

Centers for Medicare & Medicaid Services  
COVID-19 Medicaid & CHIP All State Call

June 30, 2020

3:00 pm ET

- Operator: Greetings and welcome to CMCS Allstate Medicaid and CHIP call webinar. During the presentation, all participants will be in a listen only mode. Afterwards, we will connect the question and answer session. If you have a question, please press the one followed by the four on your telephone at any time during the presentation. At that time, your line will be accessed from the conference to obtain information. You may also ask questions in the chat box at the bottom left of your screen. If at any time during the conference you need to reach an operator, please press star zero.
- Operator: As a reminder, this conference is being recorded Tuesday, June 30th, 2020. I would now like to turn the conference over to Courtney Miller. Please go ahead.
- Courtney Miller: Thank you and welcome to today's Allstate call. To start us off, I will turn to Calder Lynch for opening remarks. Calder, take it away.
- Calder Lynch: Thanks Courtney. Welcome and thanks for joining us everyone today. This afternoon we plan to share with you information on three topics. The first is we're going to have a presentation around how states can think about retaining some of the Appendix K flexibilities in your Home and Community Based Services (HCBS) waiver program, related programs that you adopted in the Public Health Emergency (PHE). This is really a continuation of a series of conversations on different authorities that we began a few weeks ago, and we've got a PowerPoint that I think is already posted online or will be soon and I will have those walk through that.
- Calder Lynch: Then we're going to highlight some of the questions and answers that are included in a forthcoming set of FAQs. We now actually have reached the final clearance stage of that document. So we are able to lean in a little bit more and share with you where we landed on some of the questions that have been percolating over the last few weeks, and then you'll see that followed up very, very soon in the written FAQs. We're just getting those formatted and ready for posting.
- Calder Lynch: Then third, we have friends on, our colleagues on from HRSA who will provide us with an update on the Medicaid distribution of the Provider Relief Fund, focusing on the process that we're going to be working together with you on for state validation of providers that are not found in the existing files but who may be submitting requests for payment under the Medicaid tranche of funding. So we've got a process we've stood up and we're going to walk through that a little bit with you all.

Calder Lynch: So those are the topics that we're doing today. As I mentioned on the Appendix K flexibility piece, we've got Ralph Lollar, the Director of the Division of Long-term Service and Support, who will be leading that presentation. This is really again focused around how states can begin thinking about retaining the types of flexibilities in your Appendix Ks beyond the end of the PHE. Now some of you may have seen that yesterday the HHS spokesperson said publicly that the department expects to extend the PHE beyond its current expiration date in July as it has once before. I know that has been a topic of considerable interest from states as we've been working together to plan for all the implications that come with that. So as soon as we get the official confirmation of that decision and notification, we will share it out, but did want to share that update with everyone from a planning perspective if you did not see that.

Calder Lynch: Then after Ralph's presentation, we'll open the lines for your questions on that topic related to the Appendix K flexibilities. We'll then move to CMCS staff as I mentioned, who will share the latest updates on the FAQs, pause for questions there and then Susan Monarez and Robert Morgan from HRSA will talk about the provider validation piece that I mentioned. We'll take questions and then, at that point as well, open it up to any questions that states may have.

Calder Lynch: So with that, let me turn it over to our next speaker.

Stephanie Kaminsky: Thanks Calder. This is Stephanie Kaminsky. I am going to just highlight a few dates for the termination of the COVID flexibilities that were not presented two weeks ago. As you can see, the slide deck that is part of today's Allstate call has a couple of the slides in it that were presented two weeks ago. However, we wanted to clarify and expand upon a couple of key dates that we did not talk about in depth last time.

Stephanie Kaminsky: So as most people know, the enhanced funding, the 6.2 percentage point increase for Federal Medical Assistance Percentages (FMAP) expires the last day of the calendar quarter in which the PHE ends. Whenever it ends, once it, if it is extended, it would be the last day of the calendar quarter in which the PHE ends. As you already know, there are four different conditions that are tied to that increased FMAP and they are listed on this slide. Three of them, the maintenance of effort, the 6008(b)(1), the premium restrictions in 6008(b)(2) and the coverage and cost sharing exemptions for testing and treatment in 6008(b)(4) all end also the last day of the calendar quarter in which this PHE ends.

Stephanie Kaminsky: There is one difference in terms of the conditions and that is the third condition, the continuous coverage enrollment condition in 6008(c)(3). That one expires the last day of the month in which the PHE ends instead of the last day of the quarter in which the PHE ends. So wanted to just stress those nuanced differences in what the statute requires for that 6.2% FMAP, and we will be putting out an FAQ that expressly shares this information, explicitly states these dates. Thank you.

Stephanie Kaminsky: With that, I think I want to turn it over to Ralph Lollar to do our next presentation on retaining Appendix K authorities.

Ralph Lollar: Thank you, Stephanie. We're going to talk about retaining the temporary authorities selected in the 1915(c) Appendix K. So let's talk about what the Appendix K is. Essentially it's a standalone appendix. It allows states to request temporary changes in order to prepare for or respond to an emergency. They can be retroactive to the date of the emergency. The changes are time limited and they are tied to people who are specifically impacted by the emergency. Public notice is not required since there is no change to the base waiver. This is a temporary situation that will end when the disaster and the issues involved in that have been ameliorated.

Ralph Lollar: States may consolidate multiple 1915(c)s into one Appendix K submission, and they can update their initial submissions to include additional changes if needed. We've had some states submit as many as five different Appendix Ks for subsequent to the initial approval. The Appendix K cannot be used to exceed statutory or regulatory authority, which is why you will see Appendix K often coupled or running concurrent with an 1135 or an 1115 authority.

Ralph Lollar: There is a template for the Appendix K. The states are required to complete that and submit it to the state plan amendment or the SPA mailbox, just like you do other SPA submissions. The completed template needs to be signed and dated by the state Medicaid director or the state Medicaid directors designate. We, at the beginning of the pandemic, created a COVID version of the template. It supports the specific flexibilities that we see states asking for during this public health emergency. That version or that section of the Appendix K has been prepopulated with the most commonly requested flexibilities and the relevant program changes. As of June 24th, 2020, 47 states and the District of Columbia have received approval for one or more Appendix Ks in response to the pandemic. They can be found at emergency preparedness and response for 1915(c) waivers webpage. We note that the information in this presentation is also applicable to the 1115 attachment K.

Ralph Lollar: So let's talk about timelines and the termination of the COVID-19 Appendix Ks. The Appendix Ks that address the COVID-19 pandemic expire one year from the effective date of that Appendix K or any earlier approved date that the state has elected. States can amend the end date of their Appendix K at any time, but the end dates cannot extend beyond one year from the last day of the month in which the president signed the proclamation of a national emergency. So that final end date is March 31st for 2021. Any extensions of waiver requirements included in the Appendix K must be concluded prior to the Appendix K's end date with the exception of the level of care recertification extension.

Ralph Lollar: All temporary exchanges must conclude, and the states must resume compliance with the language in their current approved 1915(c) waiver when the Appendix K terminates. Remember I said that the base waiver is unchanged by the Appendix

K and you will return to that. Formal public notice is not required when ending the temporary changes in the Appendix K. There is already an end date in the Appendix K.

Ralph Lollar: So with regard to retaining options beyond the expiration, states should on an ongoing basis assess whether the flexibilities will be needed beyond the end date of the waiver, March 31st or any date earlier that the states selected or whether they need permanent changes to the base 1915(c) waiver. Appendix K changes that states would like to continue after March 31st 2021 must be submitted in amendment to the state's 1915(c) waiver application through the waiver management system, the typical application process. They can be submitted at any time. The amendments must adhere to all the policies and procedures in version 3.6 of the 1915(c) waiver application and the technical guides.

Ralph Lollar: Public notice is required for substantive changes such as changes in the qualifications or service providers or changes in rate methodology. The effective date, if its changes are substantive, must be prospective. If the changes are not substantive, it may be retroactive to the first date of the waiver year or another date after where just the state elected to do so. Not all changes in the Appendix K may be approved in the standard 1915(c) waiver application. I'm going to talk about what that means now.

Ralph Lollar: So these options can be extended, and these are just some examples. States may have found that the use of telehealth or electronic message or service delivery are very helpful here, and they may wish to extend them and put them into the base 1915(c) waiver. In that case, case management, personal care services that only require verbal queuing, in home habilitation and other services that can be facilitated through telehealth or remote, we are certainly able to be placed into a standard amendment. As well as evaluations assessment and service planning meetings that can be conducted remotely. Recognizing that when you do that the state really does need to establish a process for electronic signatures.

Ralph Lollar: Home delivered meals limited to no more than two per day. Assistive technology and other services that the state feels has benefited the population and would continue to benefit the population can be added in a standard amendment. Rate increases for waiver services to enhance the provider pool the state may wish to continue them and/or to make changes in them. They certainly are welcome to do that through an amendment. And retainer payment for personal care services and/or habilitation services that include personal care when a waiver participant is hospitalized or absent from his home during a normal period of time certainly are available in the appendix, are available in the base waiver through an amendment and we have a number of states that are already doing that. Recognize that public notice and prospective effective dates are required for any amendment with substantive changes.

Ralph Lollar: So what are the options that can't be extended? I'm going to give you some examples now. Provision of waiver services in institutional settings other than

respite and/or those in acute hospital situations that are authorized through section 3715 of the CARES Act. Extensions of timeframes for level of care reevaluating, extensions of quality improvement system activities, enforcement discretion for noncompliance with the HCBS settings requirements for visitors being permissible at any time, authorization of case management entities to serve as the only willing qualified provider. So, that is actually the waiver of the conflict of interest requirement in the regulation. That cannot be extended. And changes approved by the 1135 authority. So think about extensions of the person-centered service plan recertifications, verbal signatures for persons that are service plans, the waiving of setting requirements or settings added after March 17th of 2014, are all things that cannot be added to a typical amendment and be approved by CMS.

Ralph Lollar: We've skipped ahead. Give me one second folks. Okay. So there are some other considerations you need to think about. Although formal public notice is not required when you end your Appendix K, we really do encourage you to keep your 1915(c) waiver providers and participants up to date. Especially critical would be temporary services and service limitation increases, changes to provider qualifications, rate increases, retainer payments that are only available for the Appendix K duration, those things will end. People need to know that they're ending. Methods states can use to inform stakeholders include communications from case managers, mailing of hard copy materials, email blasts, updates to the state Medicaid agency website. What works for your state is the most important method for you to select. 1915(c) quality review processes and cost estimates may be impacted by the changes states made in their Appendix Ks.

Ralph Lollar: We're more than aware of that. Certainly we would like you to contact CMS and talk about that. If you selected a date certain for the submission of those documents, we will be contacting or reaching out to you approximately 30 days before that submission date to walk through the process with you and ask if you need any assistance or technical advice. Otherwise, we will reach out and talk to you about your projected timeframe in the follow-up.

Ralph Lollar: So that leaves us with a question and answer period for you folks. We're available through the chat now. Barbara, is there anything in the chat?

Barbara Richardson: Thanks, Ralph, for the presentation. If we could have the operator remind the audience the process for the chat as well as questions over the phone, that would be great.

Operator: Thank you. Ladies and gentlemen, if you would like to register for a question, please press the one followed by the four on your telephone. You will hear a three tone prompt to acknowledge your request. Your line will be accessed from the conference to obtain information. If your question has been answered and you would like to withdraw your registration, please press the one followed by the three. Once again, to ask a question on the phone lines, it is one four. You may

also submit a chat question in the chat box at the bottom left of your screen. One moment, please.

Operator: Once again, ladies and gentleman, as a reminder on the phone lines, if you have a question you can press one four. And at this moment, I'm showing no phone questions. You may go ahead with your chat questions if you have any.

Barbara Richardson: Great. Ralph, we have a couple questions in the chat for you. So the first one is can the Appendix K be used for 1915(i) SPAs?

Ralph Lollar: Appendix Ks cannot be used for 1915(i) SPAs. The disaster relief SPA and/or a change in the 1915(i) template, both are acceptable methods of making changes during the national pandemic.

Courtney Miller: And Ralph, we have another question for you in the chat box. Is an Appendix K approval required in order to implement the section 3715 provision of the CARES Act?

Ralph Lollar: It is not. What you want to use the Appendix K for is if you're going to put any limitations on that. That option is available at the state's determination. So if you want to limit the amount of time and/or the timeframe during which you as a state are willing to fund the HCBS services in an acute care hospital, you would do so through the Appendix K. Otherwise, you no longer need the Appendix K for that flexibility.

Barbara Richardson: Great. Thanks, Ralph. We have another question in the chat for you, Ralph. The question is your slide indicated that there was a 372. Can you describe what that is?

Ralph Lollar: Sure. The CMS 372 is a report that states submit on an annual basis. That report does two things; it updates CMS on the current status of the quality structure that the state has and the assurances that they provide oversight for through performance measures. The other thing it does, it fulfills the statutory requirement that says that on an annual basis, the state will demonstrate that the cost of waiver services is less than or equal to the cost of the institution for which the waiver is set.

Ralph Lollar: So if a waiver was set against an institutional level of care for nursing facilities, that 372 would include numbers that demonstrated that the average cost for an individual receiving HCBS services in that waiver were less than and/or equal to the cost for individuals receiving services in a nursing facility setting.

Barbara Richardson: Great. Thanks, Ralph.

Ralph Lollar: No problem.

Barbara Richardson: We've got another question in the chat. You're a popular man. Will Appendix K services be subject to appeals?

Ralph Lollar: During the time that you have the Appendix K effective from the start date to the end date, that is the waiver that you are administering the services under. So appeal rights would be available for individuals who are denied access to new services. For instance, that you have set up in that Appendix K for which they demonstrate need. Those appeal rights would not be available when the Appendix K has closed because the services and flexibilities therein are no longer available.

Barbara Richardson: Great. Thanks, Ralph. Operator I think we should, given the time, I think we should turn it over to questions on the phone.

Operator: Thank you. Once again ladies and gentleman on the phone lines, as a reminder, it is one four if you have a question. Your line will be accessed from the conference to obtain information. If you would like to withdraw your registration, it is one three. To ask a question, it is one four. One moment please, we have questions in the queue. It won't be long. We have a question from the line of Tom Reese. Please, go ahead. Your line is open.

Tom Reese: Hi, in the phase in process, if you have for example a structured day program that can serve 50% of their population, can't serve the other 50%, would they still eligible for retainer payments? If so, when do the retainer payments end?

Ralph Lollar: What I'm going to do is defer retainer payments for the next presentation. We will get to that today, but I don't want to anticipate that, those responses. So if you could hold that question, I would very much appreciate it.

Tom Reese: Sure, thank you.

Ralph Lollar: Thank you.

Operator: Thank you. Our next question is from the line of Amy Lulich. Please go ahead, your line is open.

Amy Lulich: Hi. Thanks so much for this information. I believe there's just a question that was answered about whether if Appendix K services are subject to appeals and that during the time when your Appendix K is effective from the start to end date, appeals are available. But given the requirement for continuity of care and non-termination or reductions in services, like for example, somebody is denied their appeal, they technically shouldn't be terminated or reduced from that service, correct?

Ralph Lollar: We will be providing, CMS will be providing further guidance on what the MOE requires and that is another area where I don't want to step in and anticipate or

preclude a more full response to that. But we hear the question, understand it's an important question and we'll be issuing guidance that will get to the issue of what exactly is required in order to keep that enhanced funding flowing.

Barbara Richardson: Operator-

Barbara Richardson: Are there other questions-

Operator: Thank you.

Barbara Richardson: On the phone?

Operator: No further questions at this time.

Barbara Richardson: Okay, great. Well with that, I think thank you, Ralph. Terrific presentation. I think with that we will now turn it to our next topic which is our next set of frequently asked questions that Calder referenced. So I'll turn it over to Melissa Harris.

Melissa Harris: Thanks Barb. This is Melissa Harris. As Calder mentioned, we hope to have our next round of FAQs published in the next day or so I would say, but we did want to go over the policy with you of retainer payments, and at that particularly multiple periods of retainer payments because we know they have taken on such an urgency in the public health emergency. You probably know that retainer payments got their start in a state Medicaid director letter that was issued in 2000, talking about the ability of home and community based services, particularly those services that involved personal care. That the ability of them to be in parity with what is referred to as nursing facility bed-hold space and allow, if an individual is hospitalized who normally receives home and community based services, the provider to receive a retainer payment to make sure that that provider was able to resume service provisions when the individual came out of the hospital.

Melissa Harris: Over time, they've been used in disasters including more natural disasters, but certainly also including the public health emergency and states have asked for flexibility to include longer periods of time for retainer payments. So the letter in 2000 talked about a 30day maximum, and through the Appendix Ks and the 1915(c) authority, we've been able to authorize multiple periods of 30 days in disasters. So the question became what kind of policy framework were we going to have for retainer payments in this public health emergency, and were there any flexibilities for retainer payments that we could extend beyond the 1915(c) home and community based services waiver. We have previously issued some guidance that we could, through the 1115 demonstration authorize retainer payments for services that would have otherwise been provided under some of the other HCBS authorities, namely the 1915(i) state plans and the 1915(k) community [inaudible] state plans.



Melissa Harris: But we now have a policy framework that allows under those individual authorities, the 1915(c), I and K retainer payments to be authorized outside of the demonstrations. Also, the retainer payments, with some guardrails, and you'll note those guardrails in the FAQs will be allowable for a maximum of three 30 day periods. So we're talking in essential 90 days' worth of retainer payments for home and community based services providers under 1915(c), K and I. I know you're at a bit of a disadvantage because you don't have the FAQs in front of you. After you've had a chance to take a look at them, on the future calls, we can certainly go into more depth and answer some additional questions, but guardrails are designed to address duplication of payment issues.

Melissa Harris: Medicaid retainer payment funds are only one example of funding streams that are being made available during this public health emergency. And we didn't want to disadvantage providers from taking advantage of retainer payments, but we also needed to be mindful that there were those other funding streams out there. So the guardrails really speak to protections in that regard.

Melissa Harris: But the main takeaways for today are the three main home and community based services authorities and the C waiver and the 1915(i) and K state plan authorities will be able to authorize up to three periods of 30 days each of retainer payments, assuming that the guardrails in the FAQs are met. So I'll stop now and happy to answer any questions at the end of the session. Thank you.

Julie Boughn: Hey, Melissa. This is Julie Boughn. I'm the director of the data and systems group, and the questions that the FAQs that we have in batch five or pretty straightforward. They have to do with the application of enhanced match for telework capabilities, enhanced 100% match for implementation of the optional COVID testing group, and we have a pretty important question on coding requirements for Transformed Medicaid Statistical Information System (T-MSIS) and for laboratory claims for COVID testing. So they're pretty straightforward though. So I think I'm going to stop there and then hand it over to Jeremy and Todd to talk about the questions from the financial management group.

Jeremy Silanskis: Great. Thanks Julie. So I'm going to start off. This is Jeremy Silanskis, and then I'll turn it over to my colleague, Todd McMillion and we have a couple of questions to cover. The first is about treatment of personal protective equipment (PPE) and whether states can increase payments to accommodate costs related to PPE, and the answer is yes. You can do that through your state plan disaster relief template for the period of the public health emergency. Actually, we encourage states to look at your rates and check to see if you are still proficient to provide access care during the emergency period.

Jeremy Silanskis: I think it's important to note that PPE isn't a covered service. So it's a cost that can be paid in association with a covered service but not a covered service on its own. And that there are regulations 44715 that require the medicaid agency to limit participation to providers that accept as payment in full the Medicaid rates

that are paid. So that means that providers couldn't separately charge Medicaid beneficiaries for PPE costs.

Jeremy Silanskis: The second topic I wanted to cover was increases in payments temporarily to (Federally Qualified Health Centers) FQHCs to recognize additional costs that are higher for the encounters during the PHE, and states have asked whether they can do that through the SPA template and just limit it to the public health emergency. You can certainly do that through an alternative payment methodology. So that's an accessible way to increase payments to FQHCs for that period of time.

Jeremy Silanskis: So with that, I'll turn it over to Todd. Thanks.

Todd McMillion: Thank you, Jeremy. This is Todd McMillion and I'm going to cover the FAQs that we have regarding interim payment arrangements. So the first question was it basically answers, yes, states can submit a SPA to add interim payment methodology that says under specified conditions, states will make interim payments on a periodic lump sum basis to qualifying providers during the public health emergency period. These payments to providers would be in lieu of payments based on individual claims. Later, a reconciliation of actual services furnished to occur at the end of a defined interim payment period.

Todd McMillion: During the interim payment period, the provider would continue to submit claims for the services it provides. The state would adjudicate those claims to determine eligibility and coverage. However, no actual payments would be remitted to the providers based on those claims. Those would be subtracted from the interim payment amount to determine the balance either due from or to the provider upon that reconciliation.

Todd McMillion: Next, I'll talk about what information, or the FAQ talks about what information does a state need to include in a Medicaid disaster relief SPA for these interim payment arrangements. First, qualifications that providers must meet to receive interim payments in lieu of the routine claims payments. Next, the methodology for computing the interim payments, then the service period interval each interim payment would represent. So in other words, weekly, monthly, quarterly. The duration of the interim payments is also information that must be in the disaster relief SPA. The timeframe the state will use to reconcile interim payments to actual claims data. Then finally, an assurance that Federal Specific Portion (FSP) related to these interim payments in excess of actual claims, will be returned to CMS.

Todd McMillion: The next question regards is really just that can states continue to make payments on a provider's claims for Medicaid services at the same time as the provider is receiving interim payments? The answer to that question is no. The interim payment becomes the state plan payment for services until the reconciliation occurs. Lastly, we're to cover how long do states have to reconcile the interim payments made during the public health emergency. So within the SPA, the state

should establish a reasonable timeframe for the reconciliation to occur. The interim payment becomes the state plan payment for services and the reconciliation will be considered a prior period adjustment for which the time limits under 45 CFR 95.7 would apply.

Todd McMillion: Also, any claims payments in excess of the interim payments would result in increasing prior period adjustments that are also subject to the time limits under 45 CFR 95.7. If a state plan methodology pays providers via a reconciled cost methodology, payments under that methodology would continue to qualify for an exception under 45 CFR 95.19. Now I'll hand it over to the folks from CAHPG.

Shannon Lovejoy: Thanks, Todd. This is Shannon Lovejoy with the Children and Adults Health Programs Group, and we wanted to highlight a few questions that will be included in this round of FAQs. One in particular relates to providing additional guidance for it and then coverage under the optional COVID testing group. We recognize that there will be a lot of specific circumstances related to the optional COVID testing group that will likely make the process to end coverage for beneficiaries enrolled in this group that'll be a little bit different than other terminations of coverage states may have to grapple with at the end of the public health emergency. For example, the authority for benefits available to the COVID testing group sunsets at the end of the public health emergency rather than the end of the month in which the PHE will end.

Shannon Lovejoy: We also recognize states may encounter issues such as a limited availability of information for those enrolled in the group when they go to redetermine eligibility on all bases prior to termination. So the guidance that we'll be releasing will help states just counter these complexities and will specifically speak to issues related to the steps that states providing continuous coverage as a condition of receiving increased FMAPs will need to take when authority for the testing group ends as well as the steps for the requirements for terminating coverage under the COVID testing group and the availability of fair hearing rights related to the testing group.

Shannon Lovejoy: We are available to discuss the guidance in detail when we take questions. In the meantime, I will turn it over to my colleague, Stephanie Kaminsky, who I believe wanted to highlight a few more questions.

Stephanie Kaminsky: Thanks, Shannon. So yes, we have a few additional eligibility and enrollment questions in this batch. One of them relates to whether or not states can use hospital presumptive eligibility for individuals seeking coverage on the basis of disability, and indeed, states may use hospital PE as opposed to regular PE if you will, if they want to expedite medical assistance to applicants who need a disability test. We remind states that the requirements for continuous coverage under 6008 B3 do not apply to individuals receiving coverage during a presumptive eligibility period or hospital presumptive eligibility period. So that's a flexibility that's available.

Stephanie Kaminsky: We also in this batch talk a series of questions about notices and fair hearings. We clarify in contrast to an earlier FAQ that there are some flexibilities that states can employ without obtaining any type of concurrent from CMS. In particular, holding fair hearings via video conference or telephone is something that states can do today and during this PHE without any type of concurrent from CMS, and also reinstating, and states must reinstate services or eligibility, if discontinued because a beneficiary's whereabouts were unknown due to displacement, when and if the beneficiary's whereabouts do become known.

Stephanie Kaminsky: So we go into a little bit of detail about both of these flexibilities if you will, that again exist today, including things like ensuring that the fair hearing system is accessible to persons who are limited English proficient and persons who have disabilities even if it's done by video conferencing or telephone and not allowing or not being able to come to a final determination in a hearing. If an individual who needs those types of auxiliary can't access them, similarly for whereabouts unknown, states must provide notice to the beneficiary when they reinstate the benefits that were previously terminated.

Stephanie Kaminsky: We have one question about public charge. We put into this batch, we bring forward a question and answer that actually was put forward originally by DHS clarifying that the US citizenship and immigration services will not consider testing, treatment, or preventative care services, including vaccines if they become available, related to COVID-19 as part of a public charge inadmissibility determination even if such services are provided or paid for by public benefits as defined by DHS, meaning in this case Medicaid. So we wanted to ensure that individuals who are potentially affected are educated about this particular provision or this particular interpretation.

Stephanie Kaminsky: Finally, we have a few on premiums and cost sharing. In particular, questions have been asked about whether premiums can be charged during the public health emergency, and in fact, they can but states cannot terminate any beneficiary's eligibility or coverage due to unpaid premiums during the emergency period or terminate individual's eligibility due to nonpayment of premiums incurred during the PHE after the expiration of the emergency period. Of course, once this emergency period ends, states can resume what is in their state plan amendment vis-a-vis their premium practices, including potentially terminating individuals for premiums that are assessed after the PHE ends and after the beneficiary has been given a 60 day grace period to come into to pay that premium.

Stephanie Kaminsky: Lastly, there is a CHIP question in this batch which clarifies that the requirements in section 6008 B1 of the FFCRA related to MOE, maintenance of effort, and B2 related to premiums do not apply to separate CHIPs, but do apply to Medicaid beneficiaries funded by Title 21. The FAQ goes on to remind states though that under Title 21, states generally have an MOE requirement already in which they can't put into place standard methodologies or procedures that are more restrictive than those in effect on March 23rd, 2010.

- Stephanie Kaminsky: So that is what you will be seeing very soon, as we have said earlier in the call. With that, I want to turn it back to Courtney.
- Courtney Miller: Thank you, Stephanie. We'll now open for questions on the new FAQs. We're going to start through the chat box first and then we'll take some from the phone lines. Operator, can you please remind everyone what the instructions are on how to use the chat box?
- Operator: Certainly. Ladies and gentleman, if you'd like to ask a question on the chat box, you can send it in the chat box at the bottom left of your screen.
- Barbara Richardson: Great. And we have questions coming in through the chat and, first, thanks to the CMCS staff for their overviews of the FAQs. Appreciate it, as well as Stephanie Kaminsky's overview on the MOE. We have a question, Calder, for you about the timing of when the FAQs will be released.
- Calder Lynch: Yes. So actually we just got word while we were on this call that they've been cleared. So they're getting formatted. We hope to have those posted this evening or at most likely tomorrow, but we will, of course, as usual send out a blast email when those are posted with a link. You can keep checking back at Medicaid.gov, but they'll be up very soon and I know that will hopefully answer many of the questions that are probably racing through folks' minds as they listened to the overview.
- Barbara Richardson: Great. Thanks, Calder. Melissa Harris, we have some questions on retainer payments. The first one is please confirm that this means retainer payments are no longer tied to the state's nursing home bed-hold days and all states can request up to three 30 day retainer payment periods.
- Melissa Harris: Thanks for that, and I appreciate the option to... the ability to clarify. So the three 30 day periods, multiple periods, are available going forward the way they have been in the past which is in periods of disaster. Typically states would file an Appendix K to implement those multiple periods, and now we're saying that that can happen in the C waivers, the I state plan and the K state plan. So in disasters like the public health emergency we're in now, but not limited to public health emergencies, it can request up to three 30 day periods. In regular times, non-disaster times, in keeping with the language that was issued in the state Medicaid director letter in 2000, it does not need to be a disaster in order for retainer payments to be implemented, but the existing timeframe and parameters in that 2000 state Medicaid director letter still apply.
- Melissa Harris: So we're talking about a maximum in non-disaster periods of 30 days. That 30 days would be less than that if a state's nursing facility bed-hold days are below 30 days. Now there are options for every state to take. Obviously they can amend the number of their nursing facility bed-hold days if they would like to arrive at increased flexibility for HCBS retainer payments. But those parameters of the 2000 state Medicaid director letter are still intact for periods of non-disaster in

which the maximum for retainer payments is 30 days and the other threshold that a state would need to be aware of is there a nest bed-hold standard.

- Melissa Harris: We're certainly available to provide technical assistance to states as they're digesting this FAQ information, as they're looking into what kind of nest bed-hold days they have. If they want to amend that number, we can certainly walk them through that.
- Barbara Richardson: Great. Thanks, Melissa. Given the time, Courtney, I think we should just ask the operator to open up to the phone lines.
- Courtney Miller: Sounds good.
- Operator: Okay, thank you. Ladies and gentlemen on the phone lines, you can press one four if you have a question. Once again, it is one four. I'm showing no question at this moment.
- Courtney Miller: Okay. I think we'll now transition to the next agenda item. I would like to introduce Susan Monarez and Robert Morgan from HRSA who are joining us today for Provider Relief Funding updates. Welcome Susan and Robert. The floor is now yours.
- Susan Monarez: Great, thank you. I appreciate the opportunity to reengage with the states on the Provider Relief Fund. Specifically associated with the \$15 billion allocation to Medicaid and CHIP providers at the state level. I know we had a previous sort of engagement where we outlined some larger aspects of the program and the approach that would be taken to facilitate those payments. We're not going to be getting into the details as we did in the more expansive discussion associated with this payment leave, but there are, just for your sort of background, two webinars that we hosted, HRSA hosted last week on June 23rd and June 25th that do go into some depth. So if you want some additional reference, those materials are available, and we will be having another webinar July 8th in case there's others that want to get some more in depth background.
- Susan Monarez: Today we really want to focus in on the operational aspects of coordinating with the states on validating providers that were not initially reflected in the CMS list of curated eligible providers which the state provided to CMS and that we then incorporated and made available through the application portal for those providers that were on this list. In addition to the providers that were made available through the CMS and state initial lists, we expanded that curated list using T-MSIS. So we originally had about 800000 approved Medicaid or CHIP providers that would be eligible to apply for additional PRF payments. We expanded that extensively through the T-MSIS information.
- Susan Monarez: What you should have received on Friday was an email from CMS, the officials that have oversight of Medicaid or CHIP that walk you through the validation process if a provider has applied for Provider Relief funding but was not on that

curated list. Essentially, what we're doing is taking those providers and we're going to compile them, and then go back to the states and have a proven opportunity to engage to see whether or not we can validate some additional providers that would allow them to then be added to the curated list so that they could complete their application and be eligible for a payment through the Provider Relief Fund.

Susan Monarez: So I just wanted to frame that, and I'm actually going to turn it over to Robert Morgan on the HRSA team who is leading the coordination of the exchange of those providers that are not on the curated list with the states. So he'll talk about the technical aspects of this exchange and allow you an opportunity to get any clarification necessary so that we can make this as seamless as possible because we really, at the end of the day, want to make sure that all eligible Medicaid and CHIP providers are able to apply for funding to support their activities.

Susan Monarez: So with that, Robert, I'm going to turn it over to you to walk through the operational aspects of that file exchange.

Robert Morgan: Great. Thanks, Susan. This is Robert Morgan, HRSA. So building off what Susan just described, HRSA has a process to securely exchange those lists of providers who are not on the initial curated list with each state, which we are doing through Box, that's B-O-X, a secure file sharing platform. So each week, HRSA will upload the individual state files to state secure Box folders. Each state or territory's designated point of contact should have received an email invitation to their Box folder from myself earlier today. If you have [inaudible] validation for this week's wave. If you do not, you will not have received an invitation. If you do not have a Box account, you should have been directed to sign up for an account at no cost upon accepting the invite, and an account is needed to access your folder and the list of providers for validation within.

Robert Morgan: So in the shared Box folder, there will be an uploaded Excel file of providers requiring your validation for your state Medicaid and CHIP program. This file will contain some information we already have about these providers such as [inaudible 00:53:17], name, address and MPI to help you validate them. We ask that you review these providers and note in the spreadsheet two things. One, under the state designate eligibility column, confirm with each provider is an active Medicaid or CHIP provider and is not on any state exclusion list with a Y for yes or an N for no. If you're unable to confirm or are uncertain, that's a no. Two, under the state comments column, please provide a brief rationale as to why the provider was not contained in the original list of approved providers or any relevant inclusion/exclusion details, if you're able, particularly for those you marked yes.

Robert Morgan: After you have evaluated all providers, we ask that you upload a new file if you're able to the originally shared Box location. We ask that the file be completed within five business days following the day of receipt of the list of providers, which for this week means by 11:59 PM next Wednesday, July 8th,

because we're excluding the 4th holiday credited towards this Friday. We also recognize that all of you are balancing many competing priorities right now and some of you may have to work with your IT folks to get access if the invitation didn't get through your firewall the last...

Robert Morgan: There may be concern about meeting these five day turnarounds. So I just want to clarify that failure to meet the deadline does not mean the providers list will never be paid, but rather that HRSA will not be able to incorporate your validated providers whenever completed in our payment file until a subsequent payment wave. Effectively, not meeting the deadline simply means that payment to effected providers will be delayed, not that it will never occur. We also expect that over the next several weeks there will be several batches of additional providers that require your validation. Accordingly, every week we'll upload a new file to the shared Box account with additional providers that require validation since the last upload.

Robert Morgan: So with that said, if you have any questions about this process after the call, please direct them to [PRFmedicaidexchange@hrsa.gov](mailto:PRFmedicaidexchange@hrsa.gov). Now I'll hand it off, time permitting, to any questions you may have immediately for Susan and I.

Courtney Miller: Thank you, Susan and Robert, for sharing that information with us. So we'll open up for chat box questions on the Provider Relief Fund file process.

Barbara Richardson: And Courtney, we don't have any questions in the chat for HRSA. So maybe we should just open it up to the phone lines for them.

Courtney Miller: Yes. So at this time, we'll open up for general state questions that you may have. First the chat box questions and then we'll open to the phone lines.

Operator: All right, on the phone lines there are no questions, but as a reminder, it is one four if anything.

Calder Lynch: And actually I think that we're out of time and we want to be respectful of everyone's time. So we will go ahead and I think end the call there. Certainly we are available through your state leads to continue to answer questions. Then once the FAQs are actually posted, hopefully that will answer many of your questions on those topics. I did want to fire a couple of things before we wrap. One just that be on the lookout for those FAQs. We'll hopefully have those posted this evening.

Calder Lynch: Behind that, I saw some questions coming in the chat. There are two other pieces of guidance coming soon that are in stages of clearance. One is on provide guidance on the 6008 MOE requirements. We know we continue to get questions around the application under PETI and other circumstances. So that's nearing a final clearance and will be coming soon, but won't be part of the FAQs that get posted today, as well as some guidance for states on coverage of testing services and what should be covered under certain settings and sharing some CDC and



other relevant guidance from Medicare that may be helpful for states. So that's coming as well soon.

Calder Lynch: Given the holiday this weekend, our next scheduled call is not until Tuesday, July 14th. But again, please reach out to your state leads in the meantime if you've got questions because we'll be happy to work with you on those. Again, thank you all for joining us today. It's 4:00 now. So we'll go ahead and wrap this up. Have a great Independence Day weekend, and thank you for all you're doing.

Operator: Thank you, ladies and gentlemen. That does conclude today's call. We thank you for your participation and ask that you please disconnect your lines.