

Centers for Medicare & Medicaid Services
Medicaid and CHIP All State Call
March 17, 2020
2:00 pm ET

Coordinator: Thank you all for standing by. For the duration of today's conference all participant's lines will be in a listen-only mode until the question and answer session.

At that time if you would like to ask a question press Star 1. Today's call is being recorded. If you have any objections you may disconnect at this time. It is my pleasure to introduce Miss Jackie Glaze. Thank you, ma'am. You may begin.

Jackie Glaze: Hi, good afternoon everyone. This is Jackie Glaze and I'm the Acting Director of the Medicaid and CHIP Operations Group. And we're very pleased to have you with us today. We are conducting an all-state call and it will be to talk about the 1115 waiver process, the HCBS waiver, the Appendix K, Telework and Telehealth.

And we will also be having a call next Thursday as well. So we – Friday excuse me. And we will continue to have these on an ongoing basis as we are working through the COVID-19. So we appreciate your participation today. And then we do have a full agenda. So we will take your questions at the end. I would first like to introduce Calder Lynch. He is our Director of the Centers for Medicaid and CHIP services. And he will start us out so Calder.

Calder Lynch: Thank you Jackie and thank you all for joining us today. I know we've got quite a few folks and probably a lot of folks spread out all over the country. As I know that many of us have now begun working remotely as part of, you know, our response to this pandemic event so appreciate.

I know that all of you and all of us feel the urgency and the responsibility as we work to respond and make sure that the 71 million Medicaid beneficiaries across the country their needs are being met, you know, and that we're providing the appropriate flexibilities amidst COVID-19.

I want to echo what Jackie said. Today's call we're going to be talking specifically about some of the disaster waiver process available under Section 1135 that became available because of the president's declaration under the Stafford Act on Friday. We've already had a number of states submit and we've even approved the first state's request on 1135.

So we'll be talking through that. We'll also be talking through specifically some of the flexibilities available under the home and community-based services programs including the Appendix K process as well as some of the Telehealth provisions that are related specifically to HCBS and in the context of HCBS.

We'll also be talking through the first set of the Medicaid FAQs or frequently asked questions that were released last week and answering questions regarding those.

I will say we do have a second batch of FAQs that will be coming very shortly that we'll hopefully be discussing on the next call and being able to answer questions that will also get into some of the topics we've heard from states with regard to managed, you know, the implications of managed care delivery systems as well as some other issues that have arisen.

I think, you know, all of us recognize that this is a rapidly evolving situation. We are working to posture ourselves as best we can to respond rapidly to

states' needs. While there are a variety of pathways for states to receive flexibilities from CMS, we also recognize that sometimes there's not even time, you know, for those processes to play out in order for states to be able to effectively respond to the situations evolving on the ground.

So that's why you'll see also in the coming days CMS issuing additional tools and resources including a checklist for 1135 waivers to make that process easier and to, you know, have all of the waivers available under 1135 outlined where states can simply choose the ones that they want applicable to their state to help us expedite those.

Certainly we're not going to slowdown processing the ones we've already received. But we're working to streamline that process. We're working to create additional tools to support the Appendix K approval so states can see the full suite of flexibilities there. We're also looking to create some templates around some of the state plan amendments. States may be needing to submit with regard to the disaster.

But let me stress too that as we work through all these issues and, you know, we're providing guidance around the suite of flexibilities that are available, you know, states should not feel that – I don't want anyone to feel, like, paperwork is inhibiting their ability to implement the changes they need to make in their program now to be responsible to the pandemic.

We will work as expeditiously as we can to process those and get tools out to make that easier and faster. But we'll also be working with you to make sure we, you know, get the right documentation in place as we move forward. You know because of the public health emergency declaration that the secretary made, you know, many of these authorities can be approved retroactively back to the beginning of the public health emergency. We'll work together through

that. That's our commitment to make sure we have all that in place but do not want folks to feel inhibited by process.

We know that this is again a rapidly evolving situation. States need the flexibility to respond. Certainly we're available to jump on the phone, reach out to your state lead, reach out to us. We can get and help provide verbal guidance sometimes faster in case you need to move forward implementing program changes even while we work through the paperwork on the backend.

So just know that that's our commitment, that's our posture moving forward. And we're going to continue to work to remove, you know, any administrative barriers that are getting in your way of an effective response.

I also want to highlight some policy guidance that will be coming. But some decisions that we've been able to reach as we work with our partners in the Office of the General Counsel to continue to provide flexibility for states along those lines. First as I said Section 1135 authority can be provided to states and, you know, those can be approved back to the beginning of the public health emergency.

We've also determined that that authority would allow us to approve state plan amendments retroactive back even further than the beginning of the quarter in which they were submitted within the context of the public health emergency.

So I know we're rapidly approaching the end of the quarter here at the end of March which would normally be the deadline to submit a state plan amendment that would be effective in this quarter. But we can use 1135 authority to give us flexibility there in case those needs stretch beyond the end of the month.

Also we can use 1135 authority to provide flexibility on the need and timing for public notice associated with changes that states may be making in cost sharing requirements. The alternative benefit planner, ABP benefits and any payment state plan amendments. Normally there are specific requirements with regard to public notice around those. But we can use the 1135 authority to provide greater flexibility there.

So, you know, again they should not feel hampered to begin moving forward with some of those changes that they deem necessary and we'll have more guidance on those requirements for each of those spa types very soon. But I wanted to share that with you today so you have that peace of mind there.

And a similar vein, you know, a number of states of course have the concerns with regard to tribal consultation. And while it's always important to continue working closely with tribes, you know, even during the disaster situations we do have the ability to use Section 1135 authority to provide flexibility on the timing of tribal consultation to shorten those periods that would have normally been required prior to the submission of a state plan amendment or even to conduct tribal consultation after the submission of a state plan amendment.

And we'll be sharing more guidance on the requirements for each of those soon and how the 1135 authorities can be applied there.

We're also going to continue to be sharing with you all relevant guidance that's being issued by other parts of the federal government or other parts of the agency including today I believe if we haven't we'll shortly be sending some guidance that was issued today relative to Medicare coverage for Telehealth and the implementation of new flexibilities that were made available by congress recently.

In addition I think relevant some questions that we received from states, information on the Office of Civil Rights within HHS which has the responsibility for governing the HIPAA rules or the privacy rules and some flexibility they're providing there to allow for Telehealth services to be provided across a broader array of, you know, devices and means without application of some of those HIPAA restrictions.

So that'll be included in that email that we'll be sending out to folks since we know that there's been some interest in that from states as well. So I'll stop there and I'm going to turn it back over to Jackie and she is going to provide a little bit more detail with regard to the 1135 waivers and the process we'll be working through to process those. Jackie.

Jackie Glaze: Thank you Calder. So Calder did share a lot of information about the 1135 waiver process. And I know many of the states and territories do have experience with the past hurricanes, earthquakes and wildfires.

And you're familiar with it but I know there are a number of states and territories that haven't had that experience. So we want to make sure that we give you that information today so that you can begin understanding more about how the process works so that you can submit the waivers to us.

So as Calder indicated the president did declare an emergency to the Stafford Act last Friday. And then on January the 31 the HHS Secretary declared a public health emergency. And by having both of those declarations in place that allows the secretary to waive certain Medicare, Medicaid and CHIP requirements under the 1135 of the Social Security Act.

And just to be really clear the 1135 waives modification that speak to provisions of care. It does not apply to conditions of payment. So when there's payment issues that would come up those would have to be dealt through a different authority.

So the waiver -- the 1135 waivers -- are retroactive to the date of the emergency period. And in this case, it's March the 1st. So your application would be effective with that day. The waiver usually ends when the disaster period situation is over or 60 days from the issuance of the waiver. So there are times when the secretary does determine that there is a need to grant additional extensions which he has done. And in this case, there may be a need for that as well. And so those are done in 60-day increments.

The waivers the secretary can grant through specific geographic areas. He can determine whether it's going to be a state or a territory. But in this case it's the entire United States. So it's on a much larger scope. So with Calder saying that we want to make sure that you have the flexibilities that you need and you need to move forward if you have to. But we will be very responsive to your request as they are coming in. And also we are receiving a number already.

I also wanted to turn to the Disaster Response Toolkit. And I know that many of you have used this and talked a bit about it. But it is a very useful resource that I want you to take a look at. It does include a very comprehensive inventory that outlines all the strategies that are available to you. It does include existing authorities that you do not require approval from us.

And then also other strategies such as the Appendix K to the HCBS waiver that (Ralph) will be talking about shortly. It talks about also the disaster spas that you can put in place prior to the emergency or disaster. And so that you

can have those ready to go when it's time. And then you would just need to notify us when you're ready effectuate that.

We do have availability through the 1115 waiver authority. And so of course that's always used whenever the other authorities are not available to you. So many of these flexibilities are applicable through the disaster toolkit. And as I'm calling it the disaster toolkit, we are actually doing some work to it to modify it so it does include public health emergencies.

So many of these flexibilities as they can work with you now, I think that we want to make sure that we are looking at how this impacts us and so that we can ensure that we can provide a larger scope to deal with the public health emergencies.

So currently as Calder indicated we don't have a specific form or format for you to submit these requests. But we are actually developing a template now where you can go through and review the flexibilities that you may need and check those off so that we can be very expeditious in our response to you. So that is actually going through the process now.

But for the time being you would just need to submit either a letter or an email and you can actually send that to your state lead that works with you through the regional offices or you could direct it directly to me at jackie.glaze@cms.hhs.gov. So either avenue would work fine. And then we will just make sure that we are tracking those and getting the response back to you very quickly.

So I want to turn to some of the flexibilities that we have commonly approved in the past. And I want to just touch on those so that you have an idea of the types of flexibilities that are available through the 1135 waiver authority.

So states can temporarily suspend the Medicaid fee for service prior authorization requirements. There's a section 1135B1C that allows for a waiver or modification of the pre-approval requirement. The prior authorization processes are outlined in your state plan. So for that particular benefit. So you do have the flexibility so that you can relax those prior authorizations so that you can make sure that you're getting the service out to your beneficiaries as quickly as possible.

It also does require that for the fee for service providers that they extend the prior authorizations that were in place at the time of the emergency so when it began so that they will be in place through the termination of the emergency declaration. So that individuals will not have any interruption in the services and that they will be receiving their services consistently.

We only have a few flexibilities outlined through the long-term services and support. (Ralph) will talk with you shortly about many of the flexibilities that you can find and do within the Appendix K of your HCBS waiver. So many of those you can work with him and his team on so that you can be granted that type of flexibility.

There is one that I did want to call your attention to and that is where you can temporarily suspend the preadmission screening and the annual resident review which is the (PASAR) - the Level 1 and Level 2 assessments for 30 days. So you do – you are having the ability to do that temporary suspension on these types of assessments.

As far as fair hearings we do have a couple areas that I'd like to talk about here. And that does allow states for their enrollees to proceed directly to a state fair hearing without having a managed care plan resolved. So that allows

these individuals to just move directly to that process without having to work through the actual managed care plan so that they can move as quickly as possible with their fair hearing.

It also allows enrollees to have more time for their appeals. For the managed care they have more than the 120 days. And then for the fee for service appeal it could be more than the 90 days. So those are a couple areas within the fair hearings.

I want to talk a bit about the provider enrollment because that is a very, very common area where states need a lot of flexibilities during the time of disasters and public health emergencies. And it gives states a lot – territories a lot of flexibilities here so that you can streamline your provider enrollment requirements when enrolling your providers.

So you can essentially temporarily waive the payment of the application fee, the criminal background check and the site visits. And this is all on a temporary basis when you're enrolling the providers.

You can also allow your providers that are located out of state or out of territory to provide care to the individuals that are experiencing an emergency. So that would be that be nationwide at this point. States can also temporarily cease the revalidation of the providers who are located in their state that are also impacted by the emergency. So there are a lot of flexibilities in place to really help the providers make sure they're getting services out to the beneficiaries and therefore being paid timely.

A very important one is where states can temporarily waive the requirement for physicians that are either licensed out of state or through Medicare so that they can relax all the administrative requirements so that they can become

providers within their state as long as they have that equivalent licensing in another state or Medicare.

States may also look at providing payments to facilities in alternate settings. So we have learned that there are situations now where there are times when individuals will be displaced and will need to receive services through another type of facility. So that is another type of flexibility that we can create and provide as well.

So those are some of the main flexibilities of which there are quite a few and I would also ask that you go back and take a look at the disaster response toolkit because it does outline all of these types of flexibilities and we can also have a call with you if you need more further information on that.

So at this time I'm going to turn the call over to (Ralph Lollar) and he's going to talk a bit about the home and community-based services in relation to the Appendix K. Are you ready Ralph?

(Ralph Lollar): I am. Can folks hear me okay?

Calder Lynch: Yes (Ralph) go ahead.

(Ralph Lollar): Great. The Appendix K was put in place quite a while ago. And it was intended to address disaster relief. It is as Jackie indicated an amendment that we can approve retrospectively. The most – generally what we believe states will be selecting as the most common date will be January 27, 2020, which is when the secretary indicated that there was a crisis in effect. And the Appendix K can exist for up to one year.

At that time -- it would if the situation continues -- it would have to be renewed. But it is at least a year. And it does not require public notice because it is a temporary action that is time limited and addresses the issues raised by the concerned at that time as opposed to making last minute changes to the waiver.

There are some very -- we believe that states when questions are asked, like, the geographic areas affected, we recommend that you include all areas of the waiver for all individuals impacted by the COVID-19 virus. Today might be a specific area, tomorrow it might expand considerably. So leave yourself some leeway if you're completing Appendix K.

And I'm going to go over some of the most common request we've received and the most common issues we've heard of and how they can be ameliorated through Appendix K which supplies to the 1915c and can be used with regard to the 1115 where home and community-based services are incorporated.

The first issue is the settings regulation. And specifically the requirement that this is the unrestricted. Clearly the CDC is recommending, specific guidelines regarding visitation. You can waive the HCBS settings requirements. Generally we would say to use that is unnecessary. Certainly unnecessary for any setting that was added before or in effect as of March 17, 2014, because that regulation does not become as far as the effective impact is until March 17 of 2022. But you could modify for anything that's just been added since then for settings types.

With regard to services you can expand self-direction on opportunities to additional services. You certainly can add electronic methods of service delivery, telephonic, FaceTime, that type of rendering of service. You can do that for specifically case management for personnel care services that only

require verbal queueing or they have services that could be rendered through an electronic method.

And other services as you described them would be considered under that option of - we'll call it Telehealth. It's telephonic delivery of service or through some other electronic method of service delivery.

You can add and we've had the question asked a number of times. You can add home delivered meals to the waiver options of services. And the only restriction is there cannot be a full nutritional regimen of three meals per day but you could add home delivered meals. There's an option if it is not already there. You can extend the respite coverage for COVID-19 related circumstances or condition that exceed 30 days. And you could add living caregivers to provide services to individuals who are under quarantine.

With regard to provider qualifications the biggest concerns right now seem to be how to render services in a home situation particularly if the home is under quarantine by adding family members to the list of providers to render services such as personal care. You could allow a family member living in the setting that is quarantined to render services to the individual and to be paid for rendering most services.

You could add additional practitioners where you find that your provider pool is being tapped. You could modify service providers for home delivered meals that was the second question on home delivered meals. It wasn't just can we do home delivered meals but some of our traditional providers aren't able to do that at this point. We certainly could modify the service providers to extend there.

You can as far as processes go allow an extension for reassessment to reevaluations for up to a year past the due date. You can modify your assessment process for level of care. So for those cases who don't necessarily want to extend their reassessment but actually want to amend the assessment itself to abbreviate it that certainly is an option that is available to you.

You can conduct those evaluations, assessments and in-person centered service plans virtually or remotely in lieu of face to face meetings. And with regard to that the other option for states is you don't necessarily even have to use the Appendix K to do this. You can establish a process or policy on electronic signatures for forms and begin getting your forms signed electronically so people don't have to meet face to face. And the document isn't passing from person to person for signatures.

With regard to payment some of the biggest questions we've received are questions regarding retainer payments and Olmstead SMD #3 allows for retainer payments for habilitation services. So that would include both residential and day services. It will provide funding and preserve the service and the provider when closure is necessarily to prevent the spread of COVID-19.

In addition a big one that we've been asked about is increasing a service rate. You can increase a service rate to solicit a larger pool of providers. You can do so to compensate for additional risk. You can do so to compensate for additional qualifications and trainings and/or to pay for more intensive services.

So those are the biggest hitting requests we've seen and questions we've had regarding what the Appendix K will allow to be delivered. Essentially it's a

modification of services, of service providers, of assessment to allow the services to continue or to be maintained during the time of this crisis.

And again I am emphasize that the approval is retrospective and CMS' commitment is to tell you immediately upon review what cannot be approved through the Appendix K alone and may require an 1135 or an 1115 authority.

Okay Jackie I think those are the highlights here. Why don't I pass it back to you?

Jackie Glaze: Right thank you so much (Ralph). So now we're going to turn to Kenya Cantwell and she's going to share with you information about Telehealth and Telemedicine so Kenya are you ready?

Kenya Cantwell: I am thank you.

Jackie Glaze: Okay thank you.

Kenya Cantwell: Sure. So under the state plan there are certain benefits that have federal requirements for initial and annual assessments. We also have some benefits that do not have assessment requirements but due to the nature of the service initial and annual assessments are part of providing quality services and are used to ensure the medically necessary services are provided.

State plan services do not have something similar to the Appendix K. But I want to review some flexibilities that are available within the state plan authority. And the state plan benefits I'm going to focus on today are the 1915K – community first choice, the 1915J – self-directed personal attendant services, home health services and personal care services.

So the 1915K community first choice has two requirements. One is regarding the level of care determination that must be done initially and annually. And also an annual assessment of need. And that is used to gather information that feeds the person's service plan.

So for the level of care the federal regulations do not specify how states do this. Because the statute requires individuals meet an institutional level of care, we expect that states use the same criteria used to determine a level of care for institutional services. But we deferred to the state's process of determining level of care and do not specify explicit requirements for how this should be done.

It is possible for states to use other modes in addition to face to face but can use other modes to gather the information needed to determine if an individual continues to meet the level of care or meets it initially. And Telehealth or Telemedicine is something that can be used to gather this information.

Another flexibility that exists within the level of care regulations is that states may permanently waive the annual level of care requirement for an individual if there is no reasonable expectation of improvement or a significant change in the individual's condition because of the severity of a chronic condition or the degree of impairment of functional capacity.

So I also wanted to point that out as something that states could use as they're looking at ways to meet these federal regulations and if they're going to be able to get out there and perform the level of care requirements.

The other regulatory requirement is for an assessment of need. And that does call for a face to face assessment. But again for all face to face assessments it is possible for Telehealth or Telemedicine to be used and specifically for CFC

it is built into the regulation that allows for states to use more than one process or technique to obtain information including Telemedicine or other information technology in lieu of an in-person assessment.

There are some requirements around how this is done. Basically the person that's doing the assessment is the same person that has the same qualifications as the person that would do it in person. And that if necessary, an individual has help using the technology.

But that will depend on what the technology is. And that the individuals providing the opportunity for an in-person assessment. And that can happen when it is possible considering what everyone is dealing with now so I wanted to point that out.

For the 1915J that is another authority that does have an assessment of need. The assessment must be done to gather the participants' needs and strengths and preferences. And again this is where the regulation does have language that explains that there is flexibility with how this can occur. States can use more than one process and technique to obtain this information.

Home Health Services is another state plan benefit that requires face to face encounter. This may occur using Telehealth. And the face-to-face encounter must be related to the primary reason the beneficiary requires home health services. It must occur within 90 days before or 30 days after the start of the service. This is where we have also received a lot of questions about whether Telemedicine or Telehealth could be used to accomplish this requirement and the answer is yes.

And then personal care. So personal care benefit actually does not have a regulatory requirement for an assessment. But this is one of the benefits that

due to the nature of the service it is usually implemented with initial and annual assessments as part of determining the necessary services that someone should receive.

So these are just a few of the benefits that we've been getting the most questions about and the applicability and availability of Telemedicine being used to perform these assessments. And we use the term Telemedicine, Telehealth kind of interchangeably. But it all is – we view it as another way of delivering a service.

And so you might as you're going through your benefits and figuring out your plans for continuing to provide services to beneficiaries, Telemedicine and Telehealth is something that can be used for services that I have not even discussed today. It really depends on the nature of the service.

But Telemedicine and Telehealth are service delivery systems as I said and can be used to accomplish face to face assessments. Telemedicine is the use of medical information exchanged from one site to another via electronic communication.

And then Telehealth is usually the use of telecommunications and information technology to provide access to health assessments, diagnosis intervention, consultations, supervision and information across a distance. So telephones – we are getting questions about telephones. That is possible to use telephones to gather information.

Something that's really important to point out is for Telehealth, Telemedicine, there is not a requirement that a state submits a SPA. This is not something that you do have to have spelled out in your state plan. The only time that a

SPA might be necessary is if there will be a reimbursement that is different than what is already outlined in your state plan.

But because we view it as a service delivery option you are just providing the services that are described in the state plan. And it is not necessary for you to (unintelligible) this spot to say that you're using Telehealth or Telemedicine to accomplish your assessment.

So I'm going to end it there. I know that we want to leave time for questions. But before then I'm going to turn it back to Jackie because I think we have Ann Marie Costello who's going to talk about frequently asked questions.

Jackie Glaze: Yes so thank you Kenya. So Anne Marie we'll turn it to you now. Thank you.

Anne Marie Costello: Thank you Jackie and thank you to everyone that joined the call today. I want to echo the commitment of CMS to provide as much information as quickly as possible, as much technical assistance to states as we can offer. I think we've done that through a number of vehicles this all state call.

This is our second all state call and have regular all state calls on Tuesdays and Thursdays for the coming weeks to be available to answer your questions. We are doing numerous – actual dozens of individual calls with states. And we are also receiving many emails and letters from states asking questions and asking for flexibility.

Because many states asking questions and they're similar across the calls, the letters what we are trying to do is bundle up all of those questions. And put out a series of frequently asked questions so that we are not just answering a question for one state but rather that we share that information across all states and territories.

So what we did was on March 12th we released our first we call it family batch 1. Our first batch of frequently asked questions. It cuts across six categories of information, emergency preparedness, eligibility in enrollment flexibility, benefits flexibility, flexibilities related to cost sharing, financing, workforce. And then the same miscellaneous whatever else you can think you put in that bucket for you.

That first set of frequently asked questions is posted to Medicaid.gov in a COVID page. We also will be updating that document and releasing additional answers to the frequently asked questions. We hope we will have one out this week. Batch two.

That will include new sections and new categories of information including the latest managed care and 1115 flexibilities. You will see that we have some very common questions asked by many states.

So what I really wanted to do now is open the microphone. We have our subject matter experts on the line with us. So if you have questions first related to Batch 1 of our frequently asked questions, if you have anything on any of these topics our subject matter experts are available to answer your questions. And then we will turn the mic back over to all states that you could ask questions of any of the speakers that came before me.

So Jackie if you could work with the moderator to open the lines first about questions related to our frequently asked questions.

Jackie Glaze: Yes thank you Anne Marie. (Holly) we're ready to open the lines now to take questions.

Coordinator: Thank you. If you would like to ask a questions please unmute your phone, press Star 1 and record your first and last name clearly so I may introduce you. Again that is Star 1 if you would like to ask a question.

Jackie Glaze: (Holly) I'm double checking to make sure the line is open.

Coordinator: And our first question is from (Jessica). Your line is open.

(Jessica Baxem): Thank you. This is (Jessica Baxem) in Missouri. We are looking at some flexibility related to individuals who are diagnosed COVID-19 positive or in situation where we have staffing shortages for our personal care services in the home and related to our schools closing.

I understand the immediate family member question has been answered. But I did not and have not seen I apologize if it's already been put out the spouse or legal guardian if that's the only individual willing because of a COVID-19 diagnosis is that permissible and can the state request that waiver?

(Ralph Lollar): If you're looking at the Appendix K for the 1915C yes that is an option.

(Jessica Baxem): Okay so this would be state plan (unintelligible) care.

Kenya Cantwell: Hi this is Kenya and I can answer the state plan question. So that is something that we're looking at. It would probably need to come in as a request through the 1135 authority. It not something that we could do through the state plan.

(Jessica Baxem): Okay, thank you.

Kenya Cantwell: You're welcome.

Coordinator: And our next question is from (Mary Brogan) your line is open.

(Mary Brogan): Hi can you hear me?

Anne Marie Costello: We sure can.

(Mary Brogan): Okay. This is (Mary Brogan) from Hawaii asking about when a program such as an adult day health setting closes. Do we have to issue a notice of action?

Anne Marie Costello: And do you mean an adverse action – a notice to the beneficiary?

(Mary Brogan): Yes a notice of adverse action where they're no longer receiving that service.

Anne Marie Costello: So I know (Sarah DeLone) is on the line. I know we've done some – well I'm going to do it in two parts. I know we've done some thinking – (Ralph) or (Alisa) is there anything we can say around the closings of and still being able to support folks if an adult day center closes and then maybe (Sarah DeLone) you can think about if there's an adverse action implication.

(Ralph Lollar): Well we can a couple of things with regard to the 1915C and the 1115 that offer the day services through home and community-based services. And that is that the state can do a couple things. Number one is they can explore to determine if the services are habilitative in nature and can be rendered electronically that would be an option that would be open to this date. If there is an additional cost to doing that can be built into an enhanced rate.

If that is not an option and the closer is due to the CDC recommendations and/or the need to prevent the spread of COVID this state could also amend the 19UC Appendix K to amend and request retainer payment for the program while they are closed. That may mean that you are going to need to work on a

deeper provider pool for the individual who will not be receiving the Day Hab service at that time.

Calder Lynch: And this is Calder. Let me just say we recognize these are sort of extraordinary circumstances that everyone's faced with. And, you know, we're not going to be coming in and checking to see did every notice go out on time, you know, given just how this is working right? So keep us informed of what's going on and, you know, we'll work with you to figure if we need to kind of put some authorities in place.

But I think as long as we're all kind of using just a common-sense approach we can get through this and figure out what we need to do. So if it doesn't make sense to send out notices to people for temporary closure and you're working to get folks served. Then proceed with that and we can work together on figuring out how to make sure they document it right.

(Mary Brogan): Thank you very much.

Sarah Delone: Yes I think along those lines it is not that the person is being – like the benefit is being denied for them. That you are no longer are entitled to this benefit. It is that the, you know, the way – where they were getting that benefit or that service is no longer available and they are going to need new placement or new arrangement to provide it.

So like I don't feel like – the adverse action and sort of the fair hearing notices doesn't – it is a little bit of a mismatch here. And so yeah I think it is – I mean we can take it back and do a little bit more thinking. And if there is a different answer, you know, get that guidance out.

But my, you know, my reaction is along the lines of Calder those regulations are not – you are not saying this person is not entitled to it anymore.

So those regulations and notice provisions don't really come into play. We are in a just a practical situation. Let's get the person the care in the best setting that is possible. And then you sort of go back to what Ralph was talking about.

(Mary Brogan): Thank you very much.

Coordinator: And our next question is from Bonnie Silva. Your line is open.

Bonnie Silva: Thank you. This is Bonnie Silva from Colorado. I have two questions. The first one is in regards to PACE. I am glad to hear that we have received a lot of flexibility around case management and service assessments in general and lifting that face to face requirement.

PACE also requires a face to face assessment and we have not heard that we have that same flexibility. So if we could maybe put that on CMS' radar as something that is incredibly important. That would be helpful.

And then my second payment is around the retention payment for residential providers. I am hoping Ralph could go into a little bit more about how that would actually be implemented.

And sort of in the same vein if we have some flexibility on, you know, expediting I guess having residential providers actually provide a program where that makes sense. In an effort to make sure that there is some continuity of services.

Maybe that was three questions.

Ralph Lollar: Yeah this is Ralph. I am trying to sort through the one you were asking me. Are you asking how they effectuate retainer payment? How to effectuate retainer payment?

Bonnie Silva: Yeah I don't understand the retention payment for residential providers. Are you saying that they can bill for that service in the event that they have to close their residential facility?

Or are you saying they could bill – maybe this is an area where we would have a higher per diem in response to sort of everything that is happening? It is really clear for me how we implement retention payments for day program providers. It is less clear what our flexibility is for residential providers.

Ralph Lollar: Retention payment for residential providers would be in effect where an individual is for instance hospitalized and/or in a nursing facility or institutional setting as a result of the COVID virus. And CMS is funding that placement.

You can still fund the residential setting. If the residential setting is closing due to – we would have to figure out where the individual is going and how that is being funded in order to determine the efficacy of retaining their payments in those cases.

I am not saying it is not a possibility. I am just saying we need to understand more about that and what that impact means in order to give better guidance there.

With regard to increasing a rate for services. You certainly could for instance if a group home, assisted living program needed additional training, needed to pull in a nursing staff to assist the direct care staff with providing services, advice and requirements.

That could all be put into an increased rate for the service. If the providers need additional funding in order to draw in staff because they have a dearth of staff as a result of COVID. All of those things are possible.

Bonnie Silva: Great thank you.

Kerry Smith: And this is Kerry Smith. As far as your PACE question. We are in the process of collecting PACE questions and they are – we plan to have an all-state and all pace organization call next week. I think they are looking at Tuesday next week. So we will make sure folks get that information.

Calder Lynch: But we can try to maybe answer that specific question before then. So we will circle back.

Bonnie Silva: Thank you again. I think the sooner we could give – our local PACE organizations and I guess PACE organizations nationally the direction to stop unnecessary face to face contact I think that that needs to be a huge priority.

Calder Lynch: I hear you on the urgency there. We will take that back.

Coordinator: And our next question is from (Todd). Your line is open.

(Todd): Thank you. This is (Todd) from Nebraska. We just wanted to clarify. So while the presidential declaration was on March 13th. Do we understand correctly that for the 1135 authority that can be effective back to March 1st?

Jackie Glaze: That is correct. It is effective March the 1st.

Calder Lynch: I am sorry and I may have misspoke on that earlier. I apologize. Yes that is March 1st and the Appendix K and other flexibilities coming back to the beginning to the (PHE).

Jackie Glaze: Yes.

Coordinator: And our next question is from Erin Black. Your line is open.

Erin Black: Hi this is Erin Black from Michigan. Have a couple of questions but one of the questions was for individuals who have tested positive for the COVID-19. Will CMS allow states to expand coverage with no income – no limit on income? And also regardless of immigration status.

Calder Lynch: So we are working through some questions that we have gotten from states around potential 1115 authority related to that. We are lining that up with where we think the next congressional bill is going to land because I think it is going to address some of those questions at least around testing and other related services.

So we kind of want to make sure that we are lined up with where Congress is going to land on that bill. But you will see some further guidance coming from us on that front.

Erin Black: Okay and then can I ask a couple more while I am open here?

Calder Lynch: Sure. Go ahead.

Erin Black: Okay. Would CMS allow a state to auto certify all beneficiaries during the public health emergency period? I think there is concern about backup if we stop the recertification period and then all of a sudden at the end of the public health crisis, they have to do a lot of catchup. So could we auto recertify all beneficiaries during this period for the annual?

Sarah Delone: Can you say a little bit more about what you mean by auto certify? One is just to clarify you are specifically referring to the renewal process?

Erin Black: Right. Related to eligibility.

Sarah Delone: And what is auto certify mean to you?

Erin Black: So automatically recertify not – basically not requiring people to provide additional information if needed.

Sarah Delone: Jessica Stephens I think you are able to jump in. You want to jump in and I can add?

Jessica Stephens: Sure. This is Jessica. And I think maybe I can address it in two ways. There is existing flexibility which it sounds like you may be familiar with within the regulations for an emergency situation to have an exception from the timeliness standards from conducting renewals.

So recognizing that under these circumstances you may not have, you know, workforce, et cetera process renewals. That those time limits may be delayed. So I think that is part of it.

And under those circumstances that wouldn't necessarily be a difference in the renewal process as much as just not conducting them in a timely manner as you ordinarily would.

I think there is also separate flexibility related to verifications that might be applicable here. In a circumstance where this concern about individual's ability to provide the documentation for example for income.

There is flexibility within the regulations as well in an emergency circumstance to accept self-attestation of certain information. That too would help expedite the process.

So it sounds like you are – you are thinking specifically about changing the renewal process entirely. Something different from an ex part or an auto renewal process?

Erin Black: Right. I think we automatically renew for certain beneficiaries. But if we don't have the required documentation it requires follow up on that front. And I think that the request was to basically be able to auto renew everybody during this period rather than requiring the extra documentation.

Jessica Stephens: Got it.

Sarah Delone: If I can jump back in Jessica. I think this may be a little bit of a, you know, having to work state by state. I think if you are just sort of saying auto certify like without requiring even if the electronic – there is no electronic data as you would typically have to complete an ex part renewal.

Or there is electronic data but you can't get that suggests ineligibility and you would need to get additional documentation from the individual. You are

talking about just auto certifying in the face of either those two situations? No data or perhaps data incompatible with renewal?

Or you are really suggesting can you further – to do that for another 12 months that I don't think is a flexibility that we could just sort of say sure do that.

What you are really – what would be more reasonable would be to sort of work with us to say, you need to push back the renewals even, you know, sort of completing all the renewals beyond the end of the emergency.

And then I think, you know, it is hard to answer in the abstract right? We need to sort of see where we are and what is the load. I think that we recognize that states may be in a position of needing some additional time when the formal declaration of emergency is over.

But to just – I think to just auto certify you are essentially not doing a renewal in that case for those where there is no data or conflicting data with eligibility and that is probably not something that would make sense to do.

But certainly we could want to work with you to provide a reasonable timeframe to catch back up again if you will where there is going to be a backlog of renewals that haven't happened during the course of the emergency. Does that sound like it is hitting what you are talking about?

Erin Black: Yes that sounds like you are answering the question that we were posing. So thank you.

Sarah Delone: And just because we are all in different places and Calder can we just confirm that that sounds right to you?

Calder Lynch: Yes that sounds right. We also want to take a look at whatever provisions get included in the legislation that is currently moving. If there are some changes in requirements relative to at least some of the verification requirements potentially.

So we want to line all that up and we will provide further guidance once we know what that looks like. Because that may give us some additional flexibilities that we don't have now.

Erin Black: Okay thank you. One of the other pieces we are asking. Could the 1135 process be used like to – like there are pieces in our state plan related to deeper service transportation related to like the least costly mode of transportation?

Would the 1135 waiver be an option for temporarily waiving that requirement in the state plan? Those kinds of things? Because obviously we wouldn't necessarily want to do the least costly but the safest mode for individuals at this point.

Calder Lynch: That is a very good question. I am not sure we thought about that. Let me check with the team.

Kirsten Jensen: This is Kirsten Jensen and we do have several transportation questions in line that so we will add this particular nuance to the list as we start exploring those particular questions.

Erin Black: Okay we had a similar one related to medical verification for certain types of transportation as well. That would be similar. Like normally we would

require, you know, verification related to like a wheelchair lift vehicle or Medivan and those kinds of things.

Calder Lynch: Got it okay thank you. We will take that back. That is a good question.

Erin Black: Thank you so much.

Coordinator: And our next question is from Lynette Rhodes. Your line is open.

Lynette Rhodes: Hi this is Lynette from Georgia. You guys have actually answered my question. Someone else asked it. So I think we are okay.

Calder Lynch: Thank you.

Coordinator: And our next question is from (Chris Paskoff). Your line is open.

(Chris Paskoff): Hi this is (Chris Paskoff), State of Oregon and I have a few questions for you. First one is on the HCBS flexibilities in the state plan. Does that also include 1915(i)?

Man: (Unintelligible).

Woman: So is Ralph on?

Ralph Lollar: Yes. Say more of what you mean there?

(Chris Paskoff): I am sorry?

Ralph Lollar: Can you say a little more of what you mean there? What flexibilities are you asking?

(Chris Paskoff): Telehealth. Just some of the stuff that that was being discussed under the – you know the presentation. The flexibilities available.

Ralph Lollar: Those options regarding Telehealth adding to your provider pool. Those types of options are also available through the - yes.

(Chris Paskoff): Okay great thanks. Next question...

Ralph Lollar: You wouldn't use the Appendix K amendment. You would do a SPA amendment. But that doesn't eliminate the options. Okay?

(Chris Paskoff): Okay thanks. Next question is about self-attestation and we were wondering if that would also include people under MAGI. If they have lost their job see if they could do self-attestation.

Jessica Stephens: This is Jessica Stephens again. Can you specify self-attestation for...

(Chris Paskoff): For eligibility requirements. For financial eligibility requirements.

Jessica Stephens: Ah okay so for both MAGI and – well you are talking about specifically MAGI here. There are existing flexibilities within the regulation in the context of an emergency and that would certainly apply here.

Two on a case by case basis except self-attestation of eligibility criteria when it is not reasonable or not available to provide to obtaining documentation to verify certain information.

Except in specific cases where the statute or regulations otherwise call for documentation such as citizenship or immigration status.

So to answer your question specifically I think the answer is yes. That self-attestation of information for purposes of verification would be permitted for MAGI except under the examples that I provided.

(Chris Paskoff): Okay.

Calder Lynch: Jessica isn't this one of the FAQs?

Jessica Stephens: Yes it is. And I am not looking at it specifically but it is in the first batch of FAQs and I know there have been a couple of twists on the questions that we are working to respond to additionally.

(Chris Paskoff): Okay. Last question I have is whether or not presumptive eligibility determination can be done outside of hospitals?

Jessica Stephens: Yes so presumptive eligibility – this is Jessica again. Presumptive eligibility is available for all MAGI populations that the state has elected under the state plan.

Hospital presumptive eligibility is under separate authority and Medicaid and only applies – I mean sorry and can be applied on a broader basis both to MAGI populations and to non-MAGI or ABDE groups.

And I would flag that that is an area where I know we have been receiving a number of questions about states effectuating hospital presumptive eligibility for aged, blind, disabled and other non-MAGI populations.

And we are definitely happy to work with states on implementation options. But PE, presumptive eligibility more generally is available for other MAGI populations and can select other qualified entities beyond hospitals.

(Chris Paskoff): Great thank you.

Jessica Stephens: You're welcome.

Coordinator: Our next question is from (Kathy Montalbano). Your line is open.

(Kathy Montalbano): Hi thank you. My question was answered. I appreciate it. Thank you so much.

Calder Lynch: Thank you.

Coordinator: And our next question is from (Alice White). Your line is open.

(Alice White): Hi thank you this is (Alice White) from the District of Columbia. My question is I noticed in the disaster response toolkit there were a number of flexibilities where the state could implement them with CMS concurrence.

We are hoping to implement some of those flexibilities as soon as possible and just wanted to clarify and confirm I think what I heard on this call you say was that we should go ahead and implement those flexibilities and then we will get formal concurrence later? Or should we wait for formal approval before implementing? Thanks.

Calder Lynch: So I think my message generally is that for the flexibilities that we have talked through they are outlined in the Disaster Response Toolkit. They are part of sort of the standard Appendix K package or the Federal 1135. They are

outlined there. And states have a need to make immediate operational changes in response to the COVID situation. They should do so.

We will work with you to make sure we have got effective dates in place and through the various authorities. To make sure we have the paperwork, you know, cleaned up and in the right – where we need it to be. But I don't want that to be something that inhibits your ability to effectively respond to the situation.

Now where states may be looking to go beyond what we have sort of already contemplated there in the toolkit or elsewhere looking for new expenditure authorities in 1115 that we haven't contemplated.

I think that is where we certainly we want to have conversation before you move to implement. But for the other things I think you should feel safe moving forward.

(Alice White): That is great thank you.

Anne Marie Costello: And (Alice) I think you know the team is available if there is any technical assistance you need on any of those flexibilities.

(Alice White): That is great (Emery). Thank you.

Coordinator: And before we go to the next question as a reminder if you would like to ask a question please unmute your phone, press star 1 and record your name clearly when prompted so I may introduce you.

Our next question is from (Diane Nortivay). Your line is open.

(Diane Nortivay): (Nortivay). Thank you. This is (Diane Nortivay) from Pennsylvania. I have a question regarding separate CHIP programs. Just to be clear are separate CHIP programs covered under an 1135 waiver?

Sarah Delone: Jackie I am waiting for you to jump in. They are – Title 21 is listed in Section 1135. So the answer is yes. The same flexibilities that – I think as a general rule you should assume that the same flexibilities that are allowed through 1135 waiver as applied to Medicaid would also be applicable to separate CHIP.

Jackie Glaze: Thank you (Sarah). Yes that is correct.

(Diane Nortivay): And then my follow up question to that is so the – whenever you see the list additional things for like a Disaster Relief SPA. Would we do a Disaster Relief SPA in addition to be part of 1135 waiver if something isn't covered?

Sarah Delone: I think if something is covered under an 1135 waiver you don't need a separate CHIP Disaster SPA for that. There is many of these things that aren't for Medicaid. There is a number of things for which you don't need a state plan amendment but there is existing, you know, we do a documentation in a different way.

But the mechanism that we have right now is the CHIP Disaster relief SPA. So that is where there is a difference sometimes between sort of the paperwork if you will for Medicaid versus the paperwork for CHIP.

But if an 1135 authority is granted you don't need a separate SPA for that. Jackie you can correct me if that is wrong in any regard.

Jackie Glaze: You are absolutely right (Sarah) and we can certainly provide assistance if you need any with your – if you do have a Disaster Relief SPA for your CHIP population. We can certainly have a team that can work with you to explain the process and the expectations that that would fall within that.

So again you can do that in advance of the emergency or you can do it during the time of the emergency.

(Diane Nortivay): Thank you.

Coordinator: And our next question is from (Suzanne Beerman). Your line is open

(Suzanne Beerman): Oh hi I think my question was already addressed too. It was about the possibility of waiving the face to face assessment for the 1915(i). Thanks.

Coordinator: And our next question is from (Anastasia Dalton). Your line is open.

(Anastasia Dalton): Hi this is (Anastasia Dalton) from California. I have a couple of questions. One, I know we have been talking about 1115 and 1135. So I wanted to clarify.

If we submit 1135 but we have provisions that are under the 1115 that we are asking to be waived. Do we need to ask for wavier on notice for the 1115? Any guidance on that? I just want to be clear on the 1115 and 1135.

And then the second question. I believe that Jackie said earlier on the 1135 that does not apply to conditions of payment? So asking for clarification on that.

Calder Lynch: This is Calder I can start with the first one. So I would maybe think of them a little separately just because, you know, for the 1135 waivers and we are working again on getting sort of a checklist out of all the existing authorities and they are outlined in the toolkit.

You know I think we can turn those around pretty rapidly. You know within scope of sort of the disaster situation. But there may be things the states want to consider additional either 1115 waiver authority or maybe they are looking for expenditure authority to cover something beyond what would normally be allowed.

We are working through hopefully putting some parameters around how we – what that might look like in a COVID response situation to give further guidance to states.

But generally because we are under the public health emergency that does open up some additional flexibilities. One being that we don't have to apply the normal state or federal transparency requirements. So you don't need to go through the normal public notice process at the state level before submitting.

And also you know while 1115 can normally not be retroactive, you know, beyond the approval date. Under these situations they can be. Back again to the beginning of the public health emergency. So that does provide some additional flexibility.

We will hopefully have more coming soon on, you know, approaches of 1115 and that next set of FAQs will have some questions in there as well to answer those issues.

And then the second question I think I will turn it over to someone else on my staff to answer.

Jackie Glaze: Sure and on your question about the purpose of the 1135 waiver and that is to waive or modify any of the regulations that are specific to care. And so it would not be a vehicle to increase enhanced spending or to receive 100% funding or any types of payment. So it doesn't focus on that at all.

Even though it is a way to provide flexibility through the provider enrollment. So that providers can receive their payment timely. But it wouldn't be a mechanism for states or territories to get additional funding. Does that answer your question?

(Anastasia Dalton): Thank you.

Coordinator: And our next question is from (Jason Higgins). Your line is open.

(Jason Higgins): Hi this is (Jason Higgins) from Maryland. This is mostly just to clarify a concern. I thought I heard it on the call earlier. So for preadmission screening and resident review flexibility on that assessment. Is that something that would be through the 1135?

Ralph Lollar: It depends what you are asking for. If you are asking to accomplish them by electronic means. Through telephone, Facetime, et cetera. Unless you have written into your SPA that you will do them face to face you need to do nothing but begin to do your processes as completely as you described in your PASRR process electronically.

If you are looking to allow for an extension or delay in rendering the PASRR evaluation beyond that average of seven to nine days. Then you would need the 1135 authority to postpone that assessment.

So the answer is yes. It is either or. Okay? Depending on what you want to do.

(Jason Higgins): Okay so if we were talking about waiving maybe like the first 30 days something like that. That would be 1135.

Ralph Lollar: That is 1135.

(Jason Higgins): Okay thank you.

Ralph Lollar: Okay.

Coordinator: And our next question is from (Chrissy Press). Your line is open.

(Chrissy Press): Hi there. Thank you this is (Chrissy) from Texas. I had a question about the quality management required visits for 1915(c) waivers and the same for 1915(i) programs. Is it okay for us to do all desk reviews during this time when we are, you know, not traveling? Or what can we do with that?

Ralph Lollar: Sure you can do desk reviews. I would do an amendment to amend the – I would use the Appendix K to amend the modality under which you were doing them if you committed to doing them face to face in the waiver document itself.

(Chrissy Press): Okay.

Ralph Lollar: Okay?

(Chrissy Press): And what about for settings checks for 1915(i) state programs?

Ralph Lollar: You are talking about your statewide transition plan?

(Chrissy Press): No for the home and community base services adult mental health program.

Ralph Lollar: Okay. If you have written it into the I you will need to amend it in the I. If it is not written into the I, full compliance is not effectuated until March 17, 2022. So it all depends on what you have written and committed to in the SPA document itself.

Calder Lynch: But again I just want to stress that you know we recognize that everyone has got workforce impacts right now. And if that is impacting your operations and you have to make changes, you know, those are decisions that you will have to make at the local level.

And then we will work with you to make sure we get that reflected as best we can into your authorities moving forward. But certainly understand that that may take some time to work through.

(Chrissy Press): Right. Thank you so much I appreciate it.

Ralph Lollar: No problem.

Coordinator: And our next question is from (Michael Case). Your line is open.

(Michael Case): Hi thank you. This is (Michael Case) in Idaho. I think this has pretty much been asked but it has not been specific about. I understand the Appendix K

for the 1915(c) services but we do have some DD services in our 1915(i) that require those annual reassessments. Those reevaluations.

And I am wanting to verify that the extension of those reevaluations has to be done through a SPA? Or can it be part of the 1135 waiver document?

Ralph Lollar: I need you dig into that just a little bit further and follow up with folks. We can add that to the list of questions for the FAQ.

(Michael Case): That would be great. Thank you, Mr. Lollar. And the other thing you had mentioned a bill that was going through Congress. Could you provide that bill number for us?

Calder Lynch: Oh gosh I don't know the number off the top of my head. So this is the legislation that the House passed over the weekend and then was working on some technical amendments and we expect the Senate to take up and vote on later this week.

If you Google COVID bill you know you probably find it. But it is the one that provides for a lot of different provisions. And related to Medicaid specifically, the enhanced – the proposals to enhance your FMAP by I think by 6.2 percentage points for the time period of the emergency as well as some other provisions related to coverage for the uninsured.

So we can follow up with the exact sort of link to where that is. But I am sure (unintelligible).

Sarah Delone: I believe it is H.R.6201 is the number.

Calder Lynch: I knew I could count on you for knowing that (Sarah). That is 6021. Some of the Office of Legislation run down here to tell me. So 6021.

Sarah Delone: Oh 6021. All right it is wrong in the email heading thank you.

(Michael Case): All right thank you for that and we will look for the other clarification in the FAQs.

Coordinator: And our next question is from (Jason Paragon). Your line is open.

(Jason Paragon): Hello and thank you. I just had two quick questions. The first one was in relation to the very beginning that was from Jackie Glaze regarding a checklist I missed. Was that regarding 1135 that we can email her for?

And my next question...

Calder Lynch: It is something we are working to release in the next couple of days. (Unintelligible) 1135 so we will be pushing that out as soon as it is ready.

(Jason Paragon): Okay and that is just going to go out to all the states.

Jackie Glaze: Yes.

(Jason Paragon): Okay. And my other question was regarding 1135 waiver. One of my questions was will providers – I know the waiver is more geared to high enrollment and continuing services by suspending federal requirements.

One of my questions was for third party liability would that be a thing we could do where providers would not be required to pursue third party liability

for the duration of the emergency or to get payment quicker? Would that be 1135 or 1115 issue?

Calder Lynch: That is not one that had come up before. Let me ask folks if they have any thoughts.

Alissa DeBoy: I don't know if (Kerry) is on. But that might be something caller that we have to explore under 1135 and add that to our FAQ list.

Calder Lynch: Yes thank you for raising that. I am not sure that has come up yet. So we will take that back and do some thinking on it.

(Jason Paragon): Thank you so much.

Coordinator: And our next question is from (Alice Taylor). Your line is open.

(Allison Taylor): Hey (Allison Taylor) from Indiana. I have got just a few quick questions. One super basic and I know you probably said it in many different ways. But going back to the guidance issue on 3/13 and the blanket waivers.

Understand that those are pretty much just granted. So can you confirm or advise states. Do we need to do anything? Put those in writing and let you know we are taking advantage of them? There is some confusion.

A bunch of our stakeholders aren't quite sure what those mean and whether or not like what the state has to do? And so could you just go ahead and tell me that again.

Calder Lynch: Sure. Let me just start by offering a clarification because we have gotten some questions on this.

(Allison Taylor): Yes.

Calder Lynch: You know with the presidential declaration it does open the ability to grant 1135 waivers, 1135 waivers are not exclusive to Medicaid. They are also used to waive provisions of Medicare requirements or requirements around conditions of participation in Medicare that are survey and certification team review.

Those have historically either been done either, you know, at a geographic or even at provider level during a disaster. But just sort of given the nationwide scope of this particular situation CMS granted some blanket waivers relative to those Medicare requirements that have implications across the entire healthcare system.

So that is things like Medicare enrollment screening requirements for some of their providers. Some of the survey and certification requirements around survey inspections. You know so those are – there are a number of blanket waivers that were issued.

There is nothing you need to do regarding those. They are primarily Medicare focused although they certainly can impact the providers that are also treating Medicaid patients. But nothing you need to do on that front.

And we have more guidance coming soon on any additional Medicare waivers that individual providers may want to seek beyond what the blanket waivers apply for. But those wouldn't be anything that you would have to be directly involved in.

(Allison Taylor): Okay so for clarity we could even just point back to the FAQ release and say, see above. Right? I mean that is...

Calder Lynch: So for all those Medicare waivers yes you can just point them back to our Web site, all the resources that we put out. The fact sheet we have. Absolutely.

(Allison Taylor): Okay. So kind of a related question. Sorry I have two small ones to go. We have got a separate sister agency that does the licensing survey certification. And we are – have a statewide kind of response team which I am sure most states do.

The question from our survey side of the house. They seem to be under the impression that they are waiting on additional guidance on how to kind of complement the enforcement up against the waiver authorities that we talk so much about. That we have been talking about today and that we talk about kind on this side of the Medicaid shop.

Can you comment on that? Is there something else coming or is this all packaged together? I don't spend a whole lot of time on the enforcement side so that is...

Calder Lynch: No, no it is a perfectly fine question. So we also have a sister sort of component within CMS. The Center for Clinical Standards and Quality that work directly with the state survey agencies who carry out many of their functions, you know, basically on contract from CMS.

And they have certainly been pushing out a lot of guidance and direction to those agencies with regards to changes and prioritization of their work and

suspension of certain types of surveys and their activities related to COVID-19.

We have been putting that guidance – and all that guidance goes up on the main CMS Web site on the COVID page with all the resources. We have also put links to it on the Medicaid COVID resource site under the heading of survey and certification guidance.

If there are specific questions that arise regarding the intersection of their work with Medicaid please raise those to us and we can work with CCSQ to see if there is anything additional we need to provide.

(Allison Taylor): Okay great. I don't know anything specific so that is good enough for now. But I will let you know. I appreciate that.

Just a super quick question. One more. There was a question earlier about redeterminations. And so I think we kind of framed it out where we do expect states to probably push redetermination beyond the end of their redet period. I think that is mentioned in the toolkit question.

Is there a limitation on how long? Like is 3 months, 6 months, is 12 months too long in this situation? Or is there any written guidance on that?

Jessica Stephens: This is Jessica again. So the regulations specifically note the flexibility around timeliness applies during the emergency. However, I think as (Sarah) noted earlier, we recognize that being able to conduct every determination that was done that wasn't done, you know, during whatever period this ends up being for the declared emergency may not be feasible.

So I think we want to work with states on a case by case basis to really understand what the volume is and what may be reasonable in terms of extending the period.

But ultimately as noted in the regulation it is tied to the period of the emergency and then how you end up, you know, distributing the renewals after that we probably can discuss on a state by state basis.

(Allison Taylor): Okay that sounds good. So you can't really hedge your bets to say we will just give ourselves a long amount of time. This is to restate this is (unintelligible).

Calder Lynch: Yes I expect that is going to be something we come back to provide more guidance on once we get through some of the more meat of the immediate.

(Allison Taylor): Okay.

Calder Lynch: Yes clearly there is going to need to be further guidance as this continues and as we probably expect it to continue for some months.

(Allison Taylor): Okay great. That is it for me. Thanks guys. You guys, the flow of information has been really helpful. So thank you thank you.

Calder Lynch: Operator we probably only have time for about one more question.

Coordinator: All right our next question is from (Lisa Sprano). Your line is open.

(Lisa Sprano): Hi this is (Lisa Sprano) New York. Thanks for taking my question. It is along the lines of the previous questions about redeterminations. And one thing that we had discussed previously was how to document those.

And we are wondering if any more thought has been given to that and if it is possible to rather than document in each individual case if it could be documented for the time period?

So when the emergency began to some end date when it is ended that cases during that time period were renewed because of that?

Jessica Stephens: So this is Jessica again. And this question has come up in a number of states that we have talked through. Yes we think that is reasonable given that the regulations are really designed more for a situation where, you know, there might be a specific county or specific area.

And for those individuals to document on a case by case basis. To the extent that that is not possible or, you know, not reasonable to be done at this point. I think the guidance thus far has been to sort of note to the documentation clearly the individuals. And at this point it sounds like it is likely statewide.

And for cases that fall under that bucket those would be included. But I know that we are also thinking about additional flexibility here and can probably come back with additional guidance. For now though that can be your approach.

(Lisa Sprano): Thank you very much. We really appreciate all the thought that you are giving on this.

Calder Lynch: Thank you. Okay well I think that brings us about to the end of our time today. I recognize we maybe didn't get to all of the questions. So I am going to ask as Jackie gives us details on the next call.

Also to let folks know how they can get those unanswered questions to us so that we can work them into our queue. Jackie?

Jackie Glaze: So again thanks everyone for joining us today. I think we had a really good conversation and wanted to remind you that we will have a call on Friday from 1 pm to 2 pm Eastern time and we will be focusing mostly on coverage and benefits.

And then of course we will continue to have calls throughout the next weeks to come. So if you do have additional questions you can certainly speak with or send your email to your state lead and they can certainly get the question to us and we will add those to the tracker.

Or you can send those questions to myself, Jackie Glaze or (Michelle Baldie). And we can certainly add those to the tracker as well and we will respond very timely to you.

So again we appreciate your time today and thank you.

Calder Lynch: Thank you all.

Coordinator: I am sorry and this concludes today's conference. You may disconnect at this time. Speakers please stand by.

END