

Centers for Medicare & Medicaid Services
COVID-19 Medicaid & CHIP All State Call
September 15, 2020
3:00 pm ET

Coordinator: Welcome and thank you for standing by.

At this time all participants are in a listen-only mode until the question-and-answer session of today's conference. At that time, you may press star 1 on your phone to ask a question.

I would like to inform all parties that today's conference is being recorded. If you have any objections, you may disconnect at this time.

I will now turn the call over to Jackie Glaze. Thank you. You may begin.

Jackie Glaze: Thank you. And good afternoon everyone and welcome to today's all-state call.

I will now turn to Karen Shields and she will provide highlights for today's discussion and introduce our guest speakers.

Karen?

Karen Shields: Thank you, Jackie. And welcome again and thanks for joining us today.

This afternoon, we are excited to have two special guests who will continue our Lessons from the Field series. Kate Massey from the state of Michigan and Maureen Corcoran from the state of Ohio will share their state's strategies for nursing home reimbursement during the COVID-19 public health

emergency. This is a topic that was described in a CMCS information bulletin released in August where we cited Michigan and Ohio as examples. And we're excited to hear more about these states' experiences.

Kate is the Senior Deputy Director for the Medical Services Administration at the Michigan Department of Health and Human Services. And Maureen Corcoran is the Director of the Department of Medicaid at the Ohio Department of Health.

After their presentations, Amber McCarroll from our Financial Management Group will lead a facilitated discussion with Kate and Maureen before we open the lines for your questions. Following that discussion, we'll hear from (Mehreen Rashid), the Deputy Director of the State Demonstrations Group about a state Medicaid director letter on value-based care opportunities Medicaid that was just released today. Finally, we will open up the lines for your general questions.

But before we turn to our featured presentations, I wanted to share a few announcements.

I'd like to draw your attention to a notice recently issued by the IRS related to the optional COVID testing eligibility group. This IRS notice specifies that the coverage of COVID testing services for the optional COVID testing eligibility group that was adopted by many states is not minimum essential coverage or MEC. The IRS Notice number 2020-66 is posted on their Web site.

And so this has a couple of implications for Medicaid. First it means that individuals who are enrolled in the optional COVID testing group can enroll in a qualified health plan, or QHP, on one of the healthcare exchanges and

receive advance payments of the premium tax credit, or APTC. Enrollment in a QHP would mean that the individual would no longer be eligible for the optional COVID testing group under Medicaid. It also means that states will not have to issue the IRS tax form 1095-B to individuals enrolled in the testing group. In addition, individuals terminated from the optional testing group at the end of the PHE will not be entitled to a SEP or a special period through a healthcare exchange as a result of losing Medicaid coverage.

With that update, I will turn things over to Kate Massey from Michigan.

Welcome, Kate.

Kate Massey: Thanks so much. And many thanks to the CMS team for allowing Michigan to share our experience and our long-term care policy response to COVID.

What I thought I would do with the time that I've been afforded is talk a little bit about the situation that Michigan faced when we had our first surge or peak surge earlier this year and then answer a few questions that I actually think are pretty applicable to other states, including what are regional hubs -- regional hubs is the response that Michigan developed -- how are they paid, how are they selected and then what are the emerging results.

So when it comes to Michigan's experience, you know, when we - we were one of the first states kind of hit really hard with COVID. Our public health partners had issued a directive to hospitals kind of indicating and triggering a hospital surge policy. And the intent of the policy was really to make sure that people were being discharged as quickly and as safely as possible so that we could free up those hospital beds and make sure that the continuum of care was functioning as efficiently as possible.

After the public health directive was issued, there was a fair amount of distress that the Medicaid agency was hearing from the field, in particular from long-term care facilities who were feeling super stressed in being able to modify their operations and accept COVID-positive patients when they didn't feel like they had the proper preparations. And at the time, the state was also experiencing pretty severe PPE shortages throughout. And so this is clearly an issue that we needed to step in, resolve and address.

So when we kind of turned to the policy solutions, you know, there were several guiding principles that really directed how we developed our options. You know, one was prioritizing the health and safety of our nursing home residents as well as staff. We also wanted to support providers in patient care, taking into account capacity and circumstance. And so their personal and kind of individual circumstances did become really influential in the policies that we developed. And then we wanted to practice good and safe public health that managed exposure to COVID-19 through strong infection control practices.

And what we developed as a solution and what we pursued very vigorously was this concept of regional hubs. So what are these hubs? These are volunteer skilled nursing facilities, so it was a volunteer-driven policy. We asked every participating hub to have physical separation of COVID-positive treatment of residents. And so this actually got down to the granular level where nursing facilities who were interested in participating as hubs submitted floor plans to us that indicated separate entrance and exits, separate nursing stations to the extent that they could guarantee separate preparation of meal preparation and delivery that was all very much preferred.

We also required that there'd be dedicated staff. So we didn't want staff treating the regional hub component of that facility and then moving over to

treat and address the needs of non-COVID-positive patients. We required compliance with the highest infection control protocols. And then we also asked that the regional hubs comply with weekly monitoring. So there were multiple components that we asked our hubs to update us on related to PPEs, staffing, capacity, what have you, on a very regular basis.

At the peak of our first surge in Michigan we had 22 hubs participating in this program with 715 beds. So that gives you a little bit of a sense of scope. And these hubs when they signed their conditions of participation that were tied to enhanced payment needed to commit to accept transfers from two places. One was a hospital discharge incoming to the congregate care facility to really address the hospital surge policy that kind of triggered our exploration into this area. And then the second was a facility to facility or SNF-to-SNF transfer because some of our nursing homes were not able to care properly by their own admission for COVID-positive patients, and we wanted those individuals to have an outlet to receive safe and high-quality care.

I will also say that the regional hubs strategy was not the only strategy that anchored our long-term care policy response. Within the state of Michigan, we also required and requested that nursing facilities establish dedicated units, which was a lower-level cohorting that was consistent with both CDC and CMS guidance.

The dedicated units are helpful because they were the entities responsible for any of the transfers or input that the regional hubs did not cover. And they also kind of spoke to the general state preparedness that Michigan was assembling in response to COVID-19.

When it comes to how the regional hubs were paid and reimbursed, obviously they were paid their normal per diem. We have a cost-based system here in

Michigan. But there were enhanced payment elements that were attached to this particular strategy; where participating facilities, those facilities received an upfront-per-bed payment of \$5000 that lasted the duration of the first month of their participation in the program. After that upfront payment, we switched and adjusted to a per diem add-on of \$200 per day. And the justification for this additional payment was to compensate for the additional staffing requirements that we had imposed as well as any building modifications that might have been needed based on our request and requirement actually that the regional hub be segregated from the rest of the population living in that particular nursing home.

We also addressed the shortage of PPE in the state by committing to the regional hubs that they had prioritized PPE distribution from the state stockpile if they could not get PPE on the open market. So we needed to make sure that participating hubs could provide care safely. We had PPEs that we had access to. We actually did distribute through our public health partners different packages of materials based on their specific need to make sure that we were kind of seeing this through.

When it comes to how hubs were selected -- and not every hub that applied actually was selected -- we definitely looked at the survey history of the facility. So we didn't want to see any immediate jeopardy citations, any history of problematic and persistent quality of care issues, any infection control issues. We had a kind of unique for Michigan approval process where the Medicaid agency took the lead in approving applications but worked very closely with our regulatory agency who actually conducts nursing facility surveys to make sure that we had a real-time sharing of information that was pertinent to our decision-making process.

And we also included the long-term care ombudsman as a consultant in the approval process because there may have been concerns around quality or access to care that even our regulatory agency might not have been aware of, and we wanted to make sure that the advocate's perspective was taken into account.

I will also say that for facilities that passed our criteria but that looked like they could benefit from kind of additional technical assistance, part of our long-term care response in Michigan included long-term care SWAT teams, so to speak. We call them in Michigan "iPRAT teams." That stands for Infection Prevention Resource and Assessment Teams. This is a combination of public health experts who partner with local health departments to provide infection control, technical assistance in a really nonthreatening way. So they have no survey or inspection obligations. What they do is they kind of approach the facility in the spirit of collaboration and education to make sure that infection control protocols are adhered to. And in certain instances, as facilities were going through the selection and verification process, we did refer an iPRAT team visit to the facilities to make sure that their compliance with infection control was as strong as it could be.

The other element of regional hubs that was flexible and served our needs at the time was related to geographic considerations. So in Michigan, our COVID outbreaks started really in the Detroit Metro area. But as the pandemic moved along, we found that there was kind of case spread to the west of our state. And because we were able to partner really closely with our nursing homes, we actually solicited regional hub volunteers in West Michigan to address some of the same system and capacity constraints that we had first experienced in Detroit Metro.

And that kind of gets to a stakeholder engagement question, an issue just in general. We have three nursing home associations in Michigan that roughly break down to represent our for-profit, non-profit and county based facilities. And those associations were our key partners as we developed this response. We asked for volunteers. We solicited those volunteers through our associations. And when we had needs such as the emerging need in West Michigan, we were able to approach our associations and ask for assistance in recruiting qualified regional hub candidates. So that really worked out well for us.

And then as I had mentioned, we had incorporated the feedback and perspective of the long-term care ombudsman; spoke very regularly to our Elder Justice Initiative advocate and then broke down state government silos by partnering really closely with our regulatory agency.

So when it comes to the results of this effort, there's been a lot of activity as things have, quote-unquote, "settled down," which is probably a bit of a false premise. We have kind of pursued two entities - the input of two entities as we kind of emerged from our surge. One was a governor-appointed task force to focus specifically on nursing facilities and preparation for a potential second surge. So that task force was comprised of legislators, frontline staff, thought leaders within the state of Michigan and they developed a set of recommendations for us.

We also had with the help of the Michigan Health Endowment Fund, an independent evaluation of this strategy, commissioned with the Center for Health and Research Transformation, which is a policy think tank that's affiliated with the University of Michigan, they collaborated with Michigan State University to evaluate our approach and essentially came out with a report that I think at this point is only about a week, week and a half old. It

affirms that our approach at regional hubs was an appropriate response for our state at that time.

They were able to look at the data and kind of try to find metrics that indicated the value of this strategy for Michigan. They obviously found that there's a correlation between community spread and the number of our institutional cases. But within that framework, they also found that there were fewer nursing home deaths relative to total deaths compared to the US average, so not necessarily causation but potential correlation. And then they also determined that the death rate in hubs was lower than the death rate in non-hubs, which was a promising sign I think that some of the infection control standards that we set for them were strictly adhered to.

So those were the issues that I wanted to cover. I'm really looking forward to the Q&A.

And with that, I will turn it over the Maureen from Ohio.

Maureen Corcoran: Great. Thank you, Kate. And thank you to our leadership from CMS and from our partners at the federal level in this discussion.

So as you heard, my name is Maureen Corcoran. I'm the Director of Medicaid for the Ohio Department of Medicaid. It was a little bit of a mix-up. I was introduced as from the Department of Health. But let me just clarify that - so in Ohio, the Department of Health is our regulatory body and then we have a separate department of Medicaid. And you'll see as in Kate's example, how closely we try to work together.

So a little bit of the platform that was our beginning goal in the earliest days with the pandemic. Our governor reached out to our hospitals and really

asked them to come together and to be the backbone of this entire pandemic response in a real way. I'm a nurse, so I've been in healthcare now for many years and I'll tell you that it was an unbelievable amount of collaboration among and between entities who as you know are naturally competitors. So the governor asked that the state be divided up into three sort of catchment areas. He asked University of Cincinnati Health, Ohio State University and Cleveland Clinic Foundation and their president or chief medical officer to be the lead person for those zones, to be the identified leader in each of those three areas and to bring all of the hospitals together in that catchment area.

Of course the beginning stages of the pandemic, as you all know, was really focused on the hospitals and getting as many people out as possible, preparing for the surge, et cetera, et cetera. And that really is where the partnership began to grow between and among the hospitals and a recognition that there was the state - there was no state component, there was no individual hospital, there's none of us who could do this alone given the demands and particularly the capacity challenges initially.

So as that hospital infrastructure was being built, I worked with a team of people really beginning in the very earliest days to work on the nursing facility and the congregate care issues specifically. And, you know, naturally, in the earliest days, there wasn't even bandwidth to think about anything outside of the hospital concerns but we started working immediately very intensively. I do run the Department of Medicaid in my spare time as I would tell people during those months. But I was tasked with this leadership responsibility and for more than four, maybe five months, it was literally 18 hours a day, seven days a week and working in the closest way with our hospital leadership and our nursing home leadership, as well as then my colleagues in the Department of Health and I who became a team.

And the building - so the notion was to build out - or I thought of it as building on or building out this hospital collaboration with specific attention to nursing homes, assisted-living and other congregate care. And like - our basic premise was, and is, that people who live in a nursing home or similarly in assisted living, that is their home. And so from the very beginning, maybe a little bit by dumb luck as well as by some thoughtfulness, we felt like that needed to be the policy objective and we're clear from the very beginning that that was our objective to support and to honor people's desires to remain in their home and to support them being able to return to their home as quickly as possible.

And so a support network began to develop, not at all unlike what Kate described. We developed across departments, across our different state department's team called the CCURT or the Congregate Care Unified Response Team, a group of people that worked together a single mailbox, a single set of phones and such for a variety of us who had been borrowed from three, four, five departments. And part of the objective of that, as you heard in Kate's comment was to try to give a little bit of - (distance) isn't maybe the right word, but we wanted to have that team be recognized as a truly collaborative cross-departments team and not have it be identified, "Oh that's Maureen from the Department of Medicaid" or, you know, "That's (James) from Survey and Cert," but rather that we're there as a collaborative group to assist consumers, individuals as well as nursing homes.

And we began then to develop a strike force kind of responsiveness that allowed us to respond to shortages of PPE, spread within a nursing facility, providing staffing up to and including utilizing our Ohio National Guard. We began to do comprehensive 100% testing of our nursing homes. And again there, we were very fortunate to have an incredible group of Ohio National Guard clinical and medics and support people who enabled us to do that in

addition to working then with those hospital partners who would come out and help with the infection control assessment, help with additional testing if that was necessary. So really, you know, really coming together in an uncommon way.

Then specifically to talk about the payment consideration here just give you a little bit of that and then again like Kate, look forward to the question and answer and the discussion, we did not choose initially to provide enhanced payment to the nursing homes. And again that may have been a little bit of dumb (luck) in the sense that we were trying to figure out, you know, what would be happening at the federal level, what was - how best to quantify the need. We knew that the need was great but how to get our arms around it. And so a little bit of time was passing.

Ultimately, we did use quite a bit of corona relief funds, specifically for nursing homes and assisted living. So we didn't use an across-the-board rate enhancement as some states did. But specifically then, our version of the hub -- again many similarities and some slight differences from what you heard from Kate -- we called ours "Health Care Isolation Centers" or HCICs. And our intention from the beginning really was to use them as a safety valve. So we want people to be able to stay in their home. We were clear that, you know, really with a few exceptions, there isn't very much about the care required for individuals with COVID that a nursing home should not be able to provide. So they should be able to handle most of that care, with the exception of course, of ventilator care as a general rule.

However, we did want to provide a little bit of a safety valve. So we created - and very much like Kate, we created a tiered approach that allowed existing, you know, skilled nursing facilities to apply to be designated as a health care isolation center. And they could be either - they could either become for

quarantined capability or for isolation capability or both. And within that we had three tiers or three levels beginning with a \$300-payment and graduating up to \$820-payment for Level 3, if that required skill here beyond the normal capacity of a traditional NF. But then in addition to that, if there was a ventilator care required, the payment - the top level of payment was \$984.

Very similar to what Kate said, we had some additional requirements. We wanted a separate entrance, certainly a distinct space. We did not want rooms kind of sprinkled around, specific additional staffing and dedicated staffing requirements. But we really wanted to keep it as, you know, minimal as possible but it did, for example, include additional respiratory care support across the board.

We did look at survey history. But our - we kept our requirements fairly, you know, fairly targeted at the things we knew were the most important and wanted really to provide a fairly open ability for facilities to step forward. Our results or what we have today is about 13 facilities across the state. There - we have a total of 92, what are designated as quarantine beds and a total of 246 isolation beds or a facility can be a combination.

Now we did of course make it clear to all facilities that we expected them to be able to both quarantine and isolate. So this was not an exclusive kind of capacity. In other words, we do expect that you can and will do this in your own facility without additional payment on top of your normal payment, although we did come back, remember, with some corona relief funds later. But in this case, we - similar to what Kate said, we wanted it to be open to taking admission from either hospitals or other facilities that couldn't handle it, so again kind of that my notion there of a safety valve.

Finally, we did initially think that we would have to do that through a directed payment. We are more than 90% managed care state and were just obviously really pleased in working through it with CMS that we didn't have to go that route but we're able to handle it through our kind of normal reimbursement mechanisms.

Finally, in terms of the stakeholders and the partnership, we were working and continuing to work really aggressively across our departments. But we have three nursing facility association and one assisted-living association. And really between the folks that I was working with in our Department of Health as well as the rest of our nursing facility CCURT team, we were meeting with them one, often two, very often three times a week. And it was really a constant relationship to develop these things.

And so I'll stop there just that gives you a little bit of a sense of the framework or the foundation that we created.

So I'll turn it now over to Jackie.

Jackie Glaze: Thank you so much, Maureen, and thank you, Kate, for your presentation. Amber McCarroll will now lead a facilitated discussion with both Kate and Maureen.

Amber, I'll turn it over to you.

Amber McCarroll: Thank you, Jackie. And let me echo Jackie's thanks to both Maureen and Kate for your presentations. I found them very extremely interesting.

Before we open the lines for the states to ask questions, we do have a few of our own. Let me start with what have been the biggest challenges that your state has faced with implementing the reimbursement strategy you described?

Kate Massey: Maureen, do you want to start?

Maureen Corcoran: Yes, glad to. I think the biggest challenge that we encountered was - surprisingly, with the kind of rates that I mentioned and particularly at the higher end, they're reasonably generous. We expected many more facilities to step forward. And we're certainly pleased with the number that we got. But what we - this won't surprise any of us in retrospect. But what we really found is that for a very, very long time, there was not good understanding within the nursing facility leadership and staff, and so there was really a great deal of resistance to wanting to keep people or allow people to come home who had contracted, you know, the virus.

And so there were a number facilities that really did not want to be associated with being a COVID facility and feeling that their reputation might be permanently endangered by taking on that responsibility. Now, fortunately, you know, conversely, there were also some who stepped forward and in a very affirmative show of community support, you know, made it public that they were doing this and why, et cetera, but little slow on the uptake. And so that did create some difficulty for us with hospital discharges and some of the, you know, the flow of support and care that Kate mentioned.

Kate Massey: Sure. And I'll just add a couple of other challenges that we had to tackle in Michigan. You know, one is the impact to the beneficiary. And it's those beneficiaries who are in a bed, in a COVID - or in a regional hub as well as those in a facility that has agreed to be a hub. You know, beneficiaries can get confused. This was kind of put together pretty hastily. Caregivers and family

members are also kind of confused about what was happening at the kind of peak time that this was all coming together.

What the Medicaid agency did to try to alleviate some of the communication confusion was pull together kind of standard letters and notifications that the hubs were asked to distribute to all impacted individuals and obviously, you know, those letters were kind of reviewed for kind of comprehension. But we did get feedback afterwards from stakeholders that communication is something that we can work to get better at.

And I think the other thing is that as the kind of cases started to settle, it became harder for us to maintain the capacity because those regional hubs were then kind of hanging onto an empty bed that was not receiving reimbursement. The enhanced reimbursement was only provided when the bed was occupied. So over recent weeks and months we've had a fair number of hubs ask to be decommissioned. And that's something that we've honored because we don't want participation in the hubs strategy to basically be a death knell to the financial sustainability of those organizations.

Amber McCarroll: Thank you. And you've actually I think just touched on this a little bit, Kate, but is there anything else that you'd want to add about how Michigan had thought through the issue of COVID-only facilities?

Kate Massey: Sure. So for COVID-only facilities - did you want me to talk about COVID-only facilities? I can switch to that.

Amber Massey: Yes.

Kate Massey: Sure. So, you know, I think that when Michigan was kind of going through some of our policy formulation processes, we obviously gravitated to hub

stakeholders in Michigan in particular and particularly in the legislature, we're advancing COVID-only facilities as an alternative. There was also a fair amount of interest in really leveraging our alternate care sites. We had two alternate care sites in Michigan again at our peak surge.

And we took a very serious look at COVID-only and what the feasibility would be for our state. I think that there were kind of several themes of kind of question or concern that arose for us. You know, one was the strategic viability of a COVID-only facility. So, you know, COVID-only facilities take a fair amount of investment. Would they be kind of dispersed throughout the state of Michigan? What would their geographic placement be? Would we be really good and kind of spot on in terms of our COVID case forecasting to position a facility where there would be another surge or outbreak? That still remains an open question for us.

There were also concerns about what impact COVID-only facilities would have on nursing home staffing just in general because if we were basically robbing (Peter) to pay (Paul), so basically taking or kind of borrowing or leaning on the staff of an existing nursing facility who probably had their own challenges and trying to kind of take this personnel away for a COVID-only facility, kind of what would the impact be in terms of quality of care in our existing network of providers?

There's the operational concerns from the state's perspective. You know, we run a few hospitals of the state but we have never run nursing facilities. So if we were to take this on ourselves, we would be a bit adrift in how to run a nursing home effectively. I mean there are so many questions starting from, you know, what empty space do we have that could be converted to, how do we actually kind of generate supplies, set up ancillary services and so on and so forth. And that expertise does not currently reside in our Medicaid agency.

We could partner with a facility but we didn't have any nursing homes that were about to launch or go live at the time that COVID hit. So there was kind of no way that we could capitalize on something that was already kind of in the process of kind of getting started.

And then, you know, the third issue is again the beneficiary perspective which is if we were going to take an existing four walls facility and convert it entirely into a COVID-only facility, we would need to relocate people. And nursing homes service their home. We as a Medicaid agency have read up on transfer trauma and are super concerned about what the long-term effects are on residents. And they might be placed in a facility that is really far away from their originating facility, which means it puts a strain and a stressor under caregiver network.

So we have not pursued COVID-only facilities aside from a very serious look at what the policy and operational implications are. Though we have had state legislation and other stakeholders kind of encouraging us to look at that, which we have in a very serious way.

Amber McCarroll: And, Maureen, did you want to add anything about some of the thought processes that Ohio used when I think deciding against COVID-only facilities as well?

Maureen Corcoran: I think just very, very much the same as what Kate said. I think initially, you know, looking at the prospect of setting up a large environment. It just didn't seem sort of doable in a quick kind of time frame. And, you know, more than that even is, you know, as you then begin to surge, did you predict the right number or have you overdone your capacity? So it just didn't seem - it didn't seem as much worth the energy at that point in our - the development of the pandemic in Ohio.

Amber McCarroll: Sorry. I was getting an off mute.

And then finally, before we turn it over and open up the phone lines, are there any changes or adjustments that you might be considering now based on what you've learned in your experience so far?

Kate Massey: Well, in Michigan we are not short on recommendations for how to do better. And we already had a philosophy of continuous improvement. So it fits right in. But we've had recommendations coming from the task force as well as I think over 50 recommendations from the chart evaluation.

So ones that I think are most top of mind are to incorporate more stringent selection criteria for regional hubs should a second surge hit our state. So some of the recommendations that folks have made is to increase the documentation standards like around infection control training. There was also a recommendation to consider performance during the pandemic from a quantitative perspective, so looking at the death rate to case rate and kind of setting a benchmark above which selected facilities would perform.

And then I think that the kind of new element that we really need to factor into our planning, and this is something that Maureen touched on, is really involving hospitals more. So we want to make sure that there's a continuum of care between the hospital and the nursing facility that is seamless and coordinated. We can make that a requirement of our regional hubs.

One of the recommendations that came out of our task force was an exploration of an enhanced payment to our hospitals above and beyond the existing DRG for a 72-hour hold period if in the 72-hour hold the isolation

period could be completed for the individual kind of under consideration.
And that is something that we are absolutely interested in pursuing.

And then finally, you know, I think we need to look at what the sustainable payment mechanism is. There's not any debate within Michigan that these facilities deserve above what the existing per diem is but I think that the one thing that we didn't contemplate -- and I alluded to this earlier -- is how to (consider) maintaining that capacity when the need is not there because we are not in a surge.

We are going to pre-certify I think the next iteration of hubs, but I think that only gets us so far. So there is definitely a lot that we want to continue to kind of push forward on but that gives you I think a little bit of a flavor.

Maureen Corcoran: Yes. And just a couple of really sort of minor add-ons to that, we're continuing to have interest and have had, you know, a couple be added in, so kind of gradual increases. We did allow facilities to go overcapacity for the period of the pandemic thinking, you know, that would give them a little bit of an added incentive but clear, of course, that when the pandemic ended we would work with them to transition back down to their preexisting capacity.

On the infection control front, not unique to these particular facilities but I suspect all of us have really had to grapple with, you know - I mean again, I'm a nurse, so I used to work in intensive care. I just don't think that it's as common in nursing homes to deal with the level of infection control and counting, you know, donning, doffing, you know, all of the kind of infection control that you do find more commonly in the hospital.

And so that, you know, just generally, infection control and appropriate use of PPE has been one of the major things that we've tried to focus on. We did

some incentive money to each of the nursing facilities who satisfied some additional infection control expectations. So just - you know, it's really in some ways, it's sort of the basic block and tackle and just continuing to encourage people so they don't get fatigued by all of this. And of course, we know what the toll is, you know, not only on families and the individuals but the staff of the facility.

So just trying to continue to maintain a supportive, you know, relationship and continuing to bring resources to bear and finally, you know, I don't think that, you know, it can be at all overstated just how appreciative they have been, the nursing facilities and assisted-living have been, as have we, the state at the kind of resources and support that CMS and our other federal partners have been able to bring to bear because there, you know, there just is such a huge capacity and need out there.

Jackie Glaze: Thank you, Maureen. And I wanted to also thank Kate and also Amber.

I'm going to change the agenda just a little bit just in the interest of time. And I'd like to move to Mehreen Rashid at this point so she can provide an overview of the value-based care state Medicaid director letter that was issued today. And then we'll follow up with questions for the entire session or any general questions.

So, Mehreen, can I turn it over to you at this point?

Mehreen Rashid: Yes. Thank you, Jackie. And good afternoon everyone.

I'm excited to share a brief overview of the guidance released earlier today, encouraging states to take action to advance value-based care across their healthcare systems in Medicaid.

CMS has already made a strong commitment to advancing value-based care in Medicare. And this guidance is really designed to ensure that the same commitment can be brought to the state level through Medicaid.

Our ultimate goal for value-based care is to reward providers for improving the quality of care and patient outcomes in a cost-effective manner rather than for the volume of care that they provide. We expect that this shift will better prepare our healthcare systems to handle unexpected challenges such as the ongoing COVID-19 pandemic. This state Medicaid director's letter lays out a roadmap to accelerate state and Medicaid provider adoption of value-based care model. In taking this new direction, we draw upon lessons learned from both CMCS experiences in payment reform and also those in a CMS Innovation Center.

All these models have enabled CMS to better understand the opportunities and the challenges that states should consider as they craft their own reform toward a more value-driven system. Notably, we highlight that states should consider things like multi-care alignment of quality metrics to drive care transformation and ease provider burden.

In issuing this guidance, CMS did not want states to have to rely only on time-consuming, complex demonstrations or waivers to achieve value. Instead, this guidance includes a comprehensive toolkit of available federal authorities for states to adopt innovative payment reform. These authorities span from more traditional fee-for-service Medicaid, the Medicaid Managed Care to the most sophisticated, full-risk population-based payment.

Examples of payment models included in the letter include advance payment methodologies under fee-for-service, bundled payments and total cost of care

model. Each particular payment model links payment changes to quality improvement and introduces better financial accountability in a unique way.

As outlined in the guidance, CMS is now offering increased flexibility under the state plan and is willing to approve advance payments within a fee-for-service state plan framework. These advance payments, what we describe as payments prior to encounters, are subject to a number of guardrails we speak to in the letter. Most importantly, the state must ensure that the advance payments are ultimately reconciled to actual provider cost.

CMS encourages states to adopt payment reforms that have been shown to demonstrate value, particularly those models developed by the Innovation Center. Yes, we also recognize that states are in different places based on their unique healthcare landscape. For this and other reasons, we do not expect a one-size-fits-all approach toward value-based care adoption. We are committed to working with states to meet them where they are to advance value-based care and look forward to working through proposals with you to this end.

Lastly, CMCS plans to hold an in-depth Webinar for states jointly with CMMI to discuss this guidance in the coming weeks. We hope you will consider participating on this upcoming Webinar.

Thank you for this time - thank you for your time this afternoon. And with that, I'll turn the call back to Jackie.

Jackie Glaze: Thank you, Mehreen.

And we now would like to take a few questions from the audience over the presentations that you've heard today or any of the general questions that you may have for us.

So, Operator, will you open up the phone lines please?

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. If you need to withdraw your question, press star 2. It does take a few moments for the questions to come through. Thank you.

I do have a question from (Pat Curtis). Your line is open.

(Pat Curtis): Yes. This is a general question regarding the additional \$300 unemployment under Stafford Act from the President's memorandum. We know and have received that it is exempt for SNAP. I'm asking if that is also exempt from medical. To my knowledge, there has not been guidance issued on the exemptions for medical eligibility.

((Crosstalk))

Sarah DeLone: Hi, this is Sarah DeLone. I can take that, Jackie.

Yes, we have not yet issued guidance. So we have guidance forthcoming. So we are - it's working its way with some other guidance through our clearance process. Our expectations, but we do need to - before an official announcement sort of is made. But our expectation is that similar to SNAP, it is excluded from income for purposes of determining Medicaid eligibility.

(Pat Curtis): Thank you. We'll watch for the guidance then. Thank you.

((Crosstalk))

Sarah DeLone: Yes. And the \$100 depends on whether that's being - an extra state, you know, fund is kicked in or whether you're drawing that \$100-contribution from the unemployment checks that somebody otherwise would get. In the latter case, if it's just part of their - through their regular unemployment compensation, \$100 would be counted just like any other unemployment compensation benefit. (Unintelligible) extra contribution that the states made, we believe. But again, the guidance will confirm when we publish it that that would be excluded along with the \$300-federal payment.

(Pat Curtis): Thank you.

Sarah DeLone: You're welcome.

Jackie Glaze: Thanks.

((Crosstalk))

Jackie Glaze: Operator, we have time for one more question.

Coordinator: I have no other questions at this time.

Jackie Glaze: Well, great. Okay, thank you.

Okay. Karen, I'll turn it over to you then.

Karen Shields: All right. Thank you so much, Jackie. And I want to genuinely thank our speakers and our facilitators today, Kate and Maureen. Maureen, my apologies for getting your agency wrong. Thank you so much for coming and we appreciate having you guys here.

But before we close, I wanted to announce a CMCS staffing change. You all know we talked about a few state calls ago Calder being promoted into the deputy administrator and the chief of staff for the agency and Anne Marie ascending to be acting a center director role, which left a spot in our deputy director slot. And as you - those of you who are familiar with the org. chart for CMCS, we have two deputy directors in that center for the agency. And so Alissa DeBoy has graciously agreed to temporarily fill the second deputy center director position as the acting deputy center director. Most of you know Alissa. She runs the Disabled and Elderly Health Programs Group. Alissa is a very able deputy. Melissa Harris will run the DEHP temporarily.

So we're excited about those leadership transitions and we know that this team will provide continuity and continue to work together to serve you in your - and your teams in the next coming months.

We're looking forward to our next meeting. We really love these calls and appreciate your time and your attention and the ability to be able to work with you and to talk with you. And so you'll see an invitation come out for the topic and for the next call shortly. Of course if you have questions between now and then, please reach out to us and to your state leads. We're here to assist you.

We appreciate your time again and attention, and thank you for joining us today. Have a really great afternoon.

Coordinator: Thank you. That does conclude today's conference call. And 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