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

Coordinator: Welcome and 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. I will now turn the meeting over to your host (Jackie Glaze). (Jackie) you may begin.

(Jackie Glaze): Thank you and good afternoon and welcome everyone to today's All State Call. I will now turn to Anne Marie Costello our Acting Center Director and she will share highlights for today's discussion. Anne Marie.

Anne Marie Costello: Thanks (Jackie) and welcome to today's call and thanks to everyone for joining us. First up today (Jen Bowdoin) from our Disabled and Elderly Health Program's Group will present on a state health official letter that CMS released on January 7. The SHO letter describes opportunities to address the social determinants of health under Medicaid and CHIP and is intended to support state's efforts with designing programs, benefits and services that can more effectively improve population health, reduce disability and lower overall costs in the Medicaid and CHIP Programs by addressing the social determinants of health.

We have received many questions about how Medicaid and CHIP can support states' efforts around addressing social determinants of health. So we're hoping that today's presentation by (Jen) gives you all a better understanding of the opportunities addressed in the show letter. After (Jen)'s presentation we'll take your questions on the social determinants of health letter. (Sarah Spector) and Meg Barry from our Children and Adult Health Program's

Group will discuss some of the implications of the recently passed Consolidated Appropriations Act for Medicaid and CHIP.

Finally Kirsten Jensen from our Disabled and Elderly Health Program's Group will provide an update on COVID-19 vaccine coverage requirements under the PREP Act and further address adjustments they need to make to their state plan. After Kirsten's updates we'll open the line for general questions. With that I'll turn things over to (Jen) to start her presentation. (Jen).

(Jen Bowdoin): Thanks, Anne Marie and hi everyone. It's nice to be with you today. This is (Jen Bowdoin). I am Director of the Division of Community Systems Transformation in the Disabled and Elderly Health Program's Group here at CMCS. And as Anne Marie mentioned I'm going to talk with you about a state health official letter or SHO letter on opportunities in Medicaid and CHIP to address social determinants of health that CMS released on January 7th.

The purpose of the letter is to support states with designing programs, benefits and services that can more effectively improve population health, reduce disability and lower overall healthcare costs in the Medicaid and CHIP Programs by addressing social determinants of health.

Challenges related to social determinants of health such as access to nutritious food and affordable and accessible housing are not by any means new issues for many Medicaid and CHIP beneficiaries. The pandemic has heightened our collective awareness related to these issues and how they impact health outcomes, healthcare utilization and costs.

And so while COVID-19 was not necessarily the primary reason we released this letter, we think it's a particularly timely topic given the growing attention and focus on social determinants of health since the start of the public health emergency.

Before I dive into the information included in the letter one thing that is important to (note) at the outset is that this letter does not describe new flexibilities or opportunities under Medicaid and CHIP to address social determinants of health but rather it describes how states may address social determinants of health under the flexibilities available under current law. In other words it's essentially a compilation of existing opportunities that are available under the Medicaid and CHIP programs to address social determinants of health.

And we hope that by putting all of this information into a single resource we can better support states as they develop programs, services and initiatives focused on addressing social determinants of health for Medicaid and CHIP beneficiaries.

The letter's organized into several sections. After a brief introduction the letter discusses several overarching principles that CMS expects states to adhere to when offering services and supports that address social determinants of health within their Medicaid programs.

We then describe the types of services and supports that states can cover under Medicaid to address social determinants of health. And after that we discuss federal authorities and other opportunities under Medicaid and CHIP that states can use to address social determinants of health. And in this section we provide some state examples throughout to highlight some of the

ways that different states are addressing social determinants of health in their Medicaid and CHIP programs.

Specifically the federal authorities that we discuss in this section of the letter includes Section 1905A, State Plan Authority, including rehab services, rural health center and federally qualified health center services and case management and targeted case management. We also discuss Section 1915C, I, J and K HCBS authorities, Section 1115 demonstrations, Section 1945 Health Homes, managed care programs and PACE or the program of all inclusive care for the elderly.

We also discuss other opportunities under Medicaid and CHIP to address social determinants of health including integrated care models, CHIP, health services initiatives, Medicare savings programs, the Money Follows the Person demonstration and administrative procedures such as collaborations with community-based programs, data integration information sharing and outreach and enrollment activities.

And then at the end of the letter we include two summary tables. The first table provides a summary of key federal authorities for addressing social determinants of health including who is eligible to the services under that authority and examples of how the federal authority can be used by states to address social determinants of health.

And then the second table provides a summary of services and supports that can be covered under Medicaid and CHIP including illustrative examples of what states can cover, potential target populations and federal authorities that states may be able to use to cover the services and support.

The letter is fairly lengthy. It's about 51 pages. And it does get into a lot of technical details about specific federal authority. And so in the interest of time I'm going to focus mainly on the types of services and supports that states can cover under Medicaid to address social determinants of health. I'm not going to focus during this call on what states can do under specific federal authorities because it does get quite detailed.

But please reach out to your state lead if you have questions about what states can do under specific federal authority. And my contact information is also available at the end of the SHO letter if you'd like to reach out to me directly.

As, you know, states have a lot of flexibility within the constraints of certain federal rules in terms of how they design their Medicaid and CHIP programs. Consistent with this, states have flexibility to design an array of services to address social determinants of health. However the services and supports that states can cover to address social determinants of health tend to fall within several categories of services including housing related services and supports, non-medical transportation, home delivered meals, educational services, employment supports, community integration and social support and case management.

In most instances, the services and supports described in the letter can be covered for children and youth, non-elderly adults including adults with disabilities and older adults. However some of the services and supports are typically targeted at only certain populations or age groups although states may be able to cover them more broadly. In particular home delivered meals and some housing and tenancy support are not generally targeted at children. While employments are most commonly offered to non-elderly adults with disabilities. And educational supports are typically only available to children with disabilities and young adults with disabilities.

So I'm now going to hit on some of the high points related to the services and support that we discussed in the letter. Please note that there may be additional restrictions or requirements related to these services and supports then I'll discuss here.

So first off in the letter are housing related services and supports. So I'm sure that everyone on the call knows that federal financial participation is not available to state Medicaid programs for room and board except in certain medical institutions. But it is generally available under certain federal authorities for housing related services and supports that promote health and community integration.

And these housing related services and supports fall into a few subcategories including home accessibility modifications, one-time community transition costs and housing and tenancy support including pre-tendency services and tendency sustaining services.

So home accessibility modifications are either temporary or permanent changes to a home's interior or exterior structure to improve individual's ability to remain in their homes and communities. Depending upon the home structural characteristics temporary modifications can include things, like, installation of a wheelchair ramp outside the home or grab bars in the shower while permanent modifications can include enlarging a doorway to allow wheelchair passage.

It's important to note that in order to be covered under Medicaid, these services and supports must be specific to the individual's needs based on the person's disabilities or health conditions. And they can't be of general utility in the home.

Also discussed under housing related services and supports a one-time community transition cost. So these services can help individuals transition from an institutional or another provider operated congruent living arrangement such as a group home or a homeless shelter to a community based living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

One time community transition costs can include payment of necessary expenses to establish a beneficiary's basic living arrangement such as security deposits, utility activation fees and essential household furnishings.

And then finally housing related services and supports can include pre-tenancy services which assist individuals to prepare for and transition to housing. And tenancy sustaining support which is provided once an individual is housed to help the person achieve and maintain housing stability. Examples of pre-tenancy services include things, like, conducting an individualized screening and community integration assessment, developing a community integration plan, providing training on how to search for available housing or how to complete an application for housing assistance and ensuring that housing units are safe and ready for move in.

And examples of tenancy sustaining services include things, like, providing early identification and interventions for behaviors that can jeopardize housing such as lease violations, providing the beneficiary with education or training on the rules, rights and responsibilities of the tenant and landlord and connecting the individual to community resources to maintain housing - to maintain housing stability excuse me.

Another service and support that states can offer in the Medicaid program is non-medical transportation. So states have the option to cover non-medical transportation to enable individuals receiving Medicaid funded HCBS to gain access to community activities and resources such as grocery stores and places of employment when other options such as transportation by family, neighbors, friends, community agencies are unavailable.

We also talk in the letter about home delivered meals. So older adults and individuals with disabilities who need Medicaid funded HCBS may need assistance with meeting nutritional needs due to functional limitations or challenges that can make it difficult for them to go shopping or to prepare meals on their own. Home delivered meals can help to supplement the nutritional needs of these individuals when there is an assessed need. And the services are identified in the person-centered service plan.

We also in the letter talk about educational services. So under the Individuals with Disabilities Education Act children with disabilities are eligible to receive educational and related services that will help them achieve their educational goals as documented in the Child's Individualized Education Plan. Or for infants and children under the age of three the Individualized Family Service Plan.

Medicaid reimbursement is available for covered services. They're included in the Child's Individualized Education Plan or Individualized Family Service Plan if the services are provided to an eligible beneficiary by qualified Medicaid providers. States also have the option to cover Medicaid services furnished to eligible Medicaid beneficiaries in the school setting. If the children are determined to need those services, the services are furnished by qualified Medicaid providers and the services meet other federal requirements.

Another service that we talk about in the letter or a couple of areas that we talk about in the letter relates to employment support. So employment can help to lift low income individuals and families out of poverty. And in doing so it can help to address a broad range of needs that can impact health. In the letter we talk about a few ways that states can help to support employment through the Medicaid Program. For example we know that individuals with disabilities are less likely to be employed than individuals without disabilities.

Medicaid funded HCBS can provide supported employment services for individuals who need intensive ongoing support to obtain and maintain a job in competitive or customized employment or self-employment in an integrated work setting. States can also define other models of individualized supported employment that promotes community inclusion and integrated employment.

As another example related to employment Medicaid buy-in programs which are available in most states allow workers with disabilities to access Medicaid community-based services that are not available through other insurers such as personal care attendant services and by allowing these individuals to pay into Medicaid on a sliding scale. These programs have higher or no asset limits to allow individuals with disabilities who need the services to retain them while working and earning salaries above the standard Medicaid limit.

Medicaid funded HCBS can also provide opportunities for Medicaid beneficiaries to choose to receive services in their home or community rather than institutions. These programs serve a variety of targeted population groups such as older adults, people with intellectual developmental disabilities, physical disabilities and mental illness. And examples of home and community-based services that can facilitate community integration include things, like, instruction on how to utilize public transportation and

companion services to accompany the individual and provide assistance in the community.

And then the last type of service I'll mention today that we talked about in the letter is case management. So case management assists eligible individuals to gain access to needed medical, social, educational and other support. Case management services are often a critical component of the other services and supports I mentioned although case management can also be used to address a broader range of needs and to assist Medicaid and CHIP beneficiaries with accessing other Medicaid and non-Medicaid services.

So those are the main categories of services and supports that we discussed in the letter. I would encourage you all to take a look at the letter if you'd like more information what states can cover related to these services and supports and what is available under specific Medicaid authorities. And please don't hesitate to reach out to us if you have any questions or you'd like technical assistance on how to address challenges related to social determinants of health among your Medicaid and CHIP beneficiaries.

And with that I'm going to hand the call over to (Jackie Glaze) so that we can open the call up for questions about the SHO letter. (Jackie).

(Jackie Glaze): Thank you (Jen) very much for your presentation and as (Jen) indicated we're ready to take your questions now that you may have on the presentation. So operator if you could provide instructions to the audience for asking their question and open up the phone lines please.

Coordinator: Thank you, (Jackie). 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. Your name is required to introduce your question. If you need to

cancel your request you can press Star 2. Again if you would like to ask a question please press Star 1 at this time. Speakers please standby for the first question.

Speakers our first question comes from (Alondra Jones), your line is open.

(Alondra Jones): Hello everyone and thank you. I'm (Alondra Jones). I'm calling from the D.C. Department of Healthcare Finance. We're at the District of Columbia's State Medicaid Agency. And we received a copy of the letter. Thank you very much. It was really helpful and we are beginning to incorporate some of that into our work here in the district. I did have a question around core measures and if there would be any guidance from CMS or any publication of core measures related to social determinants of health in the future? Thank you.

(Jen Bowdoin): Hi this is (Jen) and I would - if we have folks from the Division of Quality and Health Outcomes I would welcome them to jump in. You know at the moment we don't have core measures related to social determinants of health. I think the Division of Quality and Health Outcomes can better address whether there are any, you know, specific plans related to the adult or child core set in this area.

(Sarah Delone): Hi this is (Sarah Delone) with the Children and Adult Health Program Group. I don't think we have anybody on to address that question today but it's a great suggestion and we'll take it back. Thanks.

(Alondra Jones): Okay, thank you.

Coordinator: Speakers at this time we do not have any additional questions in queue.

(Jackie Glaze): We will leave time at the end of the session today for more questions. So next we will now move to (Sarah Spector) and Meg Barry and they will provide a presentation on the Consolidated Appropriations Act for Medicaid and CHIP so (Sarah) I'll turn it over to you.

(Sarah Spector): Great, thanks (Jackie). So I have three provisions to highlight today. I'm going to talk about the extension of the Spousal Impoverishment Protections, the new expansion of coverage for COFA migrants and provide a brief outline of some of the income sources provided for release due to COVID-19 and their treatment for Medicaid and CHIP financial methodologies.

First, Section 205 of the Consolidated Appropriations Act of 2021 requires that state Medicaid agencies apply the Spousal Impoverishment rules to married applicants and beneficiaries eligible for home and community-based services through September 30, 2023. This is an extension of Section 2404 of the ACA which has been extended from its prior expiration date of December 18, 2020.

Section 2404 of the ACA -- the ACA's spousal provisions -- originally mandated that for the five-year period beginning January 1, 2014, states apply the rules of Section 1924 of the Social Security Act generally referred to as the Spousal Impoverishment rules to married individuals seeking Medicaid coverage of home and community-based services under several authorities.

States should continue to apply our guidance issued in 2015 and the state Medicaid director letter 15001 relating to the application of these Spousal Impoverishment related provisions for married applicants and beneficiaries eligible for home and community-based services. This extension requires states continue these protections through September 30 of 2023.

Now turning to Section 208 of the Consolidated Appropriations Act requires states and DC to provide Medicaid coverage to individuals who are COFA migrants or sometimes known as COFA citizens. COFA is the compact of the freely associated states. An agreement between the United States and the COFA states, the federally rated states of Micronesia, the Republic of the Marshall Islands and Republic of Palau.

Previously COFA migrants could only receive services necessary to treat an emergency medical condition with the exception of children under age 21 or pregnant women who can be covered with full Medicaid if the state or territory had elected the CHIPRA 214 option.

Now all of these individuals should be eligible for full coverage in Medicaid when they live in the states or DC if they are otherwise eligible under the state plan. The provision creates an option for US territories. And if a territory picks up the option the expenditures for these individuals do not count towards the territory's expenditure cap.

No state plan amendment is necessary for states or D.C. to begin this implementation of this provision. A territory that would like to elect the option should submit a state plan amendment to CMS. The provisions effective upon enactment which was December 27, 2020, so it's gone into effect. And we are continuing to do a number of things. Confirm the impact of the provision on CHIP as well as working on additional guidance for states and territories on implementation of this provision. We are available for technical assistance and encourage you if you have additional questions to contact your state lead.

Third, I'll turn to the treatment of certain income sources under the Consolidated Appropriations Act for individuals in Medicaid and CHIP

income methodologies. The statute adds a number of new provisions regarding unemployment compensation in large measure extending benefits established under the CARES Act. In general and actually as mentioned in a previous all state call our existing guidance applies to these provisions with regards to both MAGI based and non-MAGI methodologies.

So the pandemic unemployment assistance and the pandemic emergency unemployment compensation which are extended in this legislation under Sections 201 and 206 of the Consolidated Appropriations Act remain countable for Medicaid and CHIP as unemployment benefits. Federal pandemic unemployment compensation which too is extended this one under Section 203 of this legislation remains not countable under Section 2104H of the CARES Act.

A new program is created under Section 261 of the Consolidated Appropriations Act for mixed earner - it's called the Mixed Earner Unemployment Compensation. And this new program states that it is to offer it provide $100 a week for certain individuals with both self-employment and wage income. And this mixed earner unemployment is countable as unemployment benefit. It is not excluded from income, like, one of the above.

So legislation also provides grants to states' local and tribal governments for emergency rental assistance and related assistance. Section 501 of the Consolidated Appropriations Act specifies that rental assistance provided to a household from payment under this section is excluded from income and resources for the purposes of determining eligibility or the scope of coverage for any federal program or state program financed in whole or in part with federal funds. Meaning it is not countable for Medicaid under MAGI-based and non-MAGI based methodologies nor for CHIP for purposes of the underlying income and resource eligibility determinations or for scope of

coverage determination such as cost sharing or the post eligibility treatment of income.

We recognize that this legislation includes a number of other provisions that affect income counting for Medicaid and CHIP including adjustments to the tax code and certain loan forgiveness provisions or continuing to analyze the legislation. If you have specific questions we're happy to take some of them on the call. But also feel free to reach out to your Medicaid state leads or CHIP project officer. Now I'm going to hand it off to Meg Barry.

Meg Barry: Thanks (Sarah). I'm going to cover a provision on mental health parodies that apply to both Medicaid and CHIP. Section 203 of Divisions BB of the Consolidated Appropriations Act amended Section 2726A of the Public Health Services Act by adding new compliance requirements related to mental health parity specifically for health plans that impose non-quantitative treatment limitations or NQTL.

NQTLs include prior authorization and other types of utilization management policies. The law establishes a process for the secretaries of the Department of Health and Human Services and labor to require health plans and issuers to provide a comparative analysis related to the design and application of NQTLs when there's a potential violation of the requirements in parity between mental health and medical services.

We're still concerning as it's a pretty complicated provision but our read is that current or potential beneficiaries, authorized representatives and healthcare providers may file a complaint against health plans and issuers. But it's unclear as to whether a complaint can be filed against the state. CMS is seeking clarification on this one.

The law requires further guidance from the Departments of Labor, Health and Human Services and Treasury no later than 18 months from the date of enactment which was December 27, 2020, on the process and timelines to file a complaint.

These requirements apply to Medicaid and CHIP through existing cross references to the Public Health Services Act in Titles 19 and 21 of the Social Security Act. The effective date of this new law is 45 days after enactment.

Related to CHIP the legislation specifies the states with CHIP state plans that meet the requirements of CHIP parity regulations that 42CFR, 457, 496 will be considered compliant with the new law. There are several states that have not yet completed their work with us on their CHIP mental health parity SPAs. And this means that if a complaint is brought to the attention of the secretary of HHS by a beneficiary authorized representative or healthcare provider in one of these states, then the secretary may need to request a comparative analysis and additional information if needed to determine whether the plan's NQTL violate parity requirements.

For this reason and because parity rules have now been in effect since October 2, 2017, we strongly encourage all states with pending CHIP parity SPAs to provide outstanding requests for information from CMS as quickly as possible. Your CHIP project officer will be reaching out to you soon about this issue.

For Medicaid similar to CHIP states with Medicaid managed care plans in compliance with the parity regulation and 42CFR Section 438 will be considered compliant with the new law. However states with pending Medicaid parity analyses will be required to document their comparative analyses with the design and application of NQTL.

Medicaid alternative benefit plans will also be considered compliant with the new law if the state plan is in compliance with Sub Parts B of 42CFR Part 440. If you have questions about how this provision applies to Medicaid, please reach out to your Medicaid state team. (Jackie) that's it I'll turn it back to you.

(Jackie Glaze): Thank you Meg and thank you (Sarah). We'll now transition to Kirsten Jensen and she will provide an update on the COVID-19 vaccine coverage requirements under the PREP Act. Kirsten.

Kirsten Jensen: Thank you (Jackie). Hi this is Kirsten Jensen and I wanted to take a moment here to offer another reminder about the PREP Act and some of the implications for states. If your state is receiving the 6.2% FMAP bump as part of FFCRA, then coverage of the COVID-19 vaccine administration is required through the end of the quarter in which the PHE ends. We've also issued or HHS has also issued several declarations under the PREP Act that require pharmacists, technicians and interns to be qualified providers of COVID-19 vaccine administration. And if your state enrolls just pharmacies in Medicaid then the state may add pharmacies as a qualified provider as well.

So in Medicaid the free choice of provider requirements say that any willing and qualified provider must be able to enroll in the plan. Therefore we are asking states to add the PREP Act required providers to the state plan either under OLT or preventative services benefits.

My team is beginning to work through the vaccine administration and coverage SPAs that we have in-house. And we do have a relatively low number of them. And that's why I'm doing this call today. I'm asking that you take some time and make sure that pharmacists, technicians and interns

are in your state plan and qualified to be providing COVID-19 vaccine administration. So please review your state plan coverage. We are available for technical assistance or you may go ahead and submit a SPA and we can review that and start any additional conversations with you.

Secondly, we've become aware that some states may be covering vaccine and vaccine administration under the pharmacy benefit. Vaccines are not considered a covered outpatient drug and administration of vaccines is therefore not part of the pharmacy benefit. So as you're taking a moment to review your coverage related to the PREP Act you may want to consider this question as well and you may need to move that coverage into other state plan coverage such as preventive or OLP.

And again we're available for technical assistance on this point and can work with you to make sure that we're understanding the full scope of coverage that you have and where it would best fit in another part of the state plan. So with that I'll turn it back over to (Jackie).

(Jackie Glaze): Thank you Kirsten. So we're ready now to take your questions on any of the information that you heard today or any other general questions that you may have. So (Erin) if you could provide instructions one more time on how to ask questions and then open up the phone lines please.

Coordinator: Sure, thank you (Jackie). If you would like to ask a question, please press Star 1 at this time. If you want to cancel your request you can press Star 2. Speakers one moment please. Speakers our first question comes from (Alice). (Alice) your line is open.

(Alice White): Good afternoon. Thank you it's (Alice White) from the district's Department of Healthcare Finance Medicaid Agency. I did want to follow up on the last

point that was raised regarding the appropriate placement of the COVID vaccine administration benefit. I think I heard that it should not go in the pharmacy section. I did want to clarify for the district we already have - we have a pharmacy administration fee that we can pay pharmacists and a lot of the administration is happening by pharmacists.

So I am concerned about the potential complexity that it could create if we create a permanent state plan amendment where this exists elsewhere understanding that vaccines are not technically a pharmaceutical or prescription drug. But I did want to just clarify whether CMS would be providing additional specific direction around how to align with other benefits that already exist in the state plan.

Kirsten Jensen: Sure the - this is Kirsten Jensen. I think (KIRAD) recommends that we set up some technical assistance calls to make sure we really understand what you're covering under the pharmacy benefit and can properly advise on where it may need to be located. You know vaccines and vaccine administration typically is covered under our preventive services benefit. And that would be for any provider that is providing the vaccine administration.

So we would need to talk about, you know, what you're actually covering and how we might structure that or be able to point back to the payment rate that you have for your vaccine administration for the pharmacists or pharmacies without having to necessarily move that page. But I think we probably should have some technical assistance calls around this.
You're welcome to reach out to me and I can link through our operations partners or you can contact your state lead and that person will make sure the right team of people are put together to talk through this.

(Alice White): That's great, thank you.

Coordinator: Next question comes from (Virginia Perry) your line is open. (Virginia) can you try unmuting please?

(Virginia Perry): I'm sorry I'm talking with the mute on. I was inquiring about mental health parity. I just wanted to make sure that I heard correctly that there's some upcoming or some new requirements to mental health parity for a separate CHIP for states that have a separate CHIP plan - state plan is that correct?

Meg Barry: Yes that's right. There are new parity requirements. However for states that are in compliance with the CHIP requirements - sorry the parity requirements in the CHIP regulations and the Medicaid regulations will not be subject to the new requirement. So if your state does not have an approved CHIP Mental Health Parity SPA, we will be reaching out to you to make sure that that gets completed as soon as possible. And on the Medicaid side you also will need to make sure that all of your SPAs and contracts are in compliance with the rules in order to not be subject to the new rules in the…

(Virginia Perry): Okay, thank you.

Meg Barry: …SPA.

(Virginia Perry): Thank you.

Coordinator: Thank you. Next question comes from (Laura). (Laura) your line is open.

(Laura): Hi this is (Laura) from Illinois. I had a quick follow up question to something that (Mary Beth Chance) mentioned on a call last week. On a call last week she mentioned that the COVID-19 vaccine was outside of the VCS Program

so that states needed to remember not to leave its pediatric population out since vaccines were approved for 16 and up.

And I went back to the - I'm just not sure I was fully following what you said. I went back to the vaccine toolkit and it said that no said action is required to cover any newly ACIP recommended vaccines added to the pediatric vaccine schedule.

So our disaster SPA includes ages 16 and up in our budget estimate. Is that enough to meet the comment about not leaving the pediatric population out or is there something else we're supposed to be doing within the disaster SPA as well?

(Amy Lutzky): This is (Amy) from the Children and Adult's Health Program's Group - (Amy Lutzky). I don't think now (Mary Beth Hans) is actually not on our speaker line today. So I think that we will have to take that question back and follow up with you on it.

Coordinator: Okay speakers our next question comes from (Nikki). (Nikki) your line is open.

(Nikki): Hi this is (Nikki) from Pennsylvania. I have a question on No. 11 on Page 17 of the COVID-19 FAQs that were last updated January 6. This FAQ says that when the public health emergency ends states cannot seek recovery of premium payments that were failed to be paid by recipients during the public health emergency. I'm just seeking clarification on how the answer to this question is worded. It is worded where it says but who's Medicaid eligibility is maintained solely on the basis of the FFCRAs enhanced FMAP provision just makes it seem, like, maybe recovery could be pursued for certain individuals. So I just wanted to clarify if that's the case or if it's just for

anyone who fails to pay their premium payment during the public health emergency we shouldn't seek recovery.

(Jackie Glaze): (Sarah) can you take that question?

(Sarah Delone): This is (Sarah Delone). I confess I'm not completely following. I wonder if we'd be better off doing - taking that offline with you so we can make sure that we understand your question and give you the best guidance.

(Nikki): Okay, thank you.

(Jackie Glaze): Yes sure. Can I ask you to reach out to your state lead just to make sure that we don't, you know, we get back to you as promptly as possible?

(Nikki): Yes we can do that. Thank you.

(Sarah Delone): Perfect, thank you.

Coordinator: Our next question comes from (Chelsea) or possibly (Kelsey) your line is open.

(Chelsey): Hi (Chelsey) from Wisconsin.

Coordinator: Thank you your line is open.

(Chelsey): Okay I'm just confirming your (Kelsey) or (Chelsey). So I have two questions related to the information regarding the PREP Act. The first was that in our program's read of the recently released Fifth Amendment of the PREP Act, the list of covered persons was replaced and pharmacy technicians were no longer considered covered persons. I was just wondering if that is

correct just to make sure that we're aligning with PREP Act language in our SPA do we need to allow pharmacy techs still or is it only prior to that Fifth Amendment?

(Kirsten Jensen): Well I'll need to go back and take a look at that. I was not or we did not pick that up. So let me take a look at that and I'll get back with you.

(Chelsey): Okay. And I think maybe consider that because it only lists pharmacists and interns. It did not say techs anymore. And then the second question is that if our program only does enroll pharmacies and we do not enroll pharmacists, interns or techs, does our provider language only need to address pharmacies as another provider type or should we still reference pharmacists, interns and techs in accordance with the PREP Act?

(Kirsten Jensen): You should still reference the three providers and then you could include pharmacies as well.

(Chelsey): Okay, excellent, thank you for that clarification.

(Kirsten Jensen): Sure, you're welcome. Yes and we'll take a look at your first question. Our analysis didn't indicate that provider type had fallen off. So we'll go back and take another look.

(Chelsey): Thank you.

Coordinator: Our next question comes from (Lynn). (Lynn) your line is open. (Lynn) can you try and unmute please?

(Jackie Glaze): (Karen) maybe go to the next question and then maybe come back to this one if you can.

Coordinator: That was our last question in queue.

(Jackie Glaze): Okay.

(Lynn): Am I heard?

(Jackie Glaze): Let's take another…

Coordinator: Okay.

(Lynn): This is (Lynn) can you hear me now - sorry. Hello.

(Jackie Glaze): Yes we can hear you.

(Lynn): Okay thank you, sorry. My question was directed to the first presenter who mentioned the Medicaid program that allowed I believe it was under the employment support allowed the worker to earn above the normal threshold but receive some sort of supports. And I'm not sure if that was personal assistance. I'm thinking that's what she was talking about. But then if that was correct which of the options does that fall under?

(Jen Bowdoin): Hi this is (Jen Bowdoin). I think you're talking about Medicaid buy-in programs.

(Lynn): Buy-in?

(Jen Bowdoin): Yes there's the Medicaid buy-in programs. And it may make sense to reach out to your state lead and then we can get you more specific information on those programs.

(Lynn): All right, thank you.

(Jen Bowdoin): Okay, thanks.

Coordinator: Speakers we did have an additional question queue up. It's from (Jodie). (Jodie) your line is open.

(Jodie Kunkle): Hi this is (Jodie Kunkle). I work at Healthcare Authority in Washington. And I was wondering if - we're looking at how are we going to pay for mass immunization site vaccines. And we're wondering if there's not a service provider NPI but we have a billing provider NPI is that still a reimbursable service is question one? And then we're also wondering if we can have a state standing order or a county standing order as the service provider NPI?

Kirsten Jensen: This is Kirsten Jensen. We'll have to take that one back and consult with our provider enrollment staff.

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

(Jackie Glaze): We'll wait just another minute or two to see if we have any more questions and then we will close out. So (Erin) if you could watch to see if we have a question or two and then we'll close out in a minute or so.

Coordinator: Absolutely.

(Jackie Glaze): Thank you.

Anne Marie Costello: (Jackie) why don't we close out?

(Jackie Glaze): Okay, all right Anne Marie we'll turn to you.

Anne Marie Costello: Great, thanks. I just want to thank all of our presenters today for their excellent presentations and information. I know there are a couple of questions that we were not able to answer. I do want to encourage the callers to please reach out to their state leads and connect with them so that we can get your contact information and look more deeply at the issues that you raised and then we could come back and share them with the larger group as well.

We look forward to next week's call. We're still pulling together the topics and the invitation which will be forthcoming. But in addition to the questions you had today if other questions come up between calls please feel free to reach out to us or your state lead or refer the questions to next week's call. Thanks again for joining us today and hope everyone has a great rest of the day.

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

END