

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

Friday, April 10, 2020

3:00pm ET

Coordinator: Good afternoon and thank you for standing by. As a reminder today's conference is being recorded. If you have any objections you may 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 Jackie Glaze. Thank you. You may go ahead.

Jackie Glaze: Thank you (Michelle) and hi everyone and good day and welcome to today's all state call. Our focus today will be mainly around the Medicaid managed care rates and flexibilities. And I'd like to turn it over to Calder Lynch and he will share a little bit about some of the work that we have been doing over this week and then also give you a little bit more detail on what today's discussion will encompass. So Calder?

Calder Lynch: Thank you Jackie. Good afternoon everyone and hopefully everyone is enjoying this Friday afternoon as best we can. I want to thank you for joining us today. I did before we get into the main topic area of today's call want to draw your attention to news that was released by the department today with regards to distribution of the first tranche of funding from the \$100 billion provider relief on that was appropriated by the CARES Act. Beginning today it's about \$30 billion worth of that funding has begun being distributed out to providers across the country. This first round of funding again totaling \$30

billion will be distributed based on provider's total share of Medicare fee for service reimbursement in 2019.

That methodology is helping to facilitate a rapid distribution and infusion of those dollars into the American healthcare system. We are working rapidly though on the next round of funding which will include more targeted distributions that focus on providers in areas that have been particularly impacted by the COVID-19 outbreak as well as rural providers and providers of services with lower shares of Medicare reimbursement which would of course include providers who predominantly serve the Medicaid population as well as providers who are requesting reimbursement for the treatment of COVID-19 positive uninsured Americans.

So again more to come there on further rounds of funding but did just want to drop folk's attention to that information. About - that is a course is available on our Web site.

Now turning to today's topic we recognize that the COVID-19 public health emergency has in many ways change the utilization of healthcare and has created uncertainty around these changes that are exhibiting themselves in challenges both for states and their partners including managed care plans. So to help address the situation and to facilitate good planning on our call today we'll be primarily focused on some of the steps the states may take as well as the options and flexibilities that they have under our managed care authorities to respond to the situation.

In addition to our managed care team we've also invited staff from the CMS Office of the Actuary to speak about these issues and we've invited you to hopefully include your own actuaries to join us as well for this conversation.

I'd also hope that we'd be spending some time today reviewing our second set of FAQs related to the Medicaid and CHIP provisions of the FFCRA and the CARES Act on this call. Alas we were held up on trying to finalize a few last issues that will hopefully mean that when those are released they are more complete and that should be coming to you very shortly. So meanwhile our team will still be happy to provide a few highlights of what you can expect to see there.

Well but even without that we have a lot to cover today, but really quickly before we turn to that just want to provide an update that we have now received and approved 1135, at least initial approval of 1135 we were request from nearly every state. And we've now approved 26 Appendix Ks for your HCBS waivers. We did approve our very first CHIP disaster SPA in the COVID-19 emergency and we've now approved eight Medicaid disaster SPAs which provide a range of flexibility relative to eligibility, reimbursement and benefits.

We're also still processing a number of 1115 requests. We've begun approving emergency IT funding requests if states have to implement systems changes in light of either conditions in the legislation or just responding to the situation on the ground. And we're of course continuing to work with everyone individually to confirm flexibilities that you have. Again just encourage folks to reach out to your state leads if you have any questions or want to exercise any additional authorities that are available to you. I will now hand over the call to Alissa Deboy from our Disabled and Elderly Health Programs Group who is going to kick off our conversation I managed care. Alissa?

Alissa Deboy: Great, thanks Calder. Good afternoon everybody. On behalf of the Disabled and Elderly Health Programs Group I want to welcome to - welcome you to

this call to talk about managed care issues and questions that we have received in light of the COVID-19 pandemic. I also want to welcome again our colleagues from the Office of the Actuary who will assist us with this discussion today which I hope states will find helpful.

Before we get started I did want to make an announcement about some personnel (new looks) from CMS the Disabled and Elderly Health Program Group has filled a very important position related to managed care. John Giles will start with us on Monday as the new Director of the Division of Managed Care Policy. Some of you may know John who was previously a Technical Director in our Division of Managed Care Policy in the past. For the last six months he has been working for Mercer. And he also has state experience from working in the state of Oklahoma. We couldn't be more excited for his return and I hope he'll be very helpful to states of their actuaries in the coming weeks and months.

Before I turn the call over to my colleagues in OACT I do want to set the stage for this discussion that we're having today. We recognize the COVID-19 is creating enormous uncertainty in your programs. And you may be experiencing unexpected costs relating to testing and treatment for the virus but also observing significantly reduced utilization and other health care services resulting from social distancing. Further we understand that your managed care plans are an important partner in responding to the pandemic.

And we all have an interest in ensuring that these programs remain appropriately financed, that necessary care is delivered without delay and that we all maintain the amount of oversight to protect taxpayer dollars. We also understand the states are facing a number of challenges in trying to address changes in utilization both increases in utilization as well as decreases in

utilization and have requested various waivers and one on one technical assistance meetings with our managed care team.

Based on the questions that we received we want to take the opportunity on this call to make sure that all states and their actuaries understand the options and flexibilities that states have under existing managed care authority to address payment issues. Our colleagues in the Office of the Actuary will discuss some options from you in terms of complexity, mitigating managed care organization risk, cash flow, continuity of care and administrative burden. We welcome questions on these existing authorities but we also invite states and actuaries to share information and ideas that they have that will be helpful for CMS to understand or for other states to be aware of based on the experience that you have thus far. So I want to thank you again for joining us today and I'll turn it over right now to Tristan and OACT. Thanks.

Tristan Cope: Thanks Alissa. Good afternoon everyone this is Tristan Cope. I'm the Deputy Director of the Medicare and Medicaid Cost Estimate Group in the Office of the Actuary. And I'm sure that if any of you have been on a call with my team in OACT reviewing rate certifications you've heard at least some of this before. Actuarially sound capitation rates account for all reasonable, appropriate and obtainable cost. So to that end CMS understands that the costs associated with the COVID-19 pandemic could not have been reasonably prospectively included in the development of current rates. We also understand that the costs associated with the pandemic cannot reasonably be expected to be prospectively included in the rates until significantly more information is known about the virus and its spread in its treatment.

As such CMS is considering the options available through the current Medicaid managed care framework for states to cover these unforeseeable costs. And as Alissa said a little earlier some of these key consideration

include mitigating MCO risk, MCO cash flows, continuity of care and administrative burden at the state MCO and federal level for existing and future rating periods.

While any option or combination of options a state chooses to pursue to cover the costs related to COVID-19 pandemic will ultimately need approval from CMS, OACT believes there are several options that appear to be more straightforward and approvable. And additionally there are some other options that are a little bit more complex and would require - would probably require a little further discussion. I will note that the options I'm going to cover are not intended to address some providers concerns about recent reductions in utilization and therefore reductions in revenue from MCOs. CMS is internally actively discussing how to address this issue across a number of fronts.

But foremost I'm going to talk about a couple of options that we in OACT believe are relatively straightforward and ultimately approvable. The first would be incorporate a two-sided risk corridor on all medical costs. CMS and most states have experience with risk corridors making them relatively noncomplex.

And these have the potential to adequately mitigate MCO risk while not impacting beneficiaries' continuity of care. This will provide financial protection to the MCOs while also providing some limits on financial risk to the states in the event that costs are not as high as they are expected - than they were expected to be. We would also advise implementing a risk corridor on all medical costs, not just COVID-19 costs. This would be simpler to implement and would avoid risks that non-COVID-19 costs change significantly. On the other hand a risk corridor alone would not mitigate any cash flow risk to the MCOs so this option could also be combined with a rate adjustment.

Another option MCOs could see costs associated with COVID-19 back to the state to cover them on a non-risk basis. States could have MCO see either one, all COVID-19 service costs or two, all service cost per beneficiaries with COVID-19 back to the state. States would then reimburse MCOs for these costs net of premiums or capitation payments paid. And this option would eliminate MCO risk to COVID-19 and reduce cash flow risk as payments would come from the state for these costs.

This option would be straightforward, transparent and would not impact the continuity of care for beneficiaries. However it would depend on the accurate identification of relevant cost and or beneficiaries. We also think it makes sense that this option would be combined with a risk corridor to reduce the risk that the remaining costs are significantly less than originally projected.

Now I'll discuss a couple of options that would still probably require a little bit more discussion within CMS. The first is that states could carve out costs associated with COVID-19 and cover them through Medicaid fee for service. This can be accomplished in two different ways, one by carving out all COVID-19 service costs or two all service costs or beneficiaries with COVID-19.

Similar to covering these costs on a non-risk basis this option would eliminate MCO risk related to COVID-19 and reduce cash flow risk as payments would come through fee for service. We would also recommend funding this option with a risk corridor to reduce the risk that the remaining costs are significantly less than originally projected. This option does have some drawbacks however. For example this could prove to be much more administratively burdensome than other options. It could also - it would also affect beneficiaries' continuity of care and we also understand that some states have

moved significantly into managed care don't have much of a fee for service program left to utilize.

Also states could develop and submit rate amendments to prospectively add costs associated with COVID-19 to the capitation rates. This option could be accomplished in a number of ways. A couple of examples are adjusting rates for COVID-19, adjusting rates for non-COVID-19 costs or incorporating (kick) payments to name a few. This option would increase MCO cash flow and has the potential to mitigate MCO risk but only to the extent that assumption surrounding the additional costs are accurate. Given all the uncertainty surrounding the spread of the pandemic and the ultimate cost associated with treatment it would be likely - incredibly difficult to develop accurate assumptions or assess the reasonableness of the final rates.

Finally, there are a couple of options that could ultimately prove to be more difficult. One such option would be to develop and submit a retroactive rate amendment to take into account COVID-19 and non-COVID-19 cost changes. This option wouldn't address MCO cash flow concerns as any additional funding would not be paid out till the end of the rating period or after the rating period. While it would mitigate MCO risk this option would take significant time for states and/or actuaries to gather the necessary experience to develop the new rates.

States could also make retroactive non-budget neutral acuity adjustments. This option might mitigate MCO risk, however it wouldn't address cash flow concerns because again no funds would be paid until after the rating period. This option we think would also be very complex and difficult to assess which could ultimately hinder approval.

Finally, there are state directed payments. This option may provide adequate MCO cash flow and continuity of care, however we also believe it may insufficiently mitigate MCO risk. Additionally state directed payments can be complex, difficult to assess and require more careful review by CMS prior to approval. So those are some of the options that, you know, we've kind of thought through in OACT. We're happy to answer some questions at the end to the extent that anyone has any but with that I will turn it over to Laura Snyder.

Laura Snyder: Thank you Tristan. This is Laura Snyder. I'm a Technical Director in the Division of Managed Care Policy and as follow-up to that last reference of on state directed payment CMCS did want to make a few more points. As we have indicated earlier in the call we acknowledge that states are facing a number of challenges in trying to address changes in utilization both increases in utilization as well as decreases in utilization in response to COVID-19. States have inquired about what tools that are available to address these concerns particularly in a managed care environment.

For increases in utilization states can address this through a number of different options as described earlier including rate amendments and require increased fee schedules through state directed payments. CMS is committed to reviewing all managed-care actions related to responding to COVID-19 as quickly as possible. So we ask states to please submit all actions related to contract amendments, rate certification amendments and state directed payment pre-or amendments to already approved state directed payments intended to respond to COVID-19 to the mailbox that was announced earlier last week I believe as CMCSmanagedcareCOVID-19@cms.hhs.gov. This will help to ensure expeditious processing of those related actions.

For now we note that CMS is exploring options as noted earlier in the call to address the decreases in utilization. Those policy discussions are still ongoing as we explore flexibilities under different Medicaid authorities as well as opportunities available through the \$100 billion Provider Relief Fund included in the CARES Act noted at the beginning of the call. We do plan to provide additional guidance on this topic in the near future as we understand states are trying to address this concern in a very expeditious timeframe. With that I will turn it back over to Jackie for any further discussion.

Jackie Glaze: Thank you Laura, thank you Tristan and Alissa for your remarks. So at this time for the next 15 minutes we will take your questions specific to managed care and then we will return to some additional discussion and then we will take additional questions that you have at this point. So we're just asking at this time that you limit your questions to the managed care topics. So (Michelle) we're ready for you to open up the lines now so that we can take questions from the audience. (Michelle), are you there? Can others hear me?

Laura Snyder: Yes.

Alissa Deboy: Yes.

Tristan Cope: Yes, I can hear you.

Jackie Glaze: Okay.

Anne-Marie Costello: So Jackie if you don't have the operator I wonder maybe we should go to the FAQs and come back to the operator to open line?

Sarah Delone: Did we lose Jackie too?

Alissa Deboy: I think that sounds like a good idea Anne Marie.

Anne-Marie Costello: Okay, we apologize to our audience today. It looks like we are having some technical difficulties. We're going to assume the folks can hear me although I don't think maybe we are losing folks. But why don't we try and while we try to locate the operator go ahead and ask our team to give us a quick preview of some FAQs to come.

Melissa Harris: Sure, thank you Anne Marie. This is Melissa Harris in the Disabled and Elderly Health Programs Group. And from the benefit perspective I will say that some of the content that you'll see in the FAQs walks through some of the benefits that are provided to various eligibility groups both the expansion eligibility group that gets the testing services and the mandatory Medicaid groups. So the FAQs will walk through the benefit packages for each of those groups give - provide a little bit of context for some of the major categories of benefits like in vitro diagnostic product testing related services, what really are the components of those and hopefully provide clarity to some questions that we have been getting from states. So we look forward to having that out and can walk through those in greater detail with you. So that's it from the benefit side. I am happy to turn it back over maybe to Sarah Delone.

Sarah Delone: Sure. Hi, this is Sarah Delone with the Children and Adult Health Program Group. The CAP several different topic areas that are addressed in the pending FAQs that should be out shortly that I can note for you all to look for. First are FAQs on the new optional eligibility group including information on eligibility requirements, covered benefits and also some questions related to application processing and notices for that new optional eligibility group. Second, are FAQs on the CHIP and basic health program and the benefit coverage and cost-sharing implications of the Family and Children CARES Act for those programs so how those requirements around the testing benefit

and the cost sharing exemptions for testing apply in the context of CHIP and BHP. Excuse me, next are a series of questions on the conditions with states must read in order to receive the temporary FMAP increase including many of the questions we have received on how the condition in Section 6-8E3 to continue coverage for Medicaid beneficiaries through the end of the public health emergency applies in various circumstances.

First, of all the applicability of this condition to beneficiaries who do not no longer meet the level of care requirements for Home and Community-based Services Waiver Program on its application to individuals enrolled for benefits during a reasonable opportunity period, Medicaid beneficiaries who age out of a eligibility group such as a group for children, adults or former foster care individuals and also individuals who become incarcerated amongst other (unintelligible).

I do want to flag that what are not included in the set of FAQs that are soon to be released imminently are responses concerning the applicability of the 6008 B3 condition to any changes that a state may want to make in cost-sharing for non-COVID related services or post eligibility treatment of income rules or to medically needy beneficiaries. We are needing additional time to analyze those issues and we certainly didn't want to hold up the questions that we were prepared to point out so we are going to continue to analyze those and we'll provide additional guidance on those questions soon.

Finally, there are several FAQs in the upcoming posting on provisions in the CARES Act relating to the treatment of for purpose of Medicaid and CHIP eligibility of the \$600 increase in unemployment compensation payments and the \$1200 tax rebate. These were discussed on a call on Tuesday and we have FAQs coming out today. And there were also a few other changes aid in the CARES Act to federal income tax rules that may affect the MAGI-based

eligibility and determinations for some individuals for Medicaid and CHIP. And these also are addressed in the FAQs. And that's it for CAP and so that I think I would turn it over to (Rory Howe) for the Financial Management Group.

(Rory Howe): Thanks Sarah. So regarding the financial management portion of the FAQs as we mentioned last week with a few clarifications on the applicability of the 6.2 percentage point FMAP increase for certain types of expenditures and match rates. And we also have one correction to our prior FAQs. Again that correction specifies that community first choice 1915 K expenditures are in fact eligible for the 6.2 percentage point FMAP increase. And that as a - the section 6004 of the Family First Coronavirus Response Act did specify that 100% match is available for both service and administrative costs related to the new optional eligibility group. And our upcoming FAQs include information regarding how states can request advanced Medicaid funding associated with those expenditures which periods the increase match are available and also related to financial reporting requirements.

One more area that our section of the FAQs touches on as Calder mentioned on an earlier all state call the CARES Act also delayed reductions to Medicaid DISH allotments that were set to begin in May. The CARES Act actually eliminated \$4 billion in reductions that were set for fiscal year '20 and it also lowered the reductions from \$8 billion to \$4 billion for fiscal year 2021 and delayed the start of those 2021 reductions until December of 2020. So that's is a little preview of what's to come on the financial management portion of the upcoming FAQs. And with that I guess I'll turn it back over to Jackie.

Anne-Marie Costello: Jackie, are you on the line? Okay so we are having some technical difficulties. We're losing some speakers. But this is Anne-Marie Costello.

And let me see operator, (Michelle) are you available to open the lines so we can take...

Coordinator: Yes.

Anne-Marie Costello: ...take questions from our audience?

Coordinator: Yes, at this time if you'd like to ask a question please press Star 1. Again that is Star 1 if you have any questions or comments. One moment. Again you may go ahead and press Star 1 on your telephone if you'd like to ask a question. One moment please. (Nicole Coffman) you may go ahead.

(Nicole Coffman): Good afternoon. Thank you for having this form today to address these issues. So going back to many of the options that were outlined by OACT they seem focus a lot on MCO cash flow options which may in fact be the case for some programs but what is also being observed is that MCOs are in fact not experiencing significant cash flow issues due to depressed utilization. So in terms of directed payments that might be implemented by a state has OACT entertained the fact that a rate amendment may not be necessary to incorporate the directed payment?

Anne-Marie Costello: Alissa or your team can you take that question please?

Laura Snyder: So this is Laura Snyder. I can start. I think that you seem to reference the decreases in utilization so I think that we're still trying to explore different policy options for how states can address decreases in utilization in the managed care environment. Obviously rate amendment is an option. But I think that, you know, we're still explore some of the different options available to try and increase cash flow to providers in light of the decreases in utilization. And I know that those discussions are ongoing and...

(Nicole Coffman): Perhaps I can clarify a little bit because I think I - so what we're getting at here is that because of decreased utilization for other types of services if a state was going to implement a directed payment but they're not just based on utilization increased fee schedules -- something like that -- it may be that the existing rates due to the offsets due to lack of utilization in other areas are still actuarially sound to accommodate the directed payment. Does that help, just slightly different issue. So it will be whether or not a rate it would be acknowledged by OACT that a rate amendment may not be necessary for types of directed payments that may be approved by CMS.

Chris Truffer: So Laura I'd be glad to jump in too. This is Chris Truffer from the Office of the Actuary. Good to hear from you (Nicole). While recognizing that there are perhaps some offsets in the form of reductions in other types of care and services during the pandemic I think our concerns would be that it's awfully early in the process of determining what the impact of the pandemic would be. And I think we would certainly at a minimum want to understand, you know, how a state and the actuaries would, you know, be able to come to any sort of definitive conclusion about the offset and relative cost of, you know, treating COVID-19 and the offset in other services as well.

I mean I think, you know, we expect there's, you know, likely to be some significant offset in some services to be sure but I think we need to be very cautious about something like that because we don't want to, you know, further exacerbated risk to plans or providers and at the same time (unintelligible) you know, make assumptions, you know, too early in the process that could sort of exacerbate those risks either overall or cash flow risks.

(Nicole Coffman): That's correct. And thinking on one of the other issues that states are dealing with as there trying to, you know, get funds to struggling providers as quickly as possible and that they too have decreased tax revenue coming in right. So there's always the concern about the state's budget to, you know, increase capitation rates or not so, you know, understanding if the current rates would still be sufficient and actuarially sound to address the directed payments is, you know, something that's being, you know, constantly explored in an area where clarity is helpful.

Anne-Marie Costello: Thank you (Nicole) and I think we're (unintelligible) something to do there. If I could ask folks aren't speaking if they could put themselves on mute. Thank you. Operator, if you can go to the next call.

Coordinator: Thank you. And our next question comes from (Zach Aders). You may go ahead sir.

(Zach Aders): Great, thank you. So building on the question that was just asked so we're seeing some initial, you know, obviously decline in utilization and that certainly is having a fiscal impact of the Medicaid programs. But I think one aspect that I have not heard addressed yet is going into this next contract period with the economy going the opposite direction of what it was we anticipate caseload to increase. So any perspective on that from the panel as far as how the actuaries should consider that going into the next contract period?

Alissa Deboy: Chris can you address that?

Chris Truffer: Sure, I'd be glad to. So yes I mean I think there is, you know, certainly, you know, would expect that there is a, you know, a high likelihood of significant enrollment increases during the pandemic and the sort of the economic effects

of it. I think it's something that's probably worth considering. You know, there is the potential that this is a pretty significant caseload increase. It could have, you know, a number of effects up front. Certainly considering what the health status of...

Woman: I'm not sure I understand.

Chris Truffer: My - that as my phone thought I was - my laptop thought I was talking to it, sorry. Okay I'm sorry. So the - there's the potential of looking at the health status of the population is coming on and what their previous coverages was. You know, there could be a significant number of people who are coming onto Medicaid either from some sort of private insurance before or from being uninsured and that could have some consequences for their health status to the extent that it perhaps interacts with the administrative costs and whether or not that has any sort of bearing on the relative amount of both fixed and variable administrative costs that's something worth considering.

I would think depending again on the size of it if there's any sort of questions about network and bringing providers in and things like that that might be a fair consideration. And I think we'd be open to certainly understanding more. You know, it's - you know, there could be a number of effects just beyond those. I think it's probably too early for us to opine with any sort of specificity and recognize that that could vary quite a bit from state to state and even program to program as well. But we'd certainly be glad to discuss that further and, you know, have some further conversations on it or certainly discuss questions directly with any states interested.

(Zach Aders): Good thank you.

Coordinator: Thank you. And our next question comes from (Judy Moore Peterson). You may go ahead.

(Judy Moore Peterson): Thank you, thanks very much for this conversation. This question is also regarding the rates portion of the discussion. And I completely agree with the prior two people on the concerns that they're bringing up and the issues that they're bringing up. It really points out the situations that we're in right now is unprecedented and then trying to come up with rates to based on a unprecedented situation is extremely challenging for all the reasons that have already been outlined. Because of - I mean I heard you that you're still considering how to help or how to address the considerations of the dramatic drop in utilization amongst some providers and what's the best way to address that? Of course the state directed payment is one of the methods that we're considering to be able to help address those issues. And I'm just - I did hear that it takes longer to go through that review and to come up with those what the approval process from CMS.

And I'm just curious because I do know that a number of states are considering the state directed payment as a way to be able to help some providers that are hurting particularly. I'm just wondering whether any consideration has been given to streamlining those - that approval process for state directed payments given the extraordinary circumstances that we find ourselves in?

Calder Lynch: So (Judy) this is Calder. I think that's a really good point and as I'm listening and thinking about this, you know, it might make sense for us to kind of talk about this globally rather than, you know, each have to sort of navigate this individually and see if we can kind of one, understand a little bit more kind of how states are thinking about structuring types of arrangements and, you know, kind of maybe putting some framework around it what we can get

agreement and then facilitate, you know, faster approaches individually if everyone's sort of working within that, so may be interested in helping coordinate. I'd be very open to kind of thinking about that globally and coming up with an approach that we can try to expedite or streamline those processes not just with regard maybe to directed payments but also other purchases when you're thinking about relative rates.

(Judy Moore Peterson) Thank you.

Coordinator: Thank you. And our next question comes from (Gary Young). You may go ahead sir.

(Gary Young): Hi, thank you. I want to make sure I understood what the FMG spokesperson said about the 100% federal funding for the new optional group. Does that also apply to administrative costs?

Chris Truffer: Yes. It does apply to administrative costs as well that are related to those beneficiaries.

(Gary Young): Okay, thank you.

Chris Truffer: Sure.

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

(Jeff Yang): Hi. So with regard to retrospective rate amendment just curious if you could provide fiscal - for fiscal year '20 on a July to June cycle any guidance on the timing of submitting a retrospective rate amendment and expectations on when that would be approved by CMS? Thanks.

Alissa Deboy: So this is Alissa I don't know who wants to start. On timing, you know, I think we're maybe on the appropriateness of timing I don't know Chris or Tristan if you have thoughts on that.

Tristan Cope: I mean this is Tristan. So there's a - I mean within Medicaid right now I mean there's - you obviously have to deal with the two-year timely filing issues but I mean retrospective risk adjustments are allowed right now. So to the extent of timing for submission I think it's whenever a state and its actuaries have probably enough information to think that they could probably develop the capitation rates in a reasonable fashion and with a reasonable amount of certainty or reasonableness around their assumptions anyway.

And as far as being approved I know we in OACT have agreed to prioritize any sort of COVID-19 related rate amendments or rate certifications or any sort of contract actions that we normally have a hand in approving making those a priority and trying to turn those around as quickly as possible.

Alissa Deboy: Right. And I think that holds true on the CMS side. You know, the only other issues that might prevent while we could communicate something that's approvable there may be a prior action or a base year issue with the contract that we would have to work to resolve with you. But again we're prioritizing our review of any COVID action as expeditiously as possible. Thanks.

Coordinator: Thank you. Our next question comes from (Grant Porter). You may go ahead sir.

(Grant Porter): Hi, thank you. This is pertaining to retainer payments for providers to maintain the provider cash flow. So now and a good proportion of our members are in managed care but not all. And particularly for each HCBS

services and some of the CMHO services that are most likely to be hit by reduced utilization we want to ensure that there's adequate supply of once the emergency period is over. And so in considering different options one that we considered in certainly haven't pursued to the end yet so it's purely in the preliminary stage is distributing retainer payments through fee-for-service based upon the providers total utilization for the Medicaid program. And so some of those members would be in managed care and their utilization would be previously paid for by managed care. But we don't - not doing it as a directed payment through managed care but through as a fee for service payment could that then be adjusted for through our risk arrangement with the health plan. And if that's the path it's taken what kind of review would be needed either prospectively or retroactively by CMS?

Alissa Deboy: OACT do you have thoughts on this? Tristan or Chris any thoughts? Some of our speakers are...

((Crosstalk))

Alissa Deboy: ...you there Chris?

Chris Truffer: Yes, I'm here. Yes, certainly like Tristan to weigh in as well make sure - want to make sure I understand the question exactly too. But, you know, to the - you know, I think we're willing to consider those. I mean again I think our, you know, our concerns on the managed-care side are certainly looking at, you know, both the overall level of cost and risks associated with that and trying to ensure that whatever we have in place is dealing with both sort of those overall risks, the cash flow risks and recognizing that there are so, you know, various risks distributed across the system. And I think we're glad develop on, you know, some sort of specific questions on, you know, state

directed payments or lending state directed payments -- things like that -- but I think we want to consider those both...

((Crosstalk))

Calder Lynch: Yes can I...

Chris Truffer: ...(unintelligible) themselves but also considering them in the overall context of the rates scale.

Calder Lynch: So this is Calder. Can I just ask - I want to make sure I understand what you're asking. So you're looking potentially you've got, populations and services in managed care utilization way down you may want to figure out some kind of methodology to make additional payments to those providers but doing it directly through your fee-for-service program rather than through your plans. Is that what I'm hearing?

(Grant Porter): Yes precisely because we have three managed-care - it would just be - it's a lot simpler to calculate that total Medicaid revenue from looking at it across the multiple managed-care programs and providers and doing it as opposed to directing MCO one, to make \$100,000 payment and MCO to make a \$250,000 payment or whatever the math is instead of making a single payment through fee-for-service to that provider.

Calder Lynch: Okay, yes that's probably a - it's a good question and it's probably a broader conversation than just sort of the one we're having now which is more about kind of what, you know with the authority that you'd be using to make those payments and then how we reconcile that to what you've already paid the health plans to do right, and so kind of looking at that old picture. I mean they would be happy to work with you and explore that and figure out somewhat

authorities, you know, that would require and then just making sure that we had the right guardrails in place. I don't know if we fully contemplated that scenario but we can take that back and do some thinking on it.

(Grant Porter): Okay. It seems just it could be the most efficient way to ensure those safety net providers have added cash flow. And one approach that we have taken in other is to have a risk share arrangement which you mentioned at the onset with the MCOs to ensure that sort of the net-net the MCOs are not getting sort of a windfall of capitation because their utilization is down and essentially we don't want to be double paying for that utilization. So thank you.

Calder Lynch: Thank you.

Coordinator: And our next question comes from (Janet Berger). You may go ahead.

(Janet Berger): I had two questions one of which has been addressed already but the second one is more of an administrative question. The options described by Tristan would those be posted anywhere that we could download potentially?

Calder Lynch: Well certainly the recording and transcripts of this call will be, you know, made available. We can look to see if there's, you know, whether we can may be included in the FAQ so kind of more organized that way.

(Janet Berger): That'd be great. Thank you.

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

(Jenny Groster): Thanks. I want to go back to state directed payments really quickly. Just wondering if CMS has any specific suggestions for expediting the review of

state directed payments? And then along the same path recognizing the provider payments need to be tied to utilization would CMS consider approval for distribution of funds to be based on prior utilization of given the volatility and lack of credibility that we have in the more recent data?

Alissa Deboy: I know Laura has been on and off. Are you on now Laura?

Laura Snyder: I am back on. Yes. So it's - so this is Laura Snyder. I can start. So I think a couple of things that will help expedite review of state directed payments particularly those that are coming in to try and address increased costs or where states are trying to increase fee schedules in response to COVID-19, I think the simpler types of approaches the better.

So, you know, minimal fee schedule requirements for instance or, you know, some sort of fee schedule type requirement are generally much more straightforward. I do recommend, you know, if you have any questions or concerns about a state directed payment and its implementation please reach out for technical assistance and we are happy to talk through any of those requirements. And if we do recognize, you know, for instance one of the requirements for state directed payments is that they tie to a state's quality strategy and if there is an evaluation plan and we recognize that many states implementing state directed payments at this time are doing so really for access concerns.

And so I think that we are available and eager to help states to address any concerns that they may have through state directed payments. And again if you do have a fee directed payment that you were trying to implement in response to COVID-19 we do encourage you to submit that to that mailbox that I mentioned at the top of the call as well so that we can expedite that review.

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

(Lindsey Carrington): Hi there. This is (Lindsey Carrington). So I just wanted to go back to the discussions around the risk corridor that was discussed in asking whether or not what I think what I heard was CMS would be willing to approve a retroactive risk corridor. And then also wanting to know would we be able to do a risk corridor for only part of a rating period? So for example could we have the risk corridor that would only start with the COVID period or would have to cover the entire rating period?

Alissa Deboy: So I want to just start by saying in general as probably individuals on the call are familiar with our regulations know that we have a proposed regulation which we are actually proposing to not allow retroactive risk corridors. However we believe in the context of the COVID pandemic and the extraordinary nature that we are in we are certainly willing to entertain retroactive risk corridors for the situation. But I will ask my colleagues in the Office of the Actuary to opine and Laura on the other part of the conversation about what the appropriate time period is to circle back to that whether it's just the start of the COVID period or the entire rating period. So Tristan I can ask you to comment first and then Laura?

Tristan Cope: Sure, yes thanks Alissa. And I totally agree. I think we are trying to move away from these retroactive risk corridors but given the extreme nature of what's going on right now we are definitely going - we're definitely willing to consider them in this case and probably only in this case. I think it would be cleaner and possibly easier to institute this over a full year's worth of experience but I think actuarially speaking we would we probably consider a partial year. I don't know Laura if you have anything on the policy side?

Laura Snyder: No, I don't think I have anything to add to that but I just agree with Tristan's sentiment. It would seem like it would likely be easier to do over the entire rating period but if, you know, if the state is wanting to look at a smaller time period I don't think that there is any policy concerns that we would have with necessarily pursuing that type of approach.

(Lindsey Carrington): Great, thank you.

Coordinator: Thank you. Our next question comes from (Clark Phillip). You may go ahead sir.

(Clark Phillip): You just addressed my question so I think I'm good.

Coordinator: Thank you. Our next question comes from (Pat Curtis). You may go ahead.

(Pat Curtis): Yes I want to backtrack a little bit. This is an eligibility question. You indicated when you gave like a little preview of what's going to be the FAQs - - and I was on the call Tuesday so I know you clarified and I want to make sure -- that the increase to the unemployment is exempt from medical and the rest of the unemployment is not.

And I want to make sure because even as I'm sitting here I'm getting questions. We've got people now who are submitting the \$600 increase as part of their income and that that is exempt and they - we have also learned that it is not exempt for SNAP. So since we have a coordinated eligibility system we're going to have to deal with it one way for medical and another way for SNAP. I just wanted to clarify that what I heard on Tuesday and what you're going to be putting in the FAQs is correct it is the only part that is exempt is

the increase in unemployment related to the pandemic issue which is \$600 a week?

Sarah Delone: That's correct. So the underlying unemployment amount that somebody would have gotten, you know, but for passage of the CARES Act and the \$600 increase that still counts. Only the \$600 increase...

(Pat Curtis): That...

Sarah Delone: ...is what is not counted for purposes of Medicaid or CHIP eligibility?

(Pat Curtis): Okay. And apparently it is just for medical. I don't expect you to comment on SNAP but we have learned that SNAP it is not exempt for SNAP. And can you just reiterate one more time the \$1200 the people are getting is that exempt or not?

Sarah Delone: That also for - that also is exempt. It does not count as income for MAGI as well as non-MAGI neither other population. And as long as it's spent in the first 12 months, you know, of receipt it also is not, you know, it would not be considered a resource. You know, somebody gets the \$1200 in April, they haven't spent it, they put it into their bank account in May it's not counted as a resource but if it's still there after the 12 months then it would be, resource. But presumably people are going to spend it so for all intents and purposes is exempt for all purposes for Medicaid and CHIP for both...

(Pat Curtis): Thank you very...

Sarah Delone: ...MAGI and non-MAGI populations. You're welcome.

(Pat Curtis): Thank you very much.

(Stephanie Gincia): And Sarah this is (Stephanie Gincia). This is not the direction you were going in (Pat), but of course you could use R2 for the non-MAGI populations for any of these types of unemployment if you wanted to.

(Pat Curtis): Would you repeat that?

(Stephanie Gincia): I said this is not exactly the direction you were going in because you were trying to - you were concerned about the nonalignment between programs and I'm aware of some of that nonalignment but a state of course can use 1902 R2...

(Pat Curtis): R2.

(Stephanie Gincia): ...to disregard the, you know, the sort of typical unemployment income.

((Crosstalk))

(Pat Curtis): I see what you're saying okay yes, yes. I understand what you're saying now.

Sarah Delone: Just to clarify thought (Stephanie) that the old (unintelligible) are non-MAGI 1902 so the - to disregard income is no longer available for you in MAGI based populations right?

(Stephanie Gincia): That's what I said yes.

(Pat Curtis): Thank you very much.

Coordinator: Thank you. Our next question comes from (Jennifer Jacobs). You may go ahead.

(Jennifer Jacobs): Thank you. I'm really just adding a layer to the comments of previous speakers regarding state directed payments and Calder I appreciate your state that you'll consider a global streamlined solution there because we do have to make decisions in real-time. The impact - the economic impact on providers is drastic and immediate. And then the perception is that plans are sitting on capitation. So I was just wondering if you would consider as part of that solution the concept of a state directed payment that is actuarially neutral as someone described earlier and may be potentially combined with a risk corridor to address the concern about exposure for the plans. This would enable states to get cash to struggling providers and avoid applying that excessive risk to the health plans.

Calder Lynch: Thank you. No I think that's an idea worth a lot of discussion and consideration. I think, you know, it - this is evolving and we're learning through it and, you know, ideas are coming forward so I appreciate you raising that. We're going to take that off-line and talk a little bit more and maybe through an (NAM) or others pull together some folks that can refer to that conversation and see what we can come up with.

Jackie Glaze: Thank you. So were the top of the hour now so (Michelle) we'll take one more question and then we'll wrap it up for the day?

Coordinator: Thank you. And our last question is (Henry Littman). You may go ahead.

(Henry Littman): Thank you. Calder just building upon the last caller and appreciate your considering with respect to the directed payments and some parameters were the risk corridor. I was wondering one suggestion I like you to consider is within the 1-1/2% leeway provision that's already in the managed care rules

of being able to give a state the ability to work within that by reallocating dollars and also adding a risk corridor?

Alissa Deboy: I think the issue is here that you're asking for this flexibility without having to resubmit a rate certification is that right (Henry)?

(Henry Littman): No, no I think some in the recertification I think is fine. I think in terms of, you know, our state has been working on something like that and we're - we'd be ready to go to on something like that pretty quickly in terms of working since we heard about the directed payment option. So I think that a rate certification, a risk corridor and being able to work within 1-1/2% would be - give you sort of some guardrails to make sure that you're balancing the interest that OACT has talked about on the call today to making sure that the MCOs have sufficient funds, make sure that is within a reasonable level and then lastly that there is able to expedite to the needed provider network, you know, the issue of is very cogent that depending on where you are in your rate cycle your MCOs may be incurring a windfall.

You know, in our instance we have a floor that they would have to return money to us but it might not be till year from now, be a shame to see the providers go down or be harmed in terms of the access we can provide beneficiaries more so and to get that money later when it's too late to make a difference.

Calder Lynch: Thank you (Henry). That's helpful.

(Henry Littman): Thank you.

Calder Lynch: We'll - I think folks have raised some good points for consideration on that score...

(Henry Littman): This is incredible. I... Thank you. ...(unintelligible) appreciate it.

Calder Lynch: All right...

((Crosstalk))

Calder Lynch: ...well thank you all for joining us this afternoon. We'll probably (unintelligible) to the weekend, appreciate the opportunity to kind of focus on this issue. I think it helped bring some ideas to life that we can dive into further. You know, we'll continue to share information as it becomes available. As we get those FAQs cleared we'll get them out even if it's over the weekend. They'll be in folks' inbox as soon as possible. And again well I think have our next call on Tuesday. Is there anything to preview for that Jackie or Anne-Marie?

Jackie Glaze: I think we may have a couple of states that may talk a little bit about their experiences and some of the work they've done around some of the topics we've been discussing over the last few weeks so more to come on that.

Calder Lynch: Yes, and to that end if you if there's a particular topic you'd like to hear on these calls particular folks you'd like to hear from please let us know and we'll endeavor to make sure that these continue to be as useful for states as they can be. So thank you all for joining us, have a good evening.

Coordinator: Thank you. This concludes today's conference call. You may go ahead and disconnect at this time.

End