Centers for Medicare & Medicaid Services
COVID-19 Medicaid & CHIP All State Call
June 9, 2020
3:00 pm ET

Coordinator: Welcome and thank you for standing by for today's conference. All participants will be in listen-only mode for today's call. To ask a question from the phone line, please press star 1. Today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the conference over to (Jackie Glaze). You may begin.

(Jackie Glaze): Thank you. And good afternoon everyone. And welcome to today's all-state call. I'll now turn to Calder to introduce the five highlights for today's discussion. We will also introduce our guest speakers. Calder?

(Calder Lynch): Thank you, (Jackie). Good afternoon everyone. Thank you for joining us today. We have a jam-packed agenda with several guest speakers so I won't spend a lot of time in my opening remarks to make sure we have plenty of time to cover that and answer any questions that we have.

So we have three topics with separate guest speakers for each that are all related to COVID-19 and the response to the pandemic.

First we're going to be discussing a legal issue related to state scope of practice laws related to COVID-19 testing.

We'll then hear from our colleagues in New Mexico on their work to operationalize the optional COVID testing group and some of the lessons they've learned from those experiences.

And finally as some of you probably saw the news earlier today, we'll receive an update from department officials on the Medicaid and CHIP distribution of the provider relief fund, which I know has been a topic of interest among states.

So (the interest first) we'll have (Brenna Ginley) and (Will Chang) from the (HHS Office of General Counsel), who will discuss an advisory opinion on the Public Readiness and Emergency Response Act, prior to our Emergency Preparedness Act, or the Prep Act, and it's implications for state scope of practice laws and Medicaid reimbursement for COVID-19 tests ordered and administered by pharmacists.

(Brenna) serves as the deputy general counsel and the chief legal officer for CMS and (Will) serves as a deputy general counsel at (HHS) as well.

After their presentation we'll pause to take your questions on this topic for a few minutes and then following up on our discussion at last week's all state call on the Medicaid optional COVID testing group, we are pleased to have (Nicole Cuomo) join us from the state of New Mexico.

(Nicole) is the director of the medical assistance division at the New Mexico Department of Human Services. And she'll share information regarding how her agency is implementing the optional testing group.

After this presentation we'll take your questions for (Nicole) or (CMS) on topics related to operationalizing the testing group.

And finally, I'm joined by (Darcie Johnston) the director of the intergovernmental affairs division for (HHS), which will provide an update on the Medicaid and CHIP distribution of the provider relief fund announced

today.

She will discuss this latest information regarding this targeted distribution that impacts Medicaid and CHIP providers. And we'll also take questions on this topic and (Darcie) will be joined by (Tom Keane), policy advisor at (HHS) and (Susan Monarez), Director of the Office of Planning, Analysis, and Evaluation, at (HRSA), who's administering the fund.

Again, after that - her remarks, we'll pause for questions for (Tom), (Darcie) or (Susan).

And then if time permits we'll open up the line for any other general questions the states may have.

So with that in the interest of time I'll go ahead and turn it over to (Brenna) and (Will), from the Office of General Counsel. To begin the discussion on the (Prep) Act and the advisory opinion. (Brenna)?

(Will Chang): Well, good afternoon. This is (Will Chang). And thank you for joining us this afternoon in the interest in the (Prep) Act and COVID-19 tests ordered and administered by licensed pharmacists.

By way of a brief background, in early March, the US Department of Health and Human Services and FEMA developed and implemented 41 community-based drive-through testing sites in locations prioritized by the CDC in collaboration with state and local partners.

These test sites have administered over - administered COVID-19 tests to over 245,000 high-risk individuals and has served for other models.

In fact, HHS has worked with private partners including national pharmacies, CVS, Rite-Aid, Walgreens, Wal-Mart, and Health Mart, as well as retailers to further implement that testing initiative.

That program is now providing testing at 422 locations in 48 states. Nearly 70% of which are in communities with moderate to high social vulnerability and have tested over 516,000 individuals.

To further effectuate that national testing initiative, on April 8 2020, HHS, through the Office of the Assistant Secretary for Health, in working with the inter-agency testing task force, authorized licensed pharmacists to order and administer COVID-19 tests, including serology tests that the Food and Drug Administration has authorized.

HHS did so under the (Prep) Act which is a federal statute.

That step on April 8, 2020, has two legal consequences which is most- which are most pertinent to our conversation today. First, licensed pharmacists were immune from losses - for loss in most circumstances when they order and administer FDA-authorized COVID-19 tests.

And the second, no state or locality could prohibit or effectively prohibit licensed pharmacists from ordering and administering FDA authorized COVID-19 tests.

Last month, on May 19, 2020, in response from pharmacists, pharmacies, and one trade association, HHS Office of General Counsel released an advisory opinion on this very issue of whether states can still prohibit licensed pharmacists from ordering and administering COVID-19 tests in light of the (PREP) Act, the secretary's declaration, in the (OASH) authorization we just

discussed.

And the Office of General Counsel concluded that states could not prohibit or effectively prohibit licensed pharmacists from ordering and administering FDA-approved COVID-19 tests.

(Brenna)?

(Brenna Ginley): Thanks, (Will).

So, in short, (CMF) interprets references in Medicaid and CHIP laws and regulations to state laws as incorporating the (PREP) act pre-emption of those state laws, and therefore states must provide Medicaid and CHIP coverage for COVID-19 testing, where laws and regulations refer to a state law that has been pre-empted by the (PREP) Act.

So let's break that down a little.

On the Medicaid side, the three benefits under which states general provide Medicaid coverage for COVID-19 testing provided by non-physician practitioners are the mandatory laboratory services benefit, the optional other licensed practitioner benefit, and the optional diagnostic services benefit.

Federal regulations governing coverage under these three benefits all refer to practitioners acting within the scope of their practice as defined under state law.

And similarly CHIP regulations require coverage of any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitated services, whether in a facility, home, school, or other setting if

recognized by state law and only if the service is described by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by state law.

So (CMS) will interpret those references to state laws that I just went through as incorporating the (PREP) Act pre-emption of those state laws.

In other words, states must provide Medicaid and CHIP coverage for COVID-19 tests, ordered or administered by licensed pharmacists under the benefits I described, even if the pharmacists is not authorized under state law to order or administer the tests, when the (PREP) Act declaration pre-empts that state law.

And note that states will still have to meet all other applicable federal requirements for covering the benefits, such as reimbursing only those entities that are enrolled as Medicaid or CHIP providers. And we will be posting an FAQ with this information as well so you have and are able to refer to it in writing.

(Calder)?

(Calder): Alright. Thanks, (Will) and (Brenna). Why don't we turn it back over to the operator to open up lines for questions on this topic specifically for a few minutes?

Coordinator: Thank you and at this time to ask your question, please press star one, please unmute your phone and clearly record your name at the prompt. To withdraw your request, please press star two.

One moment please for the first question. Questions are coming through. One

moment, please. First question from (John Ross), your line is open.

(John Ross): Thank you. For states that don't have pharmacists as providers or for prescribing providers, is - would the state be allowed to have a pharmacy that does have an (NPI) that's a provider, could they go through that mechanism or would we have to make the pharmacy providers?

(Brenna Ginley): I will need to get back to you. (At least aside from this extra detail) that's not something we had specifically talked through and so I don't want to get out ahead of (Calder) and his team on that one.

Calder Lynch: You know, we can take that back and let me just check with the division of benefits and coverage if they have any possible (ideas now) we can follow-up.

(John Ross): Thank you.

(Kiersten): This is (Kiersten), we can follow up on that for you.

Calder Lynch: Okay, thank you.

Coordinator: Our next question from (Eve Linker), your line is open.

(Eve Linker): Good afternoon. I was wondering if you would define what you mean by administer the test. And there's a difference - I mean, when we look at laboratory services generally speaking, when we say administer the test, that means that they're actually performing the test, meaning they would have to have the appropriate CLIA certification for it.

But I'm asking whether or not by administer the test that you mean the collection of the specimen and if you could clarify that.

(Brenna Ginley): It would - if the pharmacist - it would be collection of the specimen if the pharmacist was doing that. If the pharmacy does have a CLIA lab it would cover the clear laboratory as well.

(Eve Linker): Okay, thank you.

Coordinator: At this time we are showing no further questions.

(Jackie Glaze): Thank you. Okay. So we're - now we're ready to transition to Darcie Johnston and she will discuss the Medicaid and CHIP distribution of the provider relief fund. Darcie?

(Darcie Johnston): Thank you. Good afternoon, and thank you all for all the work that you've been doing for the past few months to address the pandemic.

Today I want to share updates with you on the provider relief funds and how we are distributing the next 25 billion in funding.

Recognizing the important role providers are playing who treat the most vulnerable population, HHS announced today the distribution of additional provider relief funds to eligible Medicaid and CHIP providers.

This funding will supply relief to Medicaid and CHIP providers experiencing lost revenue, or increased expenses due to COVID-19.

We expect to distribute approximately 15 billion to eligible providers that participate in state and Medicaid and CHIP programs. And who have not previously received this hand out from the provider relief general fund allocation.

More specifically to be eligible for this funding, healthcare providers must not have received payments from the 50 billion provider relief fund general distribution, and either have directly billed their state Medicaid CHIP program, or Medicaid managed care plan for the healthcare related services between January 1, 2018, to May 31, 2020.

Examples of providers serving Medicaid, CHIP benefits, or any possible eligible services for this funding includes pediatricians, OBGYNs, opioid treatment of behavioral health providers, assisted living facilities, and other home and community-based service providers.

To apply, we are also announcing the opening of a new portal where clinicians should submit their annual patient revenue information to enhance provider relief fund portal.

Providers should expect to receive a distribution equal at last 2% of their annual revenue. Overall we expect that distribution will reach 275,000 additional providers who are helping on the front lines to provide care to vulnerable populations.

Safety net distribution. (HHS) is also announcing the distribution of 10 billion in provider relief funds to safety net hospitals to serve our most vulnerable citizens recognizing the incredible thin margins these hospitals operate on.

This payment is going to hospital that serve a disproportional number of Medicaid patients or provide large amounts on compensated care.

Qualifying hospitals will have a Medicare disproportionate payment percentage, DPP, of 22.2% or greater, an average uncompensated care per bed

of 25,000 or more - for example of 100 beds would need to provide $2,500,000 in uncompensated care, in a year to meet this requirement.

Profitability of 3% or less as reported to CMS in the most recent filed tax report.

Recipients will receive a minimum distribution of $5 million, and a maximum distribution of $50 million.

Today's announcement and the disbursements are targeted to impact those providers serving low income and minority Americans. The individuals who have suffered disproportionately from COVID-19, we are continuing to recognize this burden and address through these funding streams to continue to support providers hardest hit by the pandemic. Thank you.

(Calder Lynch): Thanks Darcie. And of course, I'll just note that additional information about this release was issued by the department this morning. We have forwarded that information out across our list - so you may have received that - you know, that information. And you can also visit, you know, (HHS.gov/providerrelief), where more of that information is posted.

But with that, I think we'll be happy to open up the line for questions for (Darcie) or our colleagues from the department related to this latest news on the provider relief fund.

Coordinator: Thank you. Once again, to ask your questions, please press star one at this time.

One moment, please.

We have a question from (Marvin Goyle). Your line is open.

(Marvin Goyle): Yes, I'm (Marvin Goyle) from Illinois Medicaid Program.

Could you clarify what specialities are covered under the $15 billion for provider relief fund? You did not mention primary care providers such as (internists) and family doctors and I just wanted to be sure, because these are people we have been hearing from who have suffered.

(Tom Keane): Thank you for the question, this is (Tom Keane) from the deputy secretary's office.

The qualification criteria is simple. It's any provider or any person who has received Medicaid funding. And so I want to thank everybody on the line for so quickly helping us collect data on your Medicaid providers. It's been very helpful in administering the program.

So specifically primary care physicians and others who have received Medicaid payments will be eligible in this distribution.

(Marvin Goyle): Thank you.

Coordinator: Next question from (Stephanie Glear), your line is open.

(Stephanie Glear): Hi, thank you.

This is (Stephanie Glear) from the (American Economy and Pediatrics). I really appreciate your leadership in getting this new round of funding out the door.

I have a couple of quick questions that hopefully you'll be able to answer and I'm sure this will be in an FAQ that will be posted tomorrow so sorry for jumping the gun.

First, are the funds going to be first come first served or can we ensure that anybody who applies who is eligible will be able to receive funding?

Second, if someone was not participating in this $50 billion general distribution general allotment but they did participate in a targeted allotment, such as the royal health hospitals and clinics, would that disqualify them from being eligible for this round?

And third if a provider received this (de minimis) payment from the $50 billion and did not apply for a subsequent round for the 20 billion follow-up fund, is there a way for them to either reapply no even though it's past the deadline or participate in Medicaid interest 50 billion?

Thank you very much.

(Tom Keane): Thank you for those questions. An answer to the first question: the timing of the submission of the application will have no impact on the funds you receive.

We'll be paying on a rolling basis and the first application and the last application will get equal consideration.

Can you remind me of your second question?

(Stephanie Glear): Yes. If someone did not participate in the general allotment but they did participate in a targeted allotment such as the Royal Health allotment, does

that disqualify them from this new round?

(Tom Keane): Participation in the general distribution disqualifies you from participating in this round. Participating in the targeted distribution does not disqualify you.

So people who have received targeted distributions are encouraged to come to the portal and apply.

And to your third question, about the de minimis payment -- if you participated in any capacity in the first distribution, you are not qualified to participate in this distribution and we are aware that there are folks who got a de minimis push payment, and have not come to the portal to ask for a true-up.

But as the program is being administered now, they will not have the opportunity to come to this portal which is directed at Medicaid and other providers. Certainly, right now Medicaid providers.

(Stephanie Glear): Thank you.

(Tom Keane): I'm going to ask my colleague (Will Brady) from the Deputy Secretary's office to color up my answer.

(Will Brady): The only thing I was going to add was, you know, even if providers aren't eligible for this, they still do will be considered in future distributions moving forward.

(Tom Keane): Does that answer your question, m'am?

(Stephanie Glear): Yes, it does. Thank you very much.

(Calder Lynch): Thanks, and this is (Calder). Before we go to the next question I just - I do want to iterate that we certainly welcome (guests on here) (nothing on here is secret, we post all these recordings of all these calls anyway), this is a call focused before state and Medicaid CHIP agencies so we ask that we prioritize questions from state agency officials, thank you.

Coordinator: The next question is from (Anna Arks), your line is open.

(Anna Arks): Hi, yes. Good afternoon. Thank you.

I'm (Anna Arks), I'm from Pennsylvania Pharmacy Services, and I just wanted to confirm - so last Wednesday, on a call with the national provider network, (SAMHSA)'s assistant Secretary (Deputy Elinore McCance-Katz), talked about funding available for (STG Medicaid Providers) and confirmed that that funding would be available for Medicaid-involved programs, including drug and alcohol programs.

Is this - is that - what she was referencing the same as this program here?

(Tom Keane): I would have to talk with Dr. (McCance-Katz) to know what she was referring to but if you are a provider who provides drug and alcohol services, opioid treatment services, and you bill Medicaid, you are eligible to apply in this distribution.

(Anna Arks): Okay, great. Thank you.

Coordinator: Next question from (Meredith Palute). Your line is open.

(Meredith Palute): Hi. Thanks for taking my question.

Yes, this is (Meredith Palute), from New Hampshire Department of Health and Human Services and I wondered if we can hear more about what revenue source the relief funds are being treated as?

This question's kind of sparked from the $10 billion distribution for the safety net providers - but I was wondering what revenues sources are being treated as for the purpose of calculating uncompensated care for (this) payments for hospitals?

(Tom Keane): I'm not sure - could you clarify your question please?

(Meredith Palute): And to this - as the funds are coming for safety net hospitals I think there was a $10 billion distribution but really for any of the provider relief funds going to hospitals, what - are they - what revenue source are they going to be considered by the hospital for the purpose of calculating uncompensated care?

(Will Brady): So - this is (Will Brady) from the Deputy Secretary's office.

Uncompensated care data's being pulled from the CMS cost reports as well as other revenue data for hospitals specifically.

(Calder Lynch): Hey Will- this is (Calder) I think the question maybe if I'm hearing it correctly is how will hospitals have to report the provider relief payments, you know, in terms of, you know, will they have to report it against the uncompensated care cost that would affect any future - is that right?

(Anna Arks): Thank you, yes. That is my question.

(Calder Lynch): Yes. And that may be something - I'm not sure if you guys have worked on

that we might have to involve our colleagues from the financial management group to work with you to consider that - that hasn't been something we've tackled yet.

(Will Brady): Yes, (Calder) I think that's right. I appreciate the question. We'll - haven't had that one come up yet but we will have huddle internally and provide feedback as soon as possible.

(Anna Arks): Okay, thank you very much.

Coordinator: Next question from (Jennifer Jacobs), your line is open.

(Jennifer Jacobs): Hi everyone. (Jen Jacobs) here in New Jersey.

Thanks again for this call series. We really appreciate the support in the Q&A and have come to rely on it. So I just wanted to take this moment to say that.

And my question is could you talk to us a little bit about how the portal process ties to the data that was submitted by state and specifically are you using our state data that we provided to validate the information that's being provided by providers through the portal?

(Tom Keane): So the data that you guys provided was absolutely essential and very robust and we know it was costly to provide, so we thank you.

Among other things we're using that data to qualify people. To make sure that people apply through the portal are in fact identified Medicaid providers.

Additionally you let us know what the payments were and other information and we're using that in program administration.

But the main purpose is to qualify applicants. So the short answer to your question is yes.

(Jennifer Jacobs): Thank you.

Coordinator: Next question from (Michelle Probert). Your line is open.

(Michelle Probert): My question's already been answered, thank you.

Coordinator: Next question from (Thomas Chatlin). Your line is open.

(Thomas Chatlin): Thank you. (Thomas Chatlin), Ohio Department of Medicaid. New Jersey just got half of my question, so thank you for asking that. According to the e-mail about the 2% is that Medicaid money only or all sources of patient revenue including private aid and private insurance?

(Tom Keane): All sources.

(Thomas Chatlin): Okay. Thank you very much.

Coordinator: Next question from (Amy Lewis). Your line is open.

(Amy Lewis): Hi, thank you. (Amy Lewis), from Illinois Department in Aging. You mentioned that providers - because the other providers such as home and community service providers - would that also including home and community-based service providers that deliver services under 1915c waivers)?

(Tom Keane): I'm going to have to ask my colleagues at (CMCS) to address that.

(Calder Lynch): Yes, as long as they, you know, were reported, you know, as a provider and they're delivery in their medical services which (require) you from the covered Medicaid benefit services, they would show up on that list.

(Amy Lewis): Okay and my second question is - I did read an early summary on (perspective) of the (CARES Act) it looks like it would include PPE - can you just confirm that PPE would be a health - a situation healthcare related services if it was in relationship to, you know, obviously treating somebody with COVID or a provider, you know, protecting themselves from COVID?

(Tom Keane): Can you explain the specific case you're thinking of? Are you --

(Amy Lewis): Sure so. In-home service - home community-based service provider, going into homes to provide help within community daily living for older adults and the older adults or the particular in-home worker, you know, is protecting themselves with PPE as not to accidentally transmit COVID.

(Tom Keane): So, we're going to initially pay based on 2% of your patient care revenues and we're collecting data on increased expenses and lost revenues and in the increased expense category we asked people to account for their increased expenses due to PPE.

(Amy Lewis): Okay. Thank you. Hey guys, thank you.

Coordinator: Next question from (DeeDee Moore-Peterson), your line is open.

(Judy Moore-Peterson): Hi, this is (Judy Moore-Peterson) from Hawaii Medicaid Program that - most of my questions have been answered but I think I got cut off and this question may have already been answered so I apologize for asking it

again.

When it comes to the providers that are able to qualify for this payment, if they are a primary care provider and they serve a balance of both Medicare and Medicaid and received money from that first round, even though they pay early through Medicare, they would no longer - they would not qualify for this - for these payments? Did I understand that correctly?

(Tom Keane): That's correct. We're paying everybody 2% of their patient care revenues and if you were included in the initial Medicare distribution. We should have paid you 2% of your Medicare - your total patient care revenues.

Many providers do not take Medicare. But do take Medicaid. The purpose of this distribution is to pay these Medicaid providers also 2% of their patient care revenues. So given that people participated in Medicare, should have already received full payment of their 2%. They are not allowed to participate in this distribution.

(Judy Moore-Peterson): All right thank you for explaining that. Thank you.

Coordinator: At this time we are showing no further questions.

(Jackie Glaze): Thank you. So now we're ready to move to the next agenda item. And (Nicole Cuomo) and (Kari Amijo) will now present on the New Mexico implementation of the optional COVID testing group. So (Nicole)?

(Nicole Cuomo): Thanks (Jackie). Hi. This is (Nicole) in New Mexico. And thank you so much for the opportunity to speak with you all today about how we're approaching the implementation of this COVID-19 testing move. And thank you for introducing our Deputy Secretary, (Kari Armijo) who's joining me today. She

has a long history in New Mexico Medicaid and worked on the development of this program. So I will start out and then I will hand it off to (Kari) and we're happy to take any questions.

So this is a little bit of an interesting implementation as I know many of you have been working through. We did submit and receive approval on our state plan amendment around the implementation plan. So before I jump into how these have outlined that I wanted to quickly let you all know how we have decided to advise our provider community with regards to COVID claims submission for the uninsured population and specifically as it relates to this program and interplay with the HRSA portal.

So last week we held a state-wide technical assistance call for all of the entities providing testing across the state of New Mexico. And given the guidance that we received from CMS last week we decided not to be prescriptive in telling providers how they could submit those and in what order. But we did give guidance that despite our implementing this program because those entities that are providing testing in our treatment can get their claims reimbursed through the HRSA portal.

And only their testing and testing related services claims reimbursed through this program in New Mexico. We did advise them that it’s a less burdensome approach for them to take that they could submit those claims there at the HRSA portal until such time as funds may no longer be available. There's a limited bucket of money associated with that portal at this time as we all know be it a significant amount of money. So we will have this as a backup option for continued reimbursement of testing for the uninsured here in New Mexico which we expect of course to be an ongoing effort here in the state as I’m sure many of you all know as well.

So one of the first things we decided to do was in light of the significant growth in our program and corresponding demand with our field offices we decided to pull these applications out. And we have a small application processing unit within our office who usually handles the incarcerated population so that we can ensure that these applications are processed very quickly. And we are turning around reimbursements for providers as soon as possible without that volume significantly impacting our field offices who are already having very large amount of volume. And at the time we were making some of these decisions we were also finishing our transition to working remotely which has been an interesting exercise.

Additionally we need to expedite coverage for this group and get this program set up fairly quickly. We use an eligibility category code that was already existing. And we use that code in combination with an unused federal match code which we happen to have in our system so that we can ensure correct claiming for federal match, 100% federal FMAP on it and then also for federal reporting purposes. So rather than set up the new testing group in our eligibility and enrollment system we set it up directly within our MMIS which allowed us to expedite the implementation.

In order to do that we created a new one page streamline application for the testing group. The form is in both English and Spanish so we're happy to share that with other states as short and simple and mostly checkboxes. Of course they ask for a Social Security Number, date of birth and an attestation of New Mexico residency, uninsured status and either a US citizen or a qualified noncitizen. On the back of the form we have all of the qualifying on citizenship statuses so that they're easily referenced there as well.

And then we advised our providers that for those individuals who cannot attest to meeting the citizenship or qualified non-citizenship criteria that they can

apply to our ESNC category Emergency Services for non-citizens. And we will be covering and attesting to that category and (Kari) might mention more about that later. Once we receive the applications either individually or in batch and actually as this call was happening I got a notification that our Department of Health has a huge batch I guess from a mobile testing site to send over. Our fiscal agents I know with MMIS is processing those applications.

We're conducting verification post eligibility. We have a safe portal. And that the approved eligibility stands for the COVID testing category will be entered into our MMIS. The MMIS already contains of course all of our regular Medicaid eligibility span and our fiscal agents can therefore tell whether someone is already enrolled in Medicaid and therefore not eligible for the new uninsured category. Finally we developed notices meeting the requirements for this group for approvals and denials and incomplete applications. And we are working on how we will disseminate those now that we're starting to receive these applications after our technical assistance call last week.

So I'm going to turn it over to (Kari). I think I covered most things but (Kari) I don't know if you wanted to talk about any of the next steps and specifically our work to try to make this mobile enabled? We just talked to a lot of our providers about the process. There is a lot of mobile testing happening here in New Mexico. And so trying to figure out how we can simplify the process so that folks can be filling out this application in their car while they're waiting in line to get to the testing site. (Kari) did you want to color anything I said or add anything on that front?

(Kari Amijo): Sure. I'll just add a couple of things (Nicole). Good afternoon everyone. A couple of things I just wanted to mention quickly that the folks who enroll under this category as (Nicole) mentioned can claim their own eligibility

category. And they go into a provider portal so that providers can look up that eligibility. They kind of show up as COVID-19 uninsured group so that providers can find them. And then once the provider sees them in the portal they can go ahead and submit the claim. So I just wanted to mention that as well.

There are providers in New Mexico that see primarily uninsured patients. And so we also have sort of concurrent with this process implemented a streamlined provider enrollment process for them to quickly enroll with us if they're really their focus is to provide services to the population. As (Nicole) mentioned we are sort of in the first phase of rolling out this program. It's right now, you know, largely actually collected on these paper application forms that we have submitted and we're working with the testing site to collect.

We do have an online application portal but it is not mobile friendly just yet. So that's going to be our next phase. And then our third phase is going to be to have an overall portal for uninsured, all uninsured clients to apply for testing related services and then get routed to the correct program for them whether that's through our Emergency Medical Services Program for individuals who don't meet the Medicaid citizenship or immigration criteria or through this program or other covered sources. So that's going to be our next phase I think. And I think (Nicole) covered everything else so be happy to send it over to CMS for questions.

Jackie Glaze: So thank you. Thanks (Kari) and thanks (Nicole). So we're ready now for the operator to open up the phone lines so that the audience can ask them questions about the implementation of the optional testing group. So operator we're ready to open up the phone lines now.

Coordinator: Once again to ask a question please press Star 1 and record your name at the prompt. One moment please. We have a question from (Chris Ann Bacon). Your line is open.

(Chris Ann Bacon): Yes hi. I'm with Utah Medicaid and my question - I have two questions. The first one is on your technical assistance call or through seeking guidance from CMS if you have gotten a question around between HRSA and Medicaid so HRSA once a claims submitted that person is eligible for that program for 30 days for claims to be submitted. What happens or if any guidance you've gotten if for example they go get a test and the provider submits to HRSA and then they need to go get another test or they end up needing treatment and they apply for the Medicaid program? We had a hospital ask us if they should be holding claims for HRSA to wait and see if someone becomes eligible for the Medicaid program. So that's my first question.

And the second question is with your Emergency Services for Non-citizens have you implemented an application process and post payment review on those claims? How do you manage that with the COVID testing? Those are my questions. Thanks.

(Nicole Cuomo): Thank you. So (Kari) do you want to talk about the plan for (EMSA) go backwards here?

(Kari Amijo): Sure so for our (EMSA) program -- that's what we call it here in New Mexico -- we have implemented an application process. It is a clunky process. It's mostly a paper based at this point we're in the process of streamlining that to make it online and to make it more friendly for testing sites to be able to help enroll people. That is going to be rolled out in early July here in New Mexico. And we always conduct a post eligibility claims review to test the medical necessity of the claims. And in this case we'll be checking for the COVID

diagnosis to make sure that their services are related to the testing.

(Nicole Cuomo): Thanks Kari. So and to your first question is a good question and one that we did review and are trying to work through as well. And I'm certainly happy to ask CMS or folks from HRSA if they want to jump in to provide any guidance there. As we are starting to see things reopen here in New Mexico we are having, you know, individuals who may have received a test back in March and then now as we head into June are potentially needing another test. And obviously the HRSA portal wasn't open and that we can imagine how that will continue to happen with surveillance testing and some interesting requirements we're seeing around back to work testing happening.

So we have not put out any guidance on that at this time. So we'll be working through that with you as well. I don't know if anybody from CMS wanted to chime in on any recommendations?

(Jessica): This is (Jessica). I'll just note that I think based on the, you know, we have HRSA colleagues on the phone with us last week that the way it would work is that for an individual who is enrolled in Medicaid even if retroactively there will be a sort of back and reconciliation process through sort of a coordination of benefits. So that in the circumstance that I think you asked about in your question if an individual is determined to have been enrolled in Medicaid at the time then there will be a sort of coordination of benefits process to ensure that benefits are, sort of coverage is billed to the right place. If not though when the individual is enrolled then Medicaid would appropriately be billed for an individual.

(Nicole Cuomo): Thanks (Jessica).

(Chris Ann Bacon): Thank you.

Coordinator: And a question from (Jane Lungo). Your line is open.

(Jane Lungo): Hi. This is (Jane Lungo). I have two questions I am with Illnois. First one is I just want to verify that after the emergency period ends whenever that is even so (unintelligible) the service before the end of the period we would still get the - a match, 100% match from this group, the testing group gets paid after the end of the billing period? The program doesn't - I mean payments would come in after - for a data service before? That is will that – will it work that way?

(Jessica): So this is (Jessica) again and I'll ask my FMG colleagues to also just confirm that I (Jane) I think you're referring to a situation where a person received services and the just the billing came in after the end of the emergency period. For example if an individual will receive services today and you submitted a claim for services provided today even though we're still in the air emergency period. Is that right?

(Jane Lungo): Right the application...

((Crosstalk))

(Jane Lungo): ...for eligibility and the claim would come in potentially after the emergency period is over but it's for a date of service before the…

(Jessica): Well so…

(Jane Lungo): …week ended.

(Jessica): ...for an application unless we're referring to, you know, coverage of

retroactive eligibility…

(Jane Lungo): Right.

(Jessica): …tt the end of the emergency period yes so I say yes in the context of retroactive eligibility. But because there's no authority for the group after the end of the public health emergency a person could not be prospectively or even currently determined eligible for the group after the public health emergency has ended because the group would no longer exist.

(Jane Lungo): If we got an application and let's say the period ends in - at the end of August we got an application on September 1 for somebody who got a test in August I guess that's still retroactive?

(Jessica): Correct yes. So…

(Jane Lungo): So if the period ends midmonth would we not be able to get coverage for the beginning of the month?

(Jessica): Yes for the beginning of the month so again let's say a scenario public health emergency ends the - let's say July, August 15. And after August 15 no claims can be paid for the individual but prior to August 15 when the group is still in effect a person can be retroactively determined eligible for that group but not prospectively determined eligible.

(Jane Lungo): Okay.

(Jessica): Yes select if – go ahead.

(Jane Lungo): So if it's August 17 application for eligibility we can find them eligible up

until the end of the emergency period in August that same month, that given month?

(Jessica): Yes but there is no claim can be made for the period between August 17 and the end of the month. Only if they received – only if the service that they received was before August 17.

(Jane Lungo): Right the date of service?

(Jessica): Right.

(Jane Lungo): Okay.

(Jessica): Yes.

(Jane Lungo): And we could approve the eligibility after the end of the, you know, like if we get it a day later or whatever. Okay I think I get that. Is that addressing guidance the dates of service versus date of determination of eligibility?

(Jessica): Not specifically but I think it's covered in the Rules related to coverage of retroactive eligibility which is in the guidance that we provided last week, but talked a little bit of about effective date of coverage and retroactive eligibility. But certainly if there are more questions we're happy to answer them off-line or here if they them as well.

(Jane Lungo): And then the next one is a little less complicated. The slides that the HRSA folks used last week in this meeting is there a link to those somewhere?

(Jessica): I believe so. I'll ask my colleagues and CMS to answer exactly where that is.

((Crosstalk))

(Sarah DeLone): This is (Sarah DeLone), we can check. I don't believe that they are but we can check with our HRSA colleagues and find out and get that sent out to folks if they are.

Anne Marie Costello: And am I to understand that when we post these scripts from this all state call that we were posting the slide deck. So we will confirm that when we post…

(Jessica): Yes we could just find out where that is. That's great.

Coordinator: At this time we are showing no further questions.

(Anne Marie Costello): So this is (Anne Marie Costello) if I could jump in just for one second. I know there was some questions that came up about the provision of covering testing services through the use of emergency – as part of emergency services from Medicaid. And I just want to put out for folks that we published some FAQ and its Question 5 in the document that we posted on April 13 which is a set of FAQs associated with the CARES Act. That would be I think a helpful reference to states.

Calder Lynch: I think we can open up for more general questions now if there are any on any other topics that we didn't cover today since we have some time.

Coordinator: And once again for your questions please press Star 1 at this time. One moment please. We have a question from (Eve Liquors). Your line is open.

(Eve Liquors): Good afternoon. I have two questions. One I'd like to go back to the pharmacist discussion. I know one of the gentlemen had asked about can we

actually pay to the pharmacy. Even further to that question is under what authority are we able to enroll and pay the pharmacist or to provide the service based on the pharmacist enrollment to do this? Because even if they are – if we're paying them for the collection we still have to have some authority. So do we need to do this under the 1135, the disaster state plan amendment or is this some - if we intend to do this longer term should we submit a traditional state plan amendment?

Alissa Deboy: (Kirsten Jensen) are you on the phone?

(Kirsten Jensen): I am. This is (Kirsten Jensen). If we could get back to you on that question as well as part of some of these operational questions we'll include that with the lab pharmacy billing question.

(Eve Liquors): Okay. And then the next question I have is is that, you know, we've had the federal public health emergency extended. And, you know, so I am sure other states are also extending their, you know, there emergency declarations as well. So we know that usually this happens only a short time before the termination of or the expiration of public health emergency which does not leave states, you know, time to act, you know, like immediately within, you know, that two days a week. So my question is whether or not CMS will be allowing like a 50 or a 90 day run a period or grace period for up to, you know, get our operations back into, you know, some sense of normalcy once the public health emergency ends?

(Sarah DeLone): This is (Sarah DeLone). Are you asking specifically about with respect to the optional testing group or were you asking a broader question?

(Eve Liquors): The broader question because obviously, you know, whether it's under the 1135 or disaster state plan amendment obviously, you know, when you start to

go back to, you know, other pieces, you know, we're going to have to have some sort of transition because just say even for like alternate site if we say that we've allowed for alternate sites for testing and then, you know, this is only good until the public health emergency and we don't have the authority to go beyond that, you know, part of our concern is to that, you know, these sites just are going to shut down.

So the public health emergency still could be, you know, necessary within, you know, at the state level and we may need to continue and to at least run out. It's not like we can get the – you get that, you know, you get determination two days later we're ready to stop every single thing that we've already implemented. So we're just wondering has CMS, you know, discussed what the plan will be in order to address that for the state.

Calder Lynch: That is a great question and I really appreciate you raising it as it's something we've actually spent a lot of time recently thinking about and working on including some conversations with colleagues over at NAMD. And our intent is to provide guidance to states prior to the end of the public health emergency and even before that to begin conversations through this call and other forums to talk about the steps that will be necessary to take down various authorities what steps the states may need to take to keep certain flexibilities in place beyond the end of the PHE.

And it's going to vary somewhat from authority to authority because there are different rules that govern what we can do under state plan, what we can do under 1135. Some of them are more lenient than others and they require different steps to maintain some of those flexibilities. Others may require that we have plans around transitions especially as we think about states coming back to normal eligibility operations and what it's going to mean to clear through some of these backlogs re-determinations and verification requests

that need to take place and how we think that those should be prioritized and what type of timeframe we're looking at.

All of that is we're hoping to bundle into, you know, a state health officer letter, a show letter that kind of what walk-through that for states and it'll give you a tool to make your own state sort of specific plan for how you're going to manage through that.

So we're absolutely working on that. We intend to begin some conversations through NAMD with states about that in the near future. And so be thinking about what those questions are so that you can flag those as we start talking through that so we can make sure that our guidance is going to be responsive to those needs. (Ann Marie) were you going to say something? I'm sorry.

(Anne Marie Costello): No Calder you beat me to the punch. That's exactly what I was going to say.

Man: Okay.

(Eve Liquors): That response is greatly and we appreciated but we just wanted to make sure that we brought that to the forefront. I'm sure the Pennsylvania is not, you know, the only state with that question. And, you know, we're very, you know, fortunate that it was I guess in some ways yes, in some ways no, but fortunate that it was extended so that we could continue to address the needs here in Pennsylvania.

Also I guess our question is is that there's a number of places the, you know, where it's talked about the extension and things like that. But there – I do not see a specific end date or an announcement of there is a, you know, this is – this current period is from X date to X date. And so we just want to make sure

that all of us are all on the same page as to what the current expiration date is of the current PHE.

Calder Lynch: So if you go to phe.gov it's actually the Web site and you click on Declarations of Public Health Emergency you will see the very first item is the latest I think renewal of that emergency that was done on April 26. And the way that works is they have to be renewed, you know, every 90 days or they expire right? So the current PHE unless renewed or ended is currently good through I believe it's July 26 which – and then of course can be renewed further from there. So that would be the place - I'm sorry July 24 would be the 90th day after that. So we will know something prior to that in terms of, you know, it being renewed or whatnot and we'll certainly share that as we know it but that is the current declaration period.

(Eve Liquors): Okay. And that was my understanding was that was the 90th day, you know, because it appears that the President's declaration and the public health declaration, you know, are good for 90 days. So we just wanted to confirm that. All right thanks very much.

Calder Lynch: Thank you. All right I think we're at time actually so appreciate everyone participation on today's call. I know we covered a lot of topics. We will convene again next Tuesday and as we have more information about that agenda we'll certainly get that shared out to folks as well, appreciate everyone's time this afternoon. Have a good rest of the week.

Coordinator: Thank you. That does conclude this conference. We do appreciate you attending. You may disconnect at this time.

End