HHS-CMS-CMCS
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3:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time, I'd like to inform all participants that today's call is being recorded. If you have any objections, you may disconnect at this time. All lines have been placed in a listen-only mode for the duration of today's conference.

I would now like to turn the call over to Ms. Jackie Glaze. Thank you, ma'am. You may begin.

Jackie Glaze: Thank you and hi everyone. And welcome to today's All State Call. On today's call, we will discuss two topics. First, Sara Harshman will spend a few minutes clarifying some questions that CMS has received regarding the COVID-19 vaccine coverage. Then, (Sheri Gaskins) from our Division of Benefit and Coverage will provide an important update on the recently released Medicaid Transportation Coverage Guide.

The Medicaid Transportation Coverage Guide includes new policies to help bolster access to necessary transportation services, including when beneficiaries may and encounter extended wait times and long-distance trips. Medicaid transportation is a critical service that assists beneficiaries with accessing covered Medicaid services and has a direct impact on health outcomes. CMS encourages states to use this guide as an aid when developing and updating policies and procedures that facilitate robust transportation programs.

I want to let folks know that we will be using the Webinar platform to share slides today. So if you're not already logged in, I would suggest that you do so now so that you can see the slides for today's presentation. You can also

submit any questions you have into the chat at any time during the presentation.

So with that, I'm pleased to introduce and turn things over to Sara. Sara, I'll turn it over to you.

Sara Harshman: Awesome. Thank you, Jackie. And hi, everyone. With the commercialization of COVID-19 vaccines, we would like to address some inquiries that we've received regarding the intersection of the Vaccines for Children Program and the Medicaid payment policy based on the HHS COVID-19 PREP Act declaration.

As CMS has explained in previous guidance, the HHS COVID-19 PREP Act declaration has Medicaid payment implications and while the declaration does not change Medicaid coverage rules, it does affect which providers are qualified to provide COVID-19 vaccinations for purposes of the Medicaid's free-choice-of-provider requirement.

Currently through December 31, 2024, the HHS COVID-19 PREP Act declaration authorizes pharmacies, pharmacists, pharmacy interns and pharmacy technicians to administer COVID-19 vaccines as long as the provider meets the conditions stated in the declaration. In addition, states are required to cover COVID-19 vaccines and their administration for nearly all Medicaid beneficiaries and there is 100% federal match for state expenditures on COVID-19 vaccine doses and their administration under the American Rescue Plan.

This coverage requirement and the 100% federal match are in effect through September 30, 2024. Therefore, currently states must identify a pathway to providing payment to certain pharmacies and pharmacy professionals both for COVID-19 vaccine doses and for their administration if the provider is qualified to administer the COVID-19 vaccine and if the Medicaid coverage of the COVID-19 vaccination is otherwise available for that beneficiary.

They still must meet all other applicable federal requirements for coverage such as reimbursing only those providers that are enrolled as Medicaid providers and covering vaccinations for only eligible individuals. And as you likely know, pediatric vaccine doses for Medicaid beneficiaries under age 19 are provided through the Vaccines for Children or VFC program.

In cases where COVID-19 vaccine doses are available from the VFC program, the beneficiary could and would generally receive a VFC-provided vaccine dose. However, if a Medicaid beneficiary under age 19 receives a non-VFC provided COVID-19 dose from a pharmacy provider that is authorized to administer the vaccine under the HHS COVID-19 PREP Act declaration, state Medicaid program should ensure that the pharmacy provider can receive payment for both the non-VFC vaccine dose and its administration. This is because the Medicaid payment policy related to the COVID-19 PREP Act declaration applies regardless of whether a pharmacy provider is enrolled as a VFC provider.

For example, if a family goes to a pharmacy for a Medicaid-covered pediatric COVID-19 vaccination, the state should identify a pathway to paying for the vaccination, even if the vaccine dose is not provided through the VFC program, as long as the administering pharmacy provider meets the conditions of the PREP Act declaration. Additionally, that dose would be - that dose provided would be matched at 100% federal match until September 30, 2024.

I want to make it clear we're focusing today on Medicaid payment policies applicable to certain pharmacy providers authorized to administer COVID-19 vaccines under the COVID-19 PREP Act and are not discussing any other sites or providers in which children may receive a COVID-19 vaccination. I also want to emphasize that today's update only applies to pediatric COVID-19 vaccinations and are not discussing any other vaccinations. If you have questions about other types of vaccinations, please send them our way, but we will not be answering them on today's call.

More information on the HHS COVID-19 PREP Act and Medicaid payment implications can be found on medicaid.gov in the materials from the

September 19, 2023, All State Call and the Medicaid CHIP and BHP COVID-19 Vaccine Toolkit.

And that concludes my update, and I'll turn it to (Sheri) for today's presentation. Thanks.

(Sheri Gaskins): All right. Good afternoon, everyone. My name is (Sheri Gaskins) and I am a Technical Director in the Division of Benefits and Coverage. On September 28, we released the long-awaited Medicaid Transportation Coverage Guide. Today, I am delighted to provide an overview of the guide by highlighting some new and existing policies. Let's start by reviewing some key concepts regarding the assurance of transportation.

The foundation of transportation in Medicaid is to ensure that beneficiaries can physically access needed care and services. First, it's important to remember that the assurance of transportation was originally based on an interpretation of the administrative section of the Medicaid statute. This assurance however, is not a requirement to pay for a ride, but rather a requirement to make certain that every Medicaid beneficiary who has no other means of transportation has access to transportation needed to receive covered care and services.

While the transportation regulations are silent, I want to make clear that the assurance applies to both emergency medical transportation as well as non-emergency medical transportation. In designing a Medicaid transportation program, states may offer transportation as an administrative activity, as an optional medical service, or both. I note that the guide provides a great deal more information about the different requirements specific to each claiming authority. Next slide.

With the passage of the Consolidated Appropriations Act in 2021, Section 209 codified the assurance of transportation in the Medicaid statute. This means that transportation is no longer an interpretation of the statute. Along with this codification, Section 209 added some additional requirements, such as minimum provider and driver standards for state Medicaid program.

I note that CMS issued prior guidance on this requirement. Section 209 required a convening of stakeholders to discuss various aspects of transportation in Medicaid. We accomplished this between March 2022 and May 2022. Section 209 also required a T-MSIS data report on transportation. The final report was issued this year and is available on medicaid.gov. And the reason we are here today, Section 209 required that we review and assess the need for updated guidance. Next slide, please.

So this slide is a listing of various topics included in the coverage guide. We wanted to provide a sample of the robustness of the coverage guide and as you can see here, there are a lot of topics that we cover. Next slide. So let's dig into some of these new policies.

First, we have amended the policy surrounding transportation for a parent or caregiver when the participation of the parent or caregiver is necessary for the child's care. We refer to this participation as necessary for the direct benefit of the child. I note that visitation for other purposes continues to be non-covered. Next slide, please.

During the listening sessions, there were several things that emerged that perhaps were exacerbated by the pandemic. These were transportation issues around wait times and long-distance trips. As background, our prior policy required beneficiaries to be in the vehicle in order to cover the transportation. There was no payment available for these unloaded miles.

Under the new policy, a state may cover wait times and time or miles expenses while the beneficiary is not in the vehicle. However, that coverage restricted - is restricted to very specific circumstances, as you can see on this slide. Next slide, please.

First, for wait times, the travel distance and transport time would make it economically feasible for the transportation provider to remain at the medical provider while the beneficiary receives services. And secondly, for unloaded miles, the most appropriate and economical transportation provider must incur

extraordinary costs for time and/or mileage to pick up or drop off the beneficiary in order for the beneficiary to receive covered services.

We would like to make that - we would like to make clear that this flexibility is at the state option under either the - or under either claiming authority, that is administrative expense or optional medical service. And that states may not cover these costs and scenarios that do not meet the criteria described in the coverage guide. States would need to submit a state plan amendment to update their coverage and payment pages to reflect this flexibility. Next slide, please. Next slide, please.

Now let's review some existing policy reminders. I'd like to emphasize that transportation should only be furnished to beneficiaries in the least costly, most appropriate mode of transportation suited to the needs of the beneficiary. As always, suitors to the needs of the beneficiary should take into account the physical and emotional condition of the beneficiary.

Additionally, while transportation should be to the nearest qualified provider, states must also adhere to the freedom-of-choice provision. Next slide, please.

Now I'd like to run through various special topics. The coverage guide highlights transportation challenges for special populations covered in the Medicaid program. We like to remind states to consider the unique needs of individuals they serve. This could be in relation to where beneficiary lives, the specific health needs or behavioral health needs of the beneficiary. States are encouraged to evaluate existing right methodologies to ensure that they recognize the unique rural transportation issues as well.

In the coverage guide, we have an entire section devoted to all of these different special topics that we heard during our stakeholder sessions from last year. Next slide, please.

So I want to spend a little bit of time covering transportation under special circumstances. You see here there's a special or extra duty, if you will, for individuals under our Early and Periodic Screening, Diagnostic and Treatment

benefit, also known as EPSDT, states are supposed to inform beneficiaries and families in a clear and non-technical manner that explains necessary assistance if transportation is available, cover the cost of transportation for a person to accompany the child if the child needs to be accompanied to the medical service.

With respect to our school-based services transportation policy, I want to emphasize that it remains unchanged. It is outlined in the coverage guide as well as in - there was recently a school-based services technical guide that was issued and the transportation policy is the same there as well.

Treatment at the scene with no transport is not coverable under a state's transportation program, but may be coverable under other Medicaid benefits. I want to emphasize this particular point as there was a program or is a program in CMMI known as ET3. And many states have elected to align their program with the Medicare program under the ET3 model. However transportation, when there's no - when there's treatment sustained with no transportation, it is not covered under the transportation benefits.

And I also want to point out -- because we've received questions on this topic -- is that transportation by law enforcement is generally not coverable under the Medicaid program. Next slide, please.

So this is why we get into brokers. Nothing remain - nothing changes in terms of brokers in the coverage guide. We do, however, add questions and different things that the state should think about if they are electing an exception to the broker authority. So we do encourage states to read that because that is the only thing within the broker policy that has been modified a bit. Next slide, please.

The coverage data also spends some time going through beneficiary support, and we want to make clear that states have the ultimate oversight responsibility. We have heard sometimes State tend - allow other state entities to operate the transportation program. And we just want to make clear that ultimately all federal Medicaid policies should be adhered to and it's the state

that has the overarching responsibility for the correct implementation of transportation.

State should inform beneficiaries of available services and provide information about assistance with transportation. State should have a process in place to ensure timeliness, effective communication and efficient resolution for unanticipated interruptions in services.

And I want to note that we heard this particular complaint during our engagement sessions last year and we'd like to remind states that ultimately it is their program. In order - it is their program to operate efficiently and make sure there are quality transportation service is provided.

And lastly on this slide, State should inform beneficiaries about how to report when they - when there's a no-show or arrange a replacement transportation provider. Next slide, please.

So related travel expenses. The federal regulations at 440.170 allow for related travel expenses, which can include the cost of meals, lodging, a transportation attendant if necessary and as I've stated before, the new policy around wait times and long distances. Coverage of related travel expenses is required for overnight long-distance trips. The cost of a provider of medical services conducting home visit, however, is not coverable under the assurance of transportation. We get this question a lot, which is why I wanted to make sure I touched upon this today.

A federal financial participation otherwise known as FFP, is not available for the use of advance of capital funds to provide us with the purchase of capital assets. We've also received this question quite a bit and it - we're trying to make clear that payment to create a fleet or to sustain a fleet is not coverable. We pay when the individual vehicle is used for a beneficiary, just to make that clear. Next slide.

As many of you know, we work with the Federal Transit Administration through the Coordinating Council on Access Mobility. CMS has been part of

that council for quite some time. And we'd like to encourage state to explore partnerships with their state department of transportation to figure out if they could better serve beneficiaries by exploring those partnerships.

But we also want to remind state that you may pay more than the rate charged to individuals with disabilities for paratransit services, but you must ensure that the rate does not exceed the rate paid for similar trips by other state human service agencies. States may pay for (FIC) throughout public transit, but must ensure that rate do not exceed the rate charged to the general public.

The coverage guide also updates our guidance around bus passes, which we now call public transit passes. And states may utilize public transit passes as long as the cost of the pass is no more than the cost of other payment methods for the trip. In the coverage guide, we illustrate this with an actual example of how states should implement purchase of public transit passes.

States may utilize public transit agencies to coordinate transportation as long as there's no conflict with Medicaid rules and policies. This is very specific to what I mentioned earlier, where if another state entity is operating a transportation program on behalf of the Medicaid program, we want to make sure that all of the federal Medicaid rules and policies are adhered to in operating that program.

And lastly, Medicaid funds may not be used to purchase or subsidize a public transit agency transportation infrastructure. So this is a similar concept to what I just mentioned about not paying for a fleet of vehicles, we pay per use. Next slide, please.

And lastly, this slide is just an overview of the state plan and what goes where. We understand that over the years, there may have been a little ambiguity over what state plan pages are necessary, so the coverage guide does go into detail about what is necessary, but I'll quickly mention that Attachment 3.1-A and 3.1-B should describe the amount, duration and scope of NEMT and/or ENT claimed as an optional medical service. Attachment

3.1-D, as in dog, should describe the transportation delivery model for NEMT and ENT.

Pages should include the types of transportation, types of providers, and how transportation will be made available to beneficiaries. If transportation is provided under managed care authority or a section 1115 demonstration, a general description should be included in that 3.1-D Page.

Also, the provider and driver screening attestation must be included and in compliance with those requirements under 1902(a)(87) of the Act.

And lastly, Attachment 4.19-B should describe any transportation payment details for transportation claimed as an optional medical service. Next slide.

And with that, that concludes my presentation on the Transportation Coverage Guide. I'll turn it over to Jackie.

Jackie Glaze: Thank you very much (Sheri), for your presentation. So we are ready now to take state's questions. And so we will begin by taking your questions through the chat function so you can begin submitting those questions now. And then we will follow by taking questions over the phone line. So (Krista), I'll turn over to you. I see we do have one question.

(Krista): Awesome. Thank you so much for the presentation. I do see a couple of questions here. The first one here is related to transportation for families. Can you please touch on an additional child like a parent or, like, a sibling or a nonpatient joining a ride because a parent does not have child care?

(Sheri Gaskins): Yes. And thank you for that question. So our past policy - our prior policy and our policy today is that if the cost of that additional child does not create a new cost to the Medicaid program -- so for example, if there is a Sedan that you send, maybe a taxi and for example, mom and child, the child who is the patient are going to the appointment and the additional sibling can sit in the car without creating an additional expense to the Medicaid program to transport that additional child, then yes, the child could come in the vehicle.

However, I do want to make clear that when the siblings outnumber the capacity of that Sedan, then the Medicaid program would not be able to send a larger vehicle, like let's say a van to accommodate all of the siblings who are not patient that day.

(Krista): Thank you so much for that answer. I have another question here for you in the chat, which is, is FMAP available for transportation for another child or children that do not have an appointment but need to accompany the parent who is taking another child to a Medicaid-covered service? So I think similar to the last question.

(Sheri Gaskins): Yes. And it's the same answer. The overarching and guiding principle is that additional children cannot create additional expense for the Medicaid program. And so far as the child who is the patient, along with the parent or caregiver, can sit in the Sedan or whatever vehicle you send, you would not be permitted to pay for a higher cost vehicle, i .e., a van or a shuttle or something like that to accommodate the additional children.

(Krista): Thank you so much. Couple more questions came through directly to me. The first one here is, the new coverage guide includes guidance that no load miles are available in extraordinary situations. Can CMS provide additional guidance on what is covered extraordinary?

(Sheri Gaskins): Right. So I will give examples, but ultimately we are going to rely on the state to define what is extraordinary. And the reason for that is because last year on our stakeholder engagement calls, we heard a lot of different stories and - about the hardship of not being able to pay for unloaded miles created in, say, rural communities.

So for example, last year we heard that there was a beneficiary who lived in a very remote area and to send a transportation provider, there - first of all there are not too many transportation providers in the area, and to send a transportation provider would be two or three hours out. And then to take that beneficiary to the medical appointment, it would not be economically feasible

for that transportation provider to take on other rides in order to be more productive that day.

So in this case, this is where the policy flexibility comes in. In this particular example, the provider could wait at the medical appointment with the beneficiary, waiting for them in order for the beneficiary to receive their care and then to be transported back home. Under this new policy flexibility, that wait time would be covered. So that is an example, but again, we defer to the state and their particular circumstances on what constitutes extraordinary.

(Krista): Thank you so much. Another question here for you is, you mentioned that treatment is - sorry. You mentioned that treatment in place is not covered under the transportation benefit. Is there another benefit other than transportation under which treatment in place may be covered?

(Sheri Gaskins): Yes. So treatment in place is - so let me back up and I appreciate this question because we get this question a lot. There's actually a informational bulletin that we issued, I believe it was in 2019. It was the ET3 Informational Bulletin. In that bulletin, we described how Medicaid can participate in the ET3 model, right?

So it's important to note that the transportation benefit is only to move people from one location to another. It is a transportation benefit. It is not a treatment benefit. However, to achieve the aims of ET3 program, a state has a lot of flexibility. First, if - for example, if you're in a state where your paramedics are licensed, some states have allowed treatment under our other licensed practitioner benefit in order to provide that treatment in place. In that circumstance, the paramedic would need to be identified in the other licensed practitioner benefit of the state plan.

This is the same thing that is true with physicians. So if your EMTs are facilitating a visit with a physician through telemedicine, it would be a physician's service. And since physician's services are a mandatory benefit, you may not even need a state plan to describe how that treatment in place is working under the physician's benefit.

So I would just ask that if you are looking to add or align with the ET3 model, so please come in and talk to us and we can work through the different variations that is out there for you to achieve the aims of the ET3 model.

(Krista): Thank you so much. Another question here. I see a lot of questions coming in, so sorry for just going off and rattling these off. But the next question here is, can we issue monthly bus passes if it's cheaper than the trips? A member may use a bus pass for other non-medical trips.

(Sheri Gaskins): Yes. So I encourage you to read the coverage guide, but I will answer this question. The bus passes is really dependent upon the amount of anticipated medical appointments you have. So you have to look at the individual circumstance, right? You can't just say, oh, they're on Medicaid, so let me issue a bus pass. You have to look at the anticipated amount of appointments.

So if the beneficiary - you use the increment of a month, in a given month you would have to do the calculation to determine how much it would cost to the Medicaid program round trip for each visit to that medical appointment and then compare it to the cost of the bus pass. If the bus pass is - is it economically advantageous to issue the bus pass, then of course you would issue the bus pass. The fact that the bus pass can be used for non-medical trips is inconsequential. The point is the Medicaid program is not paying more for the bus pass instead of the individual trips. And that's all identified in the coverage guide.

(Krista): Thank you so much. Next question here is on a different note. Is it appropriate for the broker to bundle procedure codes such as A0200 and A0090, et cetera? Also, is it appropriate for brokers to bundle procedure codes over a span of time or should claims be made for each DOS and each procedure code separately?

(Sheri Gaskins): So I'm going to - and I cannot answer that question. That sounds like a claiming question. And I would just encourage the state to figure out what

they would require from the broker. Every state does claiming differently and in my division, we don't provide any advice on that particular topic.

(Krista): Great. Thank you. Next question here from IHS Tribal Health Programs. Are they allowed to provide Medicaid services including transportation, if they generally meet the state's qualifications for providing these services and are not required to obtain a state license? Does this also mean that they would not need to meet other state requirements for certification that as otherwise required under state statute?

(Sheri Gaskins): So that's a very nuanced question and I would recommend to come to CMS to have that conversation. Generally, we want to make sure that tribal transportation providers can provide services. We do touch upon that in the coverage guide, but it sounds like the question is a bit nuanced about licensed and so I would prefer to defer that question to a more nuanced discussion.

(Krista): Great. Thank you. It sounds like we can do some follow-up on that one. The next one is also about IHS and tribal providers, so I'm not sure if it falls in that same category, but I will ask it anyway.

Additionally, do federal regulations requiring MCOs to reimburse IHS/tribal providers without the need to contract apply to transportation services?

(Sheri Gaskins): Yeah. That's a highly nuanced question. That involves managed care policy, tribal policy and dare I say other policies I'm not privy to. So I would just request that you come to CMS through your normal channels and we can have those discussions or connected to the right people.

(Krista): Great. I see two more questions right now in the chat. The first one is, I want to confirm that per the discussion on the PREP Act provisions, a non-VFC enrolled pharmacy provider who provides COVID-19 vaccine to an otherwise eligible CHIP or Medicaid child that the state can pay for that pharmacy or pharmacist for the vaccine plus the administration fee and receive 100% FMAP? So that's a question for the COVID-19 vaccine team if you guys happen to still be on the line.

Sara Harshman: Hi. Yes. This is Sara. I'm still here. So as you said, as long as the pharmacy provider meets the Covid PREP Act declaration requirements, they can provide a non-VFC dose of the COVID-19 vaccine. I do want to preface that the guidance we provided is in regards to Medicaid, and so if you want to submit that question in regards to CHIP, we'd be happy to answer it in writing.

(Krista): Great. Thanks, Sara. And there's one last question here on the Covid vaccine as well. Can you please confirm the Covid vaccine coverage applies to children as well?

Sara Harshman: Yes.

(Krista): So the - sorry. Children and CHIP as well?

Sara Harshman: Yes. As I said, today's presentation was just in regards to Medicaid, so we can follow up with some CHIP information.

(Krista): All right. Great. Well, Jackie, that concludes all of the questions that are in the chat, so I think if we want to open the phone lines, we can go ahead and do that.

Jackie Glaze: Great. Great. So thank you, (Krista). So (Missy), if you could please provide instructions, excuse me, for registering the questions and open the phone lines, please.

Coordinator: Yes, ma'am. If you would like to ask a question over the phone, please press star followed by 1. Please make sure that your phone is unmuted and record your name when prompted. If you wish to withdraw your question, you can press star 2. Please allow a moment for questions to come in. Thank you.

I'm not seeing any questions coming in yet.

Jackie Glaze: Thank you. And so we'll just wait a minute or two. And then (Krista), any questions through the chat?

(Krista): No additional questions in the chat at this moment, thanks.

Jackie Glaze: Okay. Thanks.

Coordinator: I have one that just came in. Please let me get the name, all right?

Jackie Glaze: Okay.

Coordinator: Our first question comes from (Rene). Your line is open.

(Rene): Hi. Thanks so much. Can you all hear me okay?

(Krista): Yes. We can hear you.

Jackie Glaze: We can hear you.

(Rene): Okay. Very good. So hi, I'm (Rene) with California. So just a quick question back to that PREP Act and the question for CHIP-eligible individuals, who would we send the question to, to get CMS's feedback on?

Sara Harshman: You can send it to Sara Harshman. Sara without an H. Harshman, Harsh and Man, one word, sarah.harshman@cms.hhs.gov.

(Rene): Okay. Thanks so much.

Coordinator: I'm showing no other questions at this time.

Jackie Glaze: Okay. Thank you. (Krista), are you seeing any questions?

(Krista): I'm still not seeing any additional questions in the chat.

Jackie Glaze: Okay. So we'll give it another minute or so, and then we'll conclude early. (Missy), just let us know if you see any questions within the next couple of minutes.

Coordinator: Yes, ma'am. I will.

Jackie Glaze: Okay. Since I'm not hearing or seeing any, we will close the call today. So in closing, I would like to thank Sara Harshman and (Sheri Gaskins) for their presentations today. Looking forward, we will send the topics and invitations for the next call. If you do have questions that come up, please feel free to reach out to us, your state leads, or bring your questions to the next call.

So we do thank you for joining and for asking the questions today, and we hope that you all have a great afternoon. Thank you.

Coordinator: Thank you. That does conclude today's conference. You may disconnect at this time and thank you for joining.

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