Centers for Medicare & Medicaid Services
COVID-19 Medicaid & CHIP All Sate Call
July 14, 2020
3:00 pm ET

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

Jackie Glaze: Thank you and good afternoon, and welcome, everyone, to today's All-State Call. I'll now turn to Calder, and he'll provide opening remarks and share today's highlights for the discussion. Calder?

Calder Lynch: Thanks, Jackie. Good afternoon, everyone. Thanks for joining us. We hope everyone had a great Fourth of July break and got a little rest. Now we're happy to resume our weekly call this week.

During our most recent All-State Call two weeks ago, we received really many great questions that we ran out of time and were unable to address. A lot of these questions covered a few major topic areas including those that were addressed in our most recent batch of FAQs around retainer payments, Appendix Ks, as well as key dates and other maintenance of effort requirements for the enhanced FMAP.

So, for the first portion of today's call, we're going to continue the Q&A and answer questions that we received that we were not able to get to during our last call. And then for the second portion of the call, our team is going to provide a brief update of the Medicaid and CHIP distribution of the Provider

Relief Fund and then open up the line, again, for questions, more questions, on our latest batch of FAQs that was issued back on June 30th.

Just a few reminders first before we begin with our presentations. I want to touch on one of the recurring questions that we've received regarding the extension of the Public Health Emergency. As you may know, the decision to extend the PHE is made by the Secretary of HHS. And Secretary Azar and the Vice President recently met with Governors and provided assurances that the PHE will be extended. We're awaiting the formal extension, but we're confident that the PHE will be extended beyond the end of July, and we'll continue to keep you updated as we get official word of that.

I also wanted to provide additional information about some just-released guidance. Today we issued a letter to State Medicaid Directors that formally extends the time frame for demonstrating compliance with the Home and Community-Based Settings final regulation. This guidance extends that timeline for one additional year, by which States must meet - must ensure that settings furnished using Medicaid-funded HCBS services comply with the settings criteria.

So, in effect, the timeline is extended - the deadline is extended from March 17, 2020 to March 17, 2023. And this extension, of course, was driven by the disruption to HCBS reform efforts that the Public Health Emergency has caused.

And we recognized that not only has the PHE demanded the full focus of state resources, but it's also impacted the way Providers deliver care, and so we have published this guidance with the extension along with the Frequently Asked Questions that have been updated to provide more technical information that I want to call to your attention as well.

And finally, that the letter encourages States to continue making consistent progress, not only achieving compliance with the setting rules, but also with the larger goals of rebalancing in our long-term care programs to increase the availability of person centered individualized support.

So, with that, I will turn things over to Melissa Harris to answer the questions on the way the retainer payments that we didn't get to last time. Melissa?

Melissa Harris: Thanks, Calder. So, this is Melissa. And I thought what I'd do is provide a little bit of a refresher on the retainer payment framework that we published in our last round of FAQs.

We talked about this briefly on our last call, but the document was not formally published yet, and so you all did not have the benefit of having anything in front of you as we were providing this overview. So, I thought I would do it again quickly. Hopefully now, you've had some time to digest the FAQ language.

And so, I'll reiterate that when we're talking about retainer payments, we're talking about a couple of different types of scenarios. Certainly now, in the Public Health Emergency, they are front of mind in as being a tool to protect the solvency of Home and Community-Based Services Providers. And that continues.

But retainer payments are not limited to payments of periods of disaster. Retainer payments really got their start in a 2000 State Medicaid Director Letter, and those parameters are still in effect today. That guidance talked about retainer payments up to 30 days. It was the lesser of 30 days or the number of days in which the State has nursing facility bed holds they use -

articulated in their State plan. And that type of retainer payment is available all the time. We don't need to be in a period of Public Health Emergency or have any kind of disaster or official declaration.

So, retainer payments, according to the parameters of the 2000 State Medicaid Director Letter are available, as that letter articulated, for 1915-c waivers and as re-articulated in this new FAQ document under State Plan Options in 1915-i and 1915-k. So, that's one parameter to keep in mind, in terms of the permanent availability of retainer payments.

But it is wise to remember that in that scenario the time amount and the number of days of retainer payments is limited to the number of nursing facility bed whole days in that State.

So, let's move now to retainer payments in periods of disaster where a Public Health Emergency like we're in now. States have come to us in the 1915-c waiver world over time and said that they needed to utilize more than one period of retainer payments in a series of disasters because the time frames were such that more than one period was necessary to ensure financial solvency or to protect financial solvency. And so, CMS had been authorizing more than one period of retainer payments in those disaster periods. So, that has also been continued in these FAQs.

You'll note that there is an upper limit of 90 days or three periods of 30 days each in periods of disaster. And that 90-day time frame is firm. So, we are talking about retainer payments for up to and including 90 days in periods of disaster under the 1915-c waiver and under the 1915-i State Plan and the 1915-k State Plan.

The FAQs also walk through some guardrails that are new and that apply to

multiple periods of retainer payments. And so those retainer payments really talk about the expectations that CMS has of States and Providers who avail themselves of multiple periods of retainer payments, and the guardrails go into what we hope is sufficient detail to give States and Providers some operationalizing guidance.

But we've also been getting some questions from stakeholders about what CMS means by some of the phases in the guardrails. So, we'll try to hit some of those questions briefly.

But in essence, we're making sure that retainer payments are limited to a reasonable amount, and in no case should be more than the payments the Provider was receiving under Medicaid had they been delivering services in a normal environment. And so, if a Provider was receiving, you know, an amount of dollars for the provision of Medicaid services, if that exceeds cap at which the retainer payments have to be limited, they can't exceed that amount.

States also have the ability to set a retainer payment at less than what they were providing as reimbursement for delivering a service. And so you've got that specifically listed in the FAQ language. There's also the ability for a State to say that retainer payments will not be made to a particular setting unless or until attendance falls below a specific threshold of typical enrollment. And that 75% that we have in the FAQ is just an example.

But it's to notify States that there is some discretion there in terms of the amounts of payment, and the Providers, or the circumstances in which a retainer payment kicks in, but there is that cap that can't be exceeded, and that is what the Provider would have received for the delivery of services.

We've also got some guardrails around duplicate payments. There's a lot of

money that is available now to Providers for COVID relief, and these guardrails try to name some of them explicitly, but then we also said that States and Providers should be aware of the purposes for which other payment sources are being utilized and that retainer payments should not be going to for a purpose that has already been earmarked by another funding source.

This is all to make sure that payments are being used efficiently and economically, and Medicaid funding, in the form of retainer payments, is not going to duplicate another purpose that already has funding associated with it.

Another guardrail is particularly important as it relates to staffing levels and the ability of the Provider to continue delivering services. And the guardrail states that a State must require an attestation from a Provider receiving retainer payments that it will not lay off staff and will maintain wages at existing levels. That's really critical to make sure that beneficiaries are still able to receive services because there are enough direct service workers, et cetera, employed to furnish those services.

And then, also, the final guardrail is that Agency or Providers receiving retainer payments cannot, together with other funding streams, make more money than they would have been making in typical circumstances when they are furnishing services, at least in terms of Medicaid revenues. So, the retainer payments, you know, cannot put the Provider above what kind of Medicaid revenue the Provider would have received as of the Public Health Emergency.

We've gotten a couple of questions, you know, about some of the operational aspects of this - how a State collects retainer payments for both emergency periods and regular periods. The FAQs provide some guidance around the disaster SPA availability and the Appendix K availability for COVID-related multiple periods of retainer payments.

A State who wants to make use of typical retainer payments, which would be the lesser of 30 days or the number of nursing facility bed whole days can add those retainer payments to their underlying State Plans or their underlying waivers. They don't need to file one of the Emergency Authorities. Those Emergency Authorities are available for the multiple periods of disaster-related retainer payments.

And certainly, CMS is available for technical assistance to States as they're determining the types and the durations of retainer payments and what kind of filings to make.

I'll end here by mentioning a couple of things - a couple of questions that we've been getting on those guardrails around duplicate funding streams. And so, understanding that this might have a - take on some variation across different Agencies that might have different funding streams coming into them, it might be better to have an individual technical assistance conversation with the State so we can get the nuances of an individual example.

One of the questions we've received was whether a line of credit or an owner giving a personal loan to a Provider would count as another funding stream. And that answer is No. We're talking about public funding streams here. And so the Medicaid-funded retainer payments could not be used to duplicate another public funding stream.

And then the last thing I'll say is that those same lines of credit, personal loans, also would not be treated as revenue or counted as revenue in determining the cap at which a retainer payment cannot put a Provider organization, vis-à-vis their revenue that they were receiving prior to the Public Health Emergency.

So, all of this is to say, there's a lot of different variations on the themes of this questions that we're getting. It's probably best to handle them on a one-on-one basis, but we've received a few in the few days since the questions have been on the street, so we thought we would try to head off some of these.

But our Division of Long-Term Services and Support and our Division of Benefits and Coverage are available to provide additional opportunities of technical assistance for you. And appreciate your patience as we work to nail down all of these policy nuances.

With that, I'm going to turn it over to Ralph Lawler, who's going to talk about some additional information on the Appendix K. And then we'll be available at the end for questions. Thanks.

Ralph Lollar: So, with regard to the Appendix K, it will be important for the States that are choosing to use this option of multiple - up to three episodes - of the retainer payments to document that in an updated Appendix K application.

If that is the only change you were making, you would submit the cover page with the date, identifying the waiver and adding the information that it is additive to the current waiver - to the current Appendix K. And then in the area of the retainer payments would include that the State is choosing the option of rendering multiple periods or episodes - up to three; set the limit.

And then, indicate the guardrails, and enumerate the guardrails, to ensure that they are inside the Appendix K. And any other limitations and/or processes that you want to document that you are going to have your Providers follow for this process should be included in that application.

And I think that is the most important thing that I would highlight here for folks who are considering using the multiple episodes.

Jackie Glaze: Thank you, Ralph. So, we'll now turn to Stephanie Kaminsky and she'll share some information on the maintenance of that effort. Stephanie?

Stephanie Kaminsky: All right. Thank you, Jackie.

So, two weeks ago, when we spoke, we had a slide deck, and we shared with folks an important termination date related to the Authority in the Families First Coronavirus Response Act related to 6008-b.

At that time, we stated, and we shared a slide that showed that 6008-b1, the Authority that requires States who want the 6.2% increase FMAP to maintain eligibility standards, methodologies or procedures will expire the last day of the calendar quarter in which the PHE ends. 6008-b2 requires States who want that FMAP bump to not charge premiums that exceed those that were in place as of January 1, 2020 also expires the last day of the calendar quarter in which the PHE ends.

Then 6008 b3, the provision that we've spent quite a bit of time talking about here, which requires States not to terminate individuals from Medicaid if the individuals were enrolled in the program after the date of the beginning of the emergency - that provision expires the last day of the month in which the PHE ends - not the last day of the calendar quarter, but rather, the last day of the month in which the PHE ends.

And finally, 6008-b4, which is the provision that requires States who want that FMAP bump to cover testing services and treatment for COVID-19 without imposing a copay, that provision expires the last day of the calendar

quarter in which the PHE ends.

So, we have three that expire the last day of the calendar quarter and one, this 6008-b3 that expires the last day of the month in which the PHE ends.

One person asked after the call, well, why is that the case? What is the Authority that creates this difference, this variation? And I would just point folks to the actual FFCRA - Families First Coronavirus Response Act - 6008-b language. In that statutory text, you can see the different end dates, and specifically for b-3, it says that it ends the last day of the month in which the emergency period ends. So, we are really just bringing you the statute in a different form here. And you can certainly check there for more verification.

In addition, we have the question, "How do States handle the fact that the requirement for cost-sharing required to the increased FMAP does not match the end date of the disaster SPA?" In other words, the disaster SPAs will end when the PHE ends, but there's this requirement for the cost-sharing exemption for COVID testing and treatments to continue until the last day of the calendar quarter in which the PHE ends.

And where we have landed with respect to that questions is that, yes, States have to continue that exemption through the last day of the calendar quarter of the PHE, or that the PHE ends, but we are not requiring States to submit new SPAs to extend the cost-sharing exemption through the last day of the quarter in which the PHE ends.

However, as States draw funds from the increased FMAP account in the payment management system, each State will be attesting that it is eligible for the increased FMAP; that the expenditures for which it is drawing funds are those for which the increased FMAP is applicable; and that the conditions

under which the increased FMAP is available are met.

So, that is a normal course of business, and that will continue as a type of attestation that the States are continuing to apply that exemption through the end of the calendar quarter that the PHE ends.

We have a specific question about the premium payment Authority that was 6008-b-2, which requires that states not charge higher premiums than they were charging as of January 1 during the PHE and we wanted to just reiterate that's the limitation on premium charges in Section 6008-b-2, and again, on the last day of the quarter in which the PHE ends.

And finally, we have another question that was around the definition of uninsured. The question was specifically, "If a patient who needs a COVID-19 test has Medicare Part A-only and doesn't have Medicaid - not a dual-eligible - can the Provider or the Lab be reimbursed for the COVID test either by the State's 23 Group - the optional COVID testing group that some States have adopted - or from the HRSA COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment Of the Uninsured Program - the HRSA fund for the uninsured?"

And our answer, unfortunately, is No. If a person has Medicare Part A, they are considered insured, and those two sources of funding are truly for individuals who are uninsured by the definition in the Families First Coronavirus Response Act. Having Part A Medicare does not fall within the definition in the Statute.

So, those were just some follow-up questions that came from our presentation two weeks ago. And, as I mentioned then, we do intend to put out a couple of FAQs around these termination dates, so stay tuned for those.

With that, I'll turn it back to Jackie.

Jackie Glaze: Thank you, Stephanie, and thank you, Ralph and Melissa, for your presentations. We're ready now to move on to Jen Bowden, and she's going to provide an update on the Provider Relief Fund. Jen?

Jen Bowdoin: Thanks, Jackie. And hi, everyone, it's nice to speak with you all.

So, I have just a few brief updates on the Provider Relief Fund. And so, first, as a reminder, Provider applications for payments under the Medicaid and CHIP distribution of the Provider Relief Fund are due on July 20th. This deadline is particularly important to highlight and note because with less than a week left remaining in the application period, relatively few Medicaid and CHIP Providers have applied for payments under the Medicaid and CHIP distribution. Specifically, as of last Friday, July 10th, in most States, less than 2% of the Medicaid and CHIP Providers that we think are eligible had applied for payments.

And the highest application rate in any State was only 6-1/2%. Again, the application deadline for the Medicaid and CHIP distribution is July 20th, and we would really appreciate your support and assistance in getting the word out to your Providers and encouraging them to apply.

Second, we wanted to remind States and Territories to return their validation files to HRSA as quickly as possible. As you may be aware, HRSA has received applications from some Providers that were not included on the files provided by States and Territories.

Unfortunately, HRSA is not able to process payments for Providers until they

have been validated as Medicaid and CHIP Providers in good standing. Returning the validation files in a timely way will allow HRSA to process these applications and make the payments to eligible Providers as quickly as possible.

And lastly, we wanted to make sure that you are aware that HHS recently announced additional Provider Relief Fund distributions, including an additional $3 billion for 215 Safety Net Hospitals that didn't previously qualify for the Safety Net Hospital distribution; $1 billion for certain rural hospitals and hospitals from small metropolitan areas that didn't apply for the rural distribution; and a separate distribution for dentists that were not previously eligible to apply for a payment under either the general distribution or the Medicaid and CHIP distribution.

If you'd like more information on these or other Provider Relief Fund distributions, I would encourage you to visit HHS's Provider Relief Fund Website at HHS.gov/Providerrelief - that's all one word. Again, that's HHS.gov/Providerrelief.

And with that, I will turn it back to Jackie.

Jackie Glaze: Thank you, Jen.

So, we're ready now to take any questions from the audience. If you have questions on the information that we shared today or any other questions, we're ready to take them now. So, Operator, would you please open the lines at this time?

Coordinator: At this time, if you would like to ask a question, please press Star-1 from your phone. Just speak your name clearly when prompted. If you would like to

withdraw your question, please press Star-2.

Again, if you would like to ask a question, please press Star-1 from your phone. One moment as we wait for any questions.

Greg Woods: Greg Woods.

Coordinator: Our first question comes from Greg Woods. Your line is now open.

Greg Woods: Hi, this is Greg Woods from New Jersey Medicaid. I have a quick question around the guardrails around the Appendix K retainer payments. I think I heard the presenter say a couple of times that the guardrail around a retainer payment not exceeding normal revenue is specific to Medicaid revenue. I did not see that in the FAQs and wanted to get clarification whether we should be looking at Medicaid revenues, specifically, or revenue more generally.

Melissa Harris: Hi, this is Melissa Harris. I'm getting a little bit of an echo, so (unintelligible) sound a little disjointed.

You're right. We did not qualify the word "revenue" in the FAQs. We just said that retainer payments cannot (unintelligible) Provider in excess of revenue that they received for the last two quarters. You know, we're clarifying who would have gotten (unintelligible) Medicaid revenue. That's to be a much more identifiable amount a Provider can be aware of, receive the payment does not exceed.

But the goal of the (unintelligible) is Medicaid policy for retainer payments is to make sure that the retainer payment does not bring the reimbursement to a (unintelligible) that Medicaid would reimburse that Provider in the absence of the public health emergency. So, I hope that helps.

Anne Marie Costello: Hi, this is Anne Marie Costello. Jackie, can we check with the Secretary? There's a lot of feedback.

Jackie Glaze: Yes, I was...

Calder Lynch: Can we check it that that fellow is still present? It sounds like he may be gone.

Anne Marie Costello: I am still on.

Calder Lynch: Why don't we - it sounds like the echo may be gone. Why don't we try proceeding to the next question?

Coordinator: Hello, if you are a speaker and you have your phone on speaker, if you could use your headset that might work.

Calder Lynch: And all speakers are asked to make sure that they're manually muted.

Coordinator: And if you would like to mute your line, please press Star-6.

Our next question comes from Ucseoma Nwagbara from Louisiana Department of Health. Your line is now open.

Ucseoma Nwagbara: Thank you, ma'am. Here's my question. The FAQs in fact after the June 30, you'd be aware we can't tell when an object has added. It doesn't tell of that. We have the one in (unintelligible), but it doesn't tell us exactly what (unintelligible) has added. Is there a way you can show that, or, where we can try to figure out what you added for, please.

Calder Lynch: Hello. I believe the question is to how to tell which questions are new in most recent batch of FAQs.

((Crosstalk))

Calder Lynch: Yes. So, we do have a way of telling that, if the team can just explain how to do that.

Ucseoma Nwagbara: How do I see? How do I do that? How do I know?

Calder Lynch: No, I'm asking my team to explain. Go ahead.

Calder Lynch: We lost some folks.

Ucseoma Nwagbara: I'm here.

Ucseoma Nwagbara: I call the agency...

Ralph Lollar: This is Ralph.

Sarah Delone: Hi, Ralph.

Ralph Lollar: And I think the FAQs that were just released all contain new information in them. Certainly the retainer payment discussion that starts on page 26 is all new material.

Sarah Delone: Yes. There's a link...

Man: (Unintelligible).

Sarah Delone: There's a link on Medicaid.gov and it specifically says - it's specifically says release dated June 30th and it's just in the FAQs. So they also have it integrated into the document with all FAQs but there is a standalone document on Medicaid.gov.

Ucseoma Nwagbara: Okay. Could you send me the link or something I can view?

Jackie Glaze: Can you provide your name and we'll definitely do that?

Ucseoma Nwagbara: Okay. My name is Ucseoma Nwagbara. Let me spell it for you, please.

Jackie Glaze: Okay.

Ucseoma Nwagbara: Ready?

Jackie Glaze: Yes.

Ucseoma Nwagbara: Okay. U as umbrella, C like Charles, S like sandwich, E like Edward, O like Oscar, M like Mary, A - apple. That's my first name. Last name is N like Nancy, W - William, A - Apple, G - good, B - boy, A - apple, R - Randy, and A - apple.

Jackie Glaze: Okay, thank you. And what state are you with?

Ucseom Nwagbara: I'm with Louisiana, the Department of Health.

Jackie Glaze: Got it. Thank you so much. Okay, operator, we're ready for the next question, please.

Coordinator: Our next question comes from Damon. Your line is now open.

Damon (Trazodi): Hi, good afternoon. This is Damon (Trazodi) with Advancing States. And this question is, I believe, for Melissa and Ralph. You talked a little bit about the new policies in guard rails and such for the retainer payments. And as I'm sure you know, some states had already been leveraging the flexibility to provide multiple rounds of retainer payments, and I'm curious what you anticipate the policies being to apply those guard rails or not to apply those guard rails to providers that may have already received more than one round of the 30 days of retainer payments.

Melissa Harris: Thanks, Damon. This is Melissa and I'll take a shot and invite others to weigh in. So, there's a few different categories of retainer payments, multiple periods of retainer payments. One being the request that CMS received very early in the public health emergency where states were aware based on prior disasters that they could receive multiple periods of retainer payments, and so states requested and CMS approved those retainer payments prior to these FAQs coming out. So, obviously these guard rails would not apply to those retainer payments.

Separately, we've got states that are now with these FAQs coming to understand that retainer payments are now available in the 1915-I and the 1915-K and are going to be requesting technical assistance from us to newly implement retainer payments in those state-planned authorities. Those obviously would be for prospective periods or they could be retroactive but they would be done with the understanding that these guard rails are in effect. And so we would expect the guard rails to adhere to those retainer payments for multiple periods.

The stickier issue is for the 1915-C waiver for a state that might be in negotiations right now with CMS, to implement retainer payments with a

retroactive effective date but the state is coming to us now saying this is something I'd like new CMS approval to do now and now the FAQs are on the (street) as are the guard rails.

So, we've had some conversations about this internally. I think we would talk to the state about expectations of having the guard rails apply to those retainer payments even though they're - you understand they'd be going back in time and you can't change past behavior. I think our goal would be to have them apply to newly approved retainer payments even for prior periods but we would want to talk to a state to figure out if there are any potential rough edges with that. But it's a valid question.

Damon (Trazodi): Thank you, Melissa. So, just to summarize, for states that have already (unintelligible) approved, the guard rails would not apply for states that are (unintelligible) they would apply and for states (unintelligible) approval but are thinking of retroactive approval date, that would (unintelligible) then but you would like to see them in place if at all possible.

Melissa Harris: So, you got a little garbled in that and so I'm going to try to re-summarize what I said. Retainer payments for multiple periods but CMS already approved would not be held to the guard rails. Retainer payments that CMS is now talking to a state about newly approving even for prior periods, we would want to have a conversation to see how those guard rails could be applied. I think it's our hope/slash expectation that they would be applied. That's talking about the 1915-Cs. Kind of a whole new day for retainer payments for 1915-I and K and so our expectation would be that they - in a multiple period retainer payments would come under those guard rails going forward.

Damon (Trazodi): Thank you. That's helpful.

Melissa Harris: Yes.

Ralph Lollar: I would add for clarification that it was a small number of states that Melissa is referring to in the 1915-C appendix K's. We have actively been reaching out to those states and I would also point out that many states in their Appendix K application included guard rails that ensured that the providers were not receiving double funding for the same purpose and the same payment. So, I think that there is less of an issue here than you might otherwise think applies.

Jackie Glaze: Thanks, Ralph. We're ready for the next question, please, operator.

Coordinator: Our next question comes from Jason (Coran). Your line is now open.

Jason (Coran): Thank you. We accessed retainer payments early on in March. My question surrounds the guard rail requiring an attestation that it would not lay off staff and will maintain wages at existing levels. We set our retainer payment level at 80% of what a provider would be able to bill. Expectantly, providers asked how can we then retain staff at 100% and pay them at 100% when we are only receiving 80%. Is there any guidance or any recommendations on how to respond?

Melissa Harris: This is Melissa and I would say that the guard rails for these Medicaid retainer payments are in recognition that we are one source of funding among several. And so it's very hard for us at a federal level to understand what variety the funding sources might be in play in a particular state, with a particular provider, and so the guard rails are meant to say that in the Medicaid phase there are bright lines that the amount of retainer payments can't cross, states have discretion up to those bright lines in determining what kind of resources to make available to a HCBS provider. And so there are a lot of variations on how a state could make that happen in terms of the dollar amount of the

retainer payment up to that threshold of what the provider was receiving in a quarter prior to the public health emergency, it takes a provider to receive a retainer payment. This is all at state option.

The piece about the retention of staff is to make sure that one of the key aspects of making sure beneficiaries have their services continue to be available to them is based on the need to recruit and retain staff. And a provider was receiving retainer payments and still reducing their staff capacity, then our retainer payments are not really going to plug the need that is pretty critical in the Medicaid program which is to ensure service provisions to Medicaid beneficiaries.

So, we saw that as a pretty critical guard rail. The numbers and the percentages of what kind of dollar amounts a particular provider is getting is going to happen outside the purview of CMS but we are certainly able to provide the states with technical assistance to make sure all those guard rails are understood. And if there are particular questions that a state has for us to make sure they're interpreting all their decision points correctly, we are certainly available to provide that too.

But it's also an exercise of, at the provider level, looking around at all the available funding frames including Medicaid, the possibility of Medicaid retainer payments and then looking at how each of those funding frames can be accessed for what purpose and making sure that you're staying on the right side of the Medicaid guard rails to ensure the validity of the provider's receipts of those retainer payments. It's a lot to keep in mind but we're certainly here to provide some ongoing (TA) analysis for you.

Jason (Coran): Thank you. Yes, a number of providers accessed the TTP program and...

Melissa Harris: Yes.

Jason (Coran): ...so the questions began to roll in, is that a duplicate use? I received TPE and I received retainer. Is the state going to call back any of those dollars from me now? I can evidence where they were spent but am I in jeopardy? Those are the questions we had begun to receive. But thank...

Melissa Harris: Okay.

Jason (Coran): ...you for your guidance.

Melissa Harris: Yes, and I imagine that everyone is wanting to do the right thing. The providers are wanting to do the right thing. The states are wanting to do the right thing and that's where our - a little more individualized technical assistance to really roll up our sleeves and understand the specific nuanced questions that are relevant for your state, for your group of providers. It's something we're very willing to do.

Jason (Coran): Thank you.

Coordinator: Our next question comes from Steven (Costintino). Your line is now open.

Steven (Costintino): Thank you. Steven (Costintino), Delaware Health and Social Services. Thank you for doing this. It's been very helpful. Question on the provider relief fund on Medicaid, the last round. Did you say -- just want a clarification -- did you say only 2% of the eligible providers have actually applied for that. I just want to get a clarification of that.

Jen Bowdoin: Hi, this is Jen Bowdoin. Yes, that's correct. In most states, less than 2% of the eligible providers. Certainly the providers that we've identified as eligible

based on states files and TMSIS submissions, that roughly 2% have actually submitted an application. The highest rate in any state is 6 1/2% and I think the average is somewhere less than 2% when (unintelligible)...

Steven (Costintino): So, I had two questions. Is there any sense that that deadline would be extended? And second, is there a way that states could know which providers have actually applied? Thank you very much. I appreciate it again.

Jen Bowdoin: So, the decision about whether to extend a deadline for any provider of relief fund distribution application - it is at the discretion of HHS. And at this point we haven't heard anything about an extension of that deadline and we'll certainly make states and stakeholders aware if we learn that that deadline is being extended.

And then, I'm sorry, can you repeat the second question?

Steven (Costintino): Yes. Is there any way a state can know which providers have actually applied?

Jen Bowdoin: Yes. So there is a public use file that is available. It's actually on the CDC website and you can link to it from the provider relief funds website on the HHS website. So, if you go to HHS.gov/providerrelief , you can navigate to it that way. There is a place that you can specifically click on to access data-related supplier relief funds. And you can see all provider relief fund payments by state and other filters on that page.

Steven (Costintino): It's just concerning that it's so low right now. So, I appreciate it. Thank you very much.

Calder Lynch: And Steve, this is Calder. We're definitely concerned about that as well and

are tracking and monitoring that very closely in communication with the department to try to understand what's driving that. I know we talked to NAMD as well and they requested an extension of that deadline and if we learn more, we will be sharing that.

Steven (Costintino): All right. Thank you very much, Calder.

Coordinator: At this time we currently have no questions in queue. Again, if you would like to ask a question, please press star one from your phone.

Jackie Glaze: Calder, would you like to wait a few more minutes?

Calder Lynch: Operator, did we have any last-minute questions come in?

Coordinator: We have one question - one moment. Our next question comes from (Slake Oakley). Your line is now open.

(Slake Oakley): Thank you. This is (Slake Oakley) in Alabama, and it's a question related to -- and I'm not sure you've got the answers -- but related to provider relief fund. We pay state agencies, the Medicaid agency and other provider state agencies a (unintelligible) entities, and we pay those entities and they were on list, but they have had difficulty getting through to apply to the provider portal, I think, because we all had the same tax ID number.

So I think we're assuming maybe that have to consolidate all of that information into one application, I suppose. But the other part of that issue is that we have - each one of those agencies in turn pay numerous other sub-providers who may not have exactly Medicaid provider numbers. So we are kind of encouraging them to apply as well, but considering the numbers, I'm not sure that it's showing up that very many of them are applying. It's just a

very confusing process and doesn't really apply to how we operate and pay providers. I'm not sure who we need to go to express that (unintelligible)...

Jen Bowdoin: Hi, this is (unintelligible). Sorry, go ahead Calder.

Calder Lynch: No, I was going to say. Maybe Jen, you can connect with them offline since I think there are some unique issues there but maybe we can connect with the folks at HRSA who are running the fund. So, go ahead.

Jen Bowdoin: Okay. Yes, I definitely would be interested in following up. But just in general, the entity that has the billing TIN is the entity that we need to apply and then they would have to distribute payment based on the requirements of the program and consistent with their provider attestation, to any other providers that are eligible to receive payments under that particular billing TIN. But we can follow up with you on your specific question. Can you repeat your name and then we'll follow up?

(Slake Oakley): (Slake Oakle), Alabama. Need my email or phone number?

Jen Bowdoin: Email would be great.

(Slake Oakley): Okay. It's Slake.Oakley@Medicaid.Alabama.gov.

Jen Bowdoin: Okay, we will follow up. Thank you very much.

(Slake Oakley): Okay, thank you.

Jackie Glaze: Operator, do we have any additional questions in the queue?

Coordinator: Our next question comes from Amy. Your line is now open.

Amy (Bernstein): Hi. Yes, this is Amy (Bernstein) from Massachusetts. We are beginning to think ahead to what happens through the winter and we understand that the Appendix K's already can last for up to one year and ours runs from March 1st through the end of next February. And while that seems very far off, we know we really need to think strategically and think ahead. We're wondering if it is possible to have back-to-back Appendix K authority should the need continue or if we would be required to do traditional amendments to extend that authority?

Ralph Lollar: This is Ralph and I think the answer to that question really relies on how far this - how far - how long the PHE and the pandemic lasts. So, we would be able to better guide you but we are prepared to discuss creating a new Appendix K if, in fact, the disaster lasts longer than that period of time and I think it's really significant and important that you're thinking ahead like that and we will work with you on that.

There is an importance to ensuring that any kind of disaster relief has an end date because the bottom line is there are a lot of flexibilities involved here because it doesn't change the base waiver which is why one year is the limit. This is an unprecedented time and we will look at the actions that need to be taken to ensure that the states and the individuals that we all serve are able to be sustained during this time period should it last longer than anticipated.

Amy (Bernstein): Thank you. That's very helpful.

Coordinator: At this time, we currently have no questions in queue.

Calder Lynch: All right. Well, thank you all for joining us today. We appreciate your time and the opportunity to be able to answer these questions. We'll be returning to

our weekly cadence meetings now. We look forward to having you join us next week on the 21st and we'll have information about the topic out soon. But of course in the meantime between these calls, feel free to reach out to your state leads if you have any pressing questions or need any individual assistance. Thank you for joining us and have a great day.

Coordinator: Thank you for your participation in today's conference. You may disconnect at this time.

End