Centers for Medicare & Medicaid Services
COVID-19 Medicaid and CHIP All State Call
Friday, April 24, 2020
3:00 p.m. ET

Coordinator: Welcome and thank you for standing by. At this time, all participants will be in a listen-only mode until the question and answer portion. If at that time you would like to ask a question, press Star 1. Today's conference is also being recorded. If you have any objections, please disconnect at this time.

And now I'd like to turn the call over to your host, to Jackie Glaze. Ma'am, you may begin.

Jackie Glaze: Thank you, Melissa. Good afternoon, everyone. And welcome to today's All-State call. I'll begin with Calder Lynch. He has some highlights for today and will walk through our discussion. So Calder?

Calder Lynch: Thank you, Jackie. Thank you and good afternoon, everyone. Thank you for joining us on this Friday. Today, we're going to be continuing our conversation including some lessons from the field.

We're with special guest, Sara Hall, from the State of Colorado, who will be sharing some of their experiences in utilizing the 1915C Appendix K flexibilities in response to COVID-19.

We're going to pair (Sara)'s presentation with (Ralph Lollar) from CMCS to provide some of the federal perspective around the Appendix K development and submission in order to continue assisting states in their requests and their ongoing implementation of these efforts.

After (Sara) and (Ralph)'s presentation, we'll take some questions on Appendix K if there's any particular questions on that topic and after that we'll also then share some additional information regarding the new optional eligibility group for our COVID test we have on insured individuals and then open it up to general questions from the audience.

Before we move into our special guest presentation, I wanted to highlight a couple of announcements that were made this week. The first was an announcement made first by CMS and the Office of the National Coordinator regarding our collective interoperability rules that were recently finalized.

In light of COVID-19, these agencies will be exercising discretion and forcing the new requirements under the final interoperability rules. More specifically, the requirements to establish a patient access API and provider directory API will not be enforced until July 1st of 2021.

This additional flexibility for the development and implementation of these very important efforts enables us to continue focusing on the COVID-19 pandemic while still maintaining a trajectory that will enhance patient access to health information.

I also wanted to highlight an action that the department continues to take with regards to provider relief funds as part of the Cares Act appropriation.

On Wednesday of this week, the department issued a press release that we distributed out over our listserv providing some additional details regarding further allocations of those funds.

As I had mentioned in other calls, you know, the things are continued efforts to get out to three major tranches of the provider relief funds now and over the

next several weeks.

The actions this week are really completing that first response funding to get out a general distribution of funding to providers who have some volume of Medicare fee for service going and this second release this week was really geared toward leveling off level funding to those providers in total revenue.

The second tranche of funding will focus on high-impact areas, rural providers and funding for Medicaid-only providers. I know there's a lot of interest in that and we're working with the department to provider greater, you know, information as we can about how that's going to work and we expect to have more discussion on that soon.

And then the last tranche is going to focus on providers who are providing mechanisms to reimbursed providers who are treating COVID-19 patients who are uninsured and that there's more detail with regards to how providers could register and submit claims up on the HHS Web site now.

So our hope is that (unintelligible) working to have some folks to be able to provide more detail regarding the provider relief funds and be able to answer questions regarding that and are working to do so.

In addition to that, our team in CMS continues to focus on a lot of the work that we've been doing with you all and now have for every state and nearly every territory and at least an initial approval of an 1135 regulatory authority right up to 41 Appendix K has been approved which we'll be talking more about today, 18 approved Medicaid disaster spa, 8 emergency IT funding requests.

I was very excited that on Tuesday night we released our first COVID-19

1115 demonstration approval for the State of Washington and there's information on it up on our Web site if folks want to go take a look.

We're continuing to work through all of those, as well as, the CHIP disaster spas and some of the other regulatory flexibilities that things are continuing to request and need.

So with that, I'm going to turn the conversation, I believe, over to Ralph who is going to introduce our guest speaker.

Ralph Lollar: Thank you, Calder. Just to give some initial information, your Appendix K is a disaster relief option for 1915C waivers. It's been used for a number of years to address national disasters such as hurricanes, floods, tornadoes and wild fires that allows the state to increase provider types and options to adjust rates to make retainer payments, track services and a number of other options.

It's in high demand right now due to the COVID-19 pandemic. The Appendix K is approvable retrospective to the date the Secretary identified for the pandemic January 27th of 2020.

It is - it can be in place for up to a year and it does not require public notice. One Appendix K can cover all of the state's 1915C waivers and as Calder has stated, to-date CMS has approved 41 Appendix K's for the pandemic.

Colorado's a state that has considerable experience using the Appendix K to address state needs during the COVID crisis and it gives me great pleasure to introduce Sara Hurley from Colorado to speak directly about that experience.

Sara is an HCBS and Quality Advisor at Health Care Policy and Financing in Colorado. She has a master's degree in social work from the University of

Wyoming. She spent the past 13 years working with policymakers, professional staff and community stakeholders in multiple health care programs and delivery systems.

She's worked at the Department of Health Care Policy and Financing for six years on program development, implementation and policy oversight. (Sara), I'm turning the mike over to you now.

Sara Hurley: Thank you so much for that introduction, Ralph, and good afternoon, everyone. Again, my name is Sara Hurley and I work at the Department of Health Care Policy and Financing in Denver, Colorado.

The department is our single-state Medicaid agency and we oversee and operate Health First Colorado -- which is our Colorado Medicaid Program -- Child's Health Plan Plus and other public health care programs for Colorado.

Within the department, we have the Office of Community Living which manages Colorado's Medicaid programs, services and support for older adults and persons with disabilities.

So the Office of Community Living manages Colorado's 1915C Waiver Program. Colorado has ten 1915C programs. We have 6 programs for adults and we have 4 for children.

The four programs for adults serve individuals with nursing facility level of care and they include programs for individuals who are elderly, blind and disabled, a program for individuals with community mental health support needs, a program for individuals with brain injuries and programs for individuals with a spinal cord injury.

The other two adult programs serve individuals with an ICF/IAG level of care. Out of the four children waiver programs, two serve individuals with an ICF/IAG level of care, one serves individuals with both nursing facility and hospital level of care and one with just hospital level of care.

Colorado has approximately 48,000 HCBS individuals utilizing these waiver services. We do not operate in 1915I or in 1915K programs.

So like most states, the main challenge that we've been experiencing in our LTSS programs in Colorado as a result of the COVID-19 pandemic have been really how to ensure our Medicaid members continue to receive the services they need safely in their home and community.

Some of the challenges and questions that we've encountered include how are we going to change our services where they're provided, expand their limitations during this period? How are we going to pay for possibly increasing a need for certain services? How do we make sure individuals who are providing in-home services and support to our members are safe?

And lastly how are we going to change our case management system to account for the need to reduce face-to-face interaction while still ensuring the health and welfare of our members?

So there were several steps that the State of Colorado need to consider before developed our initial Appendix K. We are fortunate enough here in Colorado to have a lot of communication with our stakeholder community.

So even before we drafted our Appendix K, the Disability Committee was able to talk with the department about some of the top issues Medicaid members were facing during this pandemic.

Some of these areas that they talked about included not being able to get food. And so the department needed to brainstorm how we could ensure that meals were being delivered.

Some of the issues were having a higher reliance on public transportation. So the department needed to look at certain safety measures to ensure that non-medical transportation was, you know, disinfected, limiting rides to only one person and having hand sanitizers in the vehicles.

Definitely having a lack of personal protective equipment, I know this challenge is not just unique to Colorado, but, you know, trying to coordinate and increase the supply of personal protective equipment for our long-term care facilities and HCBS providers has been something that we are really working on.

In addition to training individuals on the importance of using PPE and really universal precautions for sterile medical equipment repair workers, supply/delivery, et cetera.

Some of the other issues workers and care workers may not be able to continue providing services. And so how does Colorado ensure that members are still getting their personal care needs met during this period?

And then really to waive as much in-person visits as possible. And so from these conversations we determined that clearly we needed a lot of flexibility in our services.

And fortunately, the Appendix K allows a lot of it. It allowed us when possible for as many services as we could to be provided via technology

solution allowing family and legally responsible adults to provide services such as homemaker and personal care to kind of limit the need for outside individuals into the home.

In addition, allowing relatives to provide over our limitation of 40 hours of personal care a week and also an authorized representative to provide care if the personal care worker is unable to.

And lastly, allowing the - for the possibility of services to be provided in alternative locations or in smaller settings.

Clearly, with all of this, we also need to look at our budget. We needed to kind of have a discussion on balancing this as the state see a significant drop in overall state revenue we are faced with trying to balance and increase the need within services.

This required us to be really creative and really focused on changing who can provide a service while remaining within some of our current authorizations.

And as I spoke before, we had to consider how to kind of change our case management system prior to completing the Appendix K. We had to ensure that members would maintain eligibility so that Colorado removed a requirement to obtain a medical form during this pandemic.

This medical form is filled out by a licensed medical profession who as we all know are very limited on their hours, it's very hard to get in for a virtual visit, there are so many office closures.

And so Colorado is taking action wherever possible to kind of limit this administrative burden which could negatively impact the members in

accessing their services.

We also were changing formatting of daily operations to video and audio calls with our case management agencies obtaining signed forms by digital signatures and allowing additional time to obtain these forms through postal mail.

And then clearly the coordination of care and changes that are due to business closures and shortness of available staff. So really, you know, how did Colorado determine which authorities might allow for necessary emergent health care flexibilities?

Was it the 1115 or 1135 or the disaster relief spa? And really before our governor declared a state of emergency and the president declared a national emergency, Colorado had already started working on our Appendix K and our 1115.

This clearly changed due to new CMS guidance, the Family's First Response Act, the desperation of a national emergency. And so initially we really had a - so everything but the kitchen sink mentality into Appendix K.

There were just so many unknowns that we wanted to put in everything we possibly could to ensure that there wouldn't be a gap for our participants.

You know, we also had a lot of conversations with our CMS team as we have never had this emergency to this scale hit our state and, of course, the nation before.

And so we worked with them to discuss the process of where should we put these different flexibilities. They really helped a great deal with kind of

changing different requests from maybe the Appendix K to the 1135 to the disaster spa.

And then we also developed a core team of departments as I'm sure many state agencies have so many different offices. We needed to make sure that we weren't siloed and we weren't working on our own thing without talking to one another.

And so we meet daily with a participant from each office to ensure that we are coordinating these efforts. And so as (Ralph) mentioned, we have submitted a received approval for Appendix K.

We've actually submitted three Appendix K amendments and there were a lot of factors that went into determining why would we need to submit another Appendix K.

As time went on, we discovered that the first Appendix K that we had submitted we missed some necessary items. So we added some items to our level of care assessments and staffing and training ratio requirements, retainer payments and utilized the new check boxes of the first template specifically around processes for allowing extension for reassessments and reevaluations and adjusting prior approval authorization on this.

So in our experience the new COVID-19 1915C Appendix K template and instructions with that have been really beneficial. So again, we started the Appendix K very, very early and when we did, we began with doing 10 different Appendix K forms, one for each waiver program.

We felt that even though, you know, our programs are similar in some respect, they're really just too different to combine. And so we submitted all ten to

CMS, but we were able to work with CMS in order to merge those ten into one Appendix K form.

And this would cut down on so much confusion and decrease the administrative burden of having ten different amendments to manage. And with our second and third Appendix K submissions we were able to, again, use the new template which has really streamlined our amendments even more.

So our experience with the submission of additional 1915C Appendix K after our first one has been really positive. We have worked with CMS on these second/third submissions and it's been a very easy, quick turnaround.

We've been able to get approval in really an unprecedented amount of time. And the development of Appendix K template really assisted with coordination and just made the process a lot easier for all involved.

There were different requests that we hadn't even thought to include in our first submission, but with the creation of the different check boxes at the end of the template we were really able to kind of get some other ideas and really work on those different processes.

We also really appreciated the consolidated approval letter for the 1915C COVID-19 Appendix K. Clearly with 10 programs and 3 different submissions, we would've had a lot of approval letters.

So it's created a lot less confusion to have these approvals all in one letter. So Colorado has taken the approach of really over-communicating as much as possible with our providers, our waiver participants, our family members and our disability community about our Appendix K.

We have created a memo series that is on our Web site. We have developed many, many memos discussing the different changes in operations for the Medicaid program due to the Appendix K and the COVID-19 pandemic.

These range from information for case management agencies about administrative changes, it outlines in different PASRR changes, different changes to our residential services and some changes to our non-medical transportation benefits such as within this benefit, you know, we listed in our memo that rides should only be by individuals who do not have a temperature greater than a hundred degrees.

And then some rides to be limited to one member per vehicle in order to comply with social distancing requirements, and that providers still use disinfectant wipes on areas between riders.

We also utilize Webinars. The department hosts weekly Webinars on Fridays for providers, case management agencies, skilled nursing facilities, intermediate care facilities and community members.

As of today, the department has hosted 21 Webinars. All of these Webinars are posted on our Web site with the recording and the slide deck included.

And so we're able to go back to different Webinars maybe on April 7th and you're able to kind of participate, read the chat box comments. We averaged about 900 participants on Friday and we answer questions in a realtime chat box, as well as, having 30 minutes of questions after the presentation of new material.

We also have a COVID-19 specific newsletter that individuals can sign up to

receive updated information and we have a COVID-19 email inbox.

Individuals are able to email the state directly with your questions regarding COVID and this is actually how we treat, A, our FAQs which are located also on our Web site.

These FAQs are more of a at-a-glance review of the memos and the questions we get. We usually trend the questions that we receive and then we post the top three to seven concerns and questions every week.

In the beginning, we received a hundred to two hundred emails a day and since the Webinars seem to really stabilized and we slowed down to maybe 60 to 80 day.

We have a dedicated team to monitor the inbox and tracking to ensure that responses get out. Some of these things that had really emerged include things, like, retainer payments, face-to-face visits for case management agencies, tele options for services and just a lot of billing questions.

To this end, you know, has Colorado done everything perfectly? Of course not. We continue to work every day to improve the program, but there have been a lot of things that have worked for us, just as well as there are some things that we would maybe change next time.

The things that have worked really well have been working with our other state agencies. Our Department of Public Health and Environment has just been a great partner. They have been helping providers find PPE.

They review memos that we send out. They join Webinars and are helped using across agency task forces. We also have a lot of stakeholder engagement

and this has helped us limit and reduce some problems before they may have occurred.

We have large advocacy and trade organizations that read and gather questions for their group to make sure that we're able to provide the information that they're needing and use these questions along with the inbox trending to build the weekly Webinars.

We also use, you know, the CMS Web site for the approved Appendix K doc notes, the tool kits, the templates and the instruction manual. I can't stress this enough.

Also use CMS. They are incredibly helpful. They have been so great at problem solving with our state on different challenges such as different payment options, where we might be able to get approval for this service.

They have been really great at getting communication out to us, getting on the phone immediately, and really just being an incredible service for Colorado.

You know, clearly one of the biggest challenges that were occurring- that's occurring right now is how to do we operationalize all of this, you know?

As you know, you can put in all of this information into an Appendix K and then you have to figure out how can we really get this done for our state, as well as, making sure that we have a plan to when this pandemic is over to start backing out of some of these

So in short, I really wanted to talk about how our process with the Appendix K has been really beneficial. I can't say this enough. To wait until everything is perfect before you - you know, when you submit your first Appendix K in a

period of time, like when time is of the essence, it’s been really helpful for us to be able to submit these amendments to be able to have real time conversations with CMS and to have a turnaround that is very quick with our approvals.

Clearly, we have done this three times. I'm not going to say that that's our last time, but it's really nice to have that option and that open communication with CMS during this process.

And with that, I can, I think, turn it back over to Ralph.

Ralph Lollar: Hi. Thank you, Devin, that was - thank you, Sara. That was really, really informative and very much appreciated. So what I'm going to do now is give you just some tips to fall back on that you should've heard as part of our - Sara's presentation. So let's (dovetail) off of that and talk about some important things to remember.

The one that Sara hit on at the end are - which I think is so important is the Appendix K is not a one and done. If you determine that there's something else you want, you can submit an additional Appendix K with the same implementation as the first Appendix K.

You can use that Appendix K to cover one waiver, multiple waivers or all of the waivers in this state. And (Sara) has already shared that she found its use in covering all of the waivers in this state to be very helpful to her.

For retainer payments, there's nothing that prevents a state from amending the number of debt holds in a state plan. So we urge state as a put language on retainer payments into the Appendix K to cite that retainer payment time limits may not exceed the lesser of 30 consecutive days or the number of days

for which the state authorizes a payment for bed holds.

That way if you change your debt hold days you were already covered in the approved Appendix K that would have to amend. When indicating weight adjustments, make sure that you indicate the fact is a component influencing the adjustments such as increasing the provider pool, allowing for increased risk, additional training, increase intensity of services, et cetera, and set an upper limit.

For example, no more than 50% of the current rate. We - I want to make sure that you know that based on the Cares Act if the state would be rendering (HCBS) services in a hospital setting for which they will be offering Medicaid reimbursement there's no longer reason to include a limitation. The Cares Act does not cite one.

With regard to Appendix K, one final tip or hint, Appendix K's are amendments. They're temporary in nature, but they are amendments.

So when you submit it, avoid wording, like, the state is asking for and ensure that you're saying exactly what would be done in the Appendix K. So, for instance, if you are - if you want to address payment, you don't say the state is asking to increase the payment rate for a service.

You say the payment rate for a service is increased by and that will help you with the Appendix K as you publish it with your stakeholders. I also at this time want to announce some additional flexibilities that are available through the 1135 options now.

And for the 1915K community first choice level of care determination for the 1915I HCBS state plan required timeframes for initial evaluations and

assessments and for the 1915C HCBS waiver level of care determination and for re-determinations for all of them.

You can now get relief through the 1135 that will allow you to postpone a reassessment for up to one year and to begin rendering services prior to the initial assessment.

For use of a legally responsible relative to render state plan services, specifically personal care services, the 1135 can be used to waiver medically necessary services to be furnished in the event of the traditional provider work force diminishing and you can use the public health emergency to authorize use of legally responsible relatives render personal care services.

For HCBS settings requirements, many states are having to add alternate settings to their waivers and Appendix K's and Appendix I's normally a new setting added to the - any of those authorities would require that that setting come in fully compliant with the rule.

The 1135 will allow the state to waive that option. With regard to conflict of interest in a 1915C, K or I, case manager conflict of interest, you can waive that conflict of interest through an 1135 which would allow the entity that is currently rendering case management to render direct services during the pandemic and continue to include your - increase your provider pool to render direct services.

And finally, with regard to signatures on purchased center service plans, you can use the 1135 to authorize verbal consent as an alternative to a written statement.

So with that being said, I'm going to turn this over to Jackie, I believe, for a

Q&A period. Am I correct, Jackie?

Jackie Glaze: Yes, thank you, Ralph. And thank you, Sara, for your presentation. So at this time, Operator, could you open up the line so that we can take questions from the audience specific to the 1915C Appendix K?

Coordinator: Yes, ma'am. Thank you. At this time if you would like to question, please press Star 1 and record your name. Again, if you would like to ask a question, please press Star 1 at this time. One moment for questions. And one moment. And our first question comes from David. Please state your state, please.

David Ward: Oh, good afternoon. This is David Ward from Oklahoma. Ralph, I want to make sure I heard you correctly on the Appendix K and the signatures you were just speaking of.

So we - you were advising that we go through the 1135 waiver authority to grant that the signatures be - or, I'm sorry - that the signatures be waived through a verbal consent; is that correct?

(Ralph Lollar): If you want to completely waive signatures and substitute verbal consent, yes, the 1135 will be the route to get to that.

(David Ward): Thank you. And that will be applicable for the state plan and the waiver programs; is that right?

(Ralph Lollar): For person center planning purposes under any authority, absolutely.

(David Ward): Okay. Thank you.

(Ralph Lollar): You're welcome.

Coordinator: And once again, if you would like to ask a question, please press star 1. And with that, I'm showing no further questions.

(Jackie Glaze): Thank you, (Melissa). So we'll move on to our next agenda item. So (Jessica Stevens), (Rory Howe) and (Julie Boughn) will like to share guidance on operationalizing the new eligibility group through the COVID-19 testing for the uninsured individuals.

So I'll turn to (Jessica).

(Jessica Stevens): Thanks, (Jackie). We all - we wanted to just acknowledge that the number of states have sought technical assistance from us recently about how to operationalize implementation of the new COVID-19 testing, the new 23 group described in the first - a family's first Coronavirus Response Act.

And while we've had some conversations individually with states, we really understand that there is not sufficient time for states to do normal system changes that would ordinarily support a moment in any group and have been reaching out to some states to understand some of the challenges that you're facing.

But wanted to take this opportunity to provide a little bit of initial guidance to states that may be helpful as you continue, think, through and as we continue to hopefully come back with a little bit more guidance that may assist states particularly around eligibility enrollments, payment processing provider claims and expenditure reporting.

So I'll talk a little bit about the eligibility enrollment processing and then turn it over to others for the other parts of it. We did want to clarify that the

COVID testing group is a Medicaid eligibility group like any other group and for that reason there are some key things that would still apply.

For example, individuals would need to apply, consent to enrollment, receive an eligibility determination before, you know, Medicaid dollars can be paid for specific services.

So, for example, we've heard from a number of states about some options to effectively just have providers bill Medicaid directly without obtaining information from the individuals who are seeking testing.

This would need to provide individuals with some form of application that can be extraordinarily streamlined to collect some basic information like Social Security number, the declaration of citizenship or immigration status, attestation that an individual is not enrolled in other federal funded coverage and a signature that consents to essentially enrollment in Medicaid.

I wanted to flag that any dues is distributed as sample streamlined applications for states to use or modify. We know that a few states are already working on their own applications and you can feel free to reach out to us if you have not already received that and would like to.

CMS did not need to provide approval of the application, but we certainly are available to provide technical assistance as needed.

One of the other questions that we got around the - that we received around the eligibility enrollment process release to use of the verification requirements.

States may accept self-attestation of all of the eligibility factors needed for this

group, but for citizenship and immigration status. We recognize, however, that for many states the ability to track SSA and phase is only able to be done in the eligibility system. We've heard that from a number of you.

And wanted to just confirm, you know, just in regulations that for individuals who - for whom states are unable to test data sources to verify citizenship and immigration status up-front, for those who provide a declaration of citizenship or satisfaction immigration status at the time of application, those individuals should be enrolled and provided a reasonable opportunity period and the state just conduct that verification post-enrollments.

Lastly, I think on the eligibility and enrollment front we know that one of the challenges is ensuring that individuals receive a state of coverage (unintelligible) colleagues wonder that there are no requirements that individuals be enrolled in MMIS.

But to comply with provisions of the FFCRA, the continuous coverage provisions, individuals who may come back for a second or a third test after being enrolled the first time should be able to receive that without submitting a new application.

That is similar to how some states do things like family planning or emergency services, just to ensure that that coverage is continuous even if you don't have a stand in the eligibility system.

I'll turn it over to Rory to talk a little bit more about the change in processing a claim.

(Rory Howe): Thanks, (Jessica). So in our prior FAQ that we issued we did indicate that we would provide additional information on how states can report expenditures.

On the CMS 64, the claim with 100% federal matching funds for services and state administrative costs related to the new eligibility group. And while we haven't quite finalized the new expenditure report requirements on the CMS 64, we did want to provide a quick status update and some preliminary guidance.

And so to be eligible or to claim FFP at the 100% match and we will expect that, you know, states isolate those relevant services and administrative expenditures when reporting on the CMS 64 and we're currently exploring ways to make reporting, you know, those expenditures lease burdensome for states, you know?

And two options that we're looking through is either adding new sub-lines for certain CMS 64 categories of service or by adding a new form that specifically asks for the new eligibility group which would operate similar to the reporting for Medicaid expansion expenditures.

And again, we're really trying to identify the least burdensome path for states. And we also want to, you know - wanted to mention to ensure that expenditures are allowable and to create a clear audit trail, you know, we will expect states to maintain standard supporting documentation that associated with claiming expenditures in the CMS 64. So this would include, you know, the patient's name, their Social Security number, their date of birth, the date the services were provided, which services were provided, the name of the provider and the provider's location and address.

And so, you know, we will provide more detailed information as we have it. We just wanted to give you an update and lay off those expectations that we had now.

We do plan also to provide training for states once the modifications to perform are finalized and we have a new requirement.

So with that, I will turn it over to (Julie Boughn).

Julie Boughn: Thanks, Rory. So once people are determined eligible for the group and before you have to do your CMS 64 reporting, there's a process of paying the claims from the providers.

We don't have a, like, requirement that that literally be done in a states MMIS or whatever claims processing system that you use, but we do know that in order to make sure the claiming that (Rory) just talked about is accurate you have to implement cost of fees to track and store the individual claims to support the financial claiming, the support auditing and we need to make sure we get all the coding on those claims correct.

And that also will support because eventually, we will want that data reported to TMSIS, some rudimentary data around the eligible people, around the providers who provide the services, as well as, the actual claims themselves.

And so we're going to be working again more specifically on guidance around TMSIS reporting in the coming days and weeks, but we will expect that that come into TMSIS.

So I think that that sort of concludes what we're going to talk about (unintelligible) back over to (Jackie) now to do general Q&A.

(Jackie Glaze): Thank you, (Julie) and (Rory) and (Jessica). We'd like to take your questions now as (Julie) indicated. So (Melissa), can you open up the lines at this point?

Coordinator: Yes, ma'am. And once again, if you would like to ask a question, please press star 1 and record your name. Again, to ask a question, please press star 1. One moment.

Our first question comes from (Lisa). Please say your state, please?

(Lisa): Hi. This is (Lisa) from Kentucky. I have just a couple of questions. First of all, I know that there are several programs or ways for providers to get reimbursement for uninsured people who are receiving COVID testing and how do we - number one, how do we ensure no duplication of payments related to testing for individuals who are uninsured?

My second question is related to the eligibility piece. In Kentucky, we have a streamlined eligibility process. We're calling it presumptive eligibility. It's very streamlined, very similar to the process outline for eligibility.

So we are bringing individuals into our system and we have their Social Security number and all of that stuff. So they're already in our MMIS.

Is it possible that we could do some payment claims reviews and look and see if only those people who received testing that are uninsured because we can identify that in our system?

Can we pull those individuals out and include them in this group to get the 100% FMAP for them?

(Jessica Stevens): This is (Jessica). I'm going to start with your second question and maybe seek other's input on the first.

I think we might want to spend some time just to talk through your process in a little bit more detail. I think one of the things that stands out it sounds like this is not exactly what you are seeking to do, but because the uninsured testing group is not a (MAGI) eligibility group straight presumptive eligibility is not available.

Hospital presumptive eligibility, however, is an option for states - different states seeking to expand their hospital presumptive eligibility programs to include the testing group.

I think what I'm hearing though is something slightly different in Kentucky about essentially using the system in the portal and the information that you have in your current presumptive eligibility system to essentially do eligibility determinations for this group which may be a possibility, but I think we'd maybe like to talk about that a little bit more offline and fully understand how that's working; if that's okay?

(Lisa): Yes, fantastic. Thank you.

(Jessica Stevens): And can I start with other CMS callers on the first question?

Calder Lynch: This is Calder the question, you know, could vary as the option for states to adopt the test, but there is also administered through HRSA a mechanism for providers to be reimbursed for something for the uninsured.

And as your question around how to ensure (unintelligible).

(Jessica Stevens): I'm sorry. I'm sorry. You cut out.

Calder Lynch: Oh, did I cut out? I'm sorry. So is the question how to ensure not having

duplication between if you were to opt the uninsured group to reimburse for testing and there is also the program set up through HRSA to reimburse patients?

(Lisa): Yes. Yes, how do we...

Calder Lynch: Yes.

(Lisa): ... ensure no duplication of payments or - for those services.

Calder Lynch: That is a good question and I'm not sure if we've done an FAQ on that or if there's anything in the HRSA guidance, but we can check if no one on the line knows for sure and follow up in terms of what the procedures maybe need to be in place there.

(Lisa): Thank you. That would be great.

Calder Lynch: Yes.

Coordinator: Thank you. The next question comes from (Gary). And may I have your state?

(Gary): Texas.

Calder Lynch: Go ahead, (Gary).

(Gary): Okay. (Jessica), I just wanted to follow up on what you were saying about providers with respect to the new optional group. Can we use them in the eligibility verification process or not? I wasn't sure.

(Jessica Stevens): You could not use them in the sense of using them as presumptive eligibility,

like, provider (unintelligible) presumptive eligibility entities can make the eligibility determination to the extent that the state already has or would like to, you know, use providers or provider networks to serve as application assisters to help individuals complete an application that the Medicaid agency makes the final, quote/unquote, "determination" on. That would be permissible.

But I think what you're referring to more is having the providers make that determination in the way that they would through a presumptive eligibility process and unfortunately that was not an option made available with the passage of the act.

(Gary): Okay. Thank you. That's really good. That's really helpful.

Coordinator: Thank you. the next question comes from (Misty). Please state your state.

(Misty): Yes, this is (Misty) from Louisiana. I have a few questions. One, I'd like it if (Julie) could elaborate on what she thinks she means by rudimentary TMSIS requirements as compared to non-rudimentary TMSIS requirements, and then sticking with the theme of trying to figure how to get these guys in the eligibility system about making massive changes to the eligibility system.

One of the things that we had been exploring is if we have the provider that's providing the testing have the recipient fill out some sort of streamlined app when they get the test, they attest that they're uninsured, they fill out the information and the provider submits that to us and then the state has eligibility determination requirements that say that the recipient had himself attested to these criteria and the provider had attested to these criteria, that is our determination and we'll make the determination based on that.

So I'd be interested in any feedback on those thoughts. That would allow us to utilize functionality. We already have an eligibility system for HPE, but allow more than hospitals to test and submit the application for that.

(Jessica Stevens): Sure. I'll let you answer the first question. Go ahead.

(Julie Boughn): Thanks, (Jessica). Hi, (Misty). It's (Julie). So I used that phrase, "rudimentary" because we're sort of acknowledging because of the compressed time here and the sort of speedy nature that we're trying to do that we may not have everything that we have all the people, the enrollees, providers and the claims themselves that we would usually have in order to fully complete TMSIS.

And so I think what we would want to do is we said that you are doing things like outside of your normal processees and normal systems - and this sort of goes for all states - to have a conversation with you about what that might mean in terms of TMSIS.

So it's just, like, I think it's an individual kind of offline conversation that we would want to have.

(Jessica Stevens): And then on the second question, I'll break into two parts. To the extent that you're talking about using the process that you just described essentially as an expansion of your hospital presumptive eligibility program with hospitals as the providers, that would be permissible.

But I think the more specific description that you gave was really more of a presumptive eligibility process where the state would be - would not effectively be making the final determination to providers outside of the hospital would be.

And that would not be permissible; however, as I noted, self-attestation can be used to make the eligibility determination for everything but for citizenship and immigration status.

So I think there's a way to get you close to where it is that you would like to go, potentially even using the portal that you're describing, but as I said, we're doing a little bit more thinking about this and can probably come back with maybe additional flexibility and probably talk to you individually as well to see how we might help you achieve what you want to achieve.

Sarah Delone: I am also hearing in the question a little bit of a question will be about the - using providers as application assisters to help collect that information which there might be funneled through the P.E. portal. And so that's something else we may just - another angle that we may take fast and sort of trying to put through as a possibility.

(Misty): Thank you.

Coordinator: Thank you. The next question comes from (Erin). Please state your state.

Calder Lynch: (Erin), are you on mute?

Coordinator: Go ahead. (Erin)? Okay. Well, then we'll just go to the next one. The next question is from (Stewart). Sir, please state your state.

(Stewart Gordon): Yes, this is (Stewart Gordon) from the National Association of State Mental Health Program Directors. (Ralph), on the new 1135 waiver flexibilities on the level of care determinations postponing the assessment, I caught - you cited 1915I, but I'm pretty sure you cited some other authorities where they might be applicable.

Can you repeat those?

(Ralph Lollar): Sure, (Stewart). This is applicable to the 1915I, 1915K and the 1915C.

(Stewart Gordon): Thank you, (Ralph).

(Ralph Lollar): No problem. You take care.

Coordinator: Thank you. And the next question comes from (Kristin Douty). Please state your state.

(Kristin Douty): Hi. This is (Kristin) in Connecticut. I'm hoping if you can confirm for the uninsured population that they are expected to provide access to transportation, and if so, is that 100% reimbursable?

(Ralph Lollar): These are COVID testing groups?

(Kristin Douty): Yes, for the COVID testing group.

Sarah Delone: So (Calder), you may want to take that back. I mean, it's limited to testing and I think the question is whether transportation to - non-risk to medical transportation could be a testing-related service, but I don't think that we've thought about that. I don't know if my colleagues in the division of benefits and coverage in DEHPG have an off, you know - have any initial thoughts that maybe we should just take that back.

(Calder Lynch): Yes, I don't think that's come up yet, but that may be a novel issue for us to consider.

(Kristin Douty): Thank you again.

Coordinator: And the next question is from (Jane). Please state your state.

(Jane Arnold): Hi, (Jessica). This is (Jane Arnold) from Illinois. I wanted to ask about the requirement that the patient signed the application for testing coverage for the new group.

The way we've been implementing our testing centers, we have, like, a nice financial guard staff gathering and completing information in our administrative the test and to allow for an application and I think it's a contamination issue for them to add a pend to the patient.

Is there a possibility for verbal approval?

(Jessica Stevens): Hi, (Jane). So this question has come up a few times already and I don't think I'm quite ready to provide a clear answer on that today; although, you should know that we are thinking about it particularly in the context of more broadly and hope to provide a little bit more guidance on it soon.

I think we recognize the fact that a signature is needed and recognizing potential concerns here. I might ask you though, (Jane), is in the context of - in the context of receipt of the service, of the testing, is the signature being obtained that way?

And if so, how? Because one of the things that we've been thinking about is whether states could leverage that process through which individuals essentially consent to the receipt of the test to obtain a signature in the same manner?

(Jane Arnold): No, in the testing form so to speak is being developed globally. So it's outside of our area. But there's not a signature on there for the requesting the test. So it's all being done without a signature.

(Jessica Stevens): Okay. All right. That is on top of our list of things to get back to states on because we know that's a repeat question for members too. so thanks for raising it again here.

Coordinator: The next question is from (John). Please state your state.

(John Curl): Hi. This is (John Curl) with Utah Medicaid appreciate the time. A quick question regarding the stature release spa template. As we were looking through it quickly and I being kind of a bit of a state plan fanatic initially seeing that it was to be in Section 7, specifically 7.4.

We already used 7.4. So that got me thinking a little bit more about what flexibility we might have to customize this to our needs. For instance, we're looking to have a submission for an amendment to our attachment 4.19-D section.

And I would like to be able to take some of the key elements of this template, basically kind of the first page, and put that with verbiage that belongs in 4.19-D and have it all together in 4.19-D.

So if at some point down the road any auditors or anyone comes in wondering why we did something different during this time period, they would be right there together with everything else that we say on that particular topic in 4.19-D. Wondered if that would be all right.

Sarah Delone: So I'm half pausing Anne-Marie to see if you are going to jump in because we

don't have our spa maven, (Stephanie Bell), I don't think, on the line, but I think we should be able to work with you. I think it's very, very specific.

But certainly, if you've already used the section of the state plan at this - that this is numbered, we'll work with you to figure out the way around that and maybe you just follow-up with your state lead and connect us so we get you the right people.

(John Curl): Yes, appreciate that. We did submit recently at draft to our state lead and so I assume that's kind of going out, but at the point we had an opportunity.

I guess my main thing is some of these things that I would be looking to change if I had it in that Section 7, I don't know of anyone that would be thinking to go look at Section 7 or something related to reimbursement that would otherwise be in attachment 4.19-D and similar. But appreciate the feedback and we'll look forward to hearing back from our state lead.

Sarah Delone: Well, fortunately, people who aren't on the phone are very quick with their emails and I am just reading now, from Sophia Hinojoas our other, you know, lead for these disaster spas, that we can be flexible on the section in the state plan where you add the disaster relief spa that have time limited langauge. So we'll work with you.

(John Curl): Thank you very much. And hello, (Sophia). Long time.

Coordinator: And the next...

(Jackie Glaze): So we'll take one more question and then we'll wrap it up for the day.

Coordinator: Okay. The next question comes from (David). Please state you state.

(David): Yes, Oklahoma. This question's for (Ralph). Again, this is a follow-up from the first question I had regarding the person center planning. Did you say that we could ask for an 1135 waiver, the flexibilities for the comparability attestation?

I want to make sure I heard that correctly, you wanted to make sure - I mean, we could ask for some flexibilities in terms of having the same home health provider and case management provider provide the same services to the member; is that correct?

(Ralph Lollar): Sure. Conflict of interest in the CZI in the K don't allow for the provider of a direct service to also render case management or develop the person center service plan.

This 1135 waiver vow states to use case management entities to render additional direct services where there's a depletion of your natural supply of providers.

So yes, the provider would be able to render both case management and direct services in this case.

(David): Oh, I see. All right. Thank you.

(Ralph Lollar): Okay. No problem.

Calder Lynch: Okay. Well, thank you all for joining us today. Appreciate the opportunity to have some highlights of work of Colorado and be able to answer everybody's questions.

So we'll resume next week, I think, on Tuesday was our next call. Until then if you have any other questions, please don't hesitate to reach out to your state leads.

Coordinator: Thank you. And this does conclude today's conference. All parties may disconnect.

End