

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

May 1, 2020

3:00 pm ET

Coordinator: Greetings and welcome to the All State Medicaid and CHIP call. During the presentation, all participants will be in a listen-only mode. Afterwards, we'll conduct a question and answer session, and at that time, if you have a question on the phones, you can press the one followed by the four. You can also submit a written question using the chat feature located in the lower left corner of your screen. If you need to reach an operator and you're on the phones, you can press star zero. As a reminder, this conference is being recorded Friday, May 1st, 2020. I'd now like to turn it over to Jackie Glaze. Please go ahead.

Jackie Glaze: Thank you very much, and good afternoon everyone. I'd like to welcome you today's All State call. Calder will share with you the highlights for today's discussion and introduce our speakers today. So Calder?

Calder Lynch: Thank you, Jackie. Welcome, everyone. Thank you for joining us today. As you can tell, we have switched up the format today a little bit and are using a webinar so that we can better provide some information for your visual display that we think will be valuable for you to see. Today we are able to welcome two guests from our CMS Office of Enterprise Data and Analytics, also known as OEDA. We have Keri Apostle, who is the director of the Policy and Data Analytics Group within OEDA. This group produces research files and data products on CMS programs and also performs advanced analytics for CMS leadership across our program. Keri is joining us today to discuss data reporting analytics that the agency is conducting related to COVID-19. She is joined by Allison Oelschlaeger, OEDA's director, who will help answer any questions that you may have on the data and CMS's plan.

After the presentation from Keri, Julie Boughn from CMCS's own Data and Systems Group will discuss how CMCS is using T-MSIS data for COVID-19 data reporting and analytics, including how we're sharing these data with OEDA for

agency-wide dashboards. After Julie's discussion, we'll then pause to take your questions related to data reporting and analytics. Following that question break, our CMCS staff will share information regarding important provisions that were included in the CMS interim final rule with comment that was published yesterday afternoon. The IFC, as it's called, is a final rule but also provides an opportunity for individuals to submit comments to the federal register after publication, and it is currently available on the CMS website.

We're, of course, continuing to work with a number of you individually on the various flexibility and authority requests that have come in. We have now approved quite a few of those, including 1135s in every state and nearly every territory. 51 Appendix Ks, 27 disaster state plan amendments, 11 requests for emergency IT funding, and that work will, of course, continue.

All right, but now, let's begin our discussion on data reporting and analytics. I believe I'm turning it over to Keri and the OEDA team.

Keri Apostle:

Thank you, Calder, and good afternoon. Thank you for inviting me to speak today. Today, I will share more details about how we're tracking COVID-19 cases in the Medicare Fee-For-Service and Medicare Advantage programs. My goal in sharing this subset of metrics that we've generated for CMS leadership is to show how this data can be used to better inform the agency about how the pandemic is impacting CMS programs. Currently, we do not have Medicaid data to share, but we'd like to incorporate it as soon as possible so that the administrator and policy leadership can have an effective response to the pandemic.

So, if you'll turn your attention to the first slide, what you'll see in the first set of graphics is the dashboard, which is entitled COVID-19 Case Summary. Currently, we are providing weekly updates to CMS leadership on COVID-19 metrics. In the first three graphs on the slide, you'll see that we report the count of unique cases by diagnosis points, week, and CMS programs. We classify total cases into two categories based on the ICD-10 diagnosis codes on claims data.

First, we have our potential cases, which is in the blue box. Here we use official guidance published by the CDC, and we define potential cases as those with an ICD-10 diagnosis code of B97.29, which is other coronavirus as the cause of diseases classified elsewhere, and we also need one of six additional diagnoses codes. For instance, one is viral pneumonia. These six codes are provided in CDC guidance, and, if needed, we're happy to share them afterwards.

Then if you move to the yellow box, you'll see that we also have a count of COVID-19 cases. We define a COVID-19 case as those with the novel U07.1 diagnosis code. This diagnosis code went into effect very recently on April 1st, 2020. Now if we go to the next slide, on this next slide what you'll see is that we provide detailed case summary information. We show the total count of cases which is both potential plus COVID-19, and then show the national rate of cases which is expressed as a rate of cases per 100,000. On the very left-hand part of the slide, you'll see a map of the United States, and what we do is we provide this visualization so that we can better understand geographic variation among COVID cases across the United States. Underneath the map of the U.S., we provide another metric related to geography which is the rural and urban status of the beneficiary based on mailing address. In the very center of the slide we list the top 10 counties by prevalence, and this allows us to see hotspots at a more granular level. On the right-hand side of the slide, we show cases based on their first site of diagnosis such as inpatient settings, outpatient settings, the emergency department and an office setting. We also show the COVID case rates by various beneficiary characteristics such as dual and non-dual status. Then we also include additional characteristics such as reason for Medicare entitlement. So we break it down into three groups, aged, disabled, and ESRD, and then we have additional metrics for COVID cases based on sex, race, ethnicity and age group.

Not shown, but I'll briefly describe, is that we're also tracking COVID-19 laboratory testing data in the Medicare fee-for-service and Medicare Advantage programs, and we're also monitoring utilization of services to see how the pandemic is impacting service use. More specifically, we're monitoring whether we observe a decline in elective surgeries given most recent CMS guidance. We're

also monitoring whether we observe changes in the utilization of services like telehealth which have expanded during the pandemic. Lastly, we're monitoring utilization patterns to ensure that beneficiaries continue to get the necessary services that are required such as dialysis.

At this time, I'd like to turn it over to Julie, who will talk about T-MSIS and COVID data.

Julie Boughn:

Thanks very much, Keri. That's a really interesting presentation. I want to talk a little bit about how we're working to make Medicaid data part of these national analyses that Keri talked about. You heard Keri mention that we don't have Medicaid data yet for those national analyses. So while we're actually providing Medicaid data to the national analyses, it's mostly blank right now for reasons that we'll talk about as we go forward.

So we know the timing of Medicaid data at the federal level is different than the timing of Medicare data, but we obviously want to try to make this happen to be able to analyze the Medicaid data sooner rather than later. So I'm going to talk about how we can make that happen. First, I do want to show you that we actually are using T-MSIS data right now to do COVID-related analyses. So during the timespan of the public health emergency, we revamped many of our operational processes around processing T-MSIS data. So we're now creating analytic files literally as soon as we receive monthly production files from state.

So what you see here on your screen are line graphs for 2018 and 2019 of emergency department visits and another one that we called COVID related conditions where we're using guidance very similar to that, which Keri talked about, around CDC about how we can sort of identify cases that might be COVID, and we're looking at those. We're also looking at those into 2020 even though we're in the position right now where we're still waiting claims runout so that we can start to get more volume around those. We anticipate that as we get more and more into 2020 that these visualizations are going to be even more revealing.

Similar to what Keri talked about, we have plans to visualize things like all-cause mortality, preventative services because we want to see service utilization in Medicaid and we're going to also be doing county level risk estimates. I just want to pause there and thank you all for your continued timely submission of T-MSIS data because that's really what's making all of this possible. Because specific COVID related coding has just recently been finalized, most of our analyses that we're doing right now with T-MSIS data are not using actual COVID codes. That said, those codes are critical to the kind of national analysis that CMS wants to do in the future and I want to focus on those for a bit.

Go to the next slide for me, please. This slide shows the correct HCPCS code for laboratory testing including two newer ones that are for high throughput testing. I'm not really intending to dwell on the specifics here, partially because I'm really not a coding expert, but also because the guidance around these codes is readily available, and I'll point to some of it when I get closer to the end of the presentation. But I just wanted to make everybody aware of the availability of these codes right now to start using.

Go to the next slide, please. So this slide has CPT codes for procedures associated with COVID as well as the all-important COVID diagnosis code which Keri mentioned went into production in early April. I think a main message that we want to give you around these codes is urge you to make sure that your fee-for-service and MCO providers are using these codes as appropriate and that your claims and encounter systems are ready to accept them. MCOs often need to be prepared as well.

Lastly, we hope to begin to see these codes in your T-MSIS data as soon as possible as we get through claims runout and all that kind of stuff. Once we begin to receive those claims, then the data that we provide to Keri and her team will be less blank than it is right now for Medicaid and those numbers will start to show up on the CMS dashboard.

Next slide, please. Finally, I just want to give you a quick reminder about the

location of T-MSIS coding guidance. We went through all of this with T-MSIS leads in states via a webinar on April 6th. The materials from that webinar will soon be posted to the T-MSIS state support site, but participants in the webinar have already received them. We also updated the T-MSIS coding blog that day with two notices about COVID specific coding in T-MSIS. The CMS FAQs, the FAQs that we've been doing on COVID ever since the emergency began have covered various coding questions as well. I'd like to just sort of conclude by saying that if you have questions regarding any of these, please talk to your CMS T-MSIS leads or your CMS state Medicaid systems state officer. They will be able to get you on the answers that you need.

Thank you all very much for your support of having good national level data as we confront this public health emergency together. I'd like to thank my colleague Megan Maxwell from Mathematica Policy Research. She's on the call today as well. She's here just in case you have technical questions around coding that are going to be beyond my knowledge. She's also the primary author of the T-MSIS coding guidance. So she's a really good resource to have today. With that, I think I'll turn this back over to Jackie who's going to lead our first Q&A session.

Jackie Glaze: Thank you Julie and thank you Keri for your presentations. So now we're ready to begin our first session of the Q&A and that will focus on the data reporting and the analytics that we just heard Julie and Keri talk about. So Keith, can you walk through again on how the audience can submit their questions?

Coordinator: Certainly. If you'd like to register a question you can press the one followed by the four on your telephone, and you'll hear a three tone prompt to acknowledge your request. If you're not on the phone, you can submit a written question using the chat feature located in the lower left corner of your screen.

Jackie Glaze: Thank you. So the first, we'd like to start with the chat function. So those of you that would like to submit your questions through that function, we're asking that you do that now and then we will read the questions out loud and respond to those. So we'll wait for your questions.

- Barbara Richards: So we do have a couple of questions in the chat. So let me just start with the first one we've received. I think this is for our OEDA colleagues. Must the COVID diagnosis code be the primary code?
- Keri Apostle: Great question. So right now, what we're doing is we're taking a broad stroke and looking at it in both the primary and secondary positions just to make sure we've captured all of the pieces. I do believe that there may be additional guidance from CDC about whether the specific codes need to be in which positions. I'm not entirely sure. I think it differs actually a little for the interim guidance for potential cases versus the confirmed cases.  
So I would recommend following up with CDC just to confirm guidance depending on what the overall guidance is for defining those cases.
- Barbara Richards: Terrific. Thanks Keri. We do have another question about, Keri and Julie, I'm not sure if this is too technical, but can CMS give complete procedure diagnosis codes for type of service 136 and type of service 137?
- Julie Boughn: Barb, it's Julie. I cannot. Megan, go ahead.
- Megan Maxwell: I was just going to say, so for the type of service 136 that we would expect to see on claims, that type of service code is specific to the in vitro diagnostic product. So it's only the testing. The type of service code 137 though, that's broader where it captures COVID-19 testing related services. I know there have been a lot of questions from states about what exactly are the COVID testing related services, and actually, for that question, I would recommend that you look to the disaster response toolkit webpage. The FAQs document there that's for the Medicaid and CHIP programs, that goes into pretty good detail about what exactly is considered a testing related service.
- Barbara Richards: Great, thanks. So we've got another question in the chat that says will you be analyzing data by race and ethnicity?
- Allison Oelschlaeger: This is Allison. On the Medicare side, we are. We're analyzing data by race, ethnicity. There are some limitations to that data for Medicare, but I would definitely defer to Julie and team on the Medicaid side.

Julie Boughn: Yeah, on the Medicaid side, we would certainly like to. Our race and ethnicity data, though, comes from states. So it has some variability. So we tend not to overly rely on it, but we would definitely like to be able to do that.

Barbara Richards: Great, thanks. We've got another question in the chat that says "What is the timeline for Medicaid data?"

Julie Boughn: So Megan, I'm going to start and then you can sort of fill in the details, a little bit. But typically, Medicaid data is received at CMS monthly. So for example, it's May now. By the middle of May we will receive files that should include at least the beginnings of April claims. We will process those in May and then we'll start to be able to use that data for analysis later in May. What we do experience in Medicaid, and really any healthcare program, but Medicaid's a little bit more pronounced at the federal level is a claims runout period. So providers have up to a year to submit claims, and then it can sometimes take a little longer for them to actually get paid and for that data to get to CMS.

So that's sort of the time span that we're looking at, but that's I think one of the reasons why we wanted to have this subject on the call today was we were trying to urge everybody to move this data as quickly as possible and feasible. Megan, would you add anything to what I just said?

Megan Maxwell: No, I think that's great, Julie. Nothing to add.

Barbara Richards: So we've got another question in the chat that says, "How will these data be aligned with data on COVID death that is being collected by state survey agencies?"

Julie Boughn: That's a good question. I hadn't thought about it too much. We are certainly trying to use all the data that we have at our disposal at the federal level to include in analyses. Like we are trying to begin to use the what we call the death master file from Social Security Administration and things like that. But we would be welcome to hearing ideas that people have about analyses that could happen at the federal level.



Allison Oelschlaeger: I'll just add to that that CMS doesn't collect data on cause of death. We collect data on facts and date of death. So we defer to the National Center for Health Statistics, which is part of the Centers for Disease Control that collects all of that data from stateside health statistic agencies and has a database to make that information available and I believe they also are publicly reporting COVID-19 death information.

Barbara Richards: Great, thanks. We've got another question in the chat that says, "How does the lag in claims reporting affect the accuracy of the data CMS is collecting, and what adjustments must be made to account for that lag?"

Julie Boughn: I'm assuming that the question's asking about Medicaid data. So that's both a simple question and also a really, really, really big question. What we've been doing for example with those analyses that I showed you brief pictures of there is we just acknowledged that that happens. In fact, if we put the 2020 numbers up there and we were doing that using the March files, you would actually see a drop off in COVID related conditions, emergency department visits, that kind of thing. That is exactly a symptom of claims runout. We expect as we get more and more data in across the months that those lines will start to be leveled off with the ones for the end of 2019, and will even start to increase a couple of them.

So that's how it affects our analyses is that we have to always know that that's the case and what month we're in and what month data we're looking at.

Barbara Richards: Great. We've got a couple more questions in the chat, but they're pretty technical. So I think we should turn it over to Jackie to open it up for any broader questions from the audience.

Jackie Glaze: Thank you, Barbara. So Keith, we're ready to open up the phone lines at this point and take additional questions.

Coordinator: Okay. We have one from the line as (Zeyno Nixon) from Washington. Please go ahead. Your line is unmuted.

- (Zeyno Nixon): Thank you. I was going to ask about data maturation, but that question is already answered. Thank you.
- Coordinator: Thank you. The next question is from (Arvind Goyal) from Illinois. Please go ahead.
- (Arvind Goyal): Thank you very much. I wanted to ask if CMS has any way to guide us on what kind of co-morbid conditions along with COVID-19 are being reported at this time.
- Julie Boughn: Allison or Keri do you want to start with that or you want me to... Oh, this is Julie.
- Keri Apostle: We can let you start, Julie, and then we can add.
- Julie Boughn: Okay. Well, as I said in the Medicaid data, right now we are not seeing the actual COVID codes. So we're doing almost all sort of proxies to it in the analyses that we are doing. We are set up to report and visualize the COVID codes, but we're not getting the data yet. So we're really not doing any of that right this second. I would imagine that we certainly will as we go forward in receiving the data and looking at it.
- (Arvind Goyal): Thank you.
- Allison Oelschlaeger: And I'll just add on the Medicare side that Keri talked through we're doing some analyses of COVID-19 cases, and we're starting to look at co-morbidities but don't have anything that we're ready to publicly share at this point.
- (Arvind Goyal): Thank you.
- Coordinator: There are no other questions on the phone lines.
- Jackie Glaze: Thank you very much, and thanks for all the questions. So we're ready to move on to the next agenda item. We have two speakers lined up. We have Melissa Harris and Cassie Lagorio, and they're going to talk about the CMCS IFC provisions. So we'll begin with Melissa. Melissa Harris, you ready?

Melissa Harris: I am. Thanks, Jackie. So I wanted to talk about two Medicaid provisions that were included in the second interim final reg with comments that CMS has published in this public health emergency. This second IFC was put on the CMS website yesterday and will be retroactively effective to a couple of dates, the primary date being March 1st of 2020. This is largely a Medicare reg, but there are two provisions that apply to the Medicaid program that I'll walk through quickly just so you know what's out there and that we are taking comments on it.

The first is around the laboratory services benefit in Medicaid which is a mandatory benefit found at 42 CFR 440.30, 440.30. This benefit has really been in the spotlight in this public health emergency because this is the benefit that has been modified to require coverage for the in vitro diagnostic products for the testing of the virus that cause of COVID and the detection of the SARS-COVID-2 virus. In addition to that, though, given all of the need for flexibility to ensure that testing can be done in a maximum amount of scenarios and by a maximum number of practitioners, we issued a revision to 440.30 that would only take effect in periods of public health emergency and subsequent periods of active surveillance that would allow some flexibility in how a couple of provisions of the laboratory regulation are implemented.

When this flexibility kicks in, lab tests will not be limited to being provided in office or similar setting, and they will not require the order of a physician or other licensed practitioner. So this will do a couple of things. It will allow flexibility for reimbursing for lab tests that are provided in alternate locations like parking lots, and it would allow for individuals to be tested who have not gotten a formal referral or prescription for the test. This would be particularly important for people who have not gone to the doctor, who are not symptomatic, but who want to know if they have the virus.

So those flexibilities kick in, like I said, during the period of a public health emergency and during a subsequent period of active surveillance. We understand that there will be a time, even when the formal declaration of a public health emergency is over, when some of these flexibilities will still be necessary to ensure

rapid access to testing and to prevent spread of the COVID virus. So in this IFC, we have defined a period of active surveillance as an outbreak of communicable disease during which no approved treatment or vaccine is widely available. Then we've also talked about when that period of active surveillance ends, which is on the date the secretary terminates it or the date that it's two incubation periods of the last known case of the communicable disease, whichever is sooner.

We've solicited comments on a couple of specific provisions of that regulatory discussion, and so I point that out for you. Of note, we've also extended the flexibility not just for this COVID public health emergency but also for future public health emergencies and the subsequent periods of active surveillance that might follow those future public health emergencies. We're trying to learn some lessons from COVID as we go and establish some future flexibilities in the provision of these Medicaid services.

The other provision that I'll talk about is Medicaid Home Health. What we have done in this IFC is to implement sections 3708 of the Cares Act, which modified both in Medicare and Medicaid Home Health benefits to authorize nurse practitioners, certified nurse practitioners and physician assistants to order home health in addition to a physician. So the regs 42 CFR 440.70 have been modified in this IFC to allow, besides the physicians, those three additional clinicians to order home health nursing, home health aide and then the therapy services if the state makes those therapy services part of the home health benefit.

We were directed to implement section 3708 of the Cares Act in alignment with Medicare. As I mentioned, the Cares Act modified both home health benefits and it specifically directed Medicaid to implement these provisions as Medicare Home Health did. So we also used that direction to implement some changes to Medicaid's durable medical equipment provisions, which is a component of our home health benefit. It's medical supplies equipment and appliances under Medicaid Home Health. You'll see in this interim final that we have aligned with Medicare to allow other licensed practitioners, in addition to a physician, to order medical supplies equipment and appliances.

It's important to note that the Cares Act was not time limited. It is not specific to the period of the public health emergency, and so these are permanent changes to Medicaid home health benefits and this is in comparison to the first interim final rule that we issued about a month ago which implemented some time limited similar flexibilities to Medicaid Home Health that was limited to the period of the public health emergency. So comments are being solicited on both the lab provision and the home health provision. It should be published in the federal register within the next couple of days, but it is available online on the CMS.gov website. So we encourage you to take a look and submit your public comments accordingly.

So, at this point, I'm going to turn it over to Cassie to talk about the basic health program provisions that were in IFC. Thanks.

Cassie Lagorio:

Great. Thanks, Melissa. States that operate a basic health program complete a BHP blueprint which is a comprehensive written document submitted by the state to the secretary of HHS for certification, similar to a Medicaid or CHIP state plan. States are able to submit blueprint revisions for certification when they seek to make programmatic changes to their BHP. Current BHP regulations require blueprint revisions to be submitted only on a prospective basis, meaning states cannot implement the changes until the blueprint revision is certified by HHS. However, we recognize that states operating a BHP may need to implement certain programmatic changes immediately in response to the COVID-19 public health emergency.

Therefore, this IFC revises BHP regulations in 42 CFR 600.125 to permit states operating a BHP to submit revised BHP blueprints that are effective retroactive to the first day of the COVID-19 public health emergency. The changes made through these revised blueprints must be directly tied to the public health emergency and not be restrictive in nature. These revised blueprints are also not subject to the usual BHP public comment requirements as we recognize it may not be practicable to seek public comment at this time. This flexibility afforded to

BHPs through this IFC is similar to the flexibility that states currently have with Medicaid and CHIP state plan amendments during the COVID-19 public health emergency.

With that, I will turn it back to Jackie Glaze.

Jackie Glaze: Thank you, Cassie and thank you, Melissa, for your presentations. So we're ready to take questions from the audience at this point. You may ask questions about Cassie or Melissa's presentation or if you have any other questions that you may have for us. So Keith, can you provide the instructions again to the audience on how to submit their questions?

Coordinator: Certainly. Again, if you're on the phones and you'd like to register for a question, press the one followed by the four and you'll hear a three tone prompt to acknowledge your request. Then if you want to ask a question using the chat feature, it's in the lower left corner of your screen.

Jackie Glaze: Thank you, Keith. So we'd like to take your questions through the chat function at this point. So we'll be looking for your questions now. Thank you.

Barbara Richards: We have one question in the chat that I think is for our colleagues in the Disabled and Elderly Health Program group. "Can you speak about Medicaid coverage of serology (antibody tests)? The IFC seems to apply specifically to Medicare, but CMS's announcement said that both Medicare and Medicaid will be covering FDA authorized tests."

Melissa Harris: Sure, thanks. This is Melissa, and that's a great question. There were a lot of Medicare provisions in the IFC and just those two little ones in Medicaid, but these regulatory actions supplement a lot of the guidance that we are pushing out through frequently asked questions on the Medicaid side, and on our website are some frequently asked questions that dive a little bit deeper into the provision of the serology testing under Medicaid lab benefit, and the answer is yes. We do cover those. Those are part of the definition of the in vitro diagnostic product. So those are part of the mandatory benefit or the mandatory testing component that

have been added to Medicaid via the Cares Act.

So it's a good point that the regulatory provisions that were in the interim final are really just part of the story. There's an awful lot of sub regulatory guidance in the form of FAQs that are on our website as well that, hopefully together, will give states a good framework for implementing services in a public health emergency. Thanks.

Barbara Richards: We've got another question in the chat that says, "When will the FAQs related to post eligibility cost of care changes for nursing home individuals be released?"

Jackie Glaze: Calder, are you going to answer that?

Calder Lynch: Oh. As soon as possible. We're working to get those out the door. We know folks are anxious to have them. I think they are included in our next FAQs which we're hoping to have as the main topic of our Tuesday call. So having a download for them is our goal, but we're working to do so, and as soon as we're able to.

Barbara Richards: Great, thanks. At this point, that concludes all the questions in the chat.

Jackie Glaze: Thank you. So we're ready to open up the phone lines now.

Coordinator: We have a question from (Eve Lickers) from Pennsylvania. Please go ahead.

(Eve Lickers): Hi, I have two questions. The first question would be that I know that right now under one of the blanket waivers, there is a waiver of utilization reviews for inpatient hospital stays, and my question is that that is now during the time of the public health emergency. However, should the federal public health emergency extend beyond that which is needed within the state? I know that there are federal regulations that identify specifically that states could request a waiver. I was wondering whether or not that would be applicable in this instance if we needed the waiver beyond the public health emergency.

Calder Lynch: So this is Calder. I'm not sure we've got probably the full array of subject matter experts on to fully answer that question, other than I can say that I know that

there's a lot of work being done to assess the blanket waivers and the waivers that we've issued and how those will need to continue or phase as we enter into different stages of this. We can take that back and discuss that with our Medicare colleagues and raise those concerns as I know they're just like us. They're working on some of that planning as well. So let me check to see if anyone on my team has anything to add.

So we'll follow-up on that question with our colleagues in Medicare and CCSQ.

(Eve Lickers): Okay, great. Because then it does lend itself to the larger question, that was a specific question that we had, but it does lend itself to the larger issue for the other flexibilities that have been permitted. Then my second question is going to be, I guess. Related to the IFR that was released yesterday. So we have requested that flexibility. Well, we had already requested the flexibility, but to have non-physician practitioners to be able to prescribe the home health, the med supplies. But now that you're moving towards making it permanent because I know that legislation was passed for it. Are we now able to move forward outside of the 1135 authority?

Calder Lynch: Yeah. So it would depend I think on what specifically is in your state's current state plan on whether it explicitly restricts the provider types, which you could list temporarily for the disaster State Plan Amendment (SPA) and then now permanently through state and amendment that goes through the full process, but let me check to make sure with Melissa and folks that I've got that right.

Melissa Harris: That's exactly right, and we're happy to provide any technical assistance to any state to take a look at what's in your state plan and any disaster SPAs that you might have submitted for temporary broadening of the scope of practitioners to order home health. It's a best practice to be as comprehensive as possible in the coverage pages of the state plan to describe who all can order services under home health. So some states might have a specific limitation to physicians because that was the regulatory limit prior to now. Or it might be silent. Either way, it would probably be good if a state is going to take advantage of the ability to enlarge the scope of practitioners to note who those practitioners are on the state plan pages.



So, that should be a relatively simple amendment to the state plan.

It is worth saying that what we've done twice now is issue flexibilities from a federal perspective in terms of giving states the ability to choose to utilize more practitioners to order home health services. This is not a mandate on the states either during the public health emergency or afterwards, but it certainly is a flexibility that states should think about. So to the extent that we have any non-state stakeholders on the phone, the first step would be contacting your state to figure out what they're thinking about these new flexibilities both short-term and permanently in utilizing non-physician practitioners.

(Eve Lickers): Thank you. That is great because I know we have had a number of requests and we have come to CMS asking specifically about podiatrists because, unfortunately, in Pennsylvania's scope of practice for under physicians, podiatrists are not included. So we have wanted them to be covered as one of the practitioners because under Medicare statute, as you know, podiatrists are included in the definition of a physician. However, in the very next section under Medicaid they are not. So we've had some difficulties. So this opens up that piece of it very well.

But one of the things I was concerned about was that in the statute in the house resolutions that it was basically identified as the physician assistants and the nurses, but I was kind of concerned because the podiatrists not included in that because it would make sense not to because Medicare already considers them to be a physician. But I'm hoping that we will still have the flexibility to utilize the podiatrists as well as a nurse midwife.

Melissa Harris: You know, you certainly would to the extent that they are licensed during the period of a public health emergency. I think we would probably want to talk with you a little bit more about the ability to reach those practitioners beyond the public health emergency. You're right, the Cares Act language was limited to those three disciplines and your articulation of the difference between Medicare and Medicaid's definition of physician might have some merit as to why no other practitioner was listed in the Medicare descriptions of the Cares Act language. But to the extent that you want to be able to use a podiatrist to order durable medical

equipment though, that ability is permanent beyond the extent of the public health emergency because that's one of the things that we made permanent in the second IFC.

This is all very complicated, but because Medicare authorizes a whole host of other licensed practitioners to order durable medical equipment, we did our best to align with them in the second IFC for permanent release. So for Medicaid's version of durable medical equipment under home health, still that full complement of licensed practitioners can order that. If we're talking about nursing, aid or other home health services, the ability of a podiatrist to order those outside the public health emergency could be pretty limited, but we're happy to pick that thread up with you offline.

(Eve Lickers): Okay, great. Thank you very much, and we will continue to work with our local regional office.

Melissa Harris: Great, thanks.

Coordinator: There's no other phone questions at this time, but again, it is 1 then 4 to cue up.

Barbara Richards: And we do have one question in the chat, which is for our colleagues in the Disabled and Elderly Health Programs group. "If pharmacists have the approval to order and administer COVID-19 tests does this require a change to our state plan amendment or our state plan for pharmacists duties under other licensed providers?"

Melissa Harris: This is Melissa again. We would encourage the state to make sure that pharmacists are included in the state's description of the other licensed practitioners that they recognize to provide services. The OLP benefit in Medicaid is very wide open and really recognizes any practitioner who is licensed in the state to provide services that fit within the state scope of practice. So to the extent the state plan pages are either silent or don't include a pharmacist, we would suggest an amendment to the state plan to specifically call that out, and we're happy to provide that technical assistance as well.

Barbara Richards: Thanks, Melissa. We have another question in the chat that I think is for our colleagues in CAPHG. "Is the state required to continue EPSDT benefits even after age 21 during the emergency in order to receive the temporary FMAP increase?"

Sarah Delone: So this is Sarah, and we can add that to get sort of official clearance on this, but I think applying the principles that are articulated sort of throughout the FAQs on the B3 that what's required is that the same level of benefits, and that would include the extent to which a benefit is available as well as specific benefits like EPSDT. You have to cover all state plan benefits for individuals under 21 if they're medically necessary. So even if a 1905A benefit isn't covered for adults, you would need to cover that if medically necessary for kids, but all of that, that's part of the level of somebody's benefits. That would need to stay the same.

So I think the short answer is going to be yes, but we can add that to our list to get sort of formal guidance out, but that would be consistent with what we've been saying in our other FAQs.

Barbara Richards: Great. Thanks, Sarah.

Coordinator: There are no questions on the phones.

Barbara Richards: So another question around eligibility, Sarah and CAPHG, I think this is directed in your area. "Similar to the question about EPSDT after age 21, what about early intervention services for children once they turn three? Would those services remain coverable with FFP under the maintenance of effort?"

Sarah Delone: Unless my colleagues in DEHPG, that's one where we cross over, I think, in terms of our expertise in terms of how early intervention services are covered with Medicaid. So I feel a little bit out of my wheelhouse to take that off the cuff. So I think we should take that back. Unless my colleagues in DEHPG feel that they can answer it, we'll take that back and get back to you.

Melissa Harris: This is Melissa. The only thing I would add is that in Medicaid, we would do the crosswalk between an early intervention service and a Medicaid coverable service. Because the menu of services that Medicaid covers is so broad, particularly for

children, there's a good chance that there would be a large amount of overlap between early intervention and a coverable Medicaid service, in which case, the EPSDT provisions would kick in and the guidance that Sarah just gave on EPSDT would apply, but that translation to what Medicaid covers is always such an important part of the conversation when we're talking about service that has its origins outside of Title 19.

So we are happy to provide assistance with doing that crosswalk and making sure we understand what Medicaid would be reimbursing for, but if it does fall under the EPSDT rubric, then Sarah's EPSDT guidance would apply to that as well.

Barbara Richards: We have another question in the chat. The question is, "Do states have to request an 1135 waiver to reimburse hospitals and other providers for services rendered in unlicensed facilities such as hotels and community centers?"

Melissa Harris: So this is Melissa, and I'll start and Jackie and Allison, I invite you to jump in. So my understanding is yes, 1135 authority is available for reimbursement of inpatient hospital services provided in alternative locations. There is some guidance issued on this point that was issued by our colleagues in the Center for Clinical Standards and Quality. There are some parameters that need to be adhered to. The hospital needs to, in essence, retain control and oversight of those services, and it's that hospital that would bill for the services. But there is flexibility under 1135 to allow for inpatient hospital services in settings like hotels, convention centers, places like that that are not typically recognized as locations in which inpatient hospital services can be provided.

So if a state's looking to implement that flexibility, they can certainly submit an 1135 request and we and our colleagues in CCSQ would evaluate it to make sure that what we give you as an approval contains the appropriate guardrails.

Barbara Richards: Thanks, Melissa. That's all the questions in the chat at this point.

Jackie Glaze: Are there any additional questions through the phone lines?

Coordinator: No questions.

Calder Lynch: Okay, well thank you all for joining us and bearing with us through a new format. I hope having the ability to provide visual support was helpful. I believe we'll be together again on our next call on Tuesday where, again, I'll hope we'll be able to provide more information on the next round of FAQs, but until then, be well and enjoy the weekend.

Coordinator: That does conclude the conference call for today. We thank you for your participation and you can now disconnect your lines.

End