Centers for Medicare & Medicaid Services

COVID-19 Medicaid & CHIP All State Call

May 11, 2021

3:00 pm ET

Coordinator: Welcome and thank you for standing by. All parties' lines have been placed in listen-only mode until the question-and-answer session of today's call. Today's call is also being recorded. If anyone disagrees you may disconnect at this time. It is now my pleasure to turn the call over to your host, Ms. Jackie Glaze. Thank you. And you may begin.

Jackie Glaze: Thank you. And good afternoon and welcome everyone, to today's All State Call and webinar. 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 everyone. I'd like to welcome you all to today's All State call, and thanks for joining us. We have a busy agenda. I'll start by noting that we're transitioning to a new webinar platform beginning with today's call. And we'll be using the webinar for the second and third presentations today.

So if you're not logged into the new platform I suggest you do so now. We've included instructions for joining the new platform with the invitation for this week's call and sent a reminder out earlier this afternoon. If you have any challenges accessing the webinar platform, we've also posted the slides for today's call, to Medicaid.gov and included a link to the document in the reminder note we sent out before the call.

If you didn't receive the reminder note and are having trouble accessing the platform, you could download the slides and follow along with today's presentation by visiting the COVID-19 page on Medicaid.gov scrolling all the way down to the stakeholder call section of the page, and you'll see a link to today's call and the document.

We appreciate your patience as we manage the technology transitioning for these calls. And now moving to today's agenda. Last week, CMCS released an update to our Vaccine Toolkit that covers changes to vaccine policy required by the American Rescue Plan Act of 2021, and authorization of the Johnson & Johnson vaccine.

For today's first presentation, Kirsten Jensen from our Disabled and Elderly Health Programs Group and Jeremy Silanskis from our Financial Management Group, will present on the Toolkit Update. Then we're excited to be joined by some special guests, Ben Sommers and Joel Ruhter from the HHS Office of the Assistant Secretary for Planning and Evaluation, are joining us to present on a recent ASPE data release on State, County and Local Estimates of Vaccine Hesitancy for COVID-19.

We think the data set is a valuable resource that states and stakeholders can use as you think about planning for the next phase of COVID-19 vaccine distribution and vaccinating those who are the hardest to reach. After Ben and Joel's presentation, we'll take your questions on the vaccine hesitancy data.

Finally, Maria Tabakov from our Medicaid and CHIP Operations Group, Ty McMillan from our Financial Management Group, and Adrienne Delozier from our Disabled and Elderly Health Programs Group, will present updates on the processing of disaster relief, state plan amendments, including

processes for rescinding or ending Disaster SPA provisions early and processes for making Disaster SPA changes permanent.

After the SPA presentation we'll take your general questions. With that, I'll turn things over to Kirsten, to start her presentation on the Vaccine Toolkit. Kirsten?

Kirsten Jensen: Thank you, Anne Marie. Hi. This is Kirsten Jensen. And as Anne Marie mentioned, CMS issued an update to the Vaccine Administration Toolkit on May 5, 2021. The updates primarily have to do with implementation of new mandatory vaccine and vaccine administration requirements for both Medicaid and CHIP.

The toolkit has also been updated to reflect the current COVID-19 vaccine EUA approvals and that vaccines are no available to everyone aged 16 and older. During the American Rescue Plan coverage period, and this is a lot to take in, which is March 11, 2021 through the last day of the first quarter that begins one year after the last day of the Public Health Emergency.

Coverage of vaccines and vaccine administration is mandatory for most Medicaid beneficiaries including adults and children. ARP - as ARP includes coverage of vaccines but the vaccine is currently federally purchased. So vaccine coverage and reimbursement is not expected at this time.

ARP established a new mandatory at 1905(a)(iv)(f) of the Social Security Act and amended other various sections of the Act. With these changes, nearly all Medicaid beneficiaries must receive coverage of COVID-19 vaccines and their administration without cost sharing. This includes adults covered under traditional Medicaid, children covered under Medicaid, children and adults

enrolled in alternative benefit plans, and adults enrolled under limited benefit plans either through the state plan or through 1115 waivers.

Limited benefit plan eligibility groups include individuals eligible only for family planning related benefits, tuberculosis related benefits, the optional COVID-19 group which was previously referred to as the COVID-19 testing group, medically needy coverage, and those eligible, as I mentioned, through 1115 expenditure authority.

After the ARP coverage period, COVID-19 vaccine administration coverage and vaccine coverage, will revert to pre-ARP coverage rules, including those for limited benefit groups. States could opt to cover vaccine administration under various benefit categories or pursue the one percentage point increase in FMAP for expenditures on coverage of adult vaccines and their administration, as well as certain other preventive services that was authorized as part of the Affordable Care Act.

CMS will be available for technical assistance if needed, when this time comes. There is a section in the Vaccine Administration Toolkit that describes the options available at this time, and includes a table of what state plan amendments may be needed.

So with that, and I just want to correct something I said. The new benefit is actually established at 1905(a)(iv)(e) for vaccine and vaccine administration. So I want to make that clarification. And with that, I will hand it over to Jeremy Silanskis, to talk a little bit more about reimbursement and CHIP coverage.

Jeremy Silanskis: Great. Thank you, Kirsten and good afternoon everyone. In addition to the updates to the benefit section of the toolkit that Kirsten discussed, the Vaccine

Toolkit was updated to describe changes that apply to Medicaid reimbursement, as well as increases to the federal match rates for vaccine administration that apply to Medicaid and CHIP and were effectuated under the ARP.

As many of you are likely aware, on March 15, 2021 CMS updated the Medicare payment rates for COVID-19 vaccine administration. Effective for services furnished on or after March 15, 2021 the new Medicare payment rate for administering a COVID-19 vaccine, is approximately $40 to administer each dose of a COVID-19 vaccine.

This means that starting on March 15, 2021 for single dose COVID-19 vaccines Medicare will approximately $40 for its administration. Additionally, for COVID-19 vaccines requiring multiple doses, Medicare now pays approximately $40 for each dose in the series. This rate reflects updated information about the costs involved in administering the COVID-19 vaccine for different types of providers and suppliers. And the additional resources necessary to ensure the vaccine is administered safely and appropriately.

The rate will be geographically adjusted based on where the service is furnished. The toolkit has been updated to reflect the Medicare payment rates that went into effect on March 15th. As was previously described, Sections 9811 and 9821 of the ARP, established a new mandatory benefit for COVID-19 vaccines and their administration without cost sharing for nearly all Medicaid and CHIP beneficiaries.

Both provisions provide a temporary 100% match rate for amounts expended by a state for Medicaid and CHIP COVID-19 vaccines and their administration. The increased match will apply beginning April 1, 2021 and

will end on the last day of the first quarter that begins one year after the last day of the COVID-19 emergency period.

We recognize that Medicare's announcement of changes in the payment for COVID-19 vaccine administration combine with the authorization of the temporary 100% FMAP and ARP, might have implications for states with approved SPAs or pending SPAs and for states considering payment change for vaccine administration.

States with questions on the impact of these changes on their programs, should contact their CMS leads for technical assistance. We do not expect that all states will need to submit a vaccine administration payment SPA to meet the ARP FMAP period.

States may elect to apply existing general vaccine administration payment rates to the COVID-19 vaccine, because most states have adopted some form of payment for administration of vaccine. However, in the event a state does not currently pay for the administration of the COVID-19 vaccine, the state would need to submit a SPA establishing payment for the new mandatory COVID-19 vaccine benefit.

For states that have established payment for COVID-19 vaccine administration through a Disaster Relief template only, those states would need to submit payment SPA language to cover any period that exists between the end of the PHE and the end of the ARP coverage period. But because the ARP coverage period will extend beyond the PHE and the Disaster Relief SPA template expires at the end of the PHE, states will have to come back in and submit a new SPA to provide for that gap.

We intend to provide additional guidance to states on implementation of the 100% FMAP available for payment to providers for administering COVID-19 vaccines as soon - very soon, as well as guidance about state plan submission for benefits, cost sharing, and reimbursement.

We will also issue additional guidance regarding PREP Act Amendments 5, 6 and 7 and information about dental codes. We also wanted to note that for CHIP we're clarifying the toolkit that states are now required to provide COVID-19 vaccines for pregnant women, without cost sharing during the PHE, for one year after the PHE.

States with CHIP - pregnant women coverage, will need to submit a SPA demonstrating compliance with this requirement. More guidance will be forthcoming on submitting these SPAs. I hope you all find the updated toolkit information useful and informative. To access the toolkit and other Medicaid COVID-19 resources, please visit the Medicaid.gov landing page.

I will now turn it back to Jackie Glaze, to continue with our call for today. Thank you.

Jackie Glaze: Thank you, Jeremy. And thank you, Kirsten. Next, Ben Sommers and Joel Ruhter from ASPE, will discuss the data that was recently released on the vaccine hesitancy. So Ben and Joel, I'll turn it to you at this point.

Ben Sommers: Great. Thank you so much. And thank you, for - to CMCS and Anne Marie, for inviting us here today. We're really excited to tell you about this data set. And what we're going to do is give you a bit of an overview and then we'll use some of the slides to show you some screen shots. And while I'm giving the overview, if we're able to, what we'll try to do is paste the link into the Q&A,

so that you can access it directly. But we'll make sure that everyone has access to the Web site itself.

So just by way of introduction, I'm the Deputy Assistant Secretary in the Office of Health Policy at the Department of Health and Human Services. And in our office we've been analyzing data to try to help with outreach efforts to those folks who have not yet received COVID vaccination and may be open to the possibility but we really have to kind of do good outreach and to meet them where they are.

So I'm also joined today by Joel Ruhter who is one of the analysts in our office, who has been leading the data analysis, along with several colleagues. So the way this data set is structured is we took a national survey that was conducted by the Census Bureau, called the Household Pulse Survey.

And in the Pulse Survey, which is conducted online and by phone, every two weeks we get an updated round of data and one of the questions that they ask is have you received a COVID vaccination? And the other question that they're asked that we're using here, is if a COVID vaccine - once the COVID vaccine is available to you, would you get it?

And people are able to pick an option ranging from definitely get it to definitely not get it. So with that, what we're able to do is estimate for the state as a whole, all 50 states plus DC, what share of people respond that they are either probably not or definitely not going to get the vaccine.

And then we also have a second data set that we're using because we know that state level estimates are helpful but not really want, we want to do for targeted outreach. So we also then are using a much larger data set, the American Community Survey, which is the Census Bureau's biggest survey.

And with that what we're able to do, is map within each state, to local levels of around 100,000 people. And we can take the features that we know about the people in that Pulse Survey and we can say well we know that there are certain factors that track with higher or lower vaccine hesitancy rates. And we can look at things like age, sex, marital status, education, health insurance type, race/ethnicity, language spoken, etc.

We can take all of these factors into account, feed them into our model and then tell you well it's not just here's the level of hesitancy in the state as a whole, but we can actually now distinguish between different areas within the state.

We've presented - on the Web site we have two different levels that you can look at on the map. You can look by county or you can look at the local level. And the local level is defined based on the population. So we're able to look at areas of about 100,000 people. That means in cities we are able to tell you what the neighborhood estimates look like.

We have 10, 15, 20 estimates in some of the big cities. You know, if you look at Los Angeles, if you look in New York, you can really drill down. In some of the states that have more - lower population density, that 100,000 may cover several counties across the state. And so depending on where you are and what sample you're looking at, you'll see the map has different levels of detail.

But we hope you can do with this data set is you can click on it, you can get information on not only the vaccine hesitancy rates but also some important demographic context. So I'm going to turn it over now to Joel, who's going to

walk you through some of what you can access if you actually go to the Web site, and then we'll be happy to take any questions and comments.

Joel Ruhter: Great. Thank you, Ben. So as Ben described, we have posted some estimates of COVID-19 vaccine hesitancy on the ASPE Web site to hopefully help stakeholders with vaccine outreach. That - those links might not be right on the top of our Web page anymore. I know Ben said we'll hopefully post the link in the Q&A. Also if you were to go to the ASPE Web site and just search vaccine hesitancy, it comes right up.

In the next few slides I'll show a little of the data that we've posted there, as well as some of the maps of what those data look like and features there. Right. So on this slide, we've got two little stat snips of the Excel file that's posted there on the Web site. The file is called Predicted Vaccine Hesitancy by State, PUMA which is this local area Ben was talking about, and county.

And in it as Ben said, we use data from the Household Pulse Surveys to estimate what are the demographic correlates with vaccine hesitancy; what sorts of demographic factors are more or less associated with someone saying they probably or definitely would not get a COVID-19 vaccine. So we use that to predict on the larger American Community Survey sample to create these focal estimates.

So what you're seeing here on this slide, the kind of left upper portion that's below is the overview page and it has a little bit of a description of the file itself. You see some links, if you can kind of read the type, depending on how big your screen is, you know, to estimates of hesitancy by state, PUMA and county. And those are different tabs within this Excel file.

And then there's a little description of the data source. Then it mentions the See Methodological Descriptions for more Details, that's also linked on the site there. And then kind of on the bottom right is a few rows of the county level file. Just to show you the layout if you were to download and open this file, each row is a different county and then there are columns corresponding to estimates of hesitancy, of what we called hesitancy or kind of strongly hesitant.

And that's just - we've defined those who are hesitant as individuals who are saying that they either probably or definitely not would get a vaccine. And then the strongly hesitant are those who said they definitely would not. Kind of a smaller group there.

So that's the kind of raw data. It's, you know, it's a little hard to scroll through an Excel file and kind of visually know how it looks on a map. So if we could go to the next slide, so this is then a map of that county level data. It shows this kind of yellow to blue color gradient by county, indicating the estimated percentage of adults in the county who would be hesitant to get a COVID-19 vaccine.

So we also have an interactive version of this on our Web site. You can kind of pan around and zoom and click on an individual county to have it say the county and a couple of the demographic factors that we have there. Can't quite do this on this slideshow, but if you go there you can see that and that can be helpful to folks. Next slide, please.

So here we have a zoomed in map of the Chicago area. And here's where I'm going to give a little plug for PUMAs. These would be the local estimates that Ben was talking about; these local areas that are called public use microdata areas. You don't need to know the name but they are kind of these smaller,

roughly 100,000 person units of geography that let us have the most granular geographic estimates.

And why this is important is you'll see kind of the kind of southwest shore of Lake Michigan here, where Chicago is, you see that there are several of these different PUMAs. And if you were just looking at a county level map that would just show up - or much of that would just be Cook County. Right? And you wouldn't have a sense of the variation; you wouldn't know the kind of - these estimates would suggest that kind of Lincoln Park, the more affluent area, it has kind of higher or lower estimates of hesitancy and further south maybe in Pullman, they are higher.

And so if you're wanting as part of the outreach effort to kind of have a sense of where there may be more or less hesitancy based on what respondents of the Pulse Survey are saying, that's PUMA level file and the map lets you do that. So that said, you know, if you were opening up the PUMA file it's going to be really hard because these aren't geographic units that the average person has any familiarity with and that's understandable.

And so that's part of why we wanted to have this interactive map so that kind of with the file you could look around and say okay, wait, this PUMA that says the pier, where exactly is that? You kind of place it in your mind and have a sense of where - a better sense of where these hesitancy variations are. Next slide please.

And then this is simply just if you - an example of if you click on a given PUMA what pops up. So you get the name, the estimates of hesitancy that we got from our model, and the demographic, in this case the race/ethnicity demographics from the American Community Survey that underlies this map. So you can kind of see how some of the hesitancy estimates and dimorphic

kind of move as you click on different PUMAs around the country. Yes. Next slide please.

So I haven't followed - we've got the link - it does look like we have the links now in the chat, so you don't necessarily need this slide that's just put in there. But these are the URLs presented today. And if you fail to again, fail to copy down these links and we close out the WebEx and you've forgotten them, just know that if you go to ASPE.HHS.gov and search vaccine hesitancy these results should be at the top. So it should be relatively easy to find. And that's it for me.

Jackie Glaze: Thank you Ben and Joel, for sharing this data with us. So we're ready to take a few questions from states at this point. So you can begin submitting your questions first through the chat function. And then we'll follow with some questions by the phone lines. So if you're logged into the webinar you can go ahead and start submitting your questions at this point.

Ashley Setala: So it looks like we have a question that has come in through the chat that says what is the ability to handle a COVID-19 outbreak data in the map based on?

Ben Sommers: So in addition to the demographic data that came up when Joel showed you that screen shot, in the county data we have a couple of other measures that come from the CDC and from the Census Data. And so I think what the question is referring to here is in that county map you'll see there's the social vulnerability index, and then there's also an index that the CDC has developed that relates to kind of the capacity of an area to handle an epidemic, the COVID epidemic and therefore, kind of the priority of doing vaccination. This is called the CVAC Index.

There is some more documentation in the methods PDF on the same Web site, that tells you about where these data sources come from. But that's a CDC measure. That's not something that ASPE is creating. It's simply something that we added as context, along with the social vulnerability index and then the percent vaccination rate as of - CDC data from March 30.

So those are the data points that pop up in the county map when you click on it, in addition to the hesitancy and demographics.

Ashley Setala: Okay, great. And then we have another question that says were any influential factors found to have caused vaccine hesitancy or to reduce it?

Ben Sommers: Great question. So, you know, we publish the maps and the raw data sets. The next step is we are actually in the process of updating this with some newer survey data. As I mentioned, the Pulse Survey is done every two weeks, which gives us the chance to bring in some newer information.

And as part of that we are also preparing a report that is going to analyze some of the changes in hesitancy rates over the past several months, in addition to some of the trends by different demographic groups. In doing that one of the things we've been studying is the pattern of hesitancy.

Now a lot of - there have been a bunch of studies out already that have looked at this. And we know that some of the key drivers for higher hesitancy rates include race/ethnicity, lower levels of education, and actually interaction between those two as well. But younger adults also had higher hesitancy rates earlier on in the pandemic.

And then finally something that we know will be of interest to the audience here, we do look at patterns by health insurance and we find that Medicaid

beneficiaries even after taking into account those other factors, do tend to have higher hesitancy rates than folks with other types of insurance, which really points to the key role that, you know, state Medicaid programs and your community partners and plans, can play in addressing hesitancy.

Ashley Setala: Okay. Great. It looks like those are the questions that have come in through the chat, on hesitancy, so far.

Jackie Glaze: Thanks Ashley. So I'll ask (Sandy), if you can provide instructions to the participants on how to register their question through the phone lines, to see if we have any questions there.

Coordinator: Yes. If you'd like to ask a question over the phone, please press star 1. Please ensure your phone is unmuted and record your name to ask a question. Again, that is star 1 to ask a question. So one moment while we wait for any questions to come in.

Ben Sommers: While we wait, one additional point that's just worth highlighting is that the survey that we're using is for adults. And so this is for respondents 18 and over. Obviously with the new approvals for COVID vaccination in adolescents, you know, 12 to 15 and also 16 and over that were previously approved, that's going to be a really important set of questions too, around children and vaccination patterns.

We don't have that in here yet. We are hoping to do so. But we're exploring what our data options are. So that obviously is an area that we know is probably on the minds for many of you as well.

Jackie Glaze: Thank you for adding that. (Sandy)?

Coordinator: And currently, there are no questions in the…

Jackie Glaze: No? Okay.

Coordinator: No.

Jackie Glaze: Okay. So and I know we'll have time at the end of the session. So we can certainly take questions at that point. So now what we'll do is we'll turn to the CMCS team and they will share updates on the Disaster Relief SPA process. So I'll turn first to Maria Tabakov to begin her presentation. So Maria?

Maria Tabakov: Thank you, Jackie. Good afternoon everyone. As Jackie mentioned, today we will provide two processing updates for Disaster Relief State Plan Amendments. The first topic is rescinding or ending early provisions of an approved Disaster Relief SPA. Second, we will discuss options for making provisions to approve a Disaster Relief SPA Permanent.

As things have changed over time, a number of states have expressed interest in rescinding or ending Disaster Relief SPA provisions earlier than originally approved. We would like to take this opportunity today to share with you the guidance to rescind or end early Disaster Relief SPA provisions.

The Disaster Relief SPA template should not be used to rescind or end early approved provisions because the template may not be used to propose changes that restrict or limit payment, services or eligibility, or otherwise burden beneficiaries and providers.

Removing a provision from a Disaster Relief SPA or ending a provision earlier than originally approved, is considered a reduction even if the state is reverting to a previously approved state plan. Next slide please. A Notice to

Submit an amendment to rescind or end early an approved Disaster Relief provision the submission must include the following.

A rescission SPA must be submitted on a separate state plan page. CMS recommends creating a subsection to follow the approved Disaster Relief SPA pages entitled 7.4.A Rescissions to the State's Disaster Relief Policies for the COVID-19 National Emergency. Some states have used Section 7.5 for their Disaster Relief SPA so the state should use Section 7.5.A for their rescission.

So submissions are also subject to all federal submission requirements such as issuing public notice, conducting tribal consultation, admitting the submission effective date requirement for the SPA to be submitted, the quarter in which it's gone into effect. Therefore, 1135 SPA submission flexibilities may not be used for Disaster Relief by rescissions or ending provisions early.

Now I will turn it over to my colleague Ty McMillan, to cover the options for making provisions approving a Disaster Relief SPA Permanent.

Ty McMillan: Thank you, Maria. Good afternoon everyone. Yes. I would like to talk options that we have for - states have for making provisions approved in a Disaster Relief SPA Permanent. So first I would like to note that states should not have the same provision or language in an approved Disaster Relief SPA with the same or overlapping effective periods included in this permanent state plan.

States have several options and I'll go over a couple of those options in a moment, regarding the process to include provisions included in a Disaster Relief SPA in their permanent state plan. As always, CMCS will provide technical assistance to states as requested, to determine that - the best path forward to meet the state's needs.

For some additional information a link has been put into the slides that links back to a all state call from last year, in June of last year, that provided information on federal requirements for retaining Medicaid state plan flexibilities adopted during the PHE, which also included public notice, tribal consultation, and submission effective dates. Next slide please.

One option is for submitting a regular SPA before the end date of the PHE is known. The state should submit the SPA with the requested effective date of the day after the PHE ends. Now a side note is that if the SPA is required in the system MACPro, the system requires a specific effective date. So CMS will work with the state to establish a workaround if needed.

So CMS will review the SPA following all normal processes and timelines. Once that SPA is ready for approval CMS will issue the approval package with the effective date identified as the date after the PHE ends. The approval letter will contain language indicating the SPA is not effective until the date after the PHE expires.

Once the end date of that PHE is known, all SPAs approved in this matter will be reissued with a technical collection adding a specific effective date of the day after the PHE ends. Important to note, this will be an action that CMS will take. No action is required by the state. Next slide please.

The second option for states is waiting to submit the SPA until the day of the actual end of the PHE, the date of the end of the PHE is known. In a letter from US Department of Health and Human Services Acting Secretary, Norris Cochran, to governors back on January 22nd of this year, the PHE or the letter noted that the PHE will likely continue to at least the end of the 2021 calendar year, that states will receive at least 60 days' notice that the PHE is ending.

For states electing to submit permanent SPAs after the end date of the PHE is announced, the 60 day period will allow states sufficient time to conduct public notice, tribal consultation as necessary. If not already completed of course. And to submit the SPA in a manner that will preserve an effective date on the day after the PHE expires.

This would allow the initial approval of the state plan to include a final effective date without the need for a technical correction. If a state wants to go with this option, CMS as a whole, is available to work with the state on that SPA, in draft, including before the end of the PHE is known, so that the official process can move quickly.

So now I'll hand it over to Adrienne Delozier.

Adrienne Delozier: Thanks, Ty. So add a wrinkle to this process. We've had a few SPAs submitted lately that have included multiple changes in a single SPA where some of those changes are to make changes included in an approved Disaster Relief SPA Permanent, but some of the changes are entirely new.

States do have the ability to submit multiple changes within a single SPA. However, with the exception of SPAs submitted through MACPro, the entire SPA submission must have the same effective date. As you just heard, SPAs that make provisions already approved in a Disaster Relief SPA Permanent, cannot be effective until after the PHE ends. Meaning that the rest of the new provisions included in the same SPA, also could not be effective until the end of the PHE.

If you want to make multiple changes, some already approved in a Disaster Relief SPA and some entirely new and you want the new changes to be

effective before the end of the PHE, there are two options. Next slide. First, you could submit two separate SPAs. One would contain the new changes and could be effective prior to the end of the PHE assuming that all applicable federal requirements were met.

The second would contain the provisions already approved in a Disaster Relief SPA and that would be effective after the end of the PHE following the process that Ty just outlined. If you already have submitted a single SPA with both types of changes, you can work with CMS to split it in this manner. Next slide.

The other option is to submit one SPA with all the changes and also include a page to rescind the overlapping provision from your Disaster Relief SPA all with the same proposed effective date. This option allows for sunsetting of the approved Disaster Relief SPA provisions and the approval of the permanent SPA to occur simultaneously.

There are two things to note though, if you want to use this option. The entire SPA including the Disaster Relief SPA provision rescission, will be subject to all federal requirements including upper payment limit requirements, public notice, tribal consultations, and effective date limitations as applicable.

Also the rescissions to the approved Disaster Relief SPA must be submitted on a separate state plans page as Ty just - or as Maria described earlier. So I'll turn it over to Jackie Glaze to facilitate any questions.

Jackie Glaze: Thank you Adrienne, Ty, and Maria, for your presentation. So we're ready to take your questions now. So again, we'll follow the same process. You can submit your questions through the chat function and then we'll take questions over the phone line. So we'll wait for your questions.

Ashley Setala: And while we're waiting for people to submit their questions, we have a few that were pre-submitted via our Medicaid COVID-19 email box for today's call, as well as one follow up question from our last all state call that we wanted to start with.

So the first question which is - was asked on our last all state call that focused on violence prevention services in Medicaid, says has CMS thought of providing any allowances for victims of domestic violence as it applies to the information required to make a (MAGI) eligibility determination?

For example, a survivor who is no longer in the home but who is expecting the abuser to file on her behalf in such a way that his information would be required for an eligibility decision. As of yet, states have been unable to waive this requirement. Is consideration being given to these types of scenarios?

Sarah Lichtman Spector: This is Sarah Lichtman Spector. I'm the Director of the Division of Medicaid Eligibility Policy and I can take that one. We understand that for this population, contacting an abusive spouse to file jointly or obtaining information for a (MAGI) determination may pose safety or legal concerns.

The regulations around (MAGI) based income and household composition, 42 CFR 435603(f), do not include an exception for victims of domestic violence. But generally, spouses that live together and spouses that expect to file a joint tax return for the year, are in each other's (MAGI) household.

However, states do have the option to interpret 435603(f)(i) to include - to either include or not include joint filers in each other's households if they do

not live together. This option must be though applied uniformly and couldn't be directed to specific situations like domestic violence.

An individual in a transitional situation may have uncertainty about their future tax filing status, and it would be reasonable to expect that a victim of domestic violence would either file separately from the spouse or not file for the year, depending on their circumstances.

And absent any information to the contrary, it would be reasonable for the Medicaid or CHIP agency, to either determine the individual's (MAGI) as a single not joint tax filer, or to apply the non-filer rules. In any of these scenarios the abuse spouse would not be included in the victim's household because they don't live together and the victim does not expect to file jointly with the abusive spouse.

As a reminder that when determining (MAGI) based eligibility, the individual's tax filing status is based on the individual's reasonable expectation at the point in time of the application, renewal or reported change in circumstances. And because circumstances can change over time, the individual's actual filing status may turn out to be different.

States do not need to submit a state plan amendment to reflect their interpretation of 435603(f) that I've just described. But CMS certainly is available to provide additional technical assistance as requested or needed. I want to address one more scenario though. If the victim of domestic violence does expect to file jointly during the current tax year, the individual's tax filing status may change in the upcoming year.

And in this situation states can apply the reasonably predictable changes option which would not include the abusive spouse in the victim's household.

Generally, in order to elect this option, the reasonably predictable change, a state would need to submit a state plan amendment. And if you're interested in that particular option, please do contact your state lead. We're happy to provide more technical assistance.

I just want to end with a note about some particularly good resources that are available up on Medicaid.gov. We've updated and have an enormous amount of additional - a large significant slide deck on (MAGI) based household composition and income including various scenarios around household composition. And they include this particular one we've talked about today.

Those can be found on Medicaid.gov in the MAC learning collaborative tab on the Resources for States page. And from there you would select the expanding coverage learning collaborative. And I hope that this was helpful. Thanks.

Ashley Setala: Great. Thank you, Sarah. Then we have a couple of questions that were submitted around redetermination at the end of the Public Health Emergency. And the first question is around the date of termination in six months. Was that period for the end of the Public Health Emergency. And it says, if the PHE ends in December we will presumably have 60 day notice from CMS of the expiration.

So we will know in October that it will end in December. If we have an individual who is determined ineligible in October and we've done them a pre-closure notice in compliance with the show requirements at that determination, are we allowed to send the final advanced notice of closure in the beginning of December, to have benefits terminate effective January 1?

Or if the PHE ends in December do we have to wait until January to send the final advanced notice of closure? And then for the six month lookback period, if benefits terminate effective January 1, the six months period would be July 1st through December 31st. Correct?

Jessica Stephens: Thanks, (Ashley). This is Jessica Stephens. I can cover - this is a two part question. On the first question that as raised I think this is one of the areas that, you know, given some of the state feedback we've received, we are doing a little bit more thinking about and intend to provide a little bit more guidance to states in the near future. So I don't have a final answer there.

On the second question, about the six month lookback period and confirming sort of what the time period would be, I would say similarly, that there is a little bit more thinking that we're doing on that particular item as well, given some of the questions that states have raised. But yes, the - based on the guidance that we, you know provided in the December State Health Official letter, the six month period would be July 1st to December 31st.

But only with the assumption that the termination would occur effective January 1st. Because the six month period as described, is not six months to the end of the Public Health Emergency. It is six months prior to the date that the state would terminate the coverage for the individual.

So unless the state was planning to and unless we can't confirm, which we aren't at the moment, that coverage can be terminated effective January 1st, then that would not apply. Short answer, I think more thinking doing here and I know there was a question on the last all state call too, that relates to this and more to come. Thanks.

Ashley Setala: Okay. Thank you, (Jessica). And then we have one more question that was submitted around redeterminations. And it says our state adopted continuous eligibility for children. With the continuous eligibility or continuous enrollment requirement of the FFCRA we are extending enrollment for children through the PHE and beyond.

When the PHE ends and the state conducts the redetermination finding the child ineligible or the household does not respond, is the state obligated to continue enrollment for children through the extended period established due to the FFCRA provisions, even if the date is after the month the PHE ends? Is the state obligated to continue enrollment for children under the continuous eligibility provision through the - oh yes, through the extended period under the FFCRA even if that date is beyond the end of the PHE?

(Shannon Londgrin): Thanks (Ashley). This is (Shannon Londgrin). I can tackle this one. So for continuous eligibility for children, a new continuous eligibility period begins on the effective date of the child's eligibility or their renewal of eligibility. So, you know, during the Public Health Emergency and, you know, even outside of the Public Health Emergency, when a child is redetermined eligible in a state that provides continuous eligibility, the state must begin a new continuous eligibly period for that child.

And providing continuous eligibility means that the state does not act on most changes in circumstances for the child during their continuous eligibility period. You know, because continuous eligibility is tied to the renewal of eligibility or the effective date of eligibility, states are not able to grant a new continuous eligibility period for a child that's determined ineligible or whose eligibility can't be renewed.

And so while, you know, during the Public Health Emergency, while continuous eligibility may not be provided for, you know, a child that's - whose eligibility can't be renewed, we also know that states are not able to terminate coverage for most Medicaid beneficiaries through the end of the month that the Public Health Emergency ends, as a condition of receiving the increased FMAP that's authorized under the FFCRA.

So for a child who remains enrolled during the public health emergency but is not able to be provided a new continuous eligibility period, because eligibility couldn't be renewed, there is an obligation for states to continue to act on changes in circumstances that could affect their eligibility while they may remain enrolled.

And so if a change is reported and a child is later redetermined eligible then the state would begin a new continuous eligibility period at that time.

Ashley Setala: Okay. Thanks, (Shannon). Then we have a few different questions that have come in through the chat today and we have a couple for CMS around vaccines. And the first says the district got a question about whether Medicaid can pay an incentive for individuals to get vaccinated. Are there any updates on whether Medicaid will allow for the program to pay out incentives for vaccine take up among those who may be resistant?

Rory Howe: This is Rory Howe with the Financial Management Group. We have received a number of questions from states on this topic. And it is something that we're actively working on and we hope to have information out as soon as possible.

Ashley Setala: Okay. Thanks, Rory. Then we have a question that says the new toolkit says there will be more guidance forthcoming about the 100% FMAP for vaccine

administration. When can we expect that guidance and what kinds of information can we expect to be in the guidance?

Jeremy Silanskis: Hey. This is Jeremy Silanskis. So we are working on that guidance. And I don't have an estimated timeframe at this point. But, you know, we're hoping sooner rather than later. And, you know, I think in general, you know, we're looking at guidance for states in terms of claiming the 100% FMAP just in general.

Ashley Setala: Okay. Thanks, Jeremy. Then we have a question that has come in around individuals enrolled in HCBS waiver programs. And it says an individual is enrolled in an HCBS waiver program and ineligible but remaining enrolled due to COVID disenrollment restrictions.

If the individual wants to switch to a different agency for its HCBS waiver program, is that other agency required to accept this person due to the COVID rules even though the individual does not meet all of the enrollment requirements and would not be eligible for the program under normal circumstances?

And do different agencies under the same program, have to take on ineligible transfers?

Ralph Lollar: And this is Ralph Lollar. What I would say is let's start with the fact that the FFCRA doesn't change provider obligations or rights under the Medicaid requirement. But as we've indicated in the guidance, if an individual no longer meets level of care requirements for his/her current 1915(c) waiver or any other waiver that's approved in the individual states, the individual's choice of providers becomes essentially irrelevant because the individual won't have any right to coverage of C services. They're maintained on

Medicaid eligibility. But we've informed states that they don't have to be maintained on the waiver.

So essentially, if the individual is not eligible based on level of care they maintain their Medicaid eligibility but they don't maintain the eligibility for the waiver services. Therefore, the selection of waiver providers becomes an issue that is moot.

Ashley Setala: Okay. Thanks (Ralph). Then we have a question that says how would a state end a provision that was approved via 1135 waiver?

Jackie Glaze: Ashley, this is Jackie. I'll take that one. So states do have the ability to utilize their approved 1135 flexibilities as they see that they need them. So you can turn them on and off during the Public Health Emergency as you determine that you need them. And we will also provide additional guidance on states when the Public Health Emergency is ending and how to inform providers and your beneficiaries, as needed.

Ashley Setala: Thanks, Jackie. Then we have a question that says is the community spouse excess shelter map forthcoming so that states can update their systems to include the standard because it becomes effective on July 1st?

Sarah Lichtman Spector: This is Sarah Lichtman Spector. I can jump in on that one.

Gene Coffey: Okay. Go ahead.

Sarah Lichtman Spector: Good. All right. Well I'll begin (Gene), just to say that we're working on those numbers and we - they are coming shortly. And let me see if my colleague Gene Coffey, wants to jump in with anything else.

Gene Coffey: No. That's it. Yes. Thanks for your patience. We do anticipate that we are going to have the numbers published very soon. We do understand and appreciate that, you know, many of you want these figures before the end of this month so that they can be rolled out on July 1st.

So, you know, we might have them available during our (ETAG) meeting for those who participate in our (ETAG) discussion, I believe next Wednesday. But in the meantime, we are working as quickly as possible on those numbers and we do hope to get those revisions to you as soon as possible.

Ashley Setala: Okay. Thanks, Gene and Sarah. Then we have a question that's come in that's a clarification of the continuous eligibility question. And it says, just to clarify on the CE question. So as we do renewals or reevaluations at the end of the PHE, if found an individual doesn't meet the criteria or did not provide information, they get a new CE period for 12 months or no, we can close the case and turn off that logic for CE and not skip another 12 months?

(Shannon Londgrin): Hi. This is (Shannon). So I think if I understand the question I think the state is asking what they do after the Public Health Emergency. And so, you know, a continuous eligibility period is granted when a child's eligibility is renewed.

So if a child either comes up for renewal or the state is completing another redetermination at the end of the Public Health Emergency, if they are found ineligible or eligibility cannot be renewed, then a new continuous eligibility period would not start after the Public Health Emergency ends.

Ashley Setala: Okay. Thanks, (Shannon). It looks like those are the questions I had come in through the chat at this point.

Jackie Glaze: Thank you, (Ashley). So (Sandy), could you also provide instructions one additional time, to the participants on how to register their questions? Then we can take questions over the phone line at this time.

Coordinator: Of course. To ask a question, please press star 1, unmute your phone, and record your name. Once again, that is star 1, unmute your phone and record your name to ask a question. One moment, while we wait for any questions to come in.

Our first question comes from (Molly Slotnick). And I apologize if I have pronounced that wrong. You may go ahead.

(Molly Slotnick): Hi. Yes, thank you. This is (Molly) from Maine and I asked the previous question about the - when we might expect to receive the guidance about the 100% FMAP for vaccine administration. And I was wondering if CMS can provide any sort of information about the categories or topics that will be in the guidance, because these are the questions that we're asking here in Maine as we wait to receive the guidance.

So I'm wondering whether there's going to be anything about CMS report, CMS 64 reporting, anything about restrictions on eligibility groups or restrictions on provider types. Just the general categories of information that we can expect to see in that guidance. Thank you.

Jeremy Silanskis: Sure. And, you know, it is subject to review here. So nothing I can confirm at this point, but I think that that's right. What we're looking at are the processes and procedures for how you would claim the 100% through our claiming system. You know, if there are policy considerations for how you would determine the amounts eligible for 100% claiming.

So those are the kinds of questions that I think that you just hit on, that Maine is considering, we have those same considerations here at CMS.

(Molly Slotnick): Okay. Thank you.

Coordinator: Our next question comes from (Clare Middleton). You may go ahead.

(Clare Middleton): Hi. This is (Clare) with Texas. And I have a question about the PREP Act declaration and the list of providers that are included in that declaration for March 2021. I was just wondering if we're going to be required to allow those providers to bill Medicaid for COVID vaccine administration.

Kirsten Jensen: This is Kirsten Jensen. And we'll be issuing additional guidance on the PREP Act Amendments 5, 6 and 7. And they've - that guidance has been drafted and working its way through our clearance process. And we'll have more information soon on that.

Coordinator: There are no additional questions at this time in the queue.

Jackie Glaze: Thank you. (Ashley), do you see any additional questions through the chat?

Ashley Setala: No. I don't.

Jackie Glaze: Okay. So Anne Marie, do you want us to give it another few minutes?

Anne Marie Costello: No (Jackie). I think you can close us out.

Jackie Glaze: Okay. I'll turn to you then.

Anne Marie Costello: All right. Thank you. I really want to thank all of our presenters today for their excellent presentations and the information. And a special thanks to our ASPE colleagues for joining us today. Looking forward, we'll meet with you again on May (25). The topic and invitation will be forthcoming. And just a reminder, we're now meeting every two weeks.

Of course, as questions come up between these calls, feel free to reach out to us, your state leads, or bring the questions to the next call. If you'd like to pre-submit questions for the open Q&A portion of our next all state call, you can email them to MedicaidCOVID-19@CMS.HHS.gov, by 1:00 pm Eastern on the day of the call.

Thanks again for joining us today. And have a great day.

Coordinator: Thank you all for participating. You may now disconnect and have a wonderful rest of your day. Speakers, please standby.

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