All-State Medicaid and CHIP Call
July 18, 2023

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Agenda

- Fact Sheet - Returning to Regular Medicaid Renewals: Monitoring, Oversight, and Requiring States to Meet Federal Requirements
- Medicaid & CHIP Unwinding Mitigation Strategies Table
- School-Based Services Technical Assistance Center
- Open Mic Q and A

Returning to Regular Medicaid Renewals: Monitoring, Oversight, and Requiring States to Meet Federal Requirements

Fact Sheet Released on July 18th

Returning to Regular Medicaid Renewals: Monitoring, Oversight, and Requiring States to Meet Federal Requirements Fact Sheet

Learn more on Medicaid.gov

Factsheet:

Returning to Regular Medicaid Renewals: Monitoring, Oversight, and Requiring States to Meet Federal Requirements

Every American should have the peace of mind that comes with access to affordable, quality health care. As pandemic-era protections for Medicaid coverage end, states across the country are resuming their regular processes for renewing individuals' Medicaid coverage. The Biden-Harris Administration is deeply concerned about people losing health coverage during the Medicaid renewals process and will do **everything in its power to keep Americans enrolled in comprehensive health care coverage**.

Since the start of this year, **the Centers for Medicare & Medicaid Services (CMS) has already taken action to require states to comply with federal requirements and fix problems and systems issues.** As described below, when CMS has identified problems, we have worked with states to pause certain terminations, reinstate coverage, and implement systems changes immediately.

CMS urges states to take up all our strategies to help eligible people renew their coverage through Medicaid or the Children's Health Insurance Program (CHIP), or, for those who are no longer eligible, help them transition to other forms of coverage, including the Health Insurance Marketplace®[1], Medicare, or employer-sponsored coverage.

Congress Gave CMS Significant Authority to Ensure States Comply with Federal Requirements

Under the Consolidated Appropriations Act, 2023 (CAA, 2023), Congress required states to submit certain data to CMS on a monthly basis and also gave CMS a range of new authorities to ensure state compliance with federal requirements. These tools included new conditions of eligibility for enhanced federal funding. They also included certain enforcement tools, including corrective action plans (a step-by-step plan of action to achieve a specific goal, like executing eligibility renewals aligned with federal requirements). If a state fails to implement the corrective action plan, CMS can then require the state to pause certain eligibility terminations and impose financial penalties.

Monitoring and Oversight

By actively monitoring for problems, CMS is taking quick action to resolve them and reduce the number of people losing Medicaid and CHIP coverage unnecessarily. To this end, CMS has developed a **multi-pronged data monitoring strategy** to:

[1] Health Insurance Marketplace® is a registered trademark of the Department of Health & Human Services.

Medicaid & CHIP Unwinding Mitigation Strategies Table

Released July 18th

Summary of State Renewal Mitigation Strategies

Table 1: Summary of Primary Mitigations

Mitigations and Other Strategies	Description
1. Holding procedural terminations	• Hold terminations that would otherwise occur due to beneficiary non-response to the renewal form, until approved mitigations are implemented. States will redetermine eligibility for affected renewals once those mitigations are fully implemented • This strategy may apply to some or all Medicaid beneficiaries, depending on the populations affected by the area of non-compliance with renewal requirements
2. *Ex parte* attempt prior to termination	• In states that lack automated *ex parte*/administrative renewal functionality, data sources are checked, and an *ex parte* determination is completed prior to termination for people who do not return a renewal form
3. Streamlining income determinations	• Includes strategies to simplify verification of income, including use of section 1902(e)(14)(A) waiver strategies to renew eligibility based on findings from SNAP or TANF. Also includes other authorities to streamline income determinations for people with stable sources of income (e.g., pension income) or no income
4. Streamlining asset determinations	• Includes strategies to simplify the verification of resources/assets at renewal, including modifying documentation requirements, temporarily waiving asset requirements for some populations, and/or renewing eligibility based on available information for certain assets unlikely to change
5. Streamlining renewal forms and requirements	• Includes strategies to minimize requests for unnecessary information on renewal forms, including providing simplified forms, adding instructions to specify which information is required, and/or pre-populating as much information as possible (e.g., demographic information) for MAGI populations and pre-populating renewal forms for non-MAGI populations • May also include adding instructions to help identify individuals as potentially eligible on another eligibility basis
6. Enhancing the availability & accessibility of other renewal submission modalities	• Includes strategies to facilitate renewals via specific submission modalities, for states without functionality to accept renewals via a required modality (e.g., online) • May include strategies to extend call center hours, provide flexibility for recordings of telephonic signatures and/or permitting individuals/organizations to be authorized representatives to assist with submission, accept and promote submission via fax or online upload of renewal documentation
7. Enhancing outreach and in-person assistance	• May include multiple approaches to support enrollees' completion of renewals, including sending reminders via multiple modalities (text, email, phone, etc.), highlighting the availability of in-person community resources and outstation eligibility works, or partnering with managed care organizations, providers, or other resources to provide in-person assistance with the renewal process
8. Additional policy changes to support retention	• Changes to simplify the renewal or reenrollment of eligible individuals, such as extending or implementing a reconsideration period for certain populations, accepting reasonable explanations to explain data inconsistencies, extending the time beneficiaries have to return documentation, etc.
9. Operational changes to support retention	• Changes to internal state agency staffing approaches and processes, including training staff to review required information for redetermining eligibility, implementing manual workarounds, reviewing and/or exchanging data between systems, etc.
10. Supporting transitions to Marketplace coverage	• Includes strategies to facilitate transitions to the Federally Facilitate Marketplace (FFM) or State Based Marketplace (SBM) such as enhanced outreach to notify individuals of potential coverage options, providing instructions for applying and enrolling in a plan, and/or connecting individuals to Navigators or assisters to receive additional assistance

Mitigation Plan Summary, Continued

Table 2: Areas of Non-Compliance with Renewal Requirements and CMS-Approved Mitigations, by State

State	Area(s) of Non-Compliance with Renewal Requirements	Primary Mitigations and Other Strategies
Alabama	• Conducting *ex parte* renewals for some non-MAGI populations • Transferring electronic accounts to the Marketplace for relevant non-MAGI populations	• Strategy 2: *Ex parte* prior to termination • Strategy 10: Supporting transitions to Marketplace coverage
Alaska	• Conducting *ex parte* renewals for the non-MAGI population • Renewal form requests more information than needed to determine eligibility (e.g., MAGI form is not fully pre-populated or individuals must submit a new application at renewal) • Ability to submit renewal forms through all required modalities • Determining eligibility on all bases • Transferring electronic accounts to the Marketplace for relevant non-MAGI populations	• Strategy 3: Streamlining income determinations • Strategy 4: Streamlining asset determinations • Strategy 5: Streamlining renewal forms and requirements • Strategy 6: Enhancing availability and accessibility of other renewal submission modalities • Strategy 7: Enhancing outreach and in-person assistance • Strategy 8: Additional policy changes to support retention • Strategy 9: Operational changes to support retention • Strategy 10: Supporting transitions to Marketplace coverage
Arizona	• Ability to submit renewal forms through all required modalities for non-MAGI populations	• Strategy 6: Enhancing availability and accessibility of other renewal submission modalities • Strategy 7: Enhancing outreach and in-person assistance • Strategy 8: Additional policy changes to support retention
Arkansas	• Conducting *ex parte* renewals for the non-MAGI population	• Strategy 3: Streamlining income determinations • Strategy 4: Streamlining asset determinations • Strategy 5: Streamlining renewal forms and requirements • Strategy 7: Enhancing outreach and in-person assistance • Strategy 8: Additional policy changes to support retention
California	• None identified	N/A
Colorado	• None identified	N/A
Connecticut	• Ability to submit renewal forms through all required modalities is available for the non-MAGI population • Determining eligibility on all bases	• Strategy 5: Streamlining renewal forms and requirements • Strategy 6: Enhancing availability and accessibility of other renewal submission modalities • Strategy 8: Additional policy changes to support retention
Delaware	• Conducting *ex parte* renewals for the non-MAGI population	• Strategy 1: Holding procedural terminations • Strategy 2: *Ex parte* prior to termination • Strategy 7: Enhancing outreach and in-person assistance • Strategy 8: Additional policy changes to support retention
District of Columbia	• Conducting *ex parte* renewals for the non-MAGI population • Renewal form requests more information than	• Strategy 3: Streamlining income determinations • Strategy 4: Streamlining asset determinations • Strategy 5: Streamlining renewal forms and requirements

Bipartisan Safer Communities Act of 2022
School-Based Services Technical Assistance Center

Financial Management Group - Division of Reimbursement Policy
July 2023

School-Based Services (SBS) is an Administration Priority

It is a top Biden-Harris priority to strengthen and expand access to Medicaid and the Children's Health Insurance Program (CHIP).

- **Schools are important providers** of Medicaid direct medical services for children
- Medicaid and CHIP **cover more than half of all children** in the United States
- SBS can include all services covered under EPSDT, including **physical and mental health care**
- **Schools can face a high administrative burden** when seeking reimbursement for SBS
- It is CMS's goal to **help states ease the administrative burden on schools**, to promote the delivery of SBS

BSCA SBS Requirements

June 2022: Bipartisan Safer Communities Act (BSCA) passes. Requires CMS to:

1. Update claiming guide
2. Launch technical assistance center (TAC)
3. Release $50 million in grants

August 2022: CMS Informational Bulletin (CIB): School-based health services under Medicaid, including CHIP

May 2023: Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming

June 2023: Technical Assistance Center- Support State Medicaid agencies, LEAs, & school-based entities seeking to expand their capacity for providing Medicaid SBS

2024: $50 million in discretionary grant funding to states in support of implementing, enhancing, or expanding the provision of medical assistance through school-based entities under Medicaid or CHIP

SBS Programs

- **Schools are primarily providers of education** and other non-medical services
- Most **third-party healthcare payers** other than Medicaid do not reimburse for services provided in schools
- **SBS fee-for-service rates should be same as community rates**, unless justified
- Medicaid-covered services provided in schools **must meet applicable statutory and regulatory requirements**

SBS Programs (Cont'd)

- There is **no Medicaid benefit category called "School Based Services**" -SBS are Medicaid-covered services that are provided in school settings by qualified Medicaid providers enrolled in the Medicaid program.
- To be eligible for payment by Medicaid, services must be **included among those listed in Title XIX of the Act, such as those described in section 1905(a) of the Act**, and coverable under the State plan (or waiver of such plan).
- **Services must be coverable in the state plan**, which makes services available to all beneficiaries under the EPSDT benefit- which provides a comprehensive array of prevention, diagnostic, and treatment services for most low-income individuals under age 21.

How Medicaid Can Support SBS

Medicaid SBS can promote health, educational equity, and increase school attendance in a series of ways, including by:

- Helping eligible students enroll in the Medicaid program
- Connecting students' Medicaid-eligible family members with Medicaid health coverage
- Providing Medicaid-covered health services in schools and seeking payment for services furnished (any covered service under EPSDT)
- Offering Medicaid-covered services that support at-risk Medicaid eligible students

How Medicaid Can Support SBS (Cont'd)

- Performing Medicaid administrative activities to improve student wellness
- Providing Medicaid-covered services that reduce emergency room visits
- Providing Medicaid-covered services and performing Medicaid administrative activities that promote a healthy, learning environment

SBS Modernization
"Free Care" SPAs

- States have the option to **allow schools to receive Medicaid funding for SBS delivered to all children with Medicaid**, rather than only those children with an IEP, a plan or program tailored for children with disabilities
  - **2014 - Medicaid services provided without charge in schools -"Free Care"** SMDL 14-006
- **States often need a SPA to expand SBS**
- As of the date of this presentation, **13 states have expanded Medicaid payment for SBS** under their state plans: AZ, CA, CO, CT, GA, IL, KY, LA, MA, MI, NM, NV, NC, OR
- **CMS encourages all states to adopt the "Free Care" policy in Medicaid to expand access to services for all enrolled children**

SBS Releases Timeline

June 2022: Bipartisan Safer Communities Act (BSCA) passes. Requires CMS to:

1. Update claiming guide ☑ (checked)
2. Launch technical assistance center (TAC) ☑ (checked)
3. Release $50 million in grants

August 2022: CMS releases CMS Informational Bulletin (CIB): School-based health services under Medicaid, including CHIP

May 2023: CMS releases the Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming Guide

- Provides series of new flexibilities
- Updates the Medicaid School-Based Administrative Claiming Guide 2003 & Medicaid and Schools Technical Assistance Guide 1997

SBS Releases Timeline (Cont'd)

June 2023: Technical Assistance Center

1. Support State Medicaid agencies, LEAs, & school-based entities seeking to expand their capacity for providing Medicaid SBS
2. Reduce administrative burden
3. Support such entities in obtaining payment for providing Medicaid SBS
4. Ensure ongoing coordination and collaboration between ED and CMS regarding Medicaid SBS
5. Provide guidance with regard to utilization of various funding sources

2024: $50 million in discretionary grant funding to states in support of implementing, enhancing, or expanding the provision of medical assistance through school-based entities under Medicaid or CHIP

Technical Assistance Center

Recent Developments:

1. The TAC contractor has been secured.
2. Technical assistance materials have been posted on Medicaid.gov:
    - Various approved State plan amendments that include cost-based methodologies or includes additional Medicaid SBS as a result of the change in the "Free-care " policy.
    - An approved Time Study Implementation Plan
    - Sample SBS cost reports
    - State Medicaid Director Letter (14-006) – Medicaid Payment for Services Provided without Charge (Free Care)
    - A listing of HHS School-based Health Services Resources

Technical Assistance Center Vision

- **Primary Audience:**
  - LEAs, Schools, and other School-based providers
  - States (Medicaid and State education personnel)
- **Primary Purpose:**
  - Answering request of assistance from School-based providers and States.
  - Resolving new and emergent Medicaid and ED-related school-based issues.
  - Coordinating with States (Medicaid and State education personnel) and school-based providers to resolve issues
  - Reducing overall burden for all school-based providers and States

Technical Assistance Center Vision (Cont'd)

- **How will we accomplish our primary purpose:**
    - Trainings/Webinars
    - Peer learning groups and discussions
    - The release of additional technical assistance materials

Technical Assistance Center Info

- !!!!! Open for business !!!!!
- TAC website: https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/medicaid-and-school-based-services/index.html
- For any questions email the technical assistance center: SchoolBasedServices@cms.hhs.gov

How Can You Help?

- Please contact us at SchoolBasedServices@cms.hhs.gov to let us know the type of assistance you would like to receive from CMS and the Department of Education through the TAC and your vision of how the TAC should operate.

Questions