Centers for Medicare & Medicaid Services
Medicaid and CHIP All State Call
December 9, 2021
3:00 pm ET

Coordinator: Welcome and thank you for standing by. All participants will be able to listen-only until the question-and-answer portion of today's call. At that time you may press star 1 on your phone to ask a question. Today's conference is being recorded. If you have any objections, please disconnect at this time. I would now like to turn your conference over to Jackie Glaze. Thank you. You may begin.

Jackie Glaze: Good afternoon and welcome, everyone, to today's All State Call-In webinar. I will now turn to Dan Tsai, our center director, and he will provide opening remarks. Dan?

Dan Tsai: Thanks, Jackie. Hi, folks. Good afternoon or morning wherever you are. Thanks all for joining us today. We have a packed agenda.

I just want to acknowledge, folks, it is December 9. We are approaching the end of the year. It's been a long year. Folks have been doing an incredible amount of work. So thank you for your partnership on that all round at the CMS level, at the federal level and at the state level. And I guess there are, what, 22 days left in the year so.

This week we put out a bunch of things. I hope folks had a chance to look through some of that. We've gotten a range of questions and other engagements around things, including the pediatric vaccine counseling announcements from last week that we are providing much more detail on today.

Earlier this week we put out a guidance based on quite a bit of discussion with states, including some of the states that have been out with 1115s, the 12-month postpartum coverage piece of which there will be another call-in day discussion I think next week and a range of other important pieces of guidance that will have some discussion around this call.

But a lot is happening. A lot is happening on the state side. And I know there are a whole bunch of discussions we continue to engage on with states and other partners on the unwinding and many other things there.

So I hope folks are enjoying December so far with quite a bit left to do. And we thank you all for your continued engagement and partnership. So with that I'm going to pass it over to Anne Marie to get us going.

Anne Marie Costello: Hey, thanks Dan, and hi. everyone. Today there are several really important topics to cover. So let me just give you a quick rundown of the agenda.

First up we have Sara Harshman from our Center Director's Office. Stephanie Kaminsky from our financial management group. And Emily King from our Children and Adults Health Programs group.

They will provide an overview of coverage of COVID-19 standalone vaccine counseling visits in which health care providers talk to families about the importance of kids' vaccinations. While these visits can be covered for all populations as we announced last week, they are required for children under 21 years of age eligible for EPSDT.

The announcement highlights the importance of vaccination education and it's a critical step in increasing COVID-19 vaccine rates by increasing access to

information from providers as families make important decisions concerning vaccinations for their children.

After the vaccine counseling overview, Kirsten Jensen will provide an overview of our state Medicaid director letter released just this Tuesday that provides states and territories with information on changes to the Medicaid benefits package implemented by the Consolidated Appropriations Act of 2021.

The CAA added a new mandatory benefit for coverage of routine patient costs for services furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials on or after January 1, 2022.

Then Melissa Heitt from CMS' Medicare-Medicaid Coordination Office, which we fondly call the Duals Office, will join us to discuss a recent center informational bulletin that describes two ways states can help eligible individuals enroll in the Medicare Savings Program, which can make health coverage more accessible and affordable.

Finally, John Coster from our Disabled and Elderly Health Programs group will provide an oral COVID drug update. After John's presentation, we'll open the lines for your questions.

We'll use the webinar platform - we'll use the webinar slides for our first two presentations today. So if you're not logged into the webinar platform, I suggest you do so now.

Before we jump into today's presentation, I wanted to provide a few announcements. First, I wanted to highlight a couple of pieces of recently released guidance.

On Tuesday, December 7, CMS released a state health official letter providing guidance to states and implementation of a new option available under the American Rescue Plan to provide 12 months postpartum coverage to pregnant individuals who are enrolled in Medicaid or CHIP.

We are planning to host a dedicated call for states on this guidance. The call is currently scheduled for next week, December 16, and more details will be shared very shortly, with an invitation coming out to all states.

We also released the state Medicaid director letter called, State's Flexibility to Determine Financial Eligibility to Individuals in Need of Home and Community-Based Services. This letter confirms the legal authority states now have to target favorable financial eligibility methodologies and individuals who need home and community-based services and is a critical tool to help states expand HCBS eligibility.

States receiving the enhanced federal Medicaid funding for the HCBS programs under the American Rescue Plan should consider utilizing this new authority as a means to supplement their Medicaid HCBS programs.

CMS is available to provide technical assistance to states on this new authority. And we will be providing several opportunities in the coming weeks and into the new year to learn more.

Finally declared states that have claimed the 6.2% enhanced FMAP available under the FFCRA have been required to continue enrollment for Medicaid beneficiaries during the public health emergency. It is possible that some Medicaid beneficiaries who turned 65 after March of 2020 do not realize that

they should have signed up for Medicare Part D during their Medicare initial enrollment period.

The period runs from the three months before they turn 65 to three months after their birthday month. For those beneficiaries who missed the Medicare initial enrollment period, the next opportunity for them to enroll in Medicare is coming up during Medicare's general enrollment period, which runs January 1 to March 31, 2022.

We suggest that during December and January, states reach out to Medicaid beneficiaries who turned age 65 since the start of the public health emergency and have not signed up to Medicare Part B coverage to encourage them to enroll in Medicare during the general enrollment period, again which takes place between January and March of 2022.

This will ensure that if their Medicaid coverage ends during 2022, they will have their Medicare coverage in place. CMS is available for technical assistance. We'll also plan to provide more details in January about this issue.

With that, I'm going to turn things over to Sara to start our vaccine counseling presentation. Thanks, all. Sara, over to you.

Sara Harshman: Thank you, Anne Marie. We can go to the next slide. If you could go to the next slide, please. All right. Thank you, everybody. My name is there Sara Harshman and I'm a senior policy adviser in the CMS Office of the Center Director.

As you all have likely seen on December 2, CMS announced it is now requiring states to cover vaccine counseling only services through Medicaid to

create the space for children and parents to ask questions, get answers and receive the information they need from trusted health care providers.

As we will go into more deeply in a minute, CMS will also provide 100% federal match for state Medicaid expenditures on COVID-19 vaccine counseling only visits during the ARP FMAP period.

This action does not only underscore the importance of COVID-19 vaccination education but also is a critical step towards helping families by increasing their access to information from providers as they make informed decisions concerning COVID-19 vaccinations for themselves and their children.

Reports have shown that COVID-19 vaccination rates for those in Medicaid have lagged behind vaccination rates for other populations. Additionally, as we outlined in an all state call on November 9, survey data has shown that parents, many of whom are vaccinated for COVID-19 themselves, are hesitant to get their children vaccinated right away and are most comfortable getting their children vaccinated by their regular providers.

These findings highlight how critical it is that we continue to work to increase vaccination adherence for children as Medicaid and CHIP provide health insurance coverage to nearly half of all children in the United States.

Next slide, please. Vaccine counseling is not only a tool states can employ to address lags in COVID-19 vaccinations, but all pediatric and adult vaccinations. Currently states can opt to cover vaccine counseling only visits and will be reimbursed at the state's applicable federal match.

As outlined in our quarterly COVID-19 data releases and in the chart on this slide, vaccinations among Medicaid and CHIP beneficiaries under age 19 have declined for all vaccines, except influenza, during the COVID-19 public health emergency period compared to prior years.

Vaccine counseling only services are a tool for states as they help providers and families as they look to catch up on routine vaccines and well-child visits.

Next slide, please. To establish these interpretations, CMS looked to various provisions of the Medicaid statute that recognize that counseling children and their families about health care services is an important component of providing Medicaid benefits to children, in particular requirements that states cover health education as part of the Medicaid EPSDT benefit under Section 1905 of the Social Security Act.

As such, CMS interprets the EPSDT benefit to require states to cover visits in which a child under the age of 21 and their caregivers are counseled about a vaccine, but the child is not receive the vaccine.

CMS also interprets the American Rescue Plan references to the administration of a COVID-19 vaccine, including in Sections 1905(a)(4)(E) and (8)(H) of the Social Security Act to include COVID-19 vaccine counseling only visits in which no COVID-19 vaccine is injected when covered for children under age 21 as part of the EPSDT benefit.

This means that CMS will federally match state expenditures on these visits at 100%. We want to stress that this policy only applies to COVID-19 vaccine counseling only visits that are covered as part of the Medicaid EPSDT benefit.

It should also be noted that there is no comparable benefit or coverage requirement for individuals in Medicaid aged 21 or over or in a separate CHIP.

All right. And with that I'll turn it over to Stephanie Kaminsky to outline more details. Stephanie, over you.

Stephanie Kaminsky: Thanks, Sara. So we wanted to share that based on these interpretations, 100% federal match for state Medicaid expenditures on COVID-19 vaccine counseling only visits under the ARP and the EPSDT requirement will be available for the ARP FMAP period, which is April 1, 2021 through the last day of the first quarter that begins one year after the last day of the COVID-19 emergency period.

After the ARP FMAP period expires, federal matching for state Medicaid expenditures on COVID-19 vaccine administration, including on these counseling only visits, will revert to the regularly applicable percentage.

So I want to point out that the implications for other vaccines under our interpretation of EPSDT is that states must cover standalone vaccine counseling visits for all pediatric vaccines under EPSDT regardless of federal matching percentage.

Next slide, please. So just to review the date that 100% match is available for pediatric COVID-19 vaccine counseling, for states currently covering standalone pediatric COVID-19 vaccine counseling and Medicaid as part of their EPSDT, they can retroactively adjust claims back to April 1, 2021 to receive a 100% federal match for these expenditures.

For states newly implementing Medicaid coverage of standalone pediatric COVID-19 vaccine counseling as part of EPSDT, they can claim that 100% match for their expenditures on this coverage on or after April 1, 2021.

States can request Section 1135 waiver authority to enable a retroactive effective date for state plan amendments implementing this new coverage.

And, of course, we will work to ensure appropriate oversight of states claiming an allocation methodology and will place special emphasis on state expenditures claimed at 100% federal match when we conduct our quarterly and annual financial review.

Next slide, please. So for other populations, not the EPSDT populations, states can opt to cover vaccine counseling only visits in which vaccines are not delivered for all Medicaid populations under an array of Medicaid benefits. States can continue to cover these visits for beneficiaries not eligible for EPSDT.

And unless state expenditures on these visits are for standalone COVID-19 vaccine counseling covered as part of EPSDT, they will be federally matched at the regularly applicable federal match rate, not at the 100% rate.

Next slide, please. So we'll provide TA for states to change or add Medicaid coverage or payment methodologies for standalone vaccine counseling for all populations, including populations eligible for EPSDT. And this will include some technical assistance on possible state plan amendments.

I also want to just note that states may also need to make required systems changes and issue changes to Medicaid Provider Manuals and claiming instructions. And with that, I want to turn it over to Emily.

Emily King: Thanks, Stephanie. I'm Emily King with Children and Adult Health Programs Group. The situation in CHIP is a bit different. Because EPSDT it is not a requirement in chip and there is no comparable benefit or coverage requirement for individuals in a separate CHIP, Section 9821 of ARP does not apply to CHIP in the same way it applies to Medicaid.

States can cover standalone counseling for COVID-19 vaccines in CHIP, but it would be matched at the regular Title 21 match, not at 100%. If a state would like to cover standalone vaccine counseling for children or pregnant women in their separate CHIP, they do not need to submit a state plan amendment, or SPA, to do so.

And finally, if you have any questions regarding covering standalone vaccine counseling in CHIP, please reach out to your CHIP project officer. And now I will pass it back to Jackie.

Jackie Glaze: Thank you, Emily, and thank you, Sara and Stephanie. Next, we'll transition to Kirsten Jensen and she will provide an overview of the recently released state Medicaid director's letter that outlines the new state plan requirements associated with the clinical trials. So over to you, Kirsten.

Kirsten Jensen: Thank you, Jackie. We've released a state Medicaid director letter earlier this week that discusses the Consolidated Appropriations Act of 2021 that included a new mandatory 1905(a) benefit.

This benefit covers routine patient costs for items and services provided in connection with participation in qualifying clinical trials by Medicaid beneficiaries. This provision becomes effective on January 1, 2022.

Next slide, please. Routine patient costs - the new mandatory benefit requires coverage of routine patient costs that are incurred by the individual during the participation - during the time period in which they're participating in the qualifying clinical trial.

So routine patient costs include those costs for items and services provided to prevent, diagnose, monitor or treat complications resulting from participating in the qualifying clinical trial.

Additionally, items and services required for the provision of the investigational items or the service that is the subject of the trial must be covered as well. Items and services are those items and services that are otherwise covered in the state's approved state plan. This is not requiring the state to add any additional coverage throughout the state plan.

This provision is supporting Medicaid beneficiaries access to clinical trials by allowing payment for these routine patient costs during the clinical trial.

Next slide, please. Routine patient costs do not include any investigational item or service that is the subject of the qualifying clinical trial and is not otherwise covered outside of the clinical trial under the State Plan Waiver or Demonstration Project.

Next slide, please. Some examples of routine patient costs include otherwise covered physician services or laboratory services. You know, it might include lab tests or imaging kinds of scans.

We'd also like to note that the guidance does include coverage of non-emergency medical transportation to and from the clinical trial. And as part of

the non-emergency medical transportation, lodging and meals is also included in this coverage.

Next slide, please. An example of what is not covered under routine patient costs include medical imaging scans that are for the purposes of clinical trial data collection to the extent they are not used for the direct clinical management of the beneficiary.

Next slide, please. In order to receive coverage, routine patient costs for items and services must be furnished in connection with participation in a qualifying clinical trial.

The term qualifying clinical trial means a clinical trial in any phase of development that's conducted in relation to prevention, detection or treatment of any serious or life-threatening disease or condition. And this is further described in the statute. And in the letter, you will see examples of qualifying clinical trials and the link to clinicaltrials.gov.

Next slide, please. The determination for coverage for an individual participating in the clinical trials, so this is when an individual is determined to be eligible for a clinical trial, the process shall be expedited.

The review of the individual's paperwork shall be completed within 72 hours. It shall be made without limitation on the geographical location or network affiliation of the health care provider, which is the location of where the clinical trial is occurring.

It shall be based on an attestation. And the submission shall not require submission of protocols of the qualifying clinical trial or any other

documentation that may be proprietary or determined by the Secretary to be burdensome to provide.

CMS is working on developing the document that will serve as the attestation from the provider to the state. The statute calls for a form developed by the Secretary for states to use and that is in process.

Next slide, please. States will need to submit a new SPA Section 3.1(a) and 3.1(b) to effectuate this new coverage requirement. We do have these SPA templates in PRA process now and hopefully we'll have those available to states soon.

Jackie, I think I'll turn it back to you.

Jackie Glaze: Thank you, Kirsten. So next on the agenda as Melissa Heitt from the Duals Office. And she'll just discuss a recent informational bulletin on enrollment on the Medicare savings program. So, Melissa, I'll to turn to you.

Melissa Heitt: Thank you, Jackie. This is Melissa Heitt. And I work in the Medicare-Medicaid Coordination Office. While there are over 10 million individuals enrolled in the Medicare savings program, or MSPs, there are many more who are eligible but unenrolled.

A 2017 MACPAC study estimated that only 50% of eligible individuals are enrolled in MSP. MSPs can cover Medicare premiums and cost sharing.

With the recent release of increases in Part D premiums for 2022, we encourage states to look for ways to increase enrollment in MSPs.

Currently more than 10 percent of an MSP individual's income would be eaten up by Part B premiums. And this number is only expected to increase in 2022.

For those of you who are not as familiar with the MSPs, there are three major categories of MSPs. A qualified Medicare beneficiary, QMB, a specified low income beneficiaries, a SLIB, and a qualified individual, or QI.

QMBs generally have coverage of Part A and B premiums as well as cost sharing while SLIBs and QIs have coverage of Part B premiums.

The recently released survey focuses on two pathways to increase MSP enrollment. The first is the use of Medicare Part D low income subsidy, or LIS, data to initiate MSP applications. And the second one maximizing QI enrollment.

The LIS program pays for Medicare Part D prescription drug premiums and cost sharing. LIS has similar income requirements for MSPs and resource requirements that are the same as MSP.

The Medicare Improvement for Patients and Providers Act, or MIPA, require the Social Security Administration to transmit data from LIS applications through Medicaid state agencies and for states who initiate MSP applications using this data, also referred to as leads data.

However, we are concerned that not all states have implemented processes to make MSP eligibility determination from the leads data that are consistent with the MIPA standards.

For example, states must use information contained in the leads data to the maximum extent possible and only request additional information that is not contained in the leads data.

We encourage states to review this list and make sure their practices align with the requirements MIPA.

We also understand that in some situations, states may need to request additional information from individuals because they are missing some information due to a lack of alignment between LIS and MSP programs.

In order to better align the programs, we encourage states to adopt income and resource disregards under Section 1902(r)(2)(A) of the Social Security Act authority.

And for full alignment between the two programs, states will also need to adopt a definition of family size that aligns with the LIS definition.

States can also consider going further and eliminating the asset test for MSP as New Mexico has done, which would greatly increase MSP enrollment. Alternately, as a smaller step, states can also accept self-attestation for onerous documentation requirements.

We also encourage states to boost enrollment in QIs because QI allotments are 100% federal money. It is not costing the state any extra money to do so. However there was nearly $200 million in unspent QI sums in 2020.

Finally we encourage states to review CMCS' recently released set of strategies for states and territories as they return to normal operations.

Many of these strategies are particularly useful for the dual eligible population, including the sections on streamlining renewals and conducting outreach.

If your state is interested in learning more about any of these strategies to increase enrollment in the MSPs or you need further TAs, please feel free to contact me directly for assistance or you may email us at MMCO's mailbox at mmccomodernizethemsps@cms.hhs.gov. Thank you. Jackie?

Jackie Glaze: Thank you, Melissa. So next, John Coster will provide an update on an oral COVID drug. So, John, I'll turn to you.

John Coster: Thank you. Good afternoon, everybody. This is John Coster. I'm the director of the Division of Pharmacy. The Food and Drug Administration is currently considering applications from two pharmaceutical companies to authorize the use of oral COVID medications under an emergency use authorization process and that is to treat COVID in certain patients.

The initial indications are that these oral drugs generally have to be prescribed to patients shortly after they have been exposed to the virus when they're showing symptoms. But it also will help reduce progress of the disease to hospitalizations and death.

If authorized by the FDA, the federal government will be purchasing these drugs and the federal government will oversee the distribution of the drugs to the states, who will subsequently determine how those drugs are distributed within the state. So the state will be responsible for determining which providers in the states will receive these oral COVID drugs should they be authorized by the FDA.

The drugs would be used in patients to treat COVID-19 consistent with the authorization that has been given to them by the FDA. Both drugs have been submitted by the companies for authorization. There's a Merck drug and a Pfizer drug.

The FDA Advisory Committee has met on the Merck drug already and has narrowly voted to recommend the FDA authorize its use. The Pfizer drug, that application has been submitted, but the FDA Advisory Committee has not met yet so the likelihood is that Merck's drug will be authorized first. Again nothing is guaranteed, but the likelihood is that the Merck drug will be authorized first followed by the Pfizer drug.

Now under the American Rescue Plan, these oral COVID drugs would be considered treatments that would be required to be covered by the states for Medicaid and CHIP beneficiaries.

Because the federal government will be purchasing these drugs, states will only be responsible for paying the Medicaid professional dispensing fee as approved under your state plan for these oral COVID drugs.

So there'd be no charge by the pharmacy to the state for the drug. It would only be for the dispensing fee consistent with what is in your approved state plan. The pharmacies will not be permitted to charge cost sharing for these drugs.

We also remind states that the dispensing fees in your managed care plans should be sufficient to assure that beneficiaries in those plans have the same access to these drugs within the state as beneficiaries that are enrolled in the fee for service Medicaid.

Now there may be Medicare Medicaid dual eligibles whose Medicare Part D plan does not cover the dispensing fees for these oral COVID drugs. And that's because Part D does not cover emergency use authorization drugs at this point. Therefore it's possible that the Part D plan will not cover the dispensing fees.

Part D has encouraged their plans to cover the dispensing fees and cover them in a manner that would encourage the pharmacies to dispense them. But there may be situations in a dual eligible in Part D where the plan does not provide coverage of the dispensing fee for these drugs.

In those situations, Medicaid would be responsible for paying for the dispensing fee. In other words they would be covered under Medicaid for that particular drug.

The state will have to attest. In order to incorporate this into your state plan the state will have to attest that they cover the dispensing fee for these COVID drugs for the treatment of COVID. And that will be basically taken care of as part of the ARP attestation that we will be sending to the states in the near future.

So we hope to also issue written guidance on this sometime in the near future. But for the time being, I think the key point is these drugs will be purchased by the federal government.

The states will be responsible for paying the dispensing fee. And for a dual eligible if the Medicare plan does not cover the drug, doesn't cover the dispensing fee, then Medicaid would be responsible for paying the fee. Thank you.

Jackie Glaze: Thank you, John. So now we're ready to take your questions. And we'll begin by taking questions through the chat function, I do see quite a few questions at this point so you can continue to send those questions. And then we'll follow by taking your questions over the phone line. So I'll turn to you, (Ashley), to begin with the questions.

Ashley Setala: Okay. Thanks, Jackie. So we have a number of questions that have come in around the vaccine counseling. And the first one says, could you please define counseling only visit? Does it mean strictly a visit for a COVID-19 vaccine or a visit that also has the counseling?

Kirsten Jensen: This is Kirsten Jensen. It would include a visit that also has the counseling. It does not have to be just a visit about counseling.

Ashley Setala: Okay. Thanks, Kirsten. The next question says, would 100% FMAP be applicable to vaccine counseling visits performed under an FQHC or a clinic encounter if no other services are performed?

Stephanie Kaminsky: This is Stephanie. Can you repeat the question again, (Ashley)? Was that for pediatric vaccine counseling or any vaccine counseling?

Ashley Setala: So it just says vaccine counseling. It says, would 100% FMAP be applicable to vaccine counseling visits performed under an FQHC or clinic encounter if no other services are performed?

Stephanie Kaminsky: I think that what we tried to say in the slide deck is that 100% is tied to pediatric vaccine counseling. So if there was pediatric vaccine counseling and that was the only service that was provided, then it gets a little complicated with FQHCs. But yes, theoretically, that 100% is available. Yes.

It depends what payment is being made, how the state pays for that. The complicated part is how states pay the FQHC. But however they pay the FQHC, whatever their methodology is, yes, 100% is available.

Ashley Setala: Okay. The next question says regarding standalone COVID-19 vaccine counseling, will there be a separate billing procedure or modifier to identify the delivery of this counseling service?

Stephanie Kaminsky: So I don't know who else would want to chime in here. We at CMS have identified a CPT code that we believe can be used for this purpose. I'll have to take a minute to find it. Maybe I can put it in the chat or share with (Ashley) one of the ones that we found before.

Previously we found a few of them actually. And states, I think, are free to use that. In fact we think it would be a good way to identify these vaccine only visits for billing purposes.

So I don't know if others want to say more about that, but I think that, you know, we encourage that. And I can share at least one of the codes that we have found that might satisfy this need.

Ashley Setala: Okay. Thanks, Stephanie. Then we have a couple of questions that have come in on the clinical trials presentation.
And the first one says the SMD 21-005 mentions the submission of an ABP SPA to comply with the routine services in connection to a qualifying clinical trial requirement. Are ABP SPAs still supposed to be submitted through the MMDL portal or is that system defunct?

Kirsten Jensen: Sure. This is Kirsten Jensen. Yes. The MMDL system is still in use. And for states that need to update their ABP forms, you would use the MMDL system for that.

As part of our process here, the underlying coverage SPA in the 3.1(a) and (b) pages would need to be approved first and then we'll approve the ABP SPA once those SPAs are approved.

Ashley Setala: Okay. The next question says, for the clinical trial coverage of routine cost, are the states able to use their normal criteria and limits for coverage under the state plan for a recipient enrolled in the clinical trial?

Kirsten Jensen: This is Kirsten again. And the answer to that question is yes. This is not requiring the state to change coverage that you currently have in the state plan. What it's saying is if the individual is enrolled in a clinical trial and receiving care according to the parameters that we've outlined in the letter, the state needs to pay for those services as the state would otherwise pay for those services if the person were receiving care in your state.

Ashley Setala: Okay. The next question says, can you clarify that this is correct? Standalone vaccine counseling visit means that there is not a vaccine product administered as part of the visit. And it does not mean that no other services were provided on the same date of service.

Kirsten Jensen: This is Kirsten. That's correct. It means that a vaccine was not provided, but counseling about the vaccine was provided and that counseling can occur as part of another visit, say a well child visit, for example, or it could occur as its own separate visit if that should happen.

Ashley Setala: Okay. Then we have a question that says, have any states submitted state plan amendments or has there been any further guidance around the definition of coverage of services for the treatment of underlying conditions that may seriously complicate treatment of COVID-19?

Our understanding is that the broad guidance is to follow the same method employed under determinations for EPSDT. But we are wondering if anything further is available.

Kirsten Jensen: This is Kirsten Jensen. We have not issued any additional guidance. We do have SPA templates that are currently in the PRA process. And as soon as those complete their journey in that process, we will be making those available to states.

Ashley Setala: Okay. Then we have a question that says, can COVID counseling be billed if delivered to a parent when the child is not present at the time of the counseling?

Stephanie Kaminsky: This is Stephanie Kaminsky. And I am not certain of the answer to that question. We would need to take that back unless I can call a friend from SMG. If Jeremy Silanskis is on, he might be able to, but otherwise we'll take it back.

Jeremy Silanskis: Yes, I think we need to take that one back.

Ashley Setala: Okay. The next question says if the state allows the COVID counseling CPT or HCPCS code to be delivered via telehealth, can COVID counseling be delivered via telehealth?

Kirsten Jensen: This Kirsten. And I don't see any barrier to it being delivered via telehealth. States have the flexibility to determine what covered services within the state they wish to deliver via telehealth. So I think that would be acceptable.

Ashley Setala: Okay. Then we have the question that says, is there a limit to the number of COVID counseling sessions that are payable per individual if the parent or guardian continuously declines the vaccine?

Stephanie Kaminsky: This is Stephanie Kaminsky. I think we'll put that together with the other parent guardian question. I'm not aware of a limit, but I would like to think about it some more.

Ashley Setala: Okay. And then we have a question around the presentation on improving Medicare savings program enrollment. And it says when MSP was discussed earlier, self-attestation was referenced. What was that in reference to?

Melissa Heitt: Hi, this is Melissa. The self-attestation is in reference to just an option for helping to align the MSP programs and LIS programs and make it easier for individuals who are trying to - who are eligible for MSP but not enrolled, who are trying to enroll in the program.

If they self-attest for certain burdensome documentation requirements like, for instance, life insurance policies is a very difficult one that we've heard from advocates and beneficiaries. That would make it easier for them to enroll in the MSP program.

Jackie Glaze: Thanks, Melissa. Julie, we're ready now to take questions over the phone line. Can you please provide instructions to the participants on how to register their phone call and we'll see if we have questions.

Coordinator: Thank you. If you would like to ask a question, please press star 1. You will be prompted to record your first and your last name.

Please unmute your phone when recording your name. And to withdraw your question, press star 2. One moment, please, for the first question. We do have a question. One moment. Our first question comes from Pat Curtis, your line is open.

Pat Curtis: Yes. This is Pat Curtis from Illinois. And I'm interested in asking the question about the MSP LIS alignment issue. We are looking at this in Illinois right now to see if we can do a better job of aligning our LIS criteria with our own MSP criteria. There's a few variations right now which complicate things.

But if as we proceed with this, would it be possible to link the redeterminations that the LIS people - people who are enrolled in LIS -- I'm sorry -- get, I believe it's in August, once a year that they - I think it's late summer, they get a redetermination.

For those individuals in Illinois who are also enrolled at MSP, could the State of Illinois accept the LIS re-determination as a determination in the same way that we accept the LIS original eligibility criteria to be accepted as part of the MSP application?

Melissa Heitt: That's an interesting question. I think I want to actually get back to you on that question. You're from Illinois. We could follow-up over email.

Pat Curtis: Okay. Fine. Thank you. And can I ask another quick question that we're also looking at?

Melissa Heitt: Yes.

Pat Curtis: If we increase the income for MSP, the complication that we have is right now we have the QMB and we have the SLIB and the QI-1, we would need to retain those tiers of financial eligibility, the income eligibility, and we know the assets are the same.

So would we need to keep the same percentage distance in those tiers? I don't know if I'm asking my questions clearly, but if we up them all, do we have to keep like a 10% or 15% difference in the tiers?

Melissa Heitt: Yes. So you're supposed to - for whatever group you use the disregard for, you're supposed to use it for the other groups as well. So if you use - if you want to increase, let's say the income disregard of, let's say you 5% of the FTL for QMB then you would also do 5% QIs.

Pat Curtis: I see.

Melissa Heitt: And then you could also do it for QMBs and SLIBs.

Pat Curtis: And that would be used in the 1902 disregards, right, 1902(r) disregards?

Melissa Heitt: I mean, it's now in the macro pages. And it's under the less restrictive methodology. You can choose those options.

Pat Curtis: That's very helpful. Thank you very much. And if you would get back to us, we can shoot you an email regarding our question about aligning with LIS. We think that would be a great help as far as aligning and not losing people. But we'll check it - we'll get you an email on that one. Thank you.

Melissa Heitt: Thank you.

Coordinator: Our next question comes from John Morgan. Your line is open.

John Morgan: Thanks, everyone. I'm calling from Virginia Medicaid. I have two questions around eligibility for the 100% FMAP.

The first is, and it's probably easier to describe a hypothetical use case, if a provider provides say well child services for an EPSDT eligible member and as part of those services provides COVID-19 counseling. Can a typical well-child check code, like 99394, which would be for a member aged 12 to 17, would that code receive 100% FMAP?

Jeremy Silanskis: This is Jeremy. The entirety of the well-child visit would not be eligible for 100% FMAP. However, you know, the policies that we outlined in the August SHO letters describing the ARP 100% available for COVID-19 vaccine administration, they would apply.

So if you're able to have processes and procedures to identify the portion of that visit that's associated with the vaccine counseling, you could claim the 100% FMAP. And we recognize that would be, you know, somewhat of a difficult endeavor. So we're certainly willing to work with you all on that.

John Morgan: Got you. And then as a follow-up, I know someone had referenced that you had identified some codes you thought would be appropriate to bill, I guess, in the event that COVID-19 counseling is the only service that has been provided. Do you have that list of codes handy? We would love to kind of document the (MSO).

Stephanie Kaminsky: So this is Stephanie Kaminsky. I'm the one who offered that up. And I have not had a chance during this call to retrieve them. I'm sorry. I will try to take a peek now. Maybe I can find at least one or else maybe we can come up with a little list and somehow get that distributed.

John Morgan: That would be really helpful. And if I could add one follow-up question. And I very much appreciate that. Is there guidance - are there restrictions around which provider types who generally deliver E&M services can provide said COVID-19 counseling and receive that 100% FMAP?

I guess, in other words, is there a subset of E&M kind of CMS eligible providers who would qualify as typically a subset of E&M eligible providers who provide counseling whose services would not qualify for the 100% FMAP?

Stephanie Kaminsky: So I think the important link here is that it's being provided under the EPSDT benefit. But maybe Kirsten can say more about the specific providers if there's any constraint there.

Kirsten Jensen: Sure, this is Kirsten - go ahead.

Kirsten Jensen: Right. There are no restrictions on providers as part of this. But I'd like to take that back and make sure we're providing a fulsome answer. So if we could do that and get that answer back out to you, I'd appreciate that.

John Morgan: Sure thing. No, thank you for that. And I think we would at least assume that kind of within their scope of practice standard would of course apply in any situation.

I'm thinking, you know, in terms of typical E&M providers, it's really going to be, I guess, limited to physicians, you know, nurse practitioners, physician assistants. You know, I guess technically, you know, nurse anesthetists and, you know, certified nurse midwives are occasionally also considered E&M eligible. So I think that would be kind of the range. But yes, if you would get back to us, that could be very helpful.

Kirsten Jensen: And then we also have the PREP Act requirements, of course. And so I think states need to consider that here as well. But let us go back and take a look at all of that and make sure that we're - certainly providers within their scope of practice and then the PREP Act will overlay here.

John Morgan: Perfect. Yes. That and then a list of codes would be really helpful and thank you again very much.

Jeremy Silanskis: I just wanted to add to the question earlier around how to identify the portion that's available for 100% match. You know, one potential to do that would be a modifier or an add-on weight that is associated with the vaccine counseling. And that might facilitate the ability to, you know, just get to that 100% and what's available there rather than trying to, you know, distinguish what within the well-child visit would be available.

John Morgan: Got you. And then this maybe is too obvious, but just to be clear, the 100% FMAP for counseling really is in the event that the individual does not receive a vaccine. Is that true with the assumption that if the member is actually vaccinated, the $40 payout is, of course, offsetting the counseling effort?

So am I right that this 100% FMAP for counseling codes or services is really just in those instances where counseling is provided without a vaccine and therefore an admin code is not billed?

Jeremy Silanskis: So the 100% is already available for the vaccine administration and that's what we addressed in the August letter. So, you know, to the extent that somebody gets the shot then - and there would be counseling potentially involved in that as well. You know, that vaccine is available at 100%.

What we're talking about today is the additional ability to recognize those specific visits better for vaccine counseling only. So I think the answer to the question is that for the administration itself, 100% is available during the ARP FMAP period. And then now counseling separately for the PF centric population under EPSDT are also available.

John Morgan: Perfect. Thank you.

Coordinator: Our next question comes from (Ralph McGrish). Your line is open.

(Ralph McGrish): Good afternoon. Thank you very much. A follow-up question. I wanted to do listen check related to the clinical trials.

I thought I heard something about potential waiver of credentialing for managed care plans under this kind of urgent or expedient need and possibly something about out-of-network enrollment provisions being waived. And again, I just wanted to do a listen check there.

Kirsten Jensen: This is Kirsten. That was included in the letter. Do I have any colleagues from managed care on the line that could speak to that, please? If not, we'll have to take that one back.

(Ralph McGrish): Thank you.

Kirsten Jensen: Yes. So we will confer with our colleagues and provide some more information about that particular provision.

Jackie Glaze: We have time for one more question.

Coordinator: Thank you. Our last question comes from Eve Lickers. Your line is open.

Eve Lickers: Good afternoon. And I have two questions. Hopefully we can get them both done.

So my first question is, is FEMA expecting states to pay a separate fee if there is a well-child visit or some other medical visit and we expect the vaccine counseling to be provided as part of the visit?

Jeremy Silanskis: So that's not an expectation that you'll pay a separate fee. I do think to the extent that you want to claim the 100% FMAP, it might be easier to do some sort of add-on and say, you know, for the time spent that's spent in doing the counseling, we're going to, you know, pay this amount. And that way it would be easier for you all to say here's what is claimable at 100% FMAP.

Otherwise, you know, you'd have to somehow figure out and work with your provider community to figure out the time that's spent within the well-child visit associated with the counseling. And again, I think that would be somewhat of a difficult process to work through.

Eve Lickers: Okay. Thank you. And the second question I have is will CMS consider approving an APM for the pediatric vaccine only visits when, you know, normally the FQHCs or RHCs are paid the all-inclusive PTS encounter rate, which we would expect, again, would include the vaccine counseling?

Jeremy Silanskis: Yes. I think we need to talk specifically about what that would look like. You know, we've been in a lot of conversations with payer reps who have received payments the past couple of months. And it can be kind of nuanced and convoluted.

So I think that would warrant kind of an individual discussion with Stephanie to figure out what you want to do.

Eve Lickers: Okay. I'm just sure we're going to get the question so I just wanted to be prepared. But thank you. We will reach out to our regional folks. Thank you.

Stephanie Kaminsky: And this is Stephanie Kaminsky again. What state is this?

Eve Lickers: Pennsylvania.

Stephanie Kaminsky: Thank you.

Eve Lickers: Thank you.

Jackie Glaze: Thank you all. In closing I want to thank the team for their presentations today. This will be our last call for 2021 so we will reconvene in 2022 on Tuesday, January 11 from 3:00 to 4:00 p.m. Eastern Standard Time. So we will send the topics and the invitations out in the New Year.

If you do have questions before our next call, please reach out to us, your state leads or bring the questions to your next call. We would like to thank you again for joining us today and we wish everyone a very safe and happy holiday season. So thanks everyone and good afternoon.

Coordinator: Thank you for your participation. Participants, you may disconnect at this time.

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