Centers for Medicare & Medicaid Services
COVID-19 All State Call
September 1, 2020
3:00 pm ET

Operator: Welcome and thank you for standing by. All participants will be to listen-only mode until the question-and-answer sessions throughout the call during those times if you would like to ask a question please press star 1, record your name when prompted.

Now I would like to turn the call over to your host, Ms. Jackie Glaze. You may begin. Thank you.

Jackie Glaze: Thank you and good afternoon everyone and welcome to today's All-State Call. I'll now turn to Anne Marie Costello and she will share the highlights for today's discussion and introduce our guest speakers. Anne Marie.

Anne Marie Costello: Thanks, Jackie. And welcome everyone and thanks for joining us today. This afternoon we're excited to be joined by Amy Bassano and Sally Caine Leathers from the CMS Center for Medicare and Medicaid Innovation. Amy and Sally Caine will provide an overview of the recently announced Community Health Access and Rural Transformation Model also known as the CHART Model. Amy is the Deputy Director of CMMI, and Sally Caine is a CHART Model lead.

The CHART Model's aimed at addressing health disparities in rural communities through different methods. The model includes a community and hospital transformation track that will require Medicaid participation.

Following CMMI, Ellen-Marie Whelan from CMCS will review the model's Medicaid participation requirement.

After the CHART model presentation, we'll also hear updates from our CMCS

staff colleagues. John Coster will provide an update on the Medicaid Drug Rebate Program interaction with the new mandatory Medication-Assisted Treatment Drug Benefit. And Jackie Glaze will share CMCS's expectations for states that have waived provider enrollment requirements using Section 1135 waivers and what states will need to do at the end of the Public Health Emergency.

Before we move to today's presentations, I'd like to share a few updates regarding the provider relief fund. First, in case you missed it, the application deadline for the general distribution including for Medicaid and CHIP providers has been extended to September 13th. Also, last week HHS announced that it distributed almost $2.5 billion dollars in provider relief funds to more than 15,000 nursing facilities to support increased testing, staffing, and personal protective equipment needs. This distribution supplements the $4.9 billion targeted distribution for skilled nursing facilities that occurred earlier this year. HHS plans to distribute another $2 billion to nursing homes later this fall based on certain performance indicators, which will be shared in the future.

With that, I'll turn the call over Amy Bassano to start CMMI's presentation on the CHART Model. Amy.

Amy Bassano: Thank you, Anne Marie, and thank you for allowing us to join your call today. We are very excited to be able to be talking about this CHART or the Community Health Access and Rural Transformation Model. This model has been a long time in coming and is under development. We've spoken previously about how important rural issues are. And I think it's something that comes through the agency as a whole through both Medicare and Medicaid and CMMI is very pleased to be able to offer this model to rural communities and in a couple of different tracks as Anne Marie said.

Just wanted to say thank you for all of your support and feedback we've had as we've spoken to different communities over the past year-plus on these topics.

And now I'll turn it over to Sally Caine Leathers who, as Anne Marie said, is the lead of the CHART Model. And she will walk you through the model design and talk about some of the timelines and upcoming milestones as well. Sally Caine.

Sally Caine Leathers: Thanks, Amy. Hi everyone. I'm Sally Caine Leathers and I will echo Amy's excitement here. We are thrilled to be presenting to you all today an overview of the CHART Model. Like Amy said, it has been a long time coming so we're very thrilled to be able to be speaking about it publicly and talking a little bit about all the different tools that we hope to - it will provide to rural communities.

So I'll first start out giving a broad overview. Our model is going to focus on the unique healthcare challenges that are facing rural beneficiaries and providers. We know that people living in rural areas have worse health outcomes and higher rates of preventable diseases than those living in urban areas. We also know they have less access to high-quality care, transportation issues, healthcare workforce shortages, their financial insecurity as healthcare providers. And they benefit less from the technological and care delivery innovations more prevalent in urban areas.

Acknowledging these challenges, the CHART model is a voluntary model that will test whether aligning financial incentives, operational and some regulatory flexibilities with some robust technical support will help rural providers transform care at a broad scale to achieve a few key goals. Those key goals that we're going to address in CHART are one, improving access to care in rural areas; two, quality, improving quality of care and health outcomes for those rural beneficiaries; three, improving the financial stability of financial to healthcare providers; and then four, increase the adoption of alternative payment models or APMs among rural healthcare providers that are really promoting that value-based care over volume-based care where we know in rural communities you don't always have the patient base and volume to support a healthy operating margin.

So value-based payment models have accelerated nationally. But rural healthcare providers have been slow to adopt these models. The technical support and administrative infrastructure necessary to participate in APMs is often a barrier. CHART offers a framework to harness drive, creativity, and local expertise of rural communities to address rural health disparities. Focusing on that creativity element, we know that each rural community is unique and that a one size fits all approach is not going to be the solution here.

So through CHART, we're going to provide communities the opportunity to determine how best to meet their local healthcare needs. When we were designing this model, we had stakeholder input and the three most common themes that we heard when designing this model and we've made a great effort to make sure that we incorporate it into this elemental designs are one, funding, flexibility, and time. Those are the three.

So the first on funding, we have made sure that we are providing upfront funding, the seed funding to create a payment structure and a boost for rural communities to get a jump start on healthcare delivery improvements or redesign efforts that they think will best fit their community's needs.

Second, on the flexibility theme, we have made sure to build in participation options with two different tracks with design elements that allow participants to use benefit enhancements and waivers to customize the value-based redesign effort that truly fits their needs.

And then third on time, we wanted to make sure that both application periods for each track that we have in CHART first is going to take the current COVID related Public Health Emergency into account and making sure that there's ample time for applications to be submitted. And then specifically on one track that I'll talk about, the community transformation track, we built in a full prep year before implementation is ever even asked to begin that way there's plenty of time to pull in appropriate community members, get a good plan in place, and then start tracking the implementation so that you can see if you're moving the dial on any of those health outcomes that we're tracking.

So funding, flexibility, and time are two - are three elements that we definitely wanted to include and build into this design here.

Now I'll highlight the two different tracks that we have for participation options. I'll first start with the ACO Transformation Track and then go into the Community Transformation Track which has a Medicaid component and I'll spend more time there. With the ACO Transformation Track, this one is going to build off the successes of a previous model at CMMI. It's called AIM, ACO Investment Model. It encourages ACOs' participation in rural areas to take on greater financial accountability that is required under the new participation options established for the Medicare, excused me, the Shared Savings Program in the Pathways to Success Final Rule.

The CHART ACOs under this track will receive advanced shared savings payments to help rural entities engaged in value-based payments, reform and improve care coordination and quality for beneficiaries within a rural community as well as make investments necessary to reduce total cost of care.

So a quick few stats on this track. We're going to select up to 20 rural ACOs that will receive those advanced shared savings payments and we'll also concurrently join and participate in the Medicare Shared Savings Program. So you can view this ACO track as almost an on-ramp into the Shared Savings Program. The payment of those advanced shared savings amount will depend on two things. First, the level of risk that the ACO accepts under the Shared Savings Program; and two, the number of beneficiaries that you have underneath the ACO.

We will be releasing a request for applications for this track. And it's going to run in parallel with the application process and cycle of the Medicare Shared Savings Program. So with that, we will release the application in spring of 2021, and then we'll select our participants like I said up to 20 here, in the fall of 2021 with the first performance period beginning in January 2022.

And then moving to the Community Transformation Track, I'll give an overview and spend a little bit more time here. So this track is going to support lead organizations in rural communities by providing upfront funding of up to a total of $5 million for each lead organization to collaborate with their state Medicaid agency, community stakeholders, and participating hospitals to implement a community-level care transformation plan. And you can think of that as a healthcare delivery redesign strategy.

And the goal there is to achieve better health outcomes for those beneficiaries residing in that community. We're going to award up to 15 lead organizations who will be the representatives of that rural community. State Medicaid agencies are eligible to serve as a lead organization.

Each of the lead organizations can receive like I said up to $5 million in cooperative agreement funding. The lead organization will be responsible for several items that we'll definitely itemize in our application that we're releasing soon. But just to give you a foreshadow of some responsibilities, first, they'll be required to assemble an Advisory Council who will be a diverse set of members across the community to represent a holistic view of who all needs representation in that community based on the transformation plan they'd like to pursue. On that Advisory Council, the state Medicaid agency will be a required seat at the table unless they're already serving as a lead organization.

And then for this community transformation plan, this is the part where we bring the Advisory Council together. You'll have that rich diverse representation of all the different community needs present at that table or in this case probably a virtual table; where you will - they'll all put their heads together and first conduct a needs assessment of what exactly are the needs on the ground for this community, what are the struggles, what are the health outcome disparities. And then based on that being a driving factor, what can you do to improve those?
And then we'll form a care transformation strategy.
We're wanting this to be truly and at the community level and not specifically

driven down just within a hospital that may be participating in the model. We really want this to be - include hospitals as well as non-hospital providers so that you can focus on a continuum of care across the board.

Speaking of hospitals under this track we will have - the lead organization will recruit participant hospitals. And they will sign a participant agreement where they'll receive in place of their fee for service payment, they'll get a stable, predictable, capitated payment and increase operational flexibility through various waivers and benefit enhancements that we'll be offering through this track.

The lead organizations must secure multi-payer alignment in this track which will encompass financial, operational, and quality alignment. Medicaid alignment will be required and commercial alignment is encouraged.

We'll be releasing an application later this month, the Notice of Funding Opportunity. And the track will start a year-long pre-implementation period so when at the beginning when I referenced a prep year we'll kick off this track with a year-long pre-implementation period where all the different community partners will come together, assess the needs, formulate a care transformation plan, and recruit all the different participating hospitals and providers in the community and then they'll start the performance year one year later. And the performance period will run for six years total.

So in terms of this track and next steps, we will be releasing the application this month so be on the lookout for that release. In the meantime I recommend two things, first is to check out our model web site. You can go to the CMS Innovation Center where you can find the CHART Model web page.

And we have released some helpful information there. You'll find things like a press release and a fact sheet as well as a very informative webinar recording as well as PowerPoint slides. There's a few slides in particular that I would note for you. One is the lead organization slide and the Advisory Council slide where it gives some examples of who can serve in those roles

and the different composition of who will be serving on that Advisory Council. I think those would be two great partners to get your creative juices flowing of who in a community might you partner with.

So and actually the second and final thing I'll recommend for next steps is to start thinking about who you'd like to partner with. Community partners will range from payers, providers, and community stakeholder groups. So again I would again recommend viewing that Advisory Council slide on those webinar slides.

So those are next steps. And I'll reiterate one more time the timeline. The application for this track is coming out this month of September. The application for the ACO Transformation Track is coming out spring 2021. And the Model Team will be hosting some webinars and Office Hours to help facilitate any questions that we have around the release of both of those applications to help you out in the process along the way.

So with that, I'll hand it over to Ellen-Marie, our partner at CMCS who's been wonderful in helping us design the Medicaid component of the Community Transformation Track and let her highlight a few components there. Ellen-Marie.

Ellen-Marie Whelan: Thank you, Sally Caine. You did a great job. And I also just want to thank the Innovation Center. Working with Amy Bassano and Sally Caine, we've been fortunate to have been able to work with CMMI on the design of this model from the beginning. And we've been appreciative of both CMMI and CMS generally because from the inception of this, Medicaid has always been thought to have been a required component. And understanding that we cannot transform care at the community level unless Medicaid is a required component of that.

As a result, we actually worked really closely with the National Association of Medicaid Directors, NAMD, in quite a few states to make sure that the state ideas are included in the design and states' needs were addressed as we put

them all together.

And so thank you to anyone who's from NAMD or from any of the states that we met with a number of times to make sure your thoughts were included. We - I'm glad of this is because we've heard from a number of folks that there was some frustration at times that state ideas weren't incorporated. And the Innovation Center did a great job pulling together and I think working the states as we went through this process to ensure that we did integrate thoughts that states had.

And as Sally Caine noted before, funding, flexibility, and time were always key. And we heard that over and over again.

So we also, just Sally Caine really let everybody know what the issues are. Lots more information on the web site. But there's a few things that I just want to flag that I think are really important for Medicaid Directors and state Medicaid agencies. And you'll note that state Medicaid agencies have the flexibility to either apply as the applicant, as the state - as the lead agency or they can partner an application. So we wanted to make sure that if a state wanted to move forward being that lead agency they have the opportunity. But because it was required we also felt that they could partner an application.

And we also note that to ensure that Medicaid agencies have the capacity to carry out the CHART Model requirements, if you're not the lead applicant, you must be a sub-recipient of the award funds. So we just wanted to make sure that this is a list. We wanted to make sure that folks get together and do this planning in the first year and there would be funds available for state Medicaid agencies.

As Sally Caine noted, I think a really important part of this model, is the first year of this track, is a pre-implementation period. And this Administration has been - thought it was really important to make sure that we didn't launch right into the model. That there was time in this first year, in the pre-implementation period to get together, put together the Advisory Council, and

really think about what is the best path forward to transform care in the community.

The other thing I'll note is after that first pre-implementation year the model will begin that second year which is the first year of the actual implementation. We, though, will not require Medicaid to have the model designed by then. There's an extra year. So it won't be needed until year three of the model or the second implementation year that Medicaid will need to have their payment model designed. So it gives a little bit more time. Pre-implementation year you figure out what the community needs. Then there's yet another year that you'll be able to put together what you think that payment model will be.

And of course, as with all the other Innovation Center models that have a Medicaid component, the Medicaid and CHIP staff both in the regions and in Baltimore are always available to help folks think that through. We will ask you to put some of that on paper as you're applying, but we'll help you during that process, if you are selected as an applicant.

Along that line, Sally Caine mentioned the Notice of Funding Opportunity will be released sometime in September.

And I will just note that for the past couple years CMMI has been announcing the model, a little bit of time before the model actually begins, before the funding opportunity is announced.

And that's again we heard folks that having the application, starting to work on an application immediately when the model was announced didn't give a whole lot of time. So now we've got a little bit of time that we're telling folks about this model so that you can kind of ramp-up. You will find in that Notice of Funding Opportunity some more details about how we've helped think through possible ways that you can align using your state plan, using LM15 demonstration or using managed care to be able to align with the model. So you'll see more of that when it comes out.

And I think I last just want to flag that since this is focused at rural areas we wanted to make sure that if you are looking to apply and you are - you have an area that covers some of the tribal areas that you reach out to your - either the Indian Health Service and the tribe, tribal organizations, they are also interested in this model. And we wanted to make sure that they would be included as significant partners using the model to improve that quality of rural care in the areas that you may select to move forward. We encourage you if you're thinking about applying or even if you're approached to be a partner organization to reach out to the Indian Health Service and the tribes as you develop the CHART Model Application.

And just I'll reiterate the timing again since we said it quickly, the applications will be released sometime this month, in September. We will then announce the awards in the spring of 2021 and the model will begin in the summer of 2021.

So let me at this point turn it back over to Jackie Glaze. And then we can open it up for questions.

Jackie Glaze: Thank you so much Ellen-Marie and thank you, Sally Caine and Amy. So at this time, we would like to open up the phone lines, Operator, so that the audience can ask questions about the CHART Model.

Operator: Absolutely. If you'd like to ask a question please press star 1, record your name when prompted. If you would like to withdraw your question, please press star 2. One moment to see if we have any questions. I'm showing no questions at this time.

Jackie Glaze: No. Okay, no questions. Okay so maybe we'll have questions later. So we'll go ahead and transition to John Coster. And he would like to provide an update on a new mandatory MAT Drug Benefit. John.

John Coster: Sure. Good afternoon everybody. This is John Coster, Director of the Division

of Pharmacy for CMCS.

And I just want to provide for next few minutes an update on the intersection of the new mandatory Medication-Assisted Treatment Benefit with the Section 1927 Drug Rebate Program that everyone has become so familiar with.

So as everybody knows, Congress created the Support Act in 2018. It was a comprehensive law designed to reduce the abuse and misuse of opioids in the country. There's very - there's number of sections there relating to Medicaid. And one of the new Medicaid sections relates to a mandatory benefit that states will have to cover for five years starting this October. So essentially a month from today. The mandatory coverage benefit for Medication-Assisted Treatment which includes drugs and counseling services.

So the important thing to know about this as it relates to drugs is the states will now have to cover drug use for Medication- Assisted Treatment, FDA-approved uses of drugs and biologicals used for Medication-Assisted Treatment. States are already covering most of these drugs. Buprenorphine, Naltrexone, and Methadone but there's now a requirement that these drugs, dosage forms, and strengths on different delivery mechanisms be covered by the states.

When Congress drafted the law, they included this as a mandatory benefit rather than an optional benefit. So what that means, basically, is that because of the way the law has been drafted, states who have been collecting Medicaid drug rebates on these drugs will no longer be able to collect these rebates when they are used for opioid-use disorder.

So I want to make sure everyone understands that. That the new law does not provide a link to the current rebate program which is drug coverage is an optional benefit. So what the states can no longer do starting October 1st is when these drugs are used for opioid-use disorder, the states can no longer bill for Section 1927 rebates. So that includes the basic rebates and any

supplemental rebates the states might have negotiated through a supplemental rebate agreement.

Similarly, because these drugs are no longer considered covered outpatient drugs; subject to Section 1927, which is basically where the Medicaid Rebate Program is, states will not be able to use the traditional utilization management mechanisms to manage expenditures on these drugs. However, states can use, under other authority in the Medicaid rules which is 42 CFR 440.230(d), you can propose limits on the amount, duration, and scope of coverage for these drugs. For example, you can use - try to encourage the use of generic drugs, you can create a preferred drug list, or you can choose to implement prior authorizations, to manage these drug classes.

So again I want to summarize, starting October 1st, which is a month from today, these Medication-Assisted Treatment Drugs when used for opioid use disorders because some of them have multiple labeled indications will not be eligible for the traditional Medicaid rebate or supplemental rebate that states have been billing for these drugs. States also cannot use the traditional utilization management tools that they have been using under Section 1927 but they can continue to encourage the use of generic products, create a preferred drug list, or choose to manage these classes in other ways that provide coverage for the drugs because the purpose of the benefit is to expand the scope of coverage for Medication-Assisted Treatment drugs and services. But you can of course manage the benefits appropriately to, you know, encourage the most efficient use of these medications.

Now because the states, even though the states cannot collect the Section 1927 rebates; the traditional Medicaid rebate, you can negotiate your own rebate with manufacturers.

And we've had several questions from some of the supplemental rebate contractor entities about whether states can do that. We've gotten questions from states about that. Yes. You can negotiate your own separate rebates for these drugs with manufacturers and the prices that are negotiating under these

separate state rebate agreements would be exempt from Medicaid best price. So that can give you a little bit extra leverage with the drug manufacturers, in terms of trying to get a better price, for these drugs.

So again when these drugs are used for opioid use disorder, there's no 1927 rebates. You can collect those rebates when they're used for other indications on the label that are not opioid use disorder, and you can negotiate your own rebates when they're used for opioid use disorder-related issues.

In terms of reimbursement, the states are expected to reimburse pharmacies for drugs and biologicals. covered under the new benefit, consistent with their approved state's methodology. You can use the methodology in your current state plan, the AAC, Actual Acquisition Cost, plus professional dispensing fee. Or because these drugs are not covered anymore under the optional drug benefit, they're under a mandatory benefit, you can submit another methodology that we will review through the state plan amendment process.

And to assist states in reimbursing for these drugs we will continue to publish each month a NADAC, a National Average Drug Acquisition Cost, as part of the NADAC file to help states have a reimbursement metric that they can use if they want.

So again not to repeat but to summarize, beginning in a month, there's no rebates under Section 1927 for these drugs or supplemental rebates. You can negotiate your own state-only rebate with manufacturers. And you will have to determine reimbursement for these drugs, separate and apart from what's in your existing state plan, unless you want to use that methodology because these would not be considered prescribed drugs any longer under Medicaid. They're mandatorily covered drugs.

So I'll stop there and turn it back over to the moderator.

Jackie Glaze: Thank you, John. And this is Jackie Glaze again. So I have one brief update and then we'll open it up for questions from the audience.

So the update that I'd like to provide to you is about the Section 1135 provider enrollment flexibilities. And as states and territories are preparing to unwind their approved flexibility, we've been asked to provide clarification on the length of time that they would have to complete the Medicaid provider enrollments and the revalidations, once the Public Health Emergency ends.

So I'll refer you to the language that we included in the 1135 approval letter. And that does specify that states and territories have up to six months, from the expiration of the Public Health Emergency, including extensions to complete these activities. The expectation is that the providers will submit the applications during this timeframe. And then they would be required to meet all of the Medicaid participation requirements. The states would then do their review and complete that all by that six month period.

Otherwise, if states choose not to enroll the providers they must cease payment by the end of the Public Health Emergency. So that the temporarily extended providers, that would end at that point. So just wanted to make sure everyone was aware of that update as you're looking at some of the flexibilities that you have in place and looking to do some unwinding.

So at this point, we're now ready to open up the phone line to see if the audience has any questions from the presenters or any other general questions that they may have. So, Operator, can you open up the phone line?

Operator: Absolutely. If you'd like to ask a question, please press star one.

You have a question from (Pat Curtis). Your line is open.

Pat Curtis: Yes. This is Pat Curtis from Illinois. And I am just concerned it's a broken record. But just wondering if there has been any additional guidance or issued, or soon to be issued, guidance on how states should handle redeterminations. I know I asked this about a month ago. It's just that we're looking for the transition time that we have, how we're going to do the

redetermination processing, what the date will be. We need to prepare ourselves obviously and the client.

So just wondering if you have an update on that.

(Jessica Stephens): Okay.

Jackie Glaze: This is - go ahead.

(Jessica Stephens): Oh, go ahead Jackie.

Jackie Glaze: Go right ahead (Jessica). No. Go ahead (Jessica).

(Jessica Stephens): Hey (Pat). It's (Jessica).

(Pat Curtis): Hey.

(Jessica Stephens): Hi. And no big update from our - from I think the last response that we provided, which is that we are still very actively working on guidance to get out to states, to address all of the questions that you just raised and more. I know this is something that is heavily waiting on people's minds at the moment. But we will be following up soon.

And if there are any specific questions that states have, even if we're not able to address them at the moment, please share them with your state lead or directly to us. And we will at least sort of have them and make sure that we're considering all of them as we issue the guidance.

(Pat Curtis): Thank you, (Jessica). I know you guys are busy. Just a little reminder.

(Jessica Stephens): Thank you.

Operator: Our next question comes from (Henry Litman). Your line is open.

(Henry Litman): Good afternoon. Thank you again for holding these calls. My question, I know recently Medicare has published some guidance on the treatment of Provider Relief Funds and the Payroll Protection Plan.

Are we to take anything from that in terms of how it's going to apply for Medicaid for purposes of uncompensated care and other situations in terms of how it would be treated on a Cost report, and the like? I know you were considering that from a policy perspective and I'm not sure whether there's a connection there or not. And I was just trying to get some perspective.

Jackie Glaze: Do we have (Jen Bowdoin) on the line that could respond?

(Jen Bowdoin): Hi. Jen Bowdoin is here. But I think we probably need to connect with a few others within CMCS on that question.

(Henry Litman): Thank you.

(Jen Bowdoin): Because that's a question for the Financial Management Group.

Jackie Glaze: Yes. I agree.

Operator: Our next question comes from (unintelligible).

((Crosstalk))

John Coster: Yes. And we're going to have look back here and we'll get back to you on that one. Okay, (Henry)?

(Henry Litman): Thank you very much.

Operator: Our next question comes from (Kelly Piper). Your line is open.

(Kelly Piper): Thank you. Could you clarify when you say that traditionally UM Management is not allowed to manage (M86) expenditures, but prior

authorization is? Can you clarify what are the prohibited UM activities or refer us to a source for that?

John Coster: Sure we'll be putting out some additional guidance very soon that will clarify some of these questions.

But like I said, because these drugs are no longer considered covered outpatient drugs under Section 1927, the utilization management tools in that section are not applicable anymore to these drugs.

But you can still use the general amount, scope, and duration provisions of the Medicaid regulations to manage the use of these drugs. For example, I mentioned generic, you know, going to preferred generic, trying to use preferred drug lists.

But so for example in 1927 there's a specific requirement around the response time for prior authorization. And it's just a 24-hour response time and a 72-hour emergency (plot). We're not saying you couldn't use that but you could not use the provisions under Section 1927.

So more guidance on this very shortly in terms of explaining this better. But it's really to just make it clear that things in 1927 do not apply to these drugs anymore because they're not, when used for opioid use disorder, considered outpatient drugs.

Jackie Glaze: Are there other questions, Operator?

Operator: Our next question comes from (Laura Faylan). Your line is open.

(Laura Faylan): Hi. This is (Laura Faylan) from Illinois. And I just wanted to follow-up on a question or something that was discussed about a month or so ago. And I'm sorry if I missed an update along the way.

But a month or so ago when we were talking about beneficiaries who have

Medicare Part A but do not have Part B, when they're in a nursing facility in a non-Medicaid covered stay. I saw the guidance about it being bundled for like a Medicare-covered stay. But for a non-Medicare-covered stay, the nursing facilities are not sure who is responsible for that bill.

I - but when we were talking about a month ago CMS said that the uninsured testing group did not cover those individuals but because they don't have part B, if they also are not a dual and don't have Medicaid there is no one to bill. And I think CMS is going to double-check with their General Counsel's Office to see if it is that individual is responsible for the bill or if there's other guidance. I'm just wondering if a decision have been made on that.

Jackie Glaze: (Jessica), can I punt that one to you or Sara?

Woman: Sarah, do you - and Sarah.

Sarah DeLone: Yes. I'm hesitant to speak for our General Counsel. I think our understanding but I think we're still working. There appears to be a gap in the, you know, in the statutory design in terms of ensuring that all COVID testing would be covered.

And the language that defines, you know, who is uninsured for purposes of the funds that are being administered by HRSA are - is the same, as in this instance, as the definition of uninsured for purposes of the optional group so that those Medicare Part A enrolled individuals also are not eligible under, you know, sort of a plain reading of the statute for the, you know, for providers to claim reimbursements through that HRSA administered fund.

So we are still working on that issue to see if there's a way that we can't close that gap.

Operator: As a reminder, if you would like to ask a question, please press star one. Our next question comes from (Nicole Phillips). Your line is open.

(Nicole Phillips): Hi. I'm sorry. My question was answered. I just didn't remember how to take it back. Thank you.

Operator: Our next question comes from (Anita Hayes). Your line is open.

(Anita Hayes): Hi. Thank you. This is an eligibility question. And our state is preparing to provide the unemployment compensation, using the $300 federal payment, which I believe is from FEMA, and then also the $100 state-funded unemployment compensation. And so our question is, since this is no longer funded through the CARES Act, will this then become and be countable income for purposes of eligibility?

Sarah DeLone: So this is Sarah DeLone. I can field that also. I think we can give - we are working on some FAQs. And this question will be addressed in that. Tentatively, it appears hat the answer is yes. They - that income also is excluded from income under the, you know, the FEMA legislation, sort of through where that funding is from but we just finished, you know, just dotting our I's and crossing our T's to make sure that all parties are in agreement with that. And so you can expect a formal and final answer in the upcoming FAQs that we're working on.

(Anita Hayes): Okay. And did you say tentatively it will be excluded?

Sara DeLone: Excluded. Yes. Our...

(Anita Hayes): Excluded.

Sarah DeLone: Our understanding and our belief is that that income, that those payments will be excluded. That - from both - for both purposes of MAGI and non-MAGI eligibility determinations. But we just need to, you know, finish making sure there's sort of, you know, interaction with different statutes. We need to make sure we have gotten that actually correct.

So tentatively, that is the response you should expect. But again we're

confirming and we will get that confirmation in the upcoming FAQs.

(Anita Hayes): Okay. And is that for the payment only or for the federal only or federal and state?

Sara DeLone: Good question. Let me - we'll take that back and make sure that we are addressing both aspects of that.

(Anita Hayes): Okay great. Thank you.

Sarah DeLone: Yes. Thanks for the additional nuance in the question.

(Anita Hayes): Right.

Operator: I'm showing no further questions at this time.

Jackie Glaze: Okay thank you. So in closing, I'd like to thank CMMI and our CMCS colleagues for their presentations today.

And next week we'll all be taking a Labor Day break so we won't be having an All-State call. But we will reconvene on Tuesday, September the 15th. And we will follow-up with the topics in the invitation.

So again, we ask if you do have questions before the next call to reach out to us. You can also contact your state lead. And we thank you for joining and your participation and hope you all have a good afternoon. Thank you.

Operator: All participants this concludes today's conference. You may disconnect at this time. Thank you. Speakers standby.

End