Centers for Medicare & Medicaid Services
COVID-19 All State Call
Moderator: Jackie Glaze
April 3, 2020
3:00 pm ET

Coordinator: Welcome and thank you for standing by. I would like to inform all participants that your lines have been placed on a listen-only mode until the question-and-answer session of today's call. Today's call is being recorded. If anyone has any objections you may disconnect at this time. I would now like to turn the call over to Jackie Glaze. Thank you. You may begin.

Jackie Glaze: Thank you (Amanda). Hello and good day everyone. So I'd like to welcome you to today's all state call. So to begin with, Calder would like to provide opening remarks and so I will turn it over to you Calder.

Calder Lynch: Thanks Jackie. Good afternoon everyone. Thank you for joining us at the end of this week, another week. I want to appreciate all the work that everyone is doing and, you know, I know it's been a challenging time for us all. Today's call, we don't have a lot of agenda items but some important topics we want to cover.

We've actually got a special guest with us today from the CMS Center for Clinical Standards and Quality, Lisa Tripp from CCSQ is here, where she'll be providing an overview of some of the Medicare blanket waivers that were issued by the agency this week, and their implications for your programs and policies that we think are important for you to be aware of.

And then we'll - with the time remaining after that, we'll take question from the audience. So I just wanted to quickly flag a few things before I turn it

over to Lisa. Yesterday we posted our third set of general frequently asked questions to the Medicaid.gov Web site.

As with our previous updates, these FAQs were folded into our master FAQ document delineating which of these are new. Also we took the new questions and they were included in the listserv email blast that went out to everyone yesterday, so you could see specifically which questions have been added. They range across a number of topics that people are asking about. So we definitely encourage you to take a look at that.

One thing I did want to flag that we included as part of that FAQ was a streamlined eligibility verification plan addendum that's available to states. The states, you know, a number of thoughts have thought to make temporary revisions to your Medicaid and ship eligibility verification plan with regard to, you know, data matching.

These are sources you're using, etc., and so we've created a streamlined template for an addendum that you can make to those changes without having to go in and modify your overall eligibility verification plan. So that's included as a link in the addendum to the FAQs and there is an FAQ specifically on that topic.

We'll soon, within the next few days, be releasing our second set of FAQs related to the Medicaid and CHIP provision of the Family First Coronavirus Response Act and the recently signed CARES Act that there is some interplay between the two as modifications that the CARES Act made to the conditions for the enhanced FMAP under the (FFCRA) that we're going to, you know, try to provide some additional guidance around.

So hopefully by early next week we'll have those guidance and FAQs posted. We'll also - and we'll plan to set some time aside during next week's all state calls to provide an overview of both sets of FAQs. On the waiver and state plan and response we have received and approved a set of 1135 waiver requests from nearly every state. I believe we're up to about 45.

We know that there are a number of other pending flexibilities that states have requested, either, you know, through 1135 or as we're working with you to identify other authorities that we may need to turn to, to enact those, some of which would include the use of the Medicaid and CHIP Disaster Plan state plan amendments and then the template that we released.

And I'm pleased to say that on April 1st we approved our first Medicaid Disaster (Spa) from the state of Arizona. And we have several other states who are on the precipice of being approved and I think we've got about 14 of those. And I'll send a review.

We're also going continuing to process the appendix Ks, the chip disaster spas, emergency IT funding requests; we've turned at least one state around there. And of course the 1115 demonstration which I'll talk a little bit more about in a second.

We're also responding to requests from states to confirm their ability to exercise existing regulatory flexibilities that, you know, don't necessarily require, you know, affirmative approval by CMS but which we'll encourage states to reach out if you wish us to confirm some of those existing options and flexibilities that the regs already provide you. And we're doing that very informally, through email.

On the 1115 funds I do want to just sort of give you an update and give you a little bit of our approaches. We've been working with a number of states who have submitted applications into us, some of which I know are working in and I even - the submission has occurred prior to the recent legislation, the CARES Act was signed into law.

As you may know, that bill included a number of relevant appropriations. I think some of the requests that have been coming in, including I think there were about $275 million appropriated to HRSA for their health centers program, most of which has been allocated around tele-health and rural capacity.

There as over $4 billion in various housing assistance programs through HUD, including funds for housing supports for high need populations like those with AIDS, the elderly and people with disabilities that were physically set aside. There was nearly a billion dollars in appropriations for aging and disability services programs, most of which was targeted for nutrition and other supportive services for those populations through the Older Americans Act and other programs.

And finally, fortunately, there's been a lot of attention, about $100 billion that were appropriated through the department, to support eligible healthcare providers and supporting their expenses and losses during the pandemic, including investments to build surge capacity as well as infrastructure changes and of course to provide reimbursement for treatment provided to uninsured patients which - I know there should be more information coming very soon on.

It's really - it is I think broadly across the administration, our intent that these funds be leveraged as the primary resources to support the needs that they've

been allocated for. So as we work with states on their individual 1115 requests, you will not see us extending expenditure authority where other resources are available to meet those needs that are fully federally financed.

We will continue to learn more as we work through this process as those resources get deployed. And we understand those methodologies and allocations more specifically. And I know our partners across the department are working feverishly to make that happen as quickly as possible. And we will continue to work with all of you as we work through this. And are always happy to talk through state specific request strategies with you individually, and are always open to considering the requests that are targeted to your needs in light of COVID-19 where maybe those needs are not being met elsewhere.

So again, I know that many of you began your 1115s before some of those resources became available but I did just want to kind of preview for you our approach, and we'll have follow up individual conversations with states. And as we approve 1115 requests, you know, what we do in terms of what will or won't be approved at that time.

So with that, I'll have - I'm happy to turn it over to Lisa. I think Jackie, you might be setting us up for this conversation and then we'll get into the Q&A.

Jackie Glaze: Yes, thank you Calder. And as Calder indicated we're very pleased to have Lisa Tripp join us today. And Lisa is the Acting Deputy Group Director for the Survey and Operations Group within the Center for Clinical Standards and Quality. And as Calder also said, she was very instrumental in the approval of the Medicare blanket waivers which I know many of you have questions about.

So she's able to join us through 3:30 Eastern Standard Time. So if you do have questions following her presentation she may not be able to answer those today, so you could just send those questions to me and I will follow back up with Lisa and get those responses to you. So with that, Lisa I'll turn it to you.

Lisa Tripp: Thanks so much Jackie and Calder and everybody. I'm very pleased to be with you here today to talk a little bit about the Medicare waivers that were recently announced. It's hard to overstate how dramatic of an action this was. This is an unprecedented action on the part of CMS and it is - we did it because we are in an unprecedented situation that I certainly don't have to tell you guys about.

But I am very glad that we have done this as quickly as we did. The administrator has forwarded a correspondence from a variety of medical centers - Harvard, from folks that have said that they've greatly appreciate the swiftness with which we have acted to provide some very much needed flexibility in the time of COVID-19.

So I will be very happy to give you a kind of brief overview of the Waivers 101 talk and then I'll follow that up with hitting some of the highlights of the waivers that we recently announced. So with that, I'll go ahead and just kind of start the Waivers 101 piece.

As you know, we took dramatic and proactive steps to contain the spread of the 2019 novel coronavirus disease. As part of the President's emergency declaration we leveraged our regulatory resources and new rules, to rapidly plan efforts against COVID-19. We enacted numerous blanket waivers that covered all kinds of provider types, hospitals, ESRDs, nursing homes, hospice and others.

And we are in the process of working on additional waivers. In fact that has been an ongoing process since the declaration was announced. So we did announce our waivers - our main batch of waivers. We announced one batch on March 13 and announced the bulk of them this past Monday, but they are retroactive to March 1, 2020.

So let's talk a little bit about what waivers really are. And for those of you in the audience who are old enough to remember what a pencil is that had an eraser on it, imagine that you would go look at a code book and see, you know, 42 CFR whatever regulation and a waiver acts as you take like an eraser and just erase that provision that's been waived. So for those of you who are not old enough to remember pencils and erasers just imagine you're looking online and you just go to the regulatory code book and you just backspace over it and delete it.

So waivers really make a regulatory requirement go away for the pendency of the emergency. So it's a short term disappearance but it really is a disappearance. And so what we did is blanket waivers for a whole host of requirements under 1135. And what is a blanket waiver? Well blanket waivers are really powerful tools.

And once they are announced they are in effect. Okay? And they apply to all provider and supplier types for whom that regularly position has authority. Okay? And what's really unique about them is that you - the provider/supplier for whom the waiver is applicable, does not have to request the waiver. Okay? They don't have to notify CMS of the waiver, they don't have to ask permission, they don't have to do anything by law.

All that is required is when the waiver is enacted, the blanket waiver is enacted, the provider supplier for whom that regulatory provision apply, can

act according to what the waiver allows. And this is something this is very counterintuitive for people to understand. And I really realize that. I'm a lawyer by training by the way. You know, I, you know, this is a very strange thing. It's the one time the government says we're going to basically say we're going to take the rules away from you and you get to act accordingly, without even having to tell the government or ask permission from the government when you have a blanket waiver.

And so that's a very difficult thing for people to get their heads around which, you know, makes sense I think, if you think about it. The government has basically trained people that if you want, you know, if you want to do anything you have to ask permission; you've got to fill out forms; you've got to meet all of these requirements.

And then the one time where we kind of say all right, we're throwing the rules out; you don't even have to ask permission or let us know. So what we find is that very sophisticated actors in the healthcare sector, and everybody else in the healthcare sector, is often quite - there is a lot of confusion about blanket waivers.

So I want to tell you if you are one of those people who are confused about blanket waivers, you're in really good company. I got a text this morning from a very dear friend of mine who is an attorney; he's a former state survey agency director. He's now in the private sector and he just texted me about a particular waiver at issue. And I said yes, you don't need to apply for that.

He said no, we've got a message from an attorney in DC who said we have to - we've got to get permission; we've got to apply; we've got to do this. I said no, you don't have to do that. And so we went - we had a few rounds of texting where I had to convince him that it was actually, you know, if his

client was covered by the blanket waiver for what they were trying to do, and of course that's an important "if", you have to make sure - providers and suppliers have to make sure that what they're doing is actually in conformity with the provision of what was waived.

But if that's true in a blanket waiver situation we don't have to ask permission. So it's very, very counterintuitive and I think we often get many, many questions. And when we have issued blanket waivers in the past for - in isolated states like when there's been a hurricane or something, we could get a blanket waiver for the state of Florida.

You know, we would normally get many, many requests for blanket waivers and that was true when we came out with the waivers on March 13. We typically get many, many requests. So if you see very kind of prominent verbiage on our Web site that encourages people not to send a request, that's why. And we're trying to create a playing field where we give the maximum flexibility to providers and we don't want them to have to spend the time to send us correspondence and wait and worry and, you know, be concerned.

We want to be as clear as possible that if what they want to do if they are a provider covered by that particular waiver, and 1135 waivers - Section 1135 of the Social Security Act applies to Medicare, Medicaid and CHIP. So it's very broad authority.

So what I want to do right now is kind of go over to the next bit of the talk and I do want to differentiate - I've talked about blanket waivers. So I want to make some pretty fine distinctions for everybody here. There are sometimes in the waiver itself, even it's a blanket waiver, but there is a condition in the waiver.

So as we were contemplating, you know, what to do, what kinds of waivers to give, there were times where the administrator just said I'm only going to grant this waiver for facilities that are, you know, I can't recall the exact verbiage, but basically facilities that are experiencing a surge. And so yes, it's a blanket waiver, but there's a condition that has to be satisfied. You have to be - the facility has to be in a surge.

So there are times or another condition that we had for a different waiver was basically you had to be in the state that was considered impacted and we provided a link to the CDC's Web site which defined what impacted was. So I would encourage people to be careful and read the waiver carefully, but those are the exceptions.

Generally for the waivers that we issued with response to - with regard to COVID-19, they were very broad waivers and so they were all blanket waivers with just a couple of them having specifics like that. Flexibilities are different - in our vernacular in ways, flexibilities are basically, you know, just kind of singular request that we do. And we - there are quite a few on our Web site that we have historically granted.

And so those are quite common. And then we get, you know, very unique waiver requests or flexibility requests. And those that we have triaged and we have a process where we send them up to an OA committee, Office of the Administrator Committee that deliberates on them.

So we had to ramp this up very quickly as everybody knows, and I'm sure everybody is in the same boat we are. Since this has happened we've all been working around the clock. And so I wanted to take a moment and just thank you and your staff for all the hard work that I know that you're doing.

This has been a remarkable time and I feel like - and I said this to a friend, I feel like we are serving our country at this really critical moment, so I just want to make sure I thank you and your staff for all that you're doing and my colleagues over in Medicaid, and I just really want to share my appreciation because this is a very tough fight. But I know we're all doing our best.

And there's going to be more to come. We're definitely not finished with our waiver and we're going to be evaluating our waivers. So I'll tell you a minute - I'll tell you about that for a little bit. When you issue a blanket waiver and the reason we haven't done it hardly at all historically or very little, is because it applies to everybody. And so you have to make a value judgment where you realize that, you know, maybe there are cases where it shouldn't apply, you know, where it would be better for that particular hospital doesn't really need this flexibility; doesn't need to be able to do X, Y or Z.

But we have to make a choice that it's better for the public as a whole, for us to make the decision to grant the waiver as a blanket and those are tough, tough decisions. And we, you know, we thought long and hard about those types of scenarios. And we would sometimes, you know, really struggle - should we make this on a case by case basis?

But the reality is when you have a virus of this nature that impacts the entire society, every aspect of healthcare, the idea that we could remotely process on a case by case basis, all of these waiver requests, was simply just clearly not possible. So we had to make those decisions and we worked very hard at that and weighed pros and cons and had very, very robust discussions. So the products you see are from a process where we considered all of that.

But because this is an unprecedented threat and because of its scale, we just - the administrator just, you know, made the decision that this is the direction that we need to go. So more to come on that.

So what are we - what kinds of waivers did we do? So it's really pretty remarkable. We did a lot with tele-health. So our ultimate goals were to try to create the optimal healthcare situation for everybody in the country and not increase the risk of a transmission of the virus. So tele-health is a huge, huge part of that. And thanks to the development of technology, you know, we're able to do far more in tele-health than would have ever, you know, been thought possible.

So we've done remarkable things with tele-health and I think those are incredibly well received in a whole host of settings. Hospitals, nursing homes, home health and so we've really run the gamut with that. We are also trying to preserve our workforce and in particular, our physician workforce. And so we've waived a lot of direct supervision requirements. We've allowed supervision to be done via tele-health and we've also allowed other professionals to assume roles that they would not have before, without physician supervision.

So nurse practitioners and so forth and, you know, that's critical because we know in an ideal world we'd like to have as much direct physician oversight as humanly possible. We are far from that world right now. And to that end, we've waived requirements. We've basically said if you've got a license - you're licensed in the state, for the most part you are free to go and practice in another state, assuming there are no state licensure barriers in effect.

Our ability extends only to waive federal provisions; we cannot waive state provisions. So that's obviously a limiting factor. We are doing - we are

accelerating advanced payment and because we understand that in this type of environment where we're really not doing any - the only procedures that are pretty much happening are the ones that are necessary. So that is a lot of reduced income for providers.

So we have accelerated an advanced payment as well for both physician and non-physician practitioners. We have waived stark some of the (stark) provisions which basically prohibit self-dealing, self-referrals. And I know this is something that is a very important issue because literally some of the things that we've allowed in the past might have subjected providers to criminal penalties. And we did not take that likely.

But the bottom line is if you've got limited options in your community and you need essential services then we can't let the (stark) laws get in the way of that. We have done historic things with hospitals as well. We have weighed one provision of the emergency treatments and waiver act and that is the provision that relates to getting a - the screening provision.

So EMTALA gives you - anybody who presents to an emergency room is entitled to a medical screening exam that is designed to detect an emergency medical condition. They're also entitled to if there is an emergency medical condition that's detected, they're entitled to stabilizing treatment and they can't be transferred if they're unstable, basically unless it's in their best interest from a medical perspective or they request the transfer.

So we did - we waived the first part, the screening part because we know it's imperative that we be able to sort potentially COVID patients from ones who are not. As you can imagine in a waiting room of a hospital, if we could not do that kind of sorting it would be a public health disaster. So we really,

really put a lot of thought and effort into this and decided for the, you know, first time, we would waive an EMTALA requirement.

I want to also make it clear we did not waive the second part though. If you are in a hospital with an emergency department that receives Medicare you cannot be - all the regular rules with EMTALA apply on the stabilizing - transferring an unstabilized patient. So I want to make sure that I'm clear on that.

In the last minute I'll just tell you we did a lot of with nursing homes as well. We - with hospitals too, we are allowing the creation Hospitals Without Walls. We know that we are going to have hospitals that are going to be overrun and on a payment side and also on a physical plant side we have done - really gone tremendous lengths to try to give the heroes out there that would be security to know that we have their backs and that we're going to create rules that fit the situation.

So we've done a lot with Hospitals Without Walls and we've allowed for cohorting in nursing homes and its' really astonishing. It's unthinkable. If someone had said to me that we would be having this conversation six weeks ago, perhaps even four weeks ago I would not have thought it possible. But we are where we are and CMS is leading the way to do the best we can for the public.

So Jackie and Calder, thank you so much for the opportunity to address your audience. And again, my thanks for everything that they and their staff are doing.

Jackie Glaze: Thank you Lisa, so much. We really appreciate you joining us today. And we may get questions from the audience, but I will certainly bring those back to you. Thanks Lisa.

Lisa Tripp: Thank you so much. I really appreciate it.

Jackie Glaze: So (Amanda), I think we're ready at this point, to take questions from the audience. Can you open up the mic?

Coordinator: Thank you. We will now begin our question and answer session. If you'd like to ask a question please press star 1. Please unmute your phone and record your name fully and clearly when prompted. Your name is required to introduce your question. Again, that's star 1 if you'd like to ask a question. One moment please.

Calder Lynch: And while questions are queuing up, I will say I believe we shared out the press release and link to information about the blanket waivers that were issued on Monday night. All of that is available at CMS.gov. You can see information in more detail of what's going to - as Lisa mentioned the specific waivers that have been granted particularly around the establishment of alternative care sites, the Hospital Without Walls issue that she mentioned.

For folks that are interested we'll certainly have them take those questions back. But certainly a lot of information on our Web site as well.

Coordinator: Thank you. And we do have some questions. Are you ready?

Calder Lynch: Yes.

Coordinator: Thank you. Our first question comes from (Eric). Your line is open.

(Eric Elkins): Hi. Thanks for taking my question. This is (Eric Elkins) from North Dakota. And I have a question on the enhanced FMAP. With our population of our targeted low income children population, so we had a separate CHIP population before January 1, 2020, which we moved them to the optional target of low income children population on January 1st.

So the question is can the FAQs - under Section 6008 of the FFRCA it says states do not need to maintain coverage in CHIP. The question is does this continuous coverage requirement in Section 6008 does that apply to our targeted low income children now that they're in CHIP and they're in our Medicaid state plan? Thank you.

Sarah Delone: So Calder, I can take this if you want.

Calder Lynch: Yes, go ahead.

Sarah Delone: So they - just to confirm they were enrolled in your - they were - the shift happened; they were enrolled and eligible for your - the optional target low income child group in Medicaid, as of January 1st?

(Eric Elkins): Yes. That's correct.

Sarah Delone: Yes. So the requirement that - the requirement - the maintenance of effort requirement would definitely apply to those children because they are in your Medicaid program as of January 1 which is what the sort of the data which sort of everything has to be maintained as (unintelligible) policies and procedures. So yes, they would be protected by that - or that provision would apply to those kids.

(Eric Elkins): Okay. Thank you.

Sarah Delone: You're welcome.

Coordinator: Thank you. Our next question comes from (Anna). Your line is open.

(Anna): Hi. This is (Anna) from Pennsylvania. One - I actually have a couple of questions. The maintenance of effort or the - of eligibility requirements for the enhanced (FMAP) would also apply - the plan is for any Medicaid eligible population so that would include like individuals that are at the end of their postpartum period, the 60 days.

We can't close them even after they hit that 60th day, is that correct?

Sarah Delone: That's correct. And I just want to distinguish, there are two different provisions I think people - we tend to sort of (conflate) them. But one is the condition that's from 6008(b)(1) which your - maintain your eligibility standards, methodologies and procedures but sort of a more kind of standard maintenance of effort that has to do with you can apply new restricted methodologies, maybe to your age, blind and disabled populations.

You can't change - make it - institute any more difficult - any new processes that might make it more difficult for people to obtain coverage and that kind of thing. Then there's the - there is some feedback. So if folks who aren't speaking could maybe mute themselves that would be helpful.

Then there's the requirement in 6008(b)(3) to maintain coverage for anybody who is enrolled in Medicaid and receiving benefits through the end of the month in which the emergency ends. And that's in (b)(3) and that's I think

what you're referring to here. It's a continuous coverage position maybe. The useful shorthand is requested maintenance of effort.

But yes, and so yes, that would apply to those - to the women who are in the postpartum period or - and if they were receiving Medicaid because they were still pregnant or they were in the postpartum period on March 18th, they would maintain and continue that coverage through the end of the month in which the emergency ends.

(Anna): Another question - it's semi-related I supposed. It's also from the FFCRA. What kind of requirements are in place for the separate CHIP programs? I understand that like this coverage - consistent coverage does not apply to separate CHIP Programs, but are there other requirements for CHIP in order to be able to receive the enhanced (FMAP)?

Sarah Delone: There are no requirements for CHIP that are - that the - need to be met for the increased (FMAP). There are requirements for CHIP independent of the increased (FMAP), specifically related to covering testing services and to the cost sharing exemptions protection and, you know, related services. And there are FAQs on that that are - I think those are already posted.

But in terms of the 6.2% temporary (FMAP) increase there are no conditions for coverage under your separate CHIP program.

(Anna): Okay. And so that would mean - so if our premium was set to increase as a result of like annual rate negotiations, is that at all related to their can't apply more restricted methodology or - and it's exempt for a separate CHIP?

Sarah Delone: Can you say a little bit more there? I didn't quite follow and I'm not sure…

(Anna): Sure. So as a result like for annual rate negotiations with our managed care organizations the premiums are set to increase as a standard annual thing. Is that something that we cannot do at this time as part of the cost share requirement that applies to separate CHIP? Or is that something that would be considered a more restrictive methodology and a separate CHIP would be exempt from the 6008(b)(1)?

Sarah Delone: Right. So that - premiums actually fall under 6008(b)(2). There's a special - there's a special rule around premiums that only applies to Medicaid. And for that you, you know, for that space have to continue - can't raise the premiums charged in Medicaid higher than the levels that were in fact (merging) January 1st.

But regarding that separate CHIP nothing - none of the conditions that are in 6008(b) apply with respect to separate CHIPs.

(Anna): Perfect. Great. Thank you very much. That's all my questions.

Coordinator: Thank you. Our next question comes from (Laura). Your line is open.

(Laura): Hi. This is (Laura) from Illinois. And I had a question and potentially a follow up question, on the 1135 waiver, the blanket waivers. I just wanted to - it sounds like the - from what you said but because some of them were in our state's initial 1135 request and not in the initial approval letter. I just want to double check.

If all providers don't have to take any action for those waivers and it applies to the extent applicable under that regulatory provision, does that also mean that all providers could implement those for the Medicaid program as well and the state does not need to take any additional action or receive any additional

1135 letters from CMS to tell providers that they implement them - those waiver are no in effect for Medicaid beneficiaries as well?

Jackie Glaze: Calder, do you want me to take that one?

Calder Lynch: Yes. I mean I think that - yes, I'll start just by saying I think the answer is generally yes, but we're working with states individually just (unintelligible). So Jackie, do you want to kind of explain the process?

(Laura): Okay. So then as far as the (supreme) with states - oh, I'm sorry. Go ahead.

Jackie Glaze: No. Go ahead. I'm sorry. I didn't mean to interrupt.

(Laura): I was just going to say as far as working with states on nuances, is that in regards to if there is anything that was waived that is in like a state plan amendment or something like that? Is that when you have to work with them individually?

Calder Lynch: Jackie, do you want to…

Jackie Glaze: What we would like to say - yes. So essentially for it to apply for Medicaid and CHIP the providers would have to have that certification through Title 18, 19 and 21. So the providers would have to have that type of certification for those blanket waivers to apply. If they're a Medicaid only type waiver we would have to do some follow up work with the states. Does that answer your question?

(Laura): Can you say one more time the distinction between having certification for 18, 19 and 21?

Jackie Glaze: Yes. So for Section 18 would be Medicare and then 18 would be - 19 would be Medicaid and then 21 would be the CHIP population. So those are the provisions within the Social Security Act. So the providers would have to have certification as a provider, through those programs.

(Laura): Through all three. And if they have it through all of those programs then your blanket waiver applies to all three?

Jackie Glaze: Well it - well (Laura) it would mean that - so generally Medicaid follows Medicare certification. So if the provider - it would depend on where the provider is certified. So…

Anne Marie Costello: But I think (Jackie), I think - Jackie, I'm sorry to jump in. I don't think that you need a provider to be certified for all three programs. If they're certified - the blanket waiver would apply if they were certified in any of those three programs. Is that not true Jackie?

Jackie Glaze: Yes. So it would be the programs that you're wanting the blanket waiver to apply to. So those providers within that program that you're wanting that blanket waiver to apply to. So if you have CHIP providers or you have Medicaid providers they would need to be certified.

(Laura): Okay. But we can tell our - so we can tell our providers the blanket waivers that came out this week, that they can - but when they're serving Medicaid beneficiaries they should also consider them waived and could start implementing those immediately?

Jackie Glaze: Yes. That is correct.

(Laura): Okay. Thank you.

Coordinator: Thank you. Our next question comes from (Lindsay). Your line is open.

(Lindsay): Hi. This is (Lindsay) from Indiana. I'm curious if anyone has come across a situation or if anyone is requesting to have provider enrollment into their Medicaid program waived or some piece of that waived. We have numerous physicians, many of whom are retired, that are volunteering to come back into the workforce to treat COVID patients or to offer relief in the hospital for those who are treating those patients.

And our hospital association has requested that we waive our enrollment requirements under the circumstances. So I was interested if anyone has come across that.

Jackie Glaze: Calder, would you like for me to take that one?

Calder Lynch: Yes. Certainly I believe that's a commonly accessed 1135 waiver right Jackie?

Jackie Glaze: Yes. Yes. And I also believe it's in the blanket waiver that was issued this week. I will double check but I'm almost certain it was included in there.

(Lindsay): Thank you.

Coordinator: Thank you. Our next question comes from (Michelle). Your line is open.

(Michelle): Hi. This is (Michelle) from Maine. And I was calling to ask whether or not states can take a staged approach to submitting disaster relief. I have heard conflicting reports from different states as to whether everything needs to be submitted at once or whether we can submit more than once.

Jackie Glaze: Calder, would you like for me to…

Calder Lynch: Yes. It absolutely takes - you can absolutely take a staged approach. Yes. The others can add more detail.

Jackie Glaze: Yes. Most definitely you can because you can submit one disaster response waiver or you - (responding), or you can submit additional ones after that. So whatever flexibility that you need.

(Michelle): Great. Thanks so much.

Coordinator: Thank you. Our next question comes…

Sarah Delone: Before we get to the next question I want to thank our state partners in Wisconsin, this is Sarah DeLone speaking, for pointing out that there is still the maintenance of effort requirement from the I forget it now, the ACA or the Healthy Kids Act that still is in effect for CHIP. And that - so even though that's not contingent upon the (FMAP) bump you still have those maintenance of effort requirements that apply.

So I wanted to clarify that for folks. Thank you.

Coordinator: Thank you. And as a reminder, if you'd like to ask a question please press star 1. Our next question comes from (Lea). Your line is open.

(Lea): Hi. This is (Lea) in Colorado and I have questions from my case management colleagues around the continuous coverage requirement for enhanced (FMAP). They're three related questions so I'll just reel them off either to get

an answer today or to get an answer in the FAQs when those come out next week.

The first is confirming I think the question that CMS provisionally answered last week, about whether we need to maintain HCBS eligibility on current service level for all members. And if relevant, I'll add that our HCBS programs are done through waivers, not through the state plan.

The second question is if yes, does this mean that a member cannot be closed out due to not having an HCBS service for 30 days? And three, what are the requirements for correcting closure and service reductions back to March 18th?

Sarah Delone: So this is Sarah DeLone. I think we should - we do have an FAQ that's working through, you know, our process on that. I think you've added some new, you know, some sort of additional follow ups to the question that was asked last week and that we should probably take that back offline and think those through so we can get back to you and to all other states who I'm sure are interested in the same - answers to the same question.

(Lea): Thank you.

Coordinator: (Lea), does that conclude your question?

(Lea): Yes, it does. Thank you.

Coordinator: Thank you. Our next question comes from (Eve). Your line is open.

(Eve Lickers): Hi. This is (Eve) from Pennsylvania and I wanted to ask about any guidance that will be coming out related to the school based access program. Currently

we are looking at the fact that our schools who are providing services and holding classes remotely are not likely to meet the threshold required for the random moment time study. And so we are concerned about them being able to meet, you know, those - the valid percentage and how that might impact, you know, the payments that would be made to them.

Also we're looking at the fact that, you know, they're under a certified public expenditure methodology. And so there is timing related to some of the activities in which that cost reconciliation has to be completed. So I think that it was last week that there was mention that there would be some guidance that would be coming out and I was just curious when that might be.

((Crosstalk))

Jeremy Silanskis: Sure. Yes. So we do have some FAQs coming out on modifications to the random moment time study. But I think, you know, a lot of these issues are going to be state specific. So I think that your best bet is to work directly with my team here and we're happy to work through those issues with you. So if you would come in through your state rep we can get you the right people and make sure that we are working with you to address those issues.

(Eve Lickers): Okay. Thank you very much. And we do have a request in for a call with CMS to talk about the various provisions that we are looking at and also some of the other issues. Also I had one other question as it relates to the copayment exclusions.

So for the disaster (spa), it is our understanding that if we would go to - from the FAQs that you could not exclude say like based on diagnosis of - or either the individual has or is suspected of having COVID-19 we cannot waive

specific COVID payments in that way, through the disaster (spa). Is that correct?

Sarah Delone: That's correct but you can and Stephanie Kaminsky can jump on if she's on and add in of she needs to, but that's correct. But you can exempt from cost sharing COVID-related services. So you can reach the same results in terms of the cost sharing for the treatment of COVID. You just - if somebody who is infected with COVID needs other services they have a broken leg let's say, you couldn't exempt cost sharing for their broken leg and not also exempt cost sharing for other beneficiaries.

(Eve Lickers): Okay. Because that - I mean we have a few items obviously that are specific to COVID like the testing or the specimen collection. But if I have to go for an inpatient hospitalization or I have to go - have a, you know, a consultation, those are not specific to COVID without a diagnosis. So if we were to waive copayments for that it would seem that we would have - based on the FAQs, we would have to waive any copayment that would be assessed for consultations as a whole, for the entire population. Is that correct?

((Crosstalk))

Sarah Delone: Why don't, you know, I don't think - I think - go ahead Stephanie if you want to jump in. I think we have probably a very technical one on one that we can do with you and will probably get you where you need to go where you're trying to get to.

(Eve Lickers): Okay, thank you. Then we will…

Sarah Delone: Stephanie, do you want to jump in?

Stephanie Kaminsky: Sure.

(Eve Lickers): …look forward to discussing that with CMS on our call.

Stephanie Kaminsky: And can you just remind me who this was; who was asking the question?

(Eve Lickers): This is (Eve Lickers) from Pennsylvania.

Stephanie Kaminsky: Okay, great (Eve). I would just say that like others have said, we are early on the verge of releasing another set of FAQs, a lot of them around the legislation. And there are some FAQs around, you know, what does it mean to be a testing related service; what does it mean to be treatment for COVID-19? You know there are some parts of the legislation that hint at sort of associated services or approximate services, etc.

So I'm not sure about the scenario you're thinking about. I'm happy to have a conversation, you know, directly with you but please look carefully at those FAQs when they come out.

(Eve Lickers): Okay. Thank you very much.

Coordinator: Thank you. Our next question comes from (Henry). Your line is open.

(Henry): Good afternoon. Thank you for taking my question. Again, I appreciate these calls. The questions I have today are related to inmate populations and what flexibilities if any, might be available relative to the COVID testing space. And is there any exceptions to the exclusion that exists with respect to the COVID - if it didn't approach in inpatient level of care?

Calder Lynch: Thanks (Henry). I, you know, we have been - had a number of states ask us about, you know, approaches to the inpatient level of care. So we've been exploring - it sounds like you're asking more with regard to testing. I don't think we've - that's been broached yet in terms of, you know, any types of labors of the (FFP) exclusion there.

I'm happy to work with you on that but just it has not been considered at this point.

(Henry): Thank you. That's all my questions for today. I appreciate it.

Coordinator: Thank you. Our next question comes from (Anita). Your line is open.

(Anita): Hello. This is (Anita) from West Virginia. I have a question about the FFCRA and enhanced (FMAP) and the types of changes to eligibility we can make in enrollment. Are we required to or permitted, to act on like increases of income when it comes to calculating the cost of care to nursing facilities, the post eligibility treatment of income cost of care?

Calder Lynch: So let me start by saying that we've got some very detailed FAQs coming on these topics, but I think Sarah and the others can provide a little bit of information today.

(Anita): Okay, thanks.

Sarah Delone: Yes. I think actually Calder it may be best for those to go to - I mean to wait for those to come, to go through. It's a very sort of particular application of those and what that means. I'm hesitant to give - well I'll tell you where we think but it's really - it requires some legal analysis and we want to make sure that, you know, everybody is in the same place.

But probably it's going to be - people - the sort of the scope that the coverage that they're getting needs to be maintained and that's sort of the general principle that sort of cuts across all of it. But each situation has a little bit of nuance, so it would probably be best to wait until the FAQs come out. And if they don't answer it then let's - and you have another sort of variation on the theme, then we should follow up and get that answered for you.

Calder Lynch: You're right Sarah. I'm sorry. There are some tricky issues there because it's not explicit, right, and we're trying to work with those to get the cleanest interpretation we can and give you guidance. But that's definitely the types of questions that we anticipate being detailed in the next round of FAQs which again as I said earlier, we'll have out early this week. So we can follow up with them on next week's call.

(Anita): Okay. Thank you.

Coordinator: Thank you. Our next question comes from (Bea Rector). Your line is open.

(Bea Rector): Thank you. It's (Bea Rector) from Washington State. It's our understanding that the enhanced (FMAP) through FFCRA doesn't have any stipulation about any general funding savings that are generated due to that (FMAP) must be sent in the programs where the enhanced matching rate was generated. We just want to confirm an accurate understanding.

In other words, it's a state's discretion to decide whether or not to use funding generated through let's say a 1915(c) waiver to provide relief to providers in that waiver, or we have the discretion to use those funds to apply it to providers in another authority.

Calder Lynch: Thanks. That's - let me check with - I'm not aware of any restrictions on how states need to reinvest these savings from the enhanced (FMAP). But let me just double check. I don't know if (Jeremy) or anyone from the FMG team is aware of anything I'm missing there.

(Jeremy Silanskis): I don't think so. Let us take that one back though and just make sure so we're giving you the right information. But I haven't seen anything either that specifies.

(Bea Rector): Thank you very much.

Coordinator: Thank you. Our next question comes from (Kristen). Your line is open.

(Kristen Dadi): Hi. This is (Kristen Dadi) from Connecticut. My question is related to the new uninsured 23 group and I'm particularly interested in knowing when or how soon CMS anticipates releasing guidance, and particularly perhaps a draft or a template application to be used.

Calder Lynch: We have developed a template application. We're trying to figure out the fastest way to do that for you guys, which I think will be coming in the next few days hopefully. And then (Anne Marie) or Sarah did you want to pull out anything else in terms of guidance there?

Sarah Delone: We do have in the next batch of FFCRA FAQs that both will have more FAQs about these conditions for the 6.2% (FMAP) bump also to address some of the other provisions, the new optional group and some of the coverage and cost sharing provisions. Those are coming out. Was there a particular question about the…

((Crosstalk))

(Kristen Dadi): …on the eligibility side we were curious to know whether or not we could accept self-attestation of immigration status.

Sarah Delone: Well you certainly have the - I mean you need to do - you can't - no, let me - no, there's nothing in the FFCRA that changes the limitation on FFP that's available for non-citizens who are not in a satisfactory immigration status. There is of course, you know, and there's nothing that changes the verification process.

So you still - there's a reasonable opportunity period for individuals who attest to being in a satisfactory immigration status, you know, pending verification of that status. But the FFCRA doesn't change any of those rules.

(Kristen Dadi): Thank you for clarifying…

Sarah Delone: Is that helpful?

(Kristen Dadi): That was our interpretation but we wanted confirmation. Thank you.

Sarah Delone: Yes. You're welcome.

Coordinator: Thank you. Our next question comes from (Judy). Your line is open.

(Judy Marie Peterson): Hi. This is (Judy Marie Peterson) from Hawaii. And I joined late. So I apologize if this was addressed at the very start of the call. We've been getting lots of questions not about the unemployment benefits that were included in the CARES Act but just to be very clear that we will not be counting them for eligibility.

But we've also been getting lots of questions about whether the stimulus check that was in the CARES stimulus package, whether that will be - whether we will be allowed to count it or to not count it, especially for (MAGI) but also for any of the age, blindness, disabled programs.

Sarah Delone: So we think and we're still confirming (Judy) that we are fairly confident it is definitely not counted for (MAGI) and we are fairly confident that it also would not be counted for the stimulus checks for non-(MAGI) populations. But we're working with our colleagues over at IRS Treasury to confirm and we'll do that. And we'll sort of let everybody know - we'll let you know and every state know, as soon as we get that confirmation.

(Judy Marie Peterson): Thank you very much. I appreciate it.

Coordinator: Thank you. Our next…

Sarah Delone: That may be in the next - that may be in the next set of FAQs that come out on the FFCRA if we're able to do so in time.

Jackie Glaze: (Amanda), we can take one more question.

Coordinator: Thank you. Our last question comes from (Tricia). Your line is open.

(Tricia): Hi. This is (Tricia) from Maryland. You might have covered it earlier, but I know in the interim guidance final rule you were allowing Medicaid programs to have nurse practitioners and physician assistants to prescribe home health services. And I just wanted to understand the path in which we can actually implement that. Is that blanket waiver or do we need separate CMS approval?

Calder Lynch: I believe it would depend upon, you know, whether you have any particular restrictions in your state plan which would of course those could be modified using the disaster (spa) for the period of the public health emergency. That's me talking so let me let the actual experts weigh in and make sure that I didn't say anything wrong.

(Tricia): Okay.

Kirsten Jensen: Sure. This is Kirsten Jensen. That's correct. If you have language in your state plan that restricts to just physicians we would certainly need a (spa) - a disaster (spa) for that. We're also recommending that even if you don't have that language to include it in a (spa), just so that we have record that you have done that during the period of the emergency.

That most importantly it's - if you have language in your state plan that restricts it to just physician ordering only.

(Tricia): Okay. I actually think we don't have it in our state plan but we actually have regulations on it, so - but yes, we'll make sure we include it in the (disaster) spa. Thank you.

Kirsten Jensen: Yes. That would be helpful. We just want to make sure that we have some documentation of it if - you know, when we get through all of this and if there are ever any questions about it. Yes.

(Tricia): Got it. Okay. Thank you. Could I ask one other question?

Calder Lynch: Go ahead.

Woman: Sure.

(Tricia): In terms of the multiple disaster (spa)s, do you want us to only include when we do a new disaster (spa) to include the new information if the subsequent (spa) has not been approved yet? Or do you want us to keep adding everything onto the template, if that makes sense?

(Anne Marie Costello): This is (Anne Marie Costello). I would say keep them as separate (spa)s.

(Tricia): Okay. Thank you.

(Anne Marie Costello):So the (unintelligible) doesn't slow down - the teams are working very quickly to try to do the adjudication of submissions, so we wouldn't want to slow one down.

(Tricia): Okay. I appreciate it. Thank you.

Stephanie Kaminsky: But (Anne Marie) this is Stephanie and I just want to say that in some cases we just have to be careful that we're not superseding something that has - if we granted authority so we'll have to work individually if it's on the same page.

(Anne Marie Costello):Well of course. Yes, of course. You can - for the review, but I don't think we want to hold up a state until they figure out everything that they're doing.

Stephanie Kaminsky: Agreed. Agreed.

Jackie Glaze: So I'd like to thank everyone for today's call and joining us. And just reminding you that we will have another call on Tuesday and that will be at

the same time, at 3:00 pm Eastern Standard Time. So more information will be forthcoming on the topic. So we thank you all and hope you have a good weekend.

Coordinator: That concludes today's conference. Thank you for participating. You may disconnect at this time.

End