Centers for Medicare & Medicaid Services
COVID-19 Medicaid & CHIP All State Call
June 2, 2020
3:00 pm ET

Coordinator: Greetings and welcome to this CMCS, All State Medicaid and CHIP Call Webinar. During the presentation all participants will be in a listen only mode. Afterwards, we will conduct a question and answer session. If you have a question, please press the one followed by the four on your telephone at any time during the presentation. At that time, your line will briefly be accessed from the conference to obtain information. You may also ask a question via the chat located at the lower left hand corner of your screen.

If at any time during the conference you need to reach an operator, please press the star zero. As a reminder, this conference is being recorded Tuesday, June 2nd, 2020. I would now like to turn the conference over to Jackie Glaze, please go ahead.

Jackie Glaze: Thank you. Good afternoon everyone and welcome to today's All State Call. Calder will provide highlights for today's discussion and also introduce our guest speakers today. So Calder.

Calder Lynch: Thanks Jackie. Hello everyone. Thank you for joining us today. This afternoon, we're going to have a discussion regarding payment for testing for individuals that are covered under the optional testing group as well as for uninsured individuals. As I know, there's been a lot of questions and interest in how these various funding streams and programs are interacting with each other. So first we'll have members from our CMCS team provide highlights about some forthcoming guidance that we've been working on to describe how states may operationalize the optional Medicaid COVID-19 testing group.

We had hoped to have it posted at the beginning of this call. We're in the last stages of getting it ready. So we hope we'll have it finalized and posted shortly after we conclude today's discussion, but that won't stop us from giving you an overview of what to expect there. Then we're also very lucky to have joined with us, Heather Hauck, from the Health Resources and Services Administration or HRSA who will be presenting information on the COVID-19 uninsured program, which is providing reimbursement for healthcare providers for COVID-19 testing and treatment of uninsured individuals.

We are pleased that Heather can be here to provide some really good information about how their program will be operationalized. As I know, that's of interest to many Medicaid leaders. Heather is the deputy associate administrator of the HIV and AIDS Bureau at HRSA. The COVID-19 uninsured program is providing reimbursement on a rolling basis directly to eligible providers for claims that they submit for testing and treatment of COVID-19 for uninsured individuals. This is a program that is funded via the Families First Coronavirus Response Act (FFCRA) Relief Fund, as well as the Provider Relief Fund (PRF).

Again, as I mentioned, we've gotten a lot of questions from states about the interaction of that program, as well as the Medicaid optional testing groups. We hope that this discussion will help provide some answers and clarity to those questions. After these presentations Heather, as well as our CMCS staff will take your questions on this topic. Following that specific Q&A, we'll then open the lines for more general questions on any topic related to COVID-19. Before we begin that discussion, just a quick update.

I wanted to thank everyone that worked to get us the Medicaid and CHIP provider payment files to help support efforts to inform future allocations of the provider relief fund. As of Friday, May 22nd, we had transmitted files to HRSA from every state and territory. Again, really appreciate the quick action on behalf of the states and territories to pull that together and to provide that information, which will be really important as the department and HRSA moves forward with further efforts to provide support to providers across the country.

We have shared with HRSA, the state contacts related to the data collection efforts that if there are any questions in which they would need to ask a state directly, they can do so. But we of course will continue to remain engaged and supporting these efforts to the completion of the PRF program. So with that, I'll now turn it over to Jessica Stevens from CMCS to begin the discussion on operationalizing the optional Medicaid testing group. Jessica, take it away.

Jessica Stephens: Thank you Calder. As Calder noted, we had hoped to have this guidance document available for all of you before this call, but it will be available in the next day or two. What we'll be sharing and talking about briefly today is the high level key requirements for operationalizing the testing group, going through the different portions of the process that states will need to consider. Everything from the application down to submitting claims and third party liability and coordination of benefit related issues. We'll be providing some specific options and flexibilities for states to operationalize those requirements.

Given many of the questions that all of you have asked and some of the complexities and system challenges that we know states are facing, as they're thinking about whether to take up this optional testing group and if so, how to do it. Our plan though in the next few minutes is just to talk through some of the key takeaways that you'll see in more details in the guidance that we'll be releasing. While we are certainly available to answer questions here, we will also be available once you've had a chance to take a closer look at the documentation.

I will dive straight in. I'm focused first on the eligibility and enrollment related requirements and flexibilities described. As you know, that this is a group that was authorized through the FFCRA, the COVID-19 testing group or the 23 groups. It provides coverage for COVID-19 testing and testing related services at a 100% match. It's an elective option through the disaster relief State Plan Amendments (SPAs) and a number of states have already elected the option. For those that are still considering some of these issues may be helpful.

The first item relates to the application, which I know was mentioned briefly before. So I'll be brief. That because this is a group like any other, it is a group that does require an application that for states to collect specific information and the signature, states have flexibility to use a simplified application just for this group. But if so, should inform individuals that they will need to submit a full application to obtain coverage or to get a determination of eligibility on other bases.

In terms of the signature, it's needed for consent to enroll in Medicaid and can be accepted through all traditional modalities or there's additional flexibility, which is also currently available in our FAQs and which we've discussed a little bit before about the flexibility to designate provider or assister as an authorized representative for limited scope to sign on their behalf. I'm happy to answer more questions about that later.

All information that a person attests to on the application can be accepted for verification through self-attestation, but for citizenship and immigration status. States must check data sources, specifically save and SSA data for citizenship in order to verify citizenship and immigration status. But we recognize that given that a number of states are not necessarily including this group in their eligibility system, states may not be able to check those data sources upfront.

If doing that, they must provide a reasonable opportunity period or those who attest to satisfactory immigration status or citizenship and check those data sources post enrollment. One other option that a few states have asked about is the use of presumptive eligibility. While regular presumptive eligibility is not permitted for this particular testing group, hospital presumptive eligibility is. In the guidance, we note that under the CMS Hospital Without Walls initiative, hospital expansion sites under 1135 Medicare blanket waiver authority that states have designated, may also be considered as hospitals for this purpose.

States can make the election of hospital presumptive eligibility for this group through this SPA. We have some additional information about sort of claiming rates for individuals enrolled through presumptive eligibility. Briefly there's still a requirement to send notices for this group and details about what needs to be included in that notice are also described in the guidance as it would for other groups. The eligibility period remains the same. That coverage is effective the first of the month in which an individual applies or the date of the determination, depending on what states have in their existing state plan.

Individuals may have up to three months of retroactive coverage, but given that this group was effective, March 18th, 2020, coverage cannot be provided or retroactive coverage is not available any earlier than March 18th or the effective date of the state plan, if that's a later date.

Lastly, before turning it over to my colleagues to talk a little bit more about the claiming related issues, we wanted to just note about the termination process for this group. It is only available under the FFCRA through the last day of the

public health emergency (PHE). Meaning that no Federal Medical Assistance Percentages (FMAP) is available for that date, even if the end of the public health emergency falls in the middle of the month. We recognize that many states have eligibility or have enrollment through the end of the month. To the extent that that occurs, states would need to add a claims edit to ensure that states don't continue to pay for services provided after the end of the public health emergency, once we have that date.

We do recognize that states may not have the special notice before the end of the PHE and if unable to terminate, the process would be as sort of as I just described to ensure that claims are not made for individuals after that last date.

We also described some specific guidance about the termination process for individuals who are enrolled in this group at the end of the public health emergency. Specifically the requirements related to determination of eligibility on all basis prior to termination for Medicaid still apply. However, states have flexibility that we've outlined to satisfy the requirements to determine eligibility on other bases in a number of ways.

That includes sending information to individuals at the time the initial eligibility notice is sent. That coverage in the group will be terminated on the last day of the PHE and the individual may be eligible for full benefits. How to submit a full application in order to be considered for full benefits and that a final termination notice would need to be sent to the individual.

But that, that notice can include another reminder that individuals who may be eligible on other bases would need to send a final termination notice before they can be considered for full benefits. At which point individuals who submit a full application and are denied would have fair hearing based on that full application. I will turn it over to Ed Dolly to talk a little bit more about enrollment claiming systems.

Ed Dolly: Sure. Thank you, Jessica. As alluded to just a little bit earlier, states have a great deal of flexibility when it comes to operationalizing the necessary processes to support the response to the public health emergency. When the guidance is made available, you will see that we did include several examples to serve as possible options for considerations for states. But those examples are not meant to be an exhaustive list. When it comes to the response of how the individuals become enrolled, while there's not a firm requirement to use for operationalize within MMIS, we did try to give a couple other examples that help states through what process they may use.

With the key being to ensure that your process is not just thoughtful, but also includes the necessary data points and reporting to be able to support proper claiming, which we're able to speak to just a little bit later. Another key area of specific attention is the T-MSIS reporting requirements. You will find that the guidance is very straightforward in calling out the specific data elements necessary for inclusion to meet the T-MSIS requirements. But when in doubt

CMS continues to have and engage with states through the T-MSIS testing team. If there are questions, please do not hesitate to reach out to the testing team so that we can continue to run down any specific challenges states may be having.

The same is true for any questions around operationalizing processes in or around your MMIS or unique systems. Your state officer is available to help have a conversation. Let's ensure that we engage in a bi-directional conversation so that we understand what the states are trying to achieve, and we can help you get there. But again, the guidance will give several options or several examples on different processes. Not intended to be a fully exhaustive list, but on the T-MSIS requirements is very specific and states should pay attention to the data elements and segments necessary to fulfill the T-MSIS requirements. With that I would like to, I think, hand it off to Rory to talk about the actual claiming aspect for the finance piece.

Rory Howe: Thank you, Ed. Good afternoon everyone. I'd like to just provide some information on how states can report expenditures for both service and admin costs that are associated with the new optional testing group on the CMS-64 which will enable them to claim federal funding at the 100% match. To claim the 100% federal match, states need to isolate the expenditures both for services and admin, when they report on the 64 in the Medicaid budget and expenditure system.

To enable that, we're reprogramming the Medicaid budget expenditure system to create separate forms for expenditures that are eligible for the increased match. There'll be two new forms. One that's for service expenditures and one that's for administrative expenditures. We hope you will find the forms really familiar and easy to use. They're parallel to existing CMS-64 forms and include all the existing lines. So more information on those, but again, we try to make it as least burdensome as possible for state reporting.

Also to ensure that expenditures are allowable and to create a clear audit trail, we do also expect that states will continue to meet existing federal requirements regarding documenting claims for federal matching funds in the CMS-64. Again, this is something that should be familiar to those of you that work with that. Such information for services would be patient's name, social security number, date of birth, date of service, the services that were provided, the name, location, and address of the provider and any unique billing codes for services. This information we'll be able to be maintained in MMIS or an Excel file in the state system or state or county records or some other similar records.

Once new forms are available and we hope there'll be operational sometimes this month, we do intend to provide a demo or training to states staff through webinar. We'll provide more information on dates and times as soon as they're available. Additionally, as we go through the CMS-64 reporting process, we're always available to provide whatever technical assistance you may need, or answer any questions that you may have about reporting. So with that, I'd like to turn it back over to Jackie, I believe.

Jackie Glaze: Thank you, Rory, Ed and Jessica. Now we're ready for Heather to present from HRSA. Are you ready, Heather?

Heather Hauck: Yeah. Thank you.

Jackie Glaze: Okay, great.

Heather Hauck: So great. Good afternoon everyone. I think we're at the time when most people are in the afternoon. I want to first thank our CMS colleagues for inviting us today to present on the uninsured program for testing and treatment. I'm going to walk through a couple of high level slides, and then we'll be happy to respond to questions about the program. So the next slide. Thank you.

So just again, a high level overview of the Provider Relief Fund. There was the Cares Act and the Patient Protection Program Act, which together provided 170 billion in relief funds to hospitals and other healthcare providers on the frontlines of the COVID-19 response. This funding supports healthcare related expenses or lost revenue attributable to COVID-19. As a part of this overarching provider relief fund, a portion of it will be used for uninsured patients and specifically for treatment of COVID-19.

In addition, there were funds allocated through the Families First Act, and again, the Patient Protection Program Act which also will be utilized for the testing component of the uninsured program. Next slide. Great. Thank you.

I'm just going to walk through how the program works. Essentially the goal of the department was to quickly reimburse providers for COVID related testing and treatment of uninsured individuals. It essentially functions as a claims reimbursement program to healthcare providers. The program was established and set up to reimburse healthcare providers generally at Medicare rates. You can actually go on the website either through the HRSA website or through the website that you see referenced on the slide on the right hand side and see the parameters of the rates that providers are being reimbursed at, as well as other information that I'm going to talk about between the slide and the next slide.

So essentially for the testing and the treatment claims reimbursement, the program we've established for provider systems is for services that were provided to the uninsured individuals on or after February 4th, 2020. The department worked with United Healthcare. We awarded a contract to them to do this claims reimbursement processing, and we began the program towards the end of April. So on April 22nd, we essentially announced to the healthcare provider community that the uninsured program would be opening.

On April 27th, the actual website opened and what the website is, is healthcare providers that are going to be requesting claims reimbursement go onto the website and they register in the website, if they not already registered with United as a United provider. Once they've registered and they've also set up an

electronic bank account exchange with the United Bank vendor, which is Optum, providers are then able to go in and they upload their provider roster.

So in other words, if they're large healthcare entities let say a hospital they would be registering in the system as the hospital. Then they would go in and upload their provider roster of all of the doctors or nurse practitioners (NPs) or other types of healthcare providers that they would be submitting claims on behalf of. They then go into the system and they submit their patient rosters. So in other words, the patients that they are verifying are uninsured and are going to be submitting claims on behalf of.

Then last part of the process, they go in and electronically upload the claims associated with those patients that they've put into the system. Then from there it essentially follows a very similar system to what you all do in the states or what any healthcare coverage program does -- the claims are adjudicated and the payments are electronically transferred to the healthcare providers bank account. They started that process April 27th, on May 6th, the providers started uploading claims. As of May 27th, there was over $80 million in paid claims that had been done between the testing and the treatments portions of the program. Next slide.

As I said, all of the information is on the HRSA website, as well as on that United website. It lays out what the allowable expenses through this program are. So specimen collection, diagnostic, and antibody testing, testing related business in certain settings, which you can see listed there. In terms of treatment, it's sort of a wide variety of types of treatments that can be reimbursed through this program. Again, the intent of the program, intent of Congress and the intent of HHS and HRSA in implementing the program is to ensure that healthcare providers who have provided this testing and treatment services to uninsured individuals have an opportunity to be reimbursed. Again, generally at Medicare rates.

There is also language about when an FDA approved vaccine is available. The uninsured program would also have that be an allowable expense. In terms of who the eligible recipients are, again it's a wide variety of types of healthcare providers who could submit claims to the system. Eligibility is not based on their for profit or nonprofit status. Again, these sort of crosswalk, the left hand side of the slide with the right hand side of the slide, you can see the depth and the breadth of healthcare entities that could seek reimbursement through this program. Next slide.

Just in sort of a high level snapshot as of the middle of last week, so claims began being paid on May 15th. So that over $80 million that was on the previous slide is as of about a week and a half period. As of May 26th, there were over 500,000 patients who had been uploaded into the portal. Not all of those patients will have claims submitted for reimbursement or not all of them will actually be patients that can be verified in the system. That's for a variety of reasons, including they may actually have some other form of healthcare coverage that the provider was

not aware of. But when United put the claim through the system, there was another source of healthcare coverage for that patient.

So not all of those 500,000 will receive... the healthcare provider will not be reimbursed for all of those, the 500,000. Same thing with the over 330,000 claims that had been submitted. Not all of them will be processed through the system. It may be that the coding is incorrect on the claim. It could be that the service was not actually COVID related or that the patient doesn't correlate with that claim. So there's a variety of reasons why not all of those claims will be processed.

I can tell you that even since we put this slide together, these numbers have increased across the board. We continue to see the need for the program and we'll continue to, again, process claims reimbursements as long as the funding is available. The other thing to keep in mind, so the map, the map is actually the number of patients that have been submitted by state and the darker the color, the more patients. So you can see again where New York, Florida, Texas, and California, have higher proportions of patients that have been uploaded into the system. Again, some of them will have claims associated with them and some will not, but it does give you a sense again, of the need for the program. Next slide.

We wanted to make sure that you had a couple of different links to some websites. So obviously the overall Provider Relief Fund, you can go to the HHS website, the uninsured portal, which is the one I've been describing is at that link. Then some other information. Just this week, we actually started publishing on the website that you see there, the list of providers that have received reimbursement. It's broken down by if they received reimbursement for testing and/or treatment and the amount. That will be updated on a weekly basis and it will be an aggregate number.

So if provider ABC received a $1,000 this week and they got another $500 next week, it will roll up to a $1,500. Let's say it was for testing, a $1,500 amount on the website. So that will be a good source of information for folks to see which providers are actually utilizing the program. With that, I'm going to stop and turn it back over.

Jackie Glaze: Thank you, Heather. Now we'd like to take questions from the audience specific to the presentations that you just heard from Heather and our CMCS team. We'll follow the format that we've used in the past, so that we will ask that those that would like to submit questions through the chat function, do that now. So Christie, can you provide those instructions to the audience at this point?

Coordinator: Absolutely. Thank you. If you would like to register for a question over the phone line, please press the one followed by the four on your telephone. You will hear three tone prompt to acknowledge your request. Your line will then be accessed from the conference to obtain information. If your question has been

answered, and you would like to withdraw your registration, please press the one followed by the three.

Jackie Glaze: At this time, please submit your questions through the chat function. Then after we receive those questions, we will then open it up for the phone lines for those individuals. So we'll wait for your questions at this point through the chat function.

Barbara Richards: We've got a couple of questions in the chat and Heather I think these are more oriented to the HRSA side of the presentation. So the first question we have is, is it possible to get a state by state breakdown of the claims paid so we can see if our state is claiming?

Heather Hauck: That's a great question. I just wanted to acknowledge that with me on the call today from HRSA is Susan Marsiglia, who is on the uninsured program team and she will be helping me answer some of these questions. The website that I just referred to, the public use file website which is the third one on the slide that you can see right now, that has is a sortable database. So you can actually go in and sort on your state and it'll show you which providers in your state are submitting for claims and have received claims reimbursement to date.

Susan Marsiglia: This is Susan Marsiglia from HRSA. I can take the next question. It's actually a two part. It says regarding definition of uninsured, would individuals who could be eligible for Medicaid, but are not yet enrolled be covered and is there a citizenship requirement? I'll start with the second part. Healthcare providers are not required to confirm immigration status prior to submitting a claim for reimbursement for this program.

Regarding the first part, providers must verify and attest that to the best of their knowledge at the time of claim submission, the patient was uninsured at the time the services were provided. However, if the provider learns that the individual is retroactively enrolled in Medicaid, as of the date of service, the provider must return the payments for HRSA.

The next question I'm going to read and turn it over to Heather to respond. What documentation does a provider need demonstrate uninsured status as an individual? We are getting provider concerns on this. Since the provider will not know insurance status, so the provider is at risk for some of the claims.

Heather Hauck: Great. Healthcare providers collect data on patients when they come in for a service and we've all had this experience. You fill out the eight pages of forms and you give them your insurance card if you have one or other types of identification. So to the extent that a healthcare provider is collecting their normal data collection, they would be collecting that type of information. There is not a requirement of the uninsured program for a person to document their uninsured status.

It's really sort of the inverse, which is if they have some form of health insurance, they should offer that. And therefore the provider would not submit claims on that person's behalf because they would have documentation of healthcare coverage. Now, we certainly know that there are circumstances where people come in for a service and maybe it was, the drive through testing service, or maybe they came into the hospital and were immediately intubated and there was nobody there to verify their healthcare coverage.

We know that some providers may assume that a person had no healthcare coverage and submit that claim. But as it moves through the system, and there is a coordination of benefits process that happens, we would be able to determine or United would be able to determine that that person has some other form of healthcare coverage and deny the claim, or at some point recoup that claim reimbursement from the provider individual.

Susan Marsiglia: The next question is how much money is available through the HRSA uninsured program? Is there a separate cap on testing reimbursement and does the HRSA program end when the public health emergency terminates?

I can respond to this one. As Heather mentioned, there's two parts of the HRSA uninsured program. There's the portion for testing of the uninsured, and that is paid for out of the FFCRA relief fund, which includes a total of two billion dollars. One billion of that was appropriated through the FFCRA and another one billion through the Paycheck Protection Program and Healthcare Enhancement Act. The second part is for reimbursement for treatment, and that is being funded out of a portion of the Provider Relief Fund. The program is not tied to the public health emergency. It will end when the funding runs out. I'm going to turn the next question over to Heather.

The question is, the HRSA portal says if the social security number driver's license or state ID is not included, it will take longer for reimbursement? Do you have a sense of how much longer it will take?

Heather Hauck: That's a good question. I don't know that we do have a sense of how much longer it will take. It's not a level of detail that we have discussed with our colleagues at United.

Barbara Richards: Great. Thanks, Heather. This is a combined question for both Heather, as well as our CMCS colleagues. How will the HRSA fund work in states that elected to cover the uninsured group via their Medicaid program?

Jessica Stephens: This is Jessica. Sure. I'll start and maybe I can turn it over to you, Heather or Susan. In States that have elected especially COVID-19 testing group in the state plan, individuals who are enrolled in the group would not be considered uninsured for purposes of the testing portion of it. But Heather, I don't know if you want to say more about treatments. Any more to say on that?

Heather Hauck: Yes. Thank you. So that's absolutely correct for the testing portion. For the treatment portion of it, providers would be able to submit claims on behalf of uninsured individuals. Because the Medicaid optional enrollment group does not cover testing. I mean, sorry, does not cover treatment. It would be a bit of a bifurcated process in the sense that the healthcare providers could submit through the provider relief fund through the uninsured program for the treatment related costs. Again, assuming that they have the correct coding and the correct eligibility and then they meet the other eligibility requirements, it would be a different process for the treatment costs.

I think this actually relates to a question that was asked earlier, the fact that a state has the uninsured group available, essentially that has elected the option to cover the uninsured group, and may mean that a person could potentially be eligible for coverage in that group does not in itself make them ineligible to receive coverage through the testing fund. It all speaks to enrollment. That if an individual is enrolled in the group then they would not be considered uninsured for purposes of testing.

Barbara Richards: Great, thanks, Jessica and Heather. This is a related and different question. Again, I think it's both for our HRSA colleagues, as well as our CMCS colleagues. Is there some sort of data exchange to make sure the state uninsured testing group options and HRSA aren't both reimbursing the same claim? Jessica, if you want me to repeat that question, I'm happy to repeat the question.

Jessica Stephens: I think I got the question, and I think some of this deals with some of the coordination of benefit issues. Sorry, I think we did not mention that there is some additional detail on the guidance that we're releasing around coordination of benefits for this particular group. I don't know Heather, if I can turn it over to you to talk a little bit about what that process would look like from HRSA, United side.

Heather Hauck: Yes. Thank you. So there actually is currently a coordination of benefits process and I talked a little bit about this during the presentation. Where United is actually paying the clearing houses in order to figure out if a patient has some other form of healthcare coverage. They will be doing that both on a proactive basis as well as a retroactive basis. For the foreseeable future, they will be going back and doing that coordination of benefits effort, because we certainly know that in this unprecedented time people's healthcare coverage status is changing. So there will be updates to their healthcare coverage status throughout the foreseeable future.

I think that there is an opportunity to be able to look at that and make sure that there are not duplicate claims reimbursements through that process.

Jackie Glaze: We do have additional questions in the chat box, but I want to open up the phone lines so that those individuals have an opportunity to ask questions about the presentations that they just heard as well. At this time, Christie, will you open up

the phone lines? Then for those remaining questions that we have in the chat box, we will follow back up on those at a later time.

Coordinator: Thank you. Once again, as a reminder, if you would like to register for a question, please press one, four. We do have a question from the line of Arvind Goyal, please go ahead. Your line is open.

Arvind Goyal: Thank you very kindly. This is Arvind Goyal, medical director, Illinois Medicaid program. Two very brief questions. One is the payment available to first responders who attend to a patient with suspected COVID-19 outside of a facility? The second very brief question, are the visitors who are legally in the United States and undocumented people covered for testing and treatment?

Jessica Stephens: So the answer to the first one is yes, EMT services are reimbursable. Again, the program guidance is on the website and it does specifically reference EMTs. The second one, Susan, I think you answered this previously. Do you want to repeat your response?

Susan Marsiglia: Correct, yes. Healthcare providers are not required to confirm immigration status prior to submitting claims.

Arvind Goyal: Thank you.

Coordinator: Thank you. Once again, as a reminder, if you'd like to register for a question today, please press one, four. There are no further questions over the phone lines.

Jackie Glaze: Thank you. We'll give them another minute and then we will revert back to the chat box and then we will take general questions at that point. So we'll wait another minute to see if we have any questions over the phone line, Christie, and let me know, and then we'll move back to the chat function and you can give instructions on that.

Calder Lynch: I would take the next chat box question while we wait.

Barbara Richards: Okay. We've got one for the CMCS folks. Jessica, I think this is on your side. Do fair hearing requirements apply to the new COVID-19 testing group?

Jessica Stephens: Sure. Actually, Sarah Spector I know you're on, if you'd like to tackle this one.

Sarah Spector: Sure. Hi, this is Sarah Lichtman Spector. Yes, notice and fair hearing requirements apply because it is an eligibility group because of Medicaid. Because the testing group will end at the end of the PHE when an eligibility group ends, there's no fair hearing was specifically on for an individual on the basis of a group that ends by virtue of law and policy. But so advanced notice and other rights would apply in other respects.

Sarah deLone: Maybe to add onto that. One of the things that's important that... this is Sarah deLone that pairs with that, that Jessica mentioned is that there's also the requirement to examine eligibility on other bases before you terminate somebody. In order to sort of take, so there is a right to have that evaluation, and sometimes that might happen in the fair hearing context, but recognizing that that doesn't really make sense in this situation.

What states can do and this is what Jessica had mentioned earlier, is to provide individuals who are determined eligible for the optional testing group, at the point that they are determined eligible, and also when they're given their advanced notice of termination at the end of the public health emergency, that they may be eligible for full benefits and how to apply for that. So the person has a clear opportunity to submit an application for full benefits and be considered on other bases for full coverage.

Then if that determination, if they were denied eligibility, that denial would, of course receive fair hearing rights as any denial on a new application would.

Barbara Richards: There are a couple more questions in the chat box for HRSA. Two that I think are related. So I'll read them together for Heather. How much has been expended for the uninsured fund? Have you estimated how long the funding pool will last and is it first come first serve?

Heather Hauck: If you just go back one slide, the slide with the map. Oh, I'm sorry. One more back from there. Two more back from there. One more. Yeah, perfect. At the bottom right hand side, as of May 27th, a little over $80 million had been reimbursed to providers across the country. So that is again about a week and a half in to the program being up and running and starting claims reimbursements. Obviously it will depend on when providers are able to have the time to do this process and it is first come first serve. So it will be highly dependent on again, when providers across the country are able to go in and upload the claims and have them move through the process.

We don't have a sense of the timeline for these funds being fully expended. But again, certainly the volume indicates that there is a need for this program, and we anticipate that that volume will continue to increase.

Jackie Glaze: Thanks. I'll just check and ask, do we have any questions through the phone lines at this point?

Operator: Yes. Once again, if you'd like to register for a question over the phone, please press one, four. Our next question comes from the line of Nicole Comeaux. Please go ahead. Your line is open.

Nicole Comeaux: Hi. Thanks everyone. We're just wanting to push on this a little bit more. We're trying to make the guidance as simple for our providers as we can. So I hear the response being that no verification of citizenship is required prior to submission of the claim. Just want get a little bit more understanding of this as to whether or

not that verification will occur after those claims are submitted. Because I think if that is the case, we would be probably including guidance to our providers to take some additional steps in their questioning, to try and work in guidance around our Emergency Medical Services for Aliens (EMSA) program as well.

For those individuals who present without a social security number or a valid form of ID and have them fill out that form as well. So just wanted to get some clarity as to whether or not it would be helpful for us to be building in that guidance for our providers.

Heather Hauck: Nicole, I see you're asking HRSA on here, as opposed to the testing group.

Nicole Comeaux: Yes.

Heather Hauck: Susan, do you want to take that one?

Susan Marsiglia: Sure. Which question was that one?

Heather Hauck: The one about citizenship and the claims.

Susan Marsiglia: Oh, I'm sorry. Yes. So this is an additional question about citizenship. Please confirm whether citizenship status is considered in payment of the claim and no it is not.

Sarah deLone: So just to clarify, I think that Susan, the clarification that she was... this is Sarah... looking for was, we said that prior to submission of the claim, and I think Nicole was looking for a confirmation that at no point is the provider required to verify or ascertain information on citizenship or immigration status.

Susan Marsiglia: That is correct.

Nicole Comeaux: Great. Thank you all.

Barbara Richards: We've got another question in the chat. Says please confirm that if the state has implemented the optional Medicaid testing group, an individual who is not yet enrolled in that coverage group could have their testing billed by a provider using the HRSA COVID provider portal?

Jessica Stephens: This is Jessica again, that is correct. The eligibility for the testing through the HRSA portal is based on enrollment in the group. If a state has adopted the testing group, it's sort of happens on an individual level not based on whether or not the state has elected to cover the group.

Heather Hauck: Jessica, can I just clarify?

Jessica Stephens: Yes, please.

Heather Hauck: I think what I would add was if that individual then does enroll and it's retroactive, and we did the coordination of benefits process and realize that they had coverage retroactively, we would recoup those funds from the provider to avoid the double dipping issue.

Jessica Stephens: Thank you. Yes, that's a good point.

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

Coordinator: There are no further questions at this time.

Jackie Glaze: Barb, do you want to take a few more questions through the chat?

Barbara Richards: Sure. Then just to Jackie, just balance the general questions that states may have.

Jackie Glaze: Sure.

Barbara Richards: The testing questions. We've got one question about, is it fair to assume that this process has been well communicated to the American Hospital Association (AHA) and the American Medical Association (AMA)? For the uninsured program I assume. It doesn't stipulate Heather, but I assume that's correct.

Heather Hauck: Yes. AHA certainly is aware of the program and we have also communicated with other healthcare provider or related associations in a pretty broad way. So I'm fairly competent that they are aware of the program.

Barbara Richards: Great. Jackie, given the amount of time that we've got left, maybe we should just open it up to more general state questions.

Jackie Glaze: Sure. That would be fine. Any questions you may have? Let's open up the phone lines to see, we might be able to take one or two questions and then we'll turn it back to Calder. Are there any questions in the phone line?

Coordinator: Once again, as a reminder to register for a question today, please press one, four.

Calder Lynch: Maybe while we're waiting we can take another question out of the chat box.

Barbara Richards: This a question Heather, I think more for you around the provider program. Many individuals may have recently lost their insurance coverage due to unemployment and business closures. Will United have up to date information?

Heather Hauck: We're certainly aware of that challenge. That is one of the reasons why United will not only be doing a prospective coordination of benefits, but retrospective coordination of benefits to make sure that when people's healthcare coverage situation changes, that information can be updated. I again believe that there will be a series of activities or things that are done that will help us understand that a little bit more.

Susan Marsiglia: This is Susan, there was one question in the chat that was asking for confirmations related to the information Heather, you just provided about Medicaid retroactive eligibility. On the recruitment question, this would then only apply for testing services and not the treatment services. Yes, that would be correct on Medicaid optional testing group.

Sarah deLone: So the optional testing group, but if a person is determined eligible for full Medicaid benefits or for a category that covers treatment services, then the same coordination of benefits rules are going to apply.

Susan Marsiglia: Correct.

Barbara Richards: This is a question for the CMCS folks. I think more on the fair hearing sides to Sarah and team. So the question is to clarify., Although a hearing isn't required when the optional testing program end, since we are required to check, if the person is eligible for general Medicaid, if we check and find the person is ineligible for general Medicaid, we need to provide the opportunity for a hearing for the denial of general Medicaid. Is that correct?

Jessica Stephens: Correct. I think the answer to that question is yes. So let me just clarify one note around the requirement to check on other bases. What we clarify in the guidance is provide some additional guide of the states that I think Sarah deLone just provided in more detail that, that process for checking for eligibility on other bases can be achieved through notification to the beneficiary and the COVID testing group on their initial notice. Then again on their termination notice that they must submit a new application in order to get an evaluation on other bases.

At that point, the regular rules, fair hearing notice, etc. rules apply. That is the context in which a denial would require the same level of fair hearing rights as would ordinarily be expected.

Calder Lynch: But Jessica, isn't it fair to say that if the beneficiary doesn't apply and their coverage is terminated when the group ends there would not be a fair hearing right at that time?

Jessica Stephens: That's correct.

Barbara Richards: Thanks Calder and Jessica. We have a couple more questions in the chat, but I think just given the time we will follow up separately with those individuals who have asked. Jackie, let me turn it back to you.

Jackie Glaze: Thanks and I'll turn it to Calder.

Calder Lynch: Thanks. Well, appreciate everyone joining today. This was a really good discussion. I appreciate all the questions, want to thank our HRSA colleagues for joining us today and providing information that I know states have been very anxious to receive, as it impacts your own planning and efforts and operations. I do have an update that while we were on this call, our guidance on

operationalizing the testing group went through its final hurdles and we're in the process of getting that posted. So you should see that online and distributed across our website before the end of the day today.

Calder Lynch: So hopefully that will be a nice follow-up. But as we said at the beginning, if there are still questions that they have after reviewing that guidance and that we didn't answer on today's call, please just don't hesitate to reach out through your state lead. We can provide TA or get those questions answered. Jackie, any information to provide in terms of next calls or anything like that?

Jackie Glaze: No, but we'll need to follow back up on what the schedule is for next week, but we'll get that information out.

Calder Lynch: Great. Thank you so much. Everyone have a good rest of the week.

Coordinator: That does conclude the conference call for today. We thank you for your participation and ask that you please disconnect your line.

End