that are seeking to utilize the flexibilities described in the May guidance, states will need to follow the framework provided, including the implementation of a two-sided risk mitigation strategy. If states need any technical assistance on state-directed payments, please reach out and we'd be happy to discuss any issues with you.

As an alternative approach to implementing state-directed payments, some states have had a preference for implementing these enhanced payments as non-risk payment arrangements for COVID related services. As part of the CIB, we confirm that states can consider paying for services outside of the managed care competition rates, as a non-risk payment arrangement.

This arrangement can be structured as either a separate non-risk contract with your managed care plans or as an amendment to existing managed care plan contracts to include a non-risk payment arrangement. States will need to be able to identify relevant costs and beneficiaries accurately within these

contracts and states would need to amend their contracts to clearly define the benefits that the plans must cover on a risk basis, and the benefits that are excluded from the competition rates and would be covered on a non-risk basis.

States and their Actuaries would also need to determine if a rate amendment is necessary to address any services previously included in capitation rate development that now need to be removed and paid on a non-risk basis. If states choose to amend their existing contract to include a non-risk payment, states would need to comply with the applicable upper payment limits for a non-risk contract. Jackie, I think I'm turning the call now back to you for any state questions on this topic.

Jackie Glaze: Thank you, John, and thank you, Amber. So that concludes our presentations for today. So we're ready to open up the phone lines so the audience can ask any questions of the presenters that you heard today or any other general questions that you may have for us. So, Operator, please open the phone lines.

Coordinator: Thank you and we'll begin the second question and answer session. As a reminder, if you'd like to ask a question, please press Star 1 and record your name clearly. Again, if you'd like to ask a question, please press Star 1. We do have a question in queue. (Beth Beasley), your line is now open.

(Beth Beasley): Thank you. I just have a question for Steve. You said the kickoff for PERM will be November. Is there a kickoff for MEQC for a CAP?

Steve Ferraina: Yes, so we actually, this Thursday at I believe it's 1:30 -- and my colleague Joel Truman is on , so you can correct me if this is wrong -- Thursday at 1:30 we'll be doing an All State call with our MEQC states to give them an overview of this process and start getting them kind of worked into --

depending on what cycle they're in -- their next set of either reporting in November for Cycle 1 -- which includes their CAP -- or Cycle 3 will be submitting their private planning documents in November as well. But let me check, Joel, is there anything you want to add to that response?

(Joel): No, I think you've got it. Basically, Cycle 1 and 2, they're summary reports now instead of case-level reports, they'll be doing summary reports and the due date for those have been pushed back from August 1 to November 1. So the Cycle 2 states don't really have to worry about submitting until November 1, 2021. But we are expecting pilot planning documents from the Cycle 3 states and from the first round of summary reports from the Cycle 1 states due on November 1.

(Beth Beasley): Thank you.

Coordinator: Next question comes from Nicole Filps. Nicole, your line is open.

(Nicole Filp): Hi, good afternoon. I have a question around the PERM errors or PERM findings and the enhanced funding around the COVID enhanced funding. And it's - what type of impacts can the states expect if there are PERM error findings with cases that were kept open, per the policies? For example, say there's a PERM finding for eligibility related to a renewal but we kept them open because of the FFCRA, are there any impacts that the state should be expecting or concerned about?

Steve Ferraina: So this is Steve Ferraina. Just - sorry, go ahead.

(Nicole Filp): No, go ahead, Steve.

Steve Ferraina: I was just going to say I think in terms of, like, how PERM would classify

these errors based on the Section 6008 requirements, that would - I don't know that we have the right people on the line for that question right now - but I don't know, Amy or Sarah, is there anything that you think you have from, like, the CMCS policy side?

Sarah DeLone: Hi, this is Sarah DeLone. I think if a state is, you know, CMS has put out the guidance, you need to keep it. According to the CMS guidance you need to keep somebody enrolled in order to comply with the 6008(B)(3) continuous coverage requirement or the enhanced match, that was not be- that person would not be - that would not be registered as a PERM error. That's an authorized retention of eligibility, due to the FFCRA. Is that the question? Just would that be an error or not?

(Nicole Filp): Yeah.

((Crosstalk))

Sarah deLone: Yeah, it would not be an eligibility error.

Anne Marie Costello: And Sarah, this is Anne Marie. Maybe I would just add I think there are a lot of permutations of the issues, right? What happens if a state changed their verification processes, what if they had a regulatory concurring to extend timelines on certain timelines, right? I mean, some of those may or may not, so this would be considered PERM errors.

And I think, you know, our team here, our eligibility enrollment team work very closely with the Office of Financial Management that oversees PERM and will be working through those issues for that as PERM is instituted, our Office of Financial Management and the PERM reviewers have a good understanding of what the acceptable process in the state and expectations for

states. So I think that's ongoing work that we'll be doing with our Office of Financial Management colleagues.

Steve Ferraina: Yeah, and this is Steve. And just to clarify, from the MEQC perspective -- which is run out of the Center for Program Integrity -- that situation specifically about the renewals, that also would not be considered an error under MEQC. And we're planning to kind of work on some additional guidance and information on states, kind of like what Anne Marie was just saying to watch for those permutations, as well.

Coordinator: I am showing no further questions in queue, so as a reminder, if you'd like to ask a question, please Star 1. Again, if you'd like to ask a question, please press Star 1. I'm still showing no questions in queue.

Jackie Glaze: Thank you. Anne Marie, should I turn it back to you?

Anne Marie Costello: Sure, great. Thank you, Jackie. I just want to take a moment and thank everyone for joining us today. I especially want to thank our colleagues in the Office of General Counsel, the Center for Program Integrity, and our CMCS colleagues for their presentations today. I think it was very useful information. I also think the questions that we received from the audience -- while there were a number we're not able to answer -- hearing those questions really helps us develop the most appropriate frequently asked questions.

So stay tuned, we'll have more answers coming your way. Our next All state call will be held next Tuesday -- I can't believe I'm going to say this -- September 1. Yes, next week is September already. The topics and invitation are forthcoming, so watch your email.

And of course, if you have any questions that come up between now and our

next call, please feel free to reach out to any of us or in particular, reach out to your state lead and I'll make sure they funnel the questions up to us and we will try to address them in future All state calls. So again, thank you for joining us today and have a great afternoon.

Coordinator: That concludes today's conference. Thank you for participating. You may disconnect at this time. Speakers, please allow a moment of silence and stand by for your post-conference.

End