

Centers for Medicare & Medicaid Services
COVID-19 Medicaid & CHIP All State Call
December 17, 2020
5:00 pm ET

Coordinator: Good afternoon and thank you for standing by. And welcome to the state discussion on alternate care sites. As a reminder today's conference is being recorded. If you have any objections please disconnect at this time. Your lines are in a listen-only mode until the question-and-answer session of today's conference. At that time you may press Star followed by the number 1 to ask a question. Please unmute your phones and state your first and last name when prompted. It is now my pleasure to turn the conference over to Ellen-Marie Whelan. Thank you, you may begin.

Ellen-Marie Whelan: Thank you (Michelle). Since we don't have a whole lot of folks on the phone we thought we would go through and do a bit of a roll call for the states. For those of us in the federal government you'll hear from us and we'll introduce ourselves as we go through. But we thought we just wanted to let everybody know who else was on the line. For expedience sake what I'll do is I'll call out the states and if the state Medicaid director could introduce themselves and then just let us know who else from the state you have on the line from federal - help us get through as fast as possible.

So why don't I go alphabetically and I'll start with Colorado. Do you have anyone from Colorado on? Okay we'll go back...

Coordinator: Do you want me to open up all the lines right now?

Ellen-Marie Whelan: Oh actually yes, thank you that would be good.

Coordinator: Okay, sure, one moment here. And all lines are open.

Ellen-Marie Whelan: Thanks. Let's try that again. Do we have anyone on the call from Colorado?

(Bill Logan): (Bill Logan).

Ellen-Marie Whelan: Hi (Bill). Who else do you have from Colorado - just you?

Chris Underwood: This is Chris Underwood from Colorado Medicaid.

Ellen-Marie Whelan: Great. How about Connecticut? Do we have (Kate McElboy) or anyone from Connecticut on the line? How about Illinois? Anyone from Illinois?

Ben Winick: Hi this is Ben Winick Chief of Staff with the Illinois Department of Healthcare and Family Services.

(Laura Stalen): Hi (Laura Stalen) Illinois Department of Healthcare and Family Services Policy.

(Eric Lorenz): This is (Eric Lorenz) with the Illinois Emergency Management Agency Legal.

Ellen-Marie Whelan: Okay, thank you. How about Kentucky? Anyone from Kentucky?

Adam Mather: Yes this is Adam Mather Inspector General for the Cabinet Growth and Family Services. And (Trisha Okusen) is the Deputy Commissioner for the Department of Public Health is on as well.

Ellen-Marie Whelan: Thank you, welcome. How about Louisiana?

(Tara Lablone): Hi this is (Tara Lablone) the Interim Medicaid Director. And there's a couple other folks that can identify themselves.

(Cheryl Miley): This is (Cheryl Miley) Executive Staff Officer for the Bureau of Legal Services in Louisiana.

Blake Cramer: Blake Kramer, Franklin Medical Center.

Jerry Phillips: Jerry Phillips Rural Hospital Coalition.

(Brenda Lapabier): (Brenda Lapabier) Rural Hospital Coalition.

(Pam Sullivan): (Pam Sullivan) Louisiana Department of Health Legal.

Ruth Johnson: Ruth Johnson, Louisiana Department of Health.

Ellen-Marie Whelan: Louisiana is well represented. How about Maryland? Anyone from Maryland? How about Maine?

Bill Logan: Bill Logan the Director of Compliance for the Office of Maine Care Services.

Ellen-Marie Whelan: Thank you for joining. Michigan. Do we have anyone from Michigan? How about New Hampshire?

(Henry Littman): Yes (Henry Littman) the Medicaid Director and (Alisa Cohen) is out there the Deputy Director.

Ellen-Marie Whelan: Great, thank you for joining. How about Utah? And we'll go back. Anyone from Colorado?

Chris Underwood: This is Chris Underwood for Colorado.

Ellen-Marie Whelan: Hi Chris thanks for joining. How about Maryland? And any other states that I missed? So thank you all for joining. We really appreciate the opportunity to talk to you today. To kick us off I have the great pleasure of introducing you to the newest member of our CMCS Office of the Center, Director, Judith Cash who just this week will be our Acting Deputy Director for the next couple months. Thank you so much for joining us this afternoon and I'll turn it over to you.

Judith Cash: Thanks Ellen-Marie and let me echo your welcome. We're delighted to have this opportunity to talk with you this afternoon. It sounds like we have a nice mix of Medicaid experts as well as some legal colleagues and colleagues from hospital coalitions. So we're delighted to have you.

This is a really important all for us and we're glad that you're here. And we're really interested not only in sharing information with you but also hearing your questions and your comments as we go through this information. So I really appreciate your being here.

I also want to acknowledge and call out Jack Rollins and our colleagues at the National Association of Medicaid Directors who in so many ways have been great partners with us throughout this public health emergency and in so many other ways and we're delighted that Jack is with us on the call. And really helped to bring us the idea to have this conversation with you today. So thanks Jack for being here.

So I think today we're looking forward to hearing not only from some of my colleagues here at CMS. But also from our colleagues at the Federal Emergency Management Agency or FEMA and the Office of the Assistant Secretary for Preparedness and Response who will talk about funding issues related to alternative care sites. And a lot of these care sites have already been

set up. Some in your state across the country since the early spring to address some of the capacity issues related to COVID-19.

Since the beginning of the public health emergency as many of you know CMS has released numerous documents describing regulations on establishing and operating ACS' as well as a host of fact sheets, FAQs. We've done webinars. And really have tried to provide as much guidance as quickly as we can on a number of issues. And we often find that as we are working hard to get guidance out it's really helpful to have conversations, like, this in follow up just to make sure that we've addressed the issues and we've given you what you need to be able to fully use that guidance and implement your program.

Some of the documents that I've referenced are linked in the appointments that you have for this conversation. And so they're available to you as resources. But since there is so much information we really thought it would be helpful to walk through some of the key content and then give time for you all to ask questions and hopefully for us to answer those questions as you may have them.

So you just heard from Ellen-Marie. She of course is CMS' Chief Population Health Officer. And she'll start us off with an overview of the alternate care sites. And then we'll hear from our colleagues both across CMS as well as some FEMA and ASPR. And we'll stop along the way to be able to open the lines for questions. So please don't be shy. As we're going through jot down your questions as you have them. We'll open the lines in between speakers as well as at the end so that you'll have plenty of time to ask your questions. So with that I think I'll turn things back over to Ellen-Marie to get us started.

Ellen-Marie Whelan: Thanks so much Judith. So this slide again in the appointment invitation you'll see an agenda so you'll be able to track who's speaking and what we're talking about. As Judith noted we'll take questions after each set of speakers and then we'll have a general discussion at the end as well. So there may not be clarifying questions in between but we just wanted to make sure that this call is for you and we wanted to make sure that there was opportunity to answer the questions.

I'll just quickly note the three documents that are linked in the agenda. One of them CMS wrote specifically for state and local governments back I think in May. And it was on programs and payment for care that is delivered at alternate care sites. It's a really good document there.

And then there's two documents from ASPR TRACIE. You'll hear from those folks at the end of the call. But one of them is a tip sheet on funding for both establishing and operating alternate care sites. And the other is a set of slides from a webinar that we did back on that topic in May. So they'll be helpful backgrounds for the conversation.

And it's probably basic but just to level set and make sure we're all on the same page, I just want to quickly walk through some very basics about the alternate care sites before I hand it over to the experts.

We use this term to describe any building or structure that's temporarily converted or newly erected for healthcare use. There's also other - sometimes referred to as temporary expansion locations, temporary expansion sites, field hospitals or a variety of other names.

It's important to note that most ACS' developed during the public health emergency have been both established and operated by existing hospitals and

health systems. And they follow CMS' hospital without walls guidance. And this is one of the many provisions that CMS has released to help hospitals maximize and expand existing capacity.

The CMS hospital without walls waiver allows already enrolled hospitals and health systems to treat ACS' as a temporary expansion of their existing brick and mortar location. In these circumstances the local hospitals and health systems operate staff and bill for the care furnished at the alternate care site. For instance Medicare and Medicaid pay for the covered health services furnished at the ACS the same way they pay for care delivered in traditional hospital settings.

In contrast some of the states and local governments have established an ACS. And while the state and local governments may establish an ACS, who and how the ACS operated will determine if the service is delivered at the site can be reimbursed by Medicare and Medicaid.

So I'm going to turn the call over to (Lisa Trippen), (Hasan Lee) who will provide details on how the reimbursement occurs for Medicare and Medicaid at CMS' at ACS'. And then just to kind of to do the overview they will then turn the call phone over to Tod Wells. He'll describe how FEMA public assistance may help cover some ACS costs. We'll then go to questions after that and then we'll wrap up the call with Shayne Brannman who will describe some of the resources at her shop that ASPR has compiled. And then we'll end with an even broader Q&A.

So (Lisa) I will pass the mic onto you.

(Lisa Trippen): Thanks Ellen-Marie. And I'm very happy to be here today to talk with you all about the situations where Medicare will reimburse for services delivered at

alternate care sites. Most of this comes from the massive blanket waivers that we issued on March 30. And so that would be a great reference. But I'm going to break this out by kind of hospitals first as a general matter and then states and municipalities afterwards.

So in terms of the situations where Medicare will reimburse for services provided at alternate care sites, one category is in parts of hospital buildings that are not normal use for patient care. And if you were to look at our waiver documents this would be described as the physical environment waiver section.

And what that provides is that CMS will permit facility and non-facility space that is not normal use for patient care to be utilized for patient care or quarantine provided the location is approved by the state for the purpose of ensuring that safety and comfort for the patients and staff are sufficiently addressed and is consistent with the state's emergency preparedness or pandemic plan.

So that covers places in the hospital that would normally not be allowed to be used for patient care but obviously for concerns around capacity we have approved that.

The next big bucket is really sort of outside of the walls of the hospital including temporary expansion sites. And if you're looking at our waiver documents that's going to be in the temporary expansion site as part of the blanket waivers. And that says as part of CMS's hospital without walls initiative, hospitals can provide hospital services in other healthcare facilities for example, like, adjacent office space or some very other, you know, close office space or otherwise.

And sites that would not be otherwise considered to be part of a healthcare facility or they can set up new temporary expansion sites to help address the urgent need to increase capacity to care for patients.

So the last that I want to highlight that's outside of the walls of the hospital is the patient's home itself. We've done a couple of things that are very innovative to try to respond to the public health emergency with respect to allowing for reimbursement for care in the home.

Both outpatients as a blanket waiver and inpatients through the new individual waiver process that we announced on November 25 are eligible for reimbursement. The blanket waiver provisions with respect to outpatients doesn't require hospitals or states or localities, operating hospitals to get a waiver. But with respect to the inpatient acute hospital care at home that we are only granting on an individual waiver basis. And there is a waiver request portal that you can find on our Web site or that interested parties can find on our Web site. So we're in the process of setting that up now. As I mentioned that just started on November 25.

Now I'm going to pivot to situations where Medicare reimburses for care related to states and municipalities. So states can certainly use their own state hospitals to take care advantage of the waivers that I just discussed. States can also partner with other Medicare certified hospitals to provide care at alternate care sites. This is when we were trying to sort of figure out how best to respond to COVID-19 we thought that this would be an ideal provision where we would allow states and municipalities to partner with existing providers. And we thought that that would create a good, coordinated healthcare strategy. Unfortunately there were some barriers to implementing that. So the uptake of the partnership option was not as significant as we had thought initially.

And then lastly and states can apply to become a certified hospital. And the State of Maryland has done just that. So those are the three ways that state municipalities can have care reimbursed at alternate care sites. What we can't pay for is situations where states are providing or paying for care but there is no certified hospital either a government hospital or a partner hospital and the state has not gone through the hoops to become its own certified hospital. Under those circumstances Medicare can't reimburse for that.

So I'll stop there and I'll turn it over to (Hasan Lee) to discuss the Medicaid implications.

(Hasan Lee): Thanks (Lisa). Hi everyone. So just kind of emphasizing the theme that (Lisa) was talking about with regards to the operation of an alternate care site whether it's operated by an established hospital versus not. We have advised states that want to take advantage of this opportunity that if the alternate care site is run by a hospital, no additional action is required by states. States can pay the same inpatient rate as reflected in their state plan. And if they choose to pay a different rate they will need to submit a disaster release SPA.

And then similar to Medicare for those alternate care sites that are not run by an established hospital system, Medicaid would not be able to pay for those inpatient services provided at the non-hospital site.

Ellen-Marie I'll turn it over to you to see if you want to open up for questions.

Ellen-Marie Whalen: Yes, thank you. (Michelle) before we turn it to FEMA let's ask if there's any clarifying questions about Medicaid and Medicare reimbursement at alternate care sites. And there may not be but just want to make sure that we can clarify questions as we go along.

Coordinator: Thank you. At this time if there are any questions or comments you may press Star 1. Please unmute your phone and state your first and last name when prompted. Again Star 1 for any questions or comments. One moment please.

Ellen-Marie Whelan: Thank you.

Coordinator: (Brooke Belanger) you may go ahead.

(Brooke Belanger): Thank you. I had a question about hospitals operating the sites. I thought I read in some of the guidance that one hospital had to be identified as a lead. In other words multiple hospitals couldn't co-run a facility. Is that accurate?

Ellen-Marie Whelan: (Lisa) would that be you?

(Lisa Trippen): Yes.

(Will Reston): Ellen-Marie this is...

(Lisa Trippen): CM colleagues go ahead.

(Will Reston): No, no go ahead (Lisa).

(Lisa Trippen): Oh no you please go ahead.

(Will Reston): Okay, yes. I don't know if - this is (Will Reston) from the Center for Medicare. I don't know if my colleague (Erin Blackburn) is still on. But I think the answer to that question is that it's slightly complicated in that there are examples - for example I believe Ohio State University has sort of a

relationship with a couple other hospitals where they have plans where they run the facility together.

And I think from a Medicare standpoint what's important is that the sort of lines that they draw between the sort of sections of the facility that they run and the patients that they are responsible for are really clear. And that circumstance and Ellen-Marie I don't know if we can find the - I believe that that person from one of the hospitals in Ohio spoke earlier on a - like by earlier I mean, like, in April on one of our office hours calls. But they have sort of years of working and planning for a sort of disaster like scenario with these other institutions to have one of these co-managed sites.

But again I think the sort of short answer is that, like, it's a little complicated but generally speaking I think it would be allowed as long as the hospital - the hospitals sort of together have clear delineation of the sort of sections of the facility that they are running. And the patients that they are responsible for and are also sort of clearly allocating the costs across those sites or across those hospitals that are doing that. So I'm sorry for the long winded answer but I think - I don't know if (Carol) is still on and wants to add anything else.

(Carol): This is (Carol). No that's absolutely correct. And (Will) we should go back and look to see if we have any FAQ documents or reference material that gets into the complexity that we can share with everyone on the call. So we'll take that back as an action item.

(Lisa Trippen): Thank you.

Ellen-Marie Whelan: And we'll say at the end that there'll be a couple different ways to get in touch with them but one is to contact your state - your Medicaid state lead and they can help coordinate additional answers. So we want to make sure that if

we don't answer something on the phone today we can get you the answer later.

(Michelle) do we have any additional calls during the - with our CMS colleagues?

Coordinator: We have a few more questions. Martin Judd you may go ahead.

Martin Judd: Thank you. Martin Judd. I'm the Chief Operating Officer at the Metro South ACF in Illinois. I was also the Chief Operating Officer at the McCormack Place ACF in Illinois when that was active.

In Illinois we have attempted to partner with hospitals without any takers. I think there has been, you know, concern on the part of the hospital community that taking something, like, this on would create significant liability costs and potentially distractions for those hospitals.

So in doing so we've tried to explore other alternatives including independently activating and operating the ACF and creating a revenue cycle program around that.

But it seems terribly complicated and also something that perhaps may not necessarily be doable given what I understand are the needs to comply with Medicare conditions of participation for a hospital. Could you perhaps expand upon that and if there are examples of where this has been done it would be great to understand that as well and how that was done.

(Lisa Trippen): Hey this is (Lisa). I'm so sorry. I think I lost you for a second at the very end when you were phrasing your question. Would you mind just restating it for me. I'd greatly appreciate it.

Martin Judd: Sure. At this point we've tried to partner with other hospitals in the state and that has been unsuccessful.

(Lisa Trippen): Yes.

Martin Judd: So the only alternative left in Illinois would be to become an independent provider.

(Lisa Trippen): Yes.

Martin Judd: But as we understand it there's a need to comply with the CMS conditions of participation for hospitals.

(Lisa Trippen): Yes.

Martin Judd: And if you could expand upon that and what's required and if that's been done successfully elsewhere where there has not been a hospital provider we would want to understand that.

(Lisa Trippen): Sure. The State of Maryland actually went that route and became a certified hospital. And you're correct a hospital does have to, you know, demonstrate - somebody seeking, a hospital seeking certification for Medicare reimbursement purposes has to demonstrate and comply with the conditions of participation. But we have had because of the pandemic we have had a significant number of the conditions of participation that have been waived. So it's not as onerous as it has been in the past.

And so I am happy - I don't have the details of what Maryland, you know, went through. But I would be more than happy to try to, you know, make that connection if you think that would be helpful.

Martin Judd: Yes I think that would be very helpful particularly if there are waivers available and understanding what those waivers are.

(Lisa Trippen): Sure I'll be more than happy to follow back up with you and again make that connection with the State of Maryland and also provide information about what conditions of participation have been waived for hospitals.

Martin Judd: Oh that would be helpful, great, thank you so much.

Coordinator: Thank you. And our next question comes from (John Shannon). You may go ahead.

(John Shannon): Actually my colleague and partner Mr. Judd asked the very question I was going to ask so I'll see my time back.

Coordinator: Thank you. Our next question comes from Ruth Johnson. You may go ahead.

Ruth Johnson: Thank you. My question is around the reporting requirements for Medicaid. We had gotten a copy of the document. I think that's used on Medicare because all the questions are related to Medicare and said Medicare fee for service. Has Medicaid put out a reporting requirement or would hospitals that view hospital at home report and just Medicaid fee for service and managed care in those questions?

(Hasan Lee): Yes this is (Hasan Lee). Oh sorry. (Lisa) did you want to take that?

(Lisa Tripp): Yes I just wanted to clarify the question that you're asking. Are you talking about the hospital at home model that was initially announced?

Ruth Johnson: Yes ma'am.

(Lisa Tripp): Okay. Yes there is no Medicaid reporting. It's on the Medicare side that there's reporting required for the hospitals that have been approved.

Ruth Johnson: Okay. So on the Medicaid side there is no required reporting?

(Lisa Tripp): No there isn't.

Ruth Johnson: Thank you.

(Lisa Tripp): And I think the reporting that you're talking about is the hospitals are to report to Medicare right on the census population right? Is that what you're talking...

Ruth Johnson: That's correct immortality rates and whatnot, yes ma'am, yes.

(Lisa Tripp): No there is no Medicaid reporting. The waiver is a waiver of the Medicare conditions of participation and this is since it's unique and is a waiver that we're considering on a case-by-case basis that is where...

Ruth Johnson: All right. So in order to participate is Medicaid - for Medicaid participation is there anything required? Do they have to submit a waiver to participate?

(Lisa Tripp): No there is no waiver. No waiver on the Medicaid side.

Ruth Johnson: Thank you.

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

Ellen-Marie Whelan: Very good. So thank you for that question. And again we'll have time at the end to answer more questions if they come up as you hear more information. So next we'll move to Tod Wells. Tod is the Deputy Director of the Public Assistance Division in the Recovery Directorate at FEMA. So Tod we'll hand you the mic.

Tod Wells: Very good. Thank you, Ellen-Marie. And appreciate the opportunity and invitation this afternoon at the chance to talk a little bit about the public assistance program and how we are providing assistance for medical care in COVID-19 pandemic and for ACS in particular.

So just to start real quick with a short overview of the public assistance program. Public assistance we provide grant funding, state, local, tribal, territorial governments and certain private non-profit institutions including hospitals and other medical care facilities as defined in regulations for the cost of emergency protective measures to address immediate threats that result directly from the pandemic incident.

So these are the eligible entities that can apply to FEMA for public assistance funding for reimbursement of eligible costs. One thing to keep in mind the question has come up in particular in the pandemic is with regard to for profit entities. And FEMA PA cannot provide funding directly to for profit entities, any questions that come up in the context of for profit hospitals.

If and otherwise they'll (unintelligible) whether it's a state or local government or another PNP contract with a private entity for services that are eligible. We can then reimburse that eligible applicant for the cost of the

services. And they would then pay under the terms of the contract for the provision of those activities.

For medical care this is generally an eligible activity under the public assistance program in major disasters and emergency declared by the president. Under our existing policy and this is primarily articulated in the document we call the public assistance program and policy guide which is posted up on our Web site. Under our existing PA policy guide the focus is on provision of emergency medical care after a natural disaster incident. And that's really based on our experience providing recovery assistance in upwards of 70 Stafford Act major declarations per year.

For the pandemic being a different kind of incident, medical care for COVID is actually a direct result of the pandemic and is an emergency measure necessary to protect public health and safety from immediate threats of the incident itself.

So in order to meet the needs of the pandemic public assistance we have developed and issued some disaster specific policy to address the eligibility of medical care in the pandemic. So for COVID-19 eligible medical care costs include the equipment supplies and other costs that are articulated in our regular policy. But under the COVID-19 disaster specific policy it also includes the eligibility for the reimbursement of clinical care for COVID-19 patients. And this is when those costs are not covered by another funding source whether it be another grant program through another federal department of agency or insurance whether it is patient insurance, Medicare/Medicaid.

So that's just one thing to keep in mind for public assistance overall is that in the pandemic we can provide assistance that's eligible for public assistance.

But so long as there isn't another funding source that is providing assistance for the same cost.

And as part of working together with HHS I very much appreciate the opportunity to work with HHS, CMS and ASPR in particular in making sure we're providing some updated guidance with regard to PA eligibility for medical care costs associated with COVID-19.

So under the COVID-19 medical care policy and this is posted on the FEMA Web site. If you go under disaster assistance look for state and local governments and then click on the policy guidance button. Toward the bottom of the list there will be a link COVID-19 guidance. And if you click on that it has a list of COVID-19 specific guidance documents. And we'll include medical care costs eligible for public assistance policy as part of that.

So medical care that is eligible for PA funding for COVID-19 includes both emergency and inpatient clinical care for COVID-19 patients. It includes the costs for purchase, lease, delivery of specialized medical equipment necessary to respond to COVID-19. PPE is also eligible for reimbursement and we are providing a significant amount of funding through PA program for PPE both in state and local governments and to PNP hospital applicants.

Other costs include those related to disposition of medical wage. Labor costs can also be eligible when they're associated with medical staff providing treatment to COVID-19 patients. And there are stipulations within the policy for the circumstances for those specific costs that we can cover for staff time to include overtime of regular staff, straight time and overtime of temporary medical staff and the costs of staff time that is contracted to provide treatment to COVID-19 patients.

For alternate care sites in particular under the medical care policy PA can provide funding for the cost of temporary and expanded medical care facilities. So when it's necessary to meet the needs of the pandemic applicants can either expand current medical facility capacity or establish additional temporary capacity through some temporary space as has been described previously.

For PA funding eligible costs include all of the items that are listed for the medical care facilities in the policy. And in the context of the ACS this will be applicable to both COVID-19 patients and non-COVID-19 patients. The purpose of the PA funding is to support the provision of emergency protective measures. In this case the provision of medical care. So if a hospital needs some additional space to be able to treat COVID-19 patients, we can provide in accordance with the policy funding to assist with that.

If a hospital needs expansion of additional space in order to maintain and secure enough intensive care treatment space within the established facility, then that is the reason why that we can accommodate treatment of non-COVID-19 patients in the alternate space when that alternate space is necessary to be able to maintain the capacity of the original facility to provide treatment to COVID-19 patients.

Other costs for ACS include lease and purchase. The costs to secure the facility space, mobilization and demobilization costs associated with setting up and closing the temporary or expanded medical facility. Operating costs can be covered as well. And then maintenance as well for the temporary or expanded medical facility is reimbursable.

So that is a quick overview of both public assistance programs or the COVID-19 specific medical care policy and its applicability to funding that's available through for alternate care sites.

With that I'd be glad to - again additional information is available on the FEMA Web site specifically through the link to the medical care policy. So I would refer folks to that in particular. But then I'm also glad to entertain any questions this afternoon. Thank you, Ellen-Marie.

Ellen-Marie Whelan: Thank you so much. Thanks so much Tod that was a great overview.
(Michelle) do we have any questions for Tod in FEMA?

Coordinator: Thank you. Once again that is Star 1 if you do have any questions or comments. One moment please for the question. Chris Underwood you may go ahead.

Chris Underwood: Hi everybody this is Chris Underwood with Colorado. I think some of the confusion that we had early on that FEMA has come together to help us resolve is we were in the same situation as our other state partners that we couldn't get a hospital to extend their license to our alternate care site at our convention center.

And then we couldn't figure out how to license it ourselves. Going through the conditions of participation for a state agency to open up a hospital is quite the list. And when we mapped them all out we just couldn't do it right. We don't know how to administer a hospital. We're a Medicaid agency. We're a state emergency operations center. We can't run a hospital. And we couldn't meet hardly any of the conditions of participation.

But where we got stuck was we couldn't figure out how to get the FEMA reimbursement without the Medicare/Medicaid reimbursement because there was lots of documentations and conversations of well if you can't bill Medicaid and Medicare then FEMA won't pay because they're the payer after Medicaid and Medicare.

And so we kind of went in a circular until we had a sit down with FEMA and say hey we can get this thing licensed but it's going to be a state license of what we call a community clinic that allows for observation beds but not true acute care inpatient beds. But that license type is not recognized by Medicare. And actually under Medicaid rules you can't bill for inpatient services under that license type.

And once we sat down and worked out all the details with FEMA on hey you just can't bill Medicaid and Medicare it's just not allowable. But yet we're going to have a legally licensed facility to provide these alternate care sites. They were able to come around and say well based on what you've presented to us then FEMA will pay 100% of the medical costs and you aren't responsible anymore for billing Medicaid and Medicare for those costs.

And in addition those costs may exceed the traditional Medicare rate for providing services because our nurses who are in the alternate care sites are coming at a premium. And since we have contracts still in place approved by FEMA to pay for those medical care costs they were able to then reimburse if we happen to open the site. We have not opened the site yet. But they are willing to reimburse at those contracted rates.

So it took us a long time to get there. It took us about three, four months of negotiations and working through various licensing. But we've actually reached a point now where I think we've achieved the licensing and the

FEMA reimbursement. So I just wanted to throw that out there for our other states that we can help work with you in those same conversations or if FEMA has any comments about my comments that I just made.

Tod Wells:

Chris, Tod Wells from FEMA. I do appreciate that. I know that the folks there in the Region 8 office are fully engaged and they've been working hard through the pandemic. And, you know, we look to support them as we can from FEMA headquarters.

I think that your comments reflect some of the issues that we need to work through on the public assistance side to be able to get to a place where we can support funding. Things, like, legal responsibility of the applicant to be able to provide, conduct that work as you indicate. And then also just ensuring that the work is conducted in an appropriate manner such as you indicated appropriate or licensing that's appropriate to the conduct of that facility.

And then we get to a point where we can look at eligible costs and part of that is what I'd mentioned previously is we can't provide funding for costs that are being covered by another source including Medicare/Medicaid. And in the instance that - in your instance there's not that coverage from Medicare/Medicaid.

So we're not faced with a duplication of benefits which were constrained under the law from providing. Then we can look at those costs that you've incurred as eligible under the medical care policy and provide a grant funding to provide that assistance.

So I appreciate those comments. They're instructive in terms of highlighting some of the processes we go through on the public assistance program side.

Coordinator:

Thank you. Our next question comes from Ruth Johnson.

Ruth Johnson: Oh yes this question is also for FEMA. I just wanted to clarify something. Earlier you stated that if the reimbursement was needed for treatment of COVID patients and to maintain in the intensive care and services for other patients. But I think you were talking specifically about expanding the capacity of the building. Does that also cover the cost of staff?

Tod Wells: It would include the cost of the staff at the ACS site yes if those costs aren't being covered by another source.

Ruth Johnson: Okay, thank you.

Coordinator: Thank you. And once again that is Star 1 if you would like to ask a question. Our next question comes from (Eric Lorenz). You may go ahead sir.

(Eric Lorenz): Hi good afternoon. First I want to thank Tod Wells for his presentation. It was very informative. And then I was going to ask about what we do if we find ourselves - I'm from Illinois I'm sorry if I didn't say that. Martin Judd kind of outlined our situation which is very similar to where Colorado was finding itself. And I was very enthusiastic to hear that Colorado has found a solution.

I think we at Illinois are in a very similar situation. And I think we would like to start exploring those negotiations with FEMA. We're in FEMA Region 5. Do you have a recommendation for whom we should reach out to, to start those discussions?

Tod Wells: What I can do Mr. (Lorenz) is I can reach out to Region 5 and if there is a way for them to contact you I can identify the appropriate person within the region for them to reach out to you.

(Eric Lorenz): Yes I'm the IEMA general counsel and I'm familiar with...

Tod Wells: Got you.

(Eric Lorenz): We have an on-site (unintelligible) so they will know how to reach me and...

Tod Wells: Yes I'm sure they know how to reach out to you, yes sir.

(Eric Lorenz): I'll reach out to five and ask them to give you a call. Okay. And I want to alert Chris Underwood to the fact that the folks from Illinois will likely be reaching out to our counterparts in Colorado very shortly, thank you.

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

Ellen-Marie Whelan: Thank you (Michelle). And so we're going to close the meeting today hearing from Shayne Brannman. Shane is from the Office of Emergency Management and Medical Operations and the Director of ASPR TRACIE which is the Technical Resources Assistance Center and Information Exchange or TRACIE. She'll tell you about the work that they do and some of the resources available from her organization. Shayne I'll turn it over to you.

Shayne Brannman: Thank you Ellen-Marie. And good afternoon everyone and thank you for what you're doing daily to help your states and communities to overcome the arduous challenges that we're facing. ASPR's Technical Resources Assistance Center and Information Exchange is a technical assistance center focused on filling knowledge gaps in healthcare system preparedness. We have collected thousands of peer reviewed resources available for review on our Web site asprtracie.hhs.gov. ASPR TRACIE has worked closely with the COVID-19 Healthcare Resilience Taskforce and now the working group

and other partners both in the private and public sectors to collate, review, promote and develop relevant and timely resources to assist with COVID-19 preparedness and response efforts.

As part of this effort ASPR TRACIE worked with subject matter experts to develop numerous resources related to patient surge management including alternate care strategies in alternate care sites. Of particular interest to this group tonight is ASPR TRACIE's funding summary for the establishment and authorization of ACS'. This is the link that Ellen-Marie talked about earlier when we began this meeting. This tip sheet develops in collaboration with ASPR's NHPP Program, CBC, CMS, FEMA and HRSA and discusses funding available through these organizations for establishing an ACS, operation and ongoing administration of an ACS and for direct patient care costs.

Working with our FEMA colleagues just yesterday Meghan Treber who is also on the ASPR TRACIE team updated that document and that document is fresh off the presses with updates as of yesterday.

ASPR TRACIE has also been speaking to states and organizations that have successfully developed and operated ACS' to gather their experiences. And those are also on our Web site if that is of interest to you. Please check out our ASPR TRACIE resources at asprtracie.hhs.gov/covid19. But one thing I want you to remember. If you can't easily find something on the ASPR TRACIE Web site, we are a technical assistance center. So you can reach out to us by emailing us at asprtracie@hhs.gov or phoning us or doing an online form. And our staff are available during normal business hours Monday through Friday to rapidly assist you and get you the resources you need. With that Ellen-Marie I'll turn it back to you for any questions anyone might have.

Ellen-Marie Whelan: Thank you so much Shayne. And it's amazing the volume of resources that you have there and how helpful we have found them to be. So really appreciate the work that you're doing and encourage folks on the line to investigate and see what's there for them.

So we'll open up questions for Shayne and the information that they have at ASPR TRACIE or any other general questions for any of our participants. We've got about five minutes left.

Coordinator: Thank you. Once again that is Star 1 if you would like to ask a question. Please unmute your phones and state your first and last name when prompted. Ruth Johnson you may go ahead.

Ruth Johnson: Yes I'm sorry. This is a follow up to that FEMA question on clinical care. So I just want to be sure. So if a hospital opens a wing that they - that we had before in order to expand for COVID patients and non-COVID patients possibly who also have an emergency situation but because of the increase in incidents because of COVID. Would FEMA cover the cost of that clinical staff care?

Tod Wells: So Tod Wells for FEMA. I think it's going to be dependent upon some of the specifics of the individual case and just how that space is being set up and are managed. So if it is within the regular operations of the hospital facility we would not look to provide funding for staff costs for non-COVID patients. If it is in the context of an HES as a temporary or expanded space to be able to meet the needs of the pandemic, that's when we get to what we may be able to support. But it may just be dependent on an individual's past and circumstances of that particular situation.

(Lisa Tripp): And hey this is (Lisa Tripp). Ruth I'll also add that scenario and again with the caveat that I don't know all the particulars of the situation. But as a general matter sort of expanding to a wing of the hospital that had not been in use before, you know, but needed now because of COVID is a type of expansion that we would pay for - Medicare would pay for pursuant to our waivers that related to physical environment.

So that should be something that we would pay for as a general matter. Again not knowing the particulars of the circumstances you're describing.

Ruth Johnson: Thank you so much.

Coordinator: Thank you. And once again that is Star 1 if you do have any questions or comments. Our next question comes from Blake Kramer you may go ahead.

Blake Kramer: Hello. Has there been any discussion of what EMTALA obligations are for alternate care sites? You know typically there's - it's frowned upon to move a patient from an emergency department to what's deemed to be a lower level of care. And some ACS sites might be viewed as that since it might not be at the same level of acuity with the same level of approximate services as a standard four wall's hospital. I haven't seen anything about that but wanted to ask the question.

(Lisa Tripp): Hi this is (Lisa Tripp) again. I think I can help with that. So to the extent that you're describing the movement of inpatients to other places that would not implicate EMTALA because EMTALA does not cover inpatients. It just covers folks as they are presenting to the emergency department. We did waive one part of the EMTALA requirement which is the screening part. And we basically allowed emergency departments to screen off-site so as to keep COVID infected patients from other patients. So we did do that. We did not

waive the prohibition against transferring unstabilized patients though. But I hope that's helpful and if not I'm happy to answer a follow up question.

Blake Kramer: I was thinking more of a patient who is in an emergency department and is deemed to need perhaps observation care. And the med surg there is no med surg or ICU capacity that can really be found for that patient. So their move to the ACS and again the ACS is not going to have the same technical capabilities as again a hospital that has, you know, immediate ICU and so forth capabilities there. I wanted to make sure that there wasn't any potential problems with that.

(Lisa Tripp): Yes I would say and this discussion actually we're having a discussion similar to this this morning. And I apologize my dogs are barking. You know EMTALA of course requires hospitals to provide care and services within their capabilities. And so I think and this would be a very fact sensitive question.

So I don't know that there's a great kind of broad answer except to say that, you know, if it's impossible to provide necessary care and services or tests at a given hospital, that is a basis upon which one can transfer. But the transfer has to be to an appropriate receiving hospital. And so I think there could be EMTALA implications depending on how that is done and whether or not in fact that the care and services were available at the initial hospital.

Blake Kramer: Thank you very much.

Coordinator: If you'd like to ask a question please press Star 1 and clearly state your name for question introduction, one moment.

Ellen-Marie Whelan: While we're waiting for that person I think this might have to be our last call. I'm looking at the clock and cognizant of everyone's time.

Coordinator: I have no additional questions at this time.

Ellen-Marie Whelan: Perfect timing. Well first of all I want to thank all of my federal colleagues. This was extraordinarily helpful. We actually learned a lot by putting this call together. So we do want to thank (Jeff Welling) and the National Association of Medicaid Directors again for kind of springing this idea and having us put this call together.

As feedback Mr. Judd - Mr. Martin Judd I want to let you know that I did share your email address with (Lisa Tripp) who will get in touch with you and share the information about the Maryland site. Also if anyone else has any questions we've been mostly telling folks to reach out to their State Medicaid Leave.

And since this is a Medicaid call we figured you all have a way to contact that person. And to help that person figure out how they can get in touch with all of the rest of the folks on the call there. My email address Ellen-Marie Whelan is also in your invite. So if you have any questions you can certainly reach out to me there as well.

So thank you all and the state as well for the work that you're doing during this public health emergency surg. We really appreciate all of that. And thank you for joining us today. I wish you all a happy and thank you for joining us today. I wish you all a happy and safe holiday season.

Coordinator: This concludes today's conference. You may disconnect at this time. Leaders please stay on the line for final line count, one moment.

END