

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

Coordinator: Thank you for standing by. At this time all participants are in a listen-only mode. This call is being recorded. If you have any objections you may disconnect at this point. Now I will turn the meeting over to your host, Jackie Glaze. Jackie, you may begin.

Jackie Glaze: Thank you and good afternoon everyone and welcome to today's All State call. I'll now turn to Karen Shields, and she will introduce our guest speaker and share highlights for today's discussion. Karen?

Karen Shields: Thank you, Jackie. Hello everyone and thanks for joining us. On today's call we would like to welcome Dr. Doug Clarke, a medical officer at CMS, who is here to discuss a new strategy announced by CMS last week, that is designed to increase the capacity of our nation's healthcare system by providing patient care outside of a traditional hospital setting, in response to the recent rise of COVID-19 hospitalizations across the country.

These flexibilities include allowing eligible patients to receive safe hospital care in their homes, for a variety of acute care conditions such as asthma and congestive heart failure. The goal of these flexibilities is to allow healthcare services to be provided outside of a hospital setting, while allowing hospitals to focus on the increased need for care stemming from the public health emergency.

The program builds on the Hospitals Without Walls program that was announced by CMS in March of this year, and was developed to support Models at Home hospital care, throughout the country, that have seen prior success in several leading hospital institutions and networks.

Six institutions with extensive experience providing acute hospital care at home, have already submitted and received 1135 waivers for this program. Since six facilities in five states have already received approvals and we anticipate more will be coming, we wanted to have this conversation today to ensure that Medicaid and CHIP agencies were aware of these individual waiver approvals and the implications for Medicaid.

Medicaid agencies do not need to take an action to support these initiatives. Similar to other alternate care sites, Medicaid agencies do not need to seek additional waivers or authorities and there are no implications for payment.

The only circumstance under which states would be required to submit a reimbursement state plan amendment for hospital or home services, is if you would like to pay for such services differently than the approved methodology that is in your state Medicaid plan. In those cases we recommend that states submit a disaster relief (SPA) template, to make payment changes.

After Dr. Clarke's presentation, we'll take your questions on this new Hospital-at-Home initiative, including any questions you may have about how it interacts with Medicaid. Then we will continue our discussion from last week, the last few weeks, regarding continuous enrollment provisions out of the interim final rule.

Sarah DeLone, the Director of the Children and Adult Health Programs Group, and our subject matter experts, are here and will talk about the answer to a number of additional questions on the continuous enrollment provision of the interim final rule.

After those FAQs, we will open up the lines for your general questions. And so just as a reminder, the recordings and transcripts for both this and our previous meetings, are and will be posted to the COVID-19 page of our Medicaid.gov Web site.

Also if we don't get to your questions today, on the continuous enrollment provisions, you can email them to [MedicaidCOVID19@CMS.HHS.gov](mailto:MedicaidCOVID19@CMS.HHS.gov). Again, that's [MedicaidCOVID19@CMS.HHS.gov](mailto:MedicaidCOVID19@CMS.HHS.gov). And we can - we'll also take any questions that you may have and would like for us to cover on a future call.

With that, I would like to once again, welcome and turn things over to Dr. Clarke, to start his presentation.

Dr. Douglas Clarke: Thank you so much, for the kind introduction. And I'm really excited to talk to this group today. I understand that there may be some people who are more familiar with this recent action by CMS than others. So I wanted to give a brief background of the - whether it's Hospital-at-Home or - and Acute Hospital Care at Home practice, in the US over the last couple of decades, and how we ended up where we are now.

And then I'd like to walk through what this waiver entails and the process for which hospitals can be approved after making a waiver request. So real brief background, Hospital-at-Home or Acute Care at Home, has been used internationally for quite a long period of time. Most of the research in the US dates back to the mid-'90s through the early 2000s.

And the first author on a lot of these studies, is Bruce Leff at Johns Hopkins. And he built a lot of the foundational work and other groups have done this as well. It was also a very influential healthcare innovation award that was

awarded to Mount Sinai, in 2014, they ran a case controlled study over three years showing that the care was at least as safe and at least as high quality if patients were carefully selected using established selection inclusion and exclusion criteria.

This was followed up by a couple randomized control trials, the most recent one from Brigham & Women's Hospital published at the end of last year. It was pre-COVID and so the aim of the trial was actually cost and shows 38% decreased cost in the randomized control trial with equivalent safety outcomes.

Over the summer, kind of fast forwarding to how we got here, over the summer CMS was receiving quite a few inquiries from programs who had been practitioners of this type of care, whether they could start treating Medicare beneficiaries. And part of the hang-up there has been that this has never been possible with Medicare beneficiaries unless it was independently funded by a foundation or a grant because of the hospital conditions of participation that need to be met.

Many of the conditions of participation that would be problematic for this, were waived early in the public health emergency, most having to do with physical environment and property required for inpatient level care. The one condition of participation too, that were not waived, were the hospital conditions of participation which required nursing services to be provided on premises 24 hours a day, seven days a week and the immediate availability of a registered nurse for care of any patient.

So what CMS did, starting over the summer, was we - my team - Lisa Tripp, Danielle Adams, and I, really reached out to some of these experts from Brigham, Sinai, Hopkins, as well as the - some private firms - Dispatch

Health, (Unintelligible) Health, and Medically Home, who are active in this type of care, to figure out okay, if this second surge comes this fall, like we fear it might, how can we be most ready to help with any hospital capacity issues?

And as you know, the hospital capacity constraints are now a major problem throughout the country and fortunately, we're able to act pretty quickly based on a lot of this background work over the last four or five months.

So fast forwarding to what happened last week - what did CMS do? We waived these conditions of participation that I mentioned and I want to talk about who is affected and who is not affected. So first of all, this is a little different than many of the waivers you've encountered or many of us have encountered in the past. It is not a blanket waiver.

It's an individual waiver that's requested at the hospital or CMS certifications (CCN) level. These individual requests from hospitals, are evaluated by CMS. It's expected to last the duration of the public health emergency. There will be data collected and lessons learned that could guide future CMS models or initiatives. But for now, the reason this is being put in place is because of the unprecedented problems and difficulties with capacity that our hospitals are facing nationwide.

So if you go to the link provided in the CMS press release from last Wednesday or the - it's also on CMS.gov, you'll see - you'll come to a screen right before the online portal. And it shows our process for breaking down hospital programs for acute care at home based on experience. And true to our conversations with experts, 25 patients being seen previously with an acute hospital care at home program, was felt to be the point where if you can - if you were treating that many you've become an experienced organization.

And so we have one category for organizations and hospitals that have treated 25 or more where it's an expedited process based on attestations, ultimately by a C suite member of a specific hospital that's requesting a waiver. And if all of these attestations are met and their experience is such that they've had more than 25 patients previously, our number one goal will be to identify these high performing institutions, provide them (unintelligible) care and allow them to expand this excellent level of care so that our Medicare beneficiaries receive the highest level care even with hospital capacity constraints right now.

The second group of hospitals is a group that we expect many and most hospitals to fall into who have not - either not done this before or have treated fewer than 25 patients. We call this the detailed waiver request pathway. They have to attest to all of the same requirements that I'll get into in just a second, that the expedited pathway requires.

But it also requires details and, you know, showing how things - how these attestations are possible, giving us algorithms and selection criteria, these types of things, just to make sure that newer programs starting this, are able to provide the same level of care the beneficiaries expect and that we expect them to receive.

And when you go into the form, you'll need hospital information which is the CCN number. And this is a question that comes up a lot. If you have multiple hospitals in your health system you need one separate request for each CCN. So for example, there may be one central hospital and they might only need one and all the other acute hospital care at home patients, are funneled through there. But for example, Mount Sinai has three so they had to submit three.

There's a point of contact and we've gotten several questions about that. That can be anyone on the team but the real important one is the attestation. And the attester has to be a member of the C suite of the hospital. Because we really want to emphasize that this hospital is accepting responsibility for the level of care provided to these Medicare beneficiaries. And potentially Medicaid beneficiaries as your group will discuss.

So we talked about - the first question is just going to be breaking you into which experienced group you're in, 25 or more or fewer than 25. This is - the next couple of steps will make you attest for the - this is just for the experienced pathway and I'll get into the inexperienced pathway in just a moment.

One of the themes we try to emphasize is the hospitals must continue to provide or contract for services expected in a traditional acute inpatient admission. This includes pharmacy services, infusion, respiratory care including oxygen delivery, diagnostics including labs and radiology, monitoring with at least two sets of patient vital signs daily, transportation, food services including meal availability as needed by the patient, durable medical equipment, physical, occupational or speech therapy, social work and care coordination as well.

As far as clinician requirements and how frequently and whether they - the visits have to be in person or remote, we made our requirements pretty clear. But we also know that this is new to many organizations and there are a lot of questions here and I'm happy to answer any that come up.

The first visit we - patients are only allowed to enter this type of care from either an emergency department or within an inpatient hospital. So the first

visit needs to be with a physician or an APP. And that provider will write the admission orders, (H&P) and must see the patient in person.

We got a question about whether this could be the emergency physician. It can be but it should be consistent with hospital policies. So if typically a hospitalist or an internist or family doc or APP writes the admission orders in (H&P), they should be doing this in this scenario as well.

From that point on the physician can - or APP can see the patient remotely if the patient is improving and is consistent with the needs of the patient. They're required at minimum, to see either remotely or in person once a day. Also required at least once a day, in person or remotely, is the registered nurse visit.

During this either remotely or in person visit, the RN develops nursing plans consistent with hospital policies unless appropriate for the patient. If the RN believes that this - that other in person visits for that day can be seen with a mobile integrated health paramedic then that's fine. And both visits that are required, so two clinical in person touchpoints per day, can be done by the mobile integrated health paramedic.

Otherwise, if the RN feels that a nurse really should see this patient in person then at least one of those other visits needs to be with an RN. So emergency response time is a big one that comes up. We spent a lot of time with external stakeholders and internally, deciding on what was appropriate here.

And we require immediate on demand remote audio connection with the acute hospital care at home team who could immediately connect either to an RN or MD to the patient. Additionally, there needs to be in home appropriate



emergency personnel team to the patient's home within 30 minutes. This can be provided by 9-1-1 or emergency paramedics.

So we talked about admissions only being through the emergency room or inpatient hospital. But also we point out and programs will have to attest, that a defined patient selection criteria needs to be used. This can be developed internally or using one of the published or accepted externally created selection criteria, and it can be adapted as well.

So for this expedited group, experienced group, there - it's going to be monthly reporting of three metrics. One is unanticipated mortality during the acute episode of care; two is escalation rate or transfer back to a traditional hospital setting during the acute episode; and three is the volume of patients treated by the program.

So they'll also be - the last requirement is the established mentor, the presence of what we're calling a local safety committee. This is similar to motility or morbidity team but dedicated to acute hospital care at home. They'll need to review the metrics prior to admission each month to CMS.

There also needs to be, just to ensure their - that only patients requiring an acute level of care are treated by the hospital. Hospitals need to attest that they're using an accepted patient leveling process. So for the detailed (data) request process, it's largely the same but a lot more in depth.

So all of the requirements of attestations that we just went through but additionally, how they're meeting things like pharmacy, infusion, respiratory care, all those things that are required for every inpatient that need to explain how those are met in a satisfactory way.

They also need to demonstrate the initiatives of physician oversight, and how they can be provided in a way that requires - that we're requiring. They need to explain if they are using mobile integrated health paramedics, how their role in the team structure fits in and how they're able to staff an RN to go either in person or remotely to see the patient daily.

Instead of just attesting for remote monitoring, this will - for this detailed labor request we will require, you know, the hospital to explain the technology and device, staffing, any limitations based on the time or day of the weekend, really step by step and best plan of any partnerships that guaranteed the 30 minute in person response time as well. And it has to be a realistic guarantee that they can get there reliably within 30 minutes.

As far as the patient selection criteria, it's similar. We anticipate that these newer organizations or less experienced organizations, will probably use an externally created selection criteria, but it's not a requirement if they are able to come up with their own appropriate selection criteria.

The only difference in monitoring in this group it's the same three metrics we mentioned before - the acute unanticipated mortality, the escalation rate, and the volume that they'll be required to report weekly.

This is probably a lot of information. I know there are some questions. I'd be really interested in hearing your feedback and things we'd be interested in are A, something I didn't mention that you're hearing from your partners out there. Whether you're hearing a lot of interest in the demand and if there are any pain points or problems that you've identified so far.

So at this point I'll turn it back over and maybe - I think we have time for some questions.

Jackie Glaze: Dr. Clarke, thank you so much. Really appreciate your presentation. I wanted to ask you if you plan to stay on the duration of the call and I thought we could just take your questions and all questions at the end of the session, if that would work for you?

Dr. Douglas Clarke: That works perfectly.

Jackie Glaze: Great. Great. Well thank you again. So we'll take question at the end. So we'll now move onto the next agenda item and we'll continue with the discussion that we've had over the last couple of weeks on the FAQs on the maintenance of (EFR) provisions of the IFC. So Sarah DeLone and her team will take this on at this point. So, Sarah?

Sarah DeLone: Great. Thanks, Jackie. And so folks know, I have with me today Jessica Stephens, the Division Director for the Division of Enrollment Policy and Operations, Sarah Lichtman Spector, the Acting Director of the Division of the Division of Medicaid Eligibility Policy. And Gene Coffey, who is a Technical Director in our Medicaid Eligibility Division.

We have a number of FAQs on the continuous coverage condition for states to claim the temporary FMAP increase under FFCRA, lined up for today's call. If we don't get to them all, it's quite a robust set, we will certainly pick up where we leave off, on an upcoming call.

Today we're hoping to get to questions relating to disregarding excess resources accumulated during the emergency, the availability of FFP and FMAP for beneficiaries whose enrollment is maintained in order to comply with the FFCRA continuous coverage requirement; application of penalties under the Medicaid Transfers of Asset Rules; and additional question relating

to the PARIS Match Exception under the Interim Final Rule, as well as the permissibility of transferring adult group beneficiaries to Medicare Savings Programs groups, when those individuals experience a change in circumstances.

So let's jump right in, because we do have a lot of questions. And Gene, I wanted to start with you if I could. This is regarding excess resources accumulated during the public health emergency. So a number of states have been asking, for individuals who were subject to the post-eligibility treatment of income rules, and whose liability for institutional services or other long term services and support, was unchanged from March 18, 2020 through effective date of the Interim Final Rule.

So their pay liability was unchanged despite income increases due to their state's compliance with our prior guidance. Can states disregard assets that accumulated for such individuals as a result of the earlier compliance with the earlier interpretation of the FFCRA requirements? And if those assets exceed the applicable resource standards after the PHE ends?

That was a mouthful. Hopefully the question is clear.

Gene Coffey: Right. Good. And hi everybody, this is Gene Coffey from the Division of Medicaid Eligibility Policy, as Sarah said. All right. The answer here is yes. States can exercise the authority provided under Section 1902 R2 of the Social Security Act to disregard the excess resources that accumulated from March 18, 2020 through November 1, 2020 due to circumstances such as those that were described in the question.

Now this would require a state plan amendment and CMS is available to provide technical assistance to states that may be interested in exploring this

option. I do want to quickly point out that some of you participate in the monthly (ETAG) call that CMS eligibility staff host with the eligibility staff of the state Medicaid agencies.

And you may have heard me say at the last meeting, that those states that are interested in effectuating this type of disregard under their state plans should of course let us know, but should also let us know the specifics of the contours of the disregard that you would like. For example, the duration of the disregard or how much you want disregarded and so on and so forth.

So again, a state plan amendment will be necessary to effectuate this type of disregard. Let us know if you'd like to do that. Let us know some details of your objectives and we'll provide the TA necessary to get you guys where you'd like to be on this particular point.

Sarah DeLone: Super. Thanks, Gene. Jessica, turning for a moment to you, on the availability of FFP and FMAP questions that we've received. So basic question - is federal financial participation or FFP, available for individuals whom the state has determined, no longer meet eligibility requirements for any eligibility group but who remain enrolled due to the state's compliance with the continuous enrollment requirement to claim the temporary FMAP increase under Section 6008(b)(3) of the FFCRA.

Jessica Stephens: Yes. FFP is available during the PHE for individuals for whom the state is not terminating coverage in order to claim the temporary FMAP increase even if the state has found that they no longer meet eligibility requirements.

Sarah DeLone: Thanks. And how about, is FFP available for individuals who experience a change in circumstances during the PHE, that may impact eligibility if the state does not promptly redetermine the individual's eligibility?

Jessica Stephens: Yes to this one as well. However, the state may still be at risk of a perm or other eligibly related audit finding of the circumstance. So renewal regulations at 435.916, requires states to periodically renew eligibility and promptly act on changes in circumstances that may impact eligibility between renewals unless circumstances beyond the state's control justify a delay.

And that's consistent with regulations at 42 CFR 435.912(b)(2). States that are delayed in processing redeterminations are at risk of a perm or other eligibility related audit findings that the state inappropriately claimed federal funds. Again, unless the state was - the delay was caused by circumstances beyond the agency's control.

CMS still encourages states to process redeterminations based on changes in circumstances and renewals to the extent possible during the PHE. And I think as we noted last week, the ISB lifts some of the restrictions based previously based in processing changes in circumstances.

At the end of the PHE states will need to expeditiously process redeterminations and terminations that were delayed. So failure to take action on a known change in circumstances now during the PHE, or process delayed changes in circumstances and renewals at the end of the PHE will place the state at risk of a perm or other eligibility related audit findings, for not acting timely, to complete required redeterminations.

I think it's important to recognize too, that states will not be able to immediately process all delayed redeterminations once the PHE is over. And as we've mentioned, CMS will provide guidance setting forth expectations for states to process their COVID-related backlog of redeterminations at the end

of the PHE. And we will of course, be available to assist states in developing a plan to address their backlog.

Sarah DeLone: Thanks, Jessica. Let me just clarify in terms of the perm or other audit risk for states not acting on changes in circumstances. That would be for not actually acting on and effectuating a change that is permitted under the continuous - under the sort of interim final rule continuous coverage regulations. Right?

If a state is barred, like somebody has an increase in income that would make them no longer eligible for Medicaid, and the state keeps them enrolled because they are - have to, in order to comply with the continuous coverage requirement, that does not result in a perm error audit risk.

It is only if it's a change that the state is now able to act on without violating the continuous coverage requirement. Is that an accurate clarification?

Jessica Stephens: Yes. Yes, yes. It is limited to those circumstances that are permissible under the...

Sarah DeLone: Right.

Jessica Stephens: ...FFCRA.

Sarah DeLone: Right. Thank you. And final question about the applicable FMAP - so what FMAP is available for beneficiaries who are enrolled in the adult group, if the state continues the beneficiary's enrollment in the adult group, only in order to comply with the continuous coverage requirement described in Section 6008(b)(3) of the FFCRA?

Jessica Stephens: Good question. States that are not terminating enrollment through the end of the month in which the PHE ends as a condition of claiming the temporary FMAP increased authorized under 6008 of FFCRA, may claim FFP at the applicable matching rate for the group, including any increased FMAP rate during the PHE and that's for the group in which the individual is enrolled.

So this includes newly eligible beneficiaries enrolled in the adult group who would be terminated but for the state's need to comply with the continuous coverage requirement under FFCRA.

States that redetermine an individual eligible for another group during the PHE, must move individuals to the appropriate group, consisted with Title XIX if implementing regulations in the state plan, unless transferred to the other group would violate the continuous coverage requirement as implemented at Section 433-400 of the IFC, to the point Sarah, that you just made.

But for any beneficiary's move to a new group, states must make appropriate adjustments to claim FFP for the applicable match rate for the new group.

Sarah DeLone: Super. Thank you, Jessica. Gene, turning back to you if you could answer a few questions that have come in regarding the transfers of assets and application of penalty periods under the continuous coverage requirement.

So first question, with regard to individuals who seek coverage for institutional services and other long term services and supports during the public health emergency, does the continuous coverage requirement in Section 6008(b)(3) of the FFCRA, bar states from (applied) penalties, if such individuals have made improper asset transfers during their lookback periods?



Gene Coffey: All right. This is our starting point question for the transfer rules. Can states apply them at all during the public health emergency in light of FFCRA's continuous coverage requirement? The answer is that FFCRA's coverage requirement does not bar states from applying the transfer of asset rules.

As many of you know, federal Medicaid laws generally require that states apply penalties against individuals who need coverage for long term services and support and who have given away assets without receiving something of equal value in return, during their lookback period.

States must apply these rules against individuals who are in nursing facilities or whose underlying Medicaid eligibility is connected to their receipt of home and community based services delivered through 1915(c) waivers.

And separately, states have the option to apply these rules against individuals who are not in nursing facilities or receiving home and community based services through a 1915(c) waiver but are in need of other community based services available under a state plan such as home healthcare services and personal care services.

And the lookback period is generally the date that proceeds by 60 months, the date on which an individual is in need of LTSS coverage and has been determined eligible for Medicaid. That's the general transfer of asset rubric. And again, our starting point question here is can states apply these rules at all given the continuous coverage requirement in FFCRA?

And again, the answer is that FFCRA's continuous coverage requirement does not bar the application of the transfer rules. And because the continuous coverage provision does not bar states from applying the transfer of asset

rules, states should apply the rules as they ordinarily would, consistent with their state's plans.

Sarah DeLone: So Gene, is this policy limited that you just explained? Is this limited to periods beginning on or after November 2 which is the effective date of the interim final rule?

Gene Coffey: Yes, all right. So this is a very important question. The answer is no. This policy is not limited to periods beginning on or after November 2. (States) were actually permitted to apply penalties associated with an improper asset transfer before publication of the interim final rule, without running afoul of the continuous coverage requirement in (b)(3) of FFCRA.

Now we understand that we had not made this point clear prior to publication of the interim final rule and that some states may have been under the impression, you know, given the absence of our explicit (input), that application of transfer of asset rules, was prohibited by the continuous coverage provision.

But we're now confirming that the continuous coverage provision, both before and after publication of the interim final rule, is not a bar to the state's application of the transfer of asset rules, which as I noted in the previous answer, means that states should be applying the transfer rules to those in need of LTSS as they ordinarily would, under their state plans.

Sarah DeLone: So I'm guessing Gene, that any number of people listening to the call are thinking to themselves, my state thought we were not permitted to apply penalties associated with an improper asset transfer under CMS's original interpretation of the continuous coverage requirement.

We did not understand - so I'm imagining people are thinking, we did not understand that CMS guidance would've permitted us to apply such penalties if we were claiming a 6.2 percentage point FMAP increase. Can we now apply penalties that we previously could've apply but did not do so?

Gene Coffey: Okay. The answer here is yes. Again, while we understand that some states may have decided not to apply the penalties prior to the ISB's publication, or confirming that the continuous coverage provision does not bar states from applying the transfer of asset rules. And that states should apply them as they ordinarily would.

But if a state previously determined that an improper transfer within an institutionalized individual's lookback period had been made, but the state did not apply the associated penalty period, the state can and, you know, indeed the state must, apply the penalty period going forward against the nursing facility services, the institutionalized individual continues to receive.

Sarah DeLone: So if a state previously determined that an institutionalized individual made an improper asset transfer within the lookback period, but the state did not previously apply the associated penalty period, when does the penalty period begin to run? Do the months after the state determined an improper transfer had been made and before the state begins imposition of the penalty? Do those months in between count?

Gene Coffey: Okay. Yes, this is another important question. Okay. For such an institutionalized individual who continues to receive nursing facility services, the penalty period should begin as soon as practical for the state and should run in its full duration prospective from that point.

So the state would not subtract from the penalty period any month in which it delayed the evaluation of the institutionalized individual's asset transfers. Again, it would apply the full penalty prospective from the point that the state determined that the individual did in fact make a transfer for less than fair market value during his/her look back period against the individual's continued nursing facility coverage.

Sarah DeLone: So Gene, what if the state did not previously check to see if an improper asset transfer within the lookback period, was made? Because the state assumed it couldn't apply the penalty period anyway as long as it, you know, wants to claim a temporary FMAP increase. How would the state calculate the penalty period?

Gene Coffey: Okay. If the state has not yet determined whether the institutionalized individual who continues to receive LTSS, made any improper transfers during his/her lookback period, the state must do so now. The state would calculate the penalty period for institutionalized individuals who had made such transfers using the same methodology that has always applied.

So similar to the previous answer, the state must initiate the full penalty period prospectively from the date on which the state determines that an improper transfer was made during the institutionalized individual's lookback period.

Sarah DeLone: Could you - Gene, it might be helpful if you could provide an example. Can you do that?

Gene Coffey: Right. Yes, of course. So, you know, of course we prepared one just for this purpose. And our example involves (Mary Rowe). So assume that (Mary Rowe) was in a nursing facility when she applied for Medicaid on June 1, 2020 which of course, was in the center of the public health emergency and,

you know, of course at a point when the continuous coverage provision was applicable.

So she applied for Medicaid on June 1, 2020 and she was in the nursing facility. And (Mary) stayed determined that she was eligible for Medicaid as of June 1st and began providing coverage for her nursing facility services. However, possibly not surprisingly, (Mary)'s state did not investigate whether she had made any improper transfers because it believed that it could not apply any penalties while FFCRA's continuous coverage provision was in effect.

(Mary)'s state now determines, you know, based on that clarification here, it now moves to determine whether (Mary) made any such transfers during her lookback period, which in this example, would date back to June 1, 2015, which is 60 months prior to the date on which (Mary) had been determined eligible for Medicaid as an institutionalized individual.

Now suppose if the state determines in December 2020, remember (Mary)'s state had initially delayed this review, the state determines in December 2020 that (Mary) had in fact made an improper transfer at some point during her lookback period, valued at we'll say, for purposes of this hypothetical, \$60,000 and that the average monthly cost of nursing facility services in (Mary)'s state, \$10,000.

Now of course, under the statute the penalty is calculated by dividing \$60,000 by \$10,000 which of course, is six. So (Mary)'s state would calculate the penalty to be six months long and would apply a six month penalty beginning in December, which means that (Mary) will be denied coverage for her nursing facility services from December 2020 through May 2021.

Of course, you know, any exceptions that (Mary) believes exist to the application of the transfer rules like undue hardship, and so on and so forth, you know, would have to be evaluated if she asserted any. But, you know, barring any exceptions, again the penalty in (Mary)'s example here, would begin in December 2020 and it would run through May of 2021, a six month long penalty.

Sarah DeLone: Thank you, Gene. That was helpful. So Jackie, I know we're starting to run a little bit close on time. I'm hoping maybe we can just do a couple of questions on PARIS and verifications and probably have to pick up with the rest of them next week. Did - are hoping we can get to just the first couple because we have been - which is a little bit of a repeat from an earlier All State call, as we've been hearing some confusion about the scope of the policy related to the PARIS Match Exception codified in the interim final rule at 433.400(d)(1)(ii)(I).

And what implications that regulatory provision does or does not have for beneficiaries in other situations who do not respond to a request for additional information from a state. So I want to just do about three Q&As on that provision and the basic requirements and what implication it has for other situations or does not have as the case may be.

And then I think we'll pick up next week with some additional new questions on this PARIS Match Exception. So Jessica back to you. Can you just give us a primer again on what exactly the regulation at 433.400(d)(1)(ii)(I) which we are referring to as the PARIS Match Exception, what does that regulation allow?

Jessica Stephens: Sure. And happy to come back and talk in more detail later too. But important to note, there are three data matches available through the Public

Assistance Reporting Information System or PARIS. And one of them which we refer to here, is the PARIS Interstate Match.

The interstate match compares enrollment styles submitted by all participating states in a given quarter and returns a match for any individuals found as being enrolled in any public benefit program in two or more states at the time the match is conducted. And the PARIS Match Exception in the ISB, relates specifically to the interstate match, the PARIS Interstate Match.

The exception set forth at Section 433.400(d)(1)(ii)(I) of the ISB, allows states to treat a beneficiary as not being a state resident for purposes of the continuous coverage requirements in Section 6008(d)(3) of FFCRA if three conditions are met.

First, the beneficiary must be identified through the PARIS Interstate Match as enrolled in a public benefit in another state; second, the state must have taken reasonable steps available to verify residency but been unable to do so, and that includes a number of things including communicating with the other state in which the PARIS Match had identified the individual as enrolled.

And third, the beneficiary must not have responded to a request from the state for additional information, to verify residency. And only if all three of those conditions are met is the state permitted to treat the beneficiary as no longer being a state resident for purposes of the continuous coverage requirement.

Because 6008(b)(3) of FFCRA permits states to terminate beneficiaries who are no longer a state resident, this means that the state may terminate the beneficiary. However, I think it's also important to note that if a beneficiary's eligibility is terminated under the PARIS Match Exception and the state later

obtains information to verify that individual's state residency, the beneficiary's enrollment must be reinstated back to the date of termination.

Sarah DeLone: Thanks. (Jackie), I just want to check in with you. Are we okay to do a couple more or should we pen the rest until next time?

Jackie Glaze: I would say if you're okay, let's pen so that we can take some questions. I know that we didn't have time for Dr. Clarke's questions so I want to make sure that we give the participants enough time to ask the questions. So can we pend those for next week?

Sarah DeLone: Absolutely. If I can make one quick point which is just to note that the PARIS Match Exception is very narrow and it is very specific to the situation which a PARIS Match identifies somebody as potentially, you know, as enrolled in another benefit program in another state and therefore potentially not a state resident.

It does not apply to any other situations where a state residency is called into question. And it does not authorize a termination of any other beneficiaries for failure to return information that was requested as part of a renewal or a processing of change in circumstance.

So we will address those points in more detail, next week. But that seems to be the area of confusion and I wanted to just put that out there now, for folks. So thanks Jackie. Back to you.

Jackie Glaze: Thank you, Sarah and team. So now we're ready to open up the phone lines. So we'll take any questions you have for the presenters today, or any general questions you may have. So Operator, we're ready to open up the phone lines at this point.



Coordinator: All right. Thank you. If you would like to ask a question, please press star 1 at this time. Please unmute your phone and record your name clearly when prompted. To cancel your request you can press star 2. Again, to ask a question, please press star 1. And speakers, give me just a moment for the questions to queue up.

All right speakers, our first question comes from (Greg). (Greg), your line is open.

(Greg Neehoff): Thanks. This is (Greg Neehoff) in Ohio. We'd like to get some clarification on effective dates and public notice requirements for SPAs that are unwinding flexibilities that we adopted earlier, under the Disaster Relief SPAs. So specifically, we're wondering if the public notice and timely submission requirements are waived or can be waived for these unwinding SPAs as they were for the Disaster Relief SPAs.

Sarah DeLone: I'm - so I think Jackie, I think we probably should take that back. I'm going to venture - this is Sarah DeLone, venture to say that probably those do apply but I think we should probably take that back and I'm not sure we have all the people on the call who would really be the experts there.

Jackie Glaze: Yes. So we will, we will follow back up.

Sarah DeLone: Yes.

Alissa Deboy: Well this is (Alissa). I agree with that assessment...

Sarah DeLone: Okay.

Alissa Deboy: ...Sarah, and we should talk internally and we can respond back at one of these calls. Thank you.

Sarah DeLone: Yes. Yes. Thanks for the question.

Coordinator: All right. Our next question comes from (Douglas). (Douglas), your line is open.

(Doug Henckel): Hi. This is (Doug Henckel), also from Ohio. I was just wanting to know if there's any hospital or home concept called (Homedicare) procedure that would be paid for. Would that still be under the normal DRG payment methodology or some alternative?

Dr. Douglas Clarke: Yes, this is Doug Clarke. It would be under the normal DRG payment methodology. Everything - we're not altering anything to do with payment. Just this nursing hospital condition of participation. So for all payments issues it would be as if this patient were admitted to an inpatient hospital.

(Doug Henckel): Great. Thank you. That was really helpful. I have another question that we - is there any insight on when the (coding) update for January will be released?

Dr. Douglas Clarke: You cut out there in the middle. I missed, was that for the...

(Doug Henckel): I'm sorry. I was looking for information on when the coding updates for January will be released for the (unintelligible) HCPCS codes.

Dr. Douglas Clarke: I think that's for the CMCS folks. Right?

(Doug Henckel): Yes. Probably.

Jackie Glaze: ...specifically about - are you asking about the vaccine?

Kirsten Jensen: No. This is Kirsten Jensen.

((Crosstalk))

Kirsten Jensen: It should be released in the very near future.

(Doug Henckel): Okay. Thank you.

Kirsten Jensen: Yes.

Coordinator: All right. Our next question comes from (Brett). (Brett), your line is open.

(Brett): Hi, yes. This is (Brett) from Mass Health. I had a couple of questions here. First, and I believe you might have touched on this at the beginning of the call, but I didn't hear all of it. For those states that are interested in reimbursing hospitals, rendering services through Hospital-at-Home, what exactly would the state need to submit to CMS in order to get that expenditure authority?

(Jeremy Silanskis): Hi. This is (Jeremy Silanskis) from the financial management group. It depends. So if you are not going to change your rates, you're just going to pay using your approved state plan methodology then, you know, you wouldn't necessarily need to do anything from the reimbursement perspective.

However, if you do choose to, you know, change your methodology for the services that would be provided in the home setting, then you'd have to go through the normal state plan process and come in and amend your plan, which you could do through the Disaster Relief Template.

(Brett): Okay. And on the coverage side, is there anything that states would need to do? And the only reason I'm specifically asking is just because of the definition of inpatient services in 42 CFR 440, I forget exactly which section, but where it refers to services rendered in a facility.

Kirsten Jensen: This is Kirsten Jensen again, from benefits and coverage. And we do not believe that a state plan amendment is necessary on the coverage side. We defer to the conditions of participation which are then part of this Hospital-at-Home initiative through the Medicare side.

(Brett): Okay. Terrific. That's really helpful. And then I have just one other question about the reimbursement for vaccines. Is this the correct venue for that or should I punt that for a very different call?

Alissa Deboy: No. Please go ahead.

(Brett): Sure. So we've noticed on the CMS Web site, that you have a Part B fee schedule for the vaccine administration, but there are also a series of asterisks that suggest that based on geography and provider types, some of the reimbursement rates might vary.

And we were wondering if CMS can provide any additional clarification on how, you know, certain (faith) facility providers or institutional providers - hospitals, FQHCs, will be reimbursed by Medicare for administration.

Alissa Deboy: Okay. Well we don't have our Medicare folks on the line to talk about reimbursement.

(Brett): Okay.

Alissa Deboy: I thought you were going to ask a Medicaid question. So that would probably have to be something that you submit to the mailbox and we'll hopefully get some of our Medicare folks to help address your question or you could talk to your state lead because that will require a Medicare expert that we don't have on the phone right now.

(Brett): Okay. Terrific. Thank you very much.

Coordinator: Our next question comes from (Kristen). (Kristen), your line is open.

(Kristen): Good afternoon. This is (Kristen) in Connecticut. I have a question that's a clarification from last week on continuous enrollment. Can you confirm that states should continue enrollment in the adult group if the individual was enrolled on or after March 18th and no longer qualifies for the adult group but also does not qualify for another Medicaid group but qualifies for MSP? Should we make...

Sarah DeLone: So it...

(Kristen): ...the enrollment in the adult group?

Sarah DeLone: If the individual qualifies for a Medicare savings program group that is a Medicaid group, right? So that would be either a (QINBI), a (SLMBI), QI, QDWI. Any of those - those are Medicaid groups. Both the Medicare and actually technically, the Medicaid that provides our minimum essential coverage. So those are tier one - those are considered tier one coverage, the MSP groups.

So in that case, you should now - need to now, terminate the coverage in the adult group and enroll the person in the Medicare Savings Program Group. That does not violate the continuous coverage requirements and so that's what should - that's what should be done. If the individual...

(Kristen): Okay.

Sarah DeLone: ...is not eligible for the MSP group or any other group, that's when you would continue their coverage in the adult group or any other tier one group I should say.

(Kristen): Okay. We weren't sure because it's not full Medicaid.

Sarah DeLone: That's correct. But the person...

(Kristen): But I hear you. Yes.

Sarah DeLone: ...does still have minimum - they still have minimum essential coverage. Yes. So...

(Kristen): Through Medicare?

Sarah DeLone: ...the one sort of (quirky) one. Yes. They - and they have it, you know, dually but yes, yes.

(Kristen): Okay. Great. Thank you very much.

Sarah DeLone: You're welcome.

Coordinator: Our next question comes from (Jacy Cooper). Your line is open.

(Jacy Cooper): Hello. Thank you very much. So my question is for Dr. Clarke, regarding the Hospital-at-Home. And I apologize if I missed it because I joined just a few minutes late and you may have talked about it in your opening remarks. However, will the Hospital-at-Home initiative and process, be available for Medicaid providers? And if so, when would that be available?

Dr. Douglas Clarke: I think I'll let my CMCS colleagues have first crack at that one and I can fill in where needed.

(Jacy Cooper): Thanks.

Jackie Glaze (Hye Sun) or (Ellen Marie), would you respond please?

(Hye Sun Lee): Yes. This is (Hye Sun Lee). (Jacy), can you clarify what you mean by Medicaid providers? You may have missed this but Dr. Clarke in his presentation, talked about the - (this would) require hospitals to submit an application for an individual 1135 waiver. And he also shared that once the hospital does get approved on the Medicare side (with the) 1135 waiver, the hospitals could also provide services to Medicaid patients as well.

(Jacy Cooper): So I must not have been on when he said that, which is why I was asking the clarifying question. So I just want to make sure I understand the steps. So the state does not need to take any actions on our own for an 1135. And as I heard the previous response regarding the finances, if we were to pay the same rate we would not have to make any Disaster SPA request.

But once a hospital submits the application and is approved through the Medicare process, that would also apply on the Medicaid side and they could

bill and provide the services on both the Medicaid and the Medicare side. Is that a fair understanding of what you said?

(Hye Sun Lee): Yes, it is.

(Jacy Cooper): Okay. Perfect. Thank you so much. And I apologize that I missed that beginning remark. So thank you.

(Hye Sun Lee): Okay. No problem.

Jacquelin Glass: We'll take one additional question.

Coordinator: All right. Our next question comes from (Shawn). (Shawn), your line is open.

(Shawn Botticker): Hi. This is (Shawn) with Colorado. I have a question about the (interim) rule. In regards to agency errors and the fact of validly enrolled and that now being an acceptable reason to close, how will this affect - if states can't identify agency errors, how would that affect us from an audit perspective? Would we still have an audit finding and payback of FMAP if there was an agency error found in an audit?

Sarah DeLone: Yes. I mean the interim final rule does not sort of override any of the, you know, the rules regarding perm or other audits. So if you, you know, if you, you know, make an error on an (unintelligible) and, you know, an application that's going to, you know, be a perm error.

If you need to keep that person on because it's not - it doesn't sort of - it doesn't mean that the - it doesn't always mean the person is not validly enrolled. Right? So it depends. But if it's an error it's an error. And if it's



going to - if it would've been an error pre-IFC or pre this continuous coverage requirement, it would be an error, you know, under the - under perm.

So the answer to that - sort of that basic question, is yes. So there's nothing in the IFC that sort of changes, you know, the auditor's roles or responsibilities to look for whether determinations were made correctly or not.

(Shawn Botticker): Okay. Thank you. And then in regards to the tiers, is CMS going to expect states to have an identifier in their systems, to identify changes amongst programs based on the tiers that you came out with?

Sarah DeLone: Can you - I don't think so. Could you say a little bit more about what you mean by identifier? And maybe actually we're one minute over so I wonder maybe we should loop back with you and probably connect with our data and systems group also, to see what it is...

(Shawn Botticker): Sure.

Sarah DeLone: ...that you're thinking about. What's your name again?

(Shawn Botticker): I'm (Shawn Botticker) with Colorado.

Sarah DeLone: Okay. And (Shawn), maybe you can contact your state lead so we make sure that I - I'm not sure if I'm going to spell your name...

(Shawn Botticker): Sure.

Sarah DeLone: ...correctly or not. So if you could send that question to your state lead and we'll convene the right people and get back to you.

(Shawn Botticker): Sure. Thanks.

Sarah DeLone: Thank you.

Jackie Glaze: So in closing, I'd like to thank Dr. Clarke, Sarah DeLone and her team, for their excellent presentations and information today. Looking forward, the invitation and topics for next call will be forthcoming.

If you do have additional information or questions on the continuous enrollment provisions, you could submit them in writing to MedicaidCOVID19 all one word at CMS dot HHS dot gov for a potential response during a future call. So if you do have questions between calls please reach out to us, your state lead, or bring them to the next call.

So we thank you for joining today. And we hope everyone has a good afternoon. Thank you.

Coordinator: That concludes today's conference. Thank you all for participating. You may now disconnect.

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