Centers for Medicare & Medicaid Services

COVID-19 Medicaid & CHIP All State Call

April 27, 2021

3:00 pm ET

Operator: Greetings and welcome to the CMCS All State Medicaid and CHIP Call webinar. During the presentation, all participants will be in a listen-only mode. Afterwards, we will conduct a question and answer session. If you would like to register a question over the phone, please press the one followed by the four on your telephone at any time. You'll hear a three tone prompt to acknowledge your request and your line will then be accessed from the conference to obtain your first and last name. If at any time during the conference you need to reach an operator, please press star zero. As a reminder, this conference is being recorded Tuesday, April 27th, 2021. I would now like to turn the call over to Jackie Glaze. Please go ahead.

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 Castello, 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 everyone. Thank you very much for joining us. Medicaid plays an important role in meeting the needs of those who have experienced violence or trauma and need healthcare services, either immediately or over their lifespans. And states have tremendous flexibility to tailor their benefits to best serve the needs of their populations, including ways to support survivors of violence. On today's call, Melissa Harris from our Disabled and Elderly Health Programs Group will provide an overview of how Medicaid can be used to reimburse certain community violence intervention programs. After that presentation, we'll stop and take your questions. We'll also leave plenty of time at the end to take your general questions. Today we'll use a webinar, so if you're not logged into the webinar platform, I suggest you do so now. Before we jump in, I wanted to make a few announcements.

Anne Marie Costello: First, I wanted to make sure that everyone is aware that last Friday, Secretary Becerra officially renewed the COVID-19 public health emergency (PHE). The renewal took effect on April 21st, and extends the PHE for another 90 days. Second, I wanted to highlight that next week, CMS will host a webinar and state implementation of extension of full Medicaid to COFA migrants. As a reminder, COFA migrants are

individuals living in the U.S. And territories under the Compacts of Free Association (COFA). COFA is an arrangement between the United States and the three Pacific Islands sovereign states of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau. The webinar will focused on providing technical assistance to implementation of the extension of Medicaid coverage to COFA migrants while states, the federally-facilitated Exchange, and the Hub make updates.

Anne Marie Costello: CMS will discuss short term workarounds and implementation strategies states can utilize to conduct eligibility verifications and determinations. We'll also hear from two states about their implementation experiences. The webinar will be held on Tuesday, May 4th, from 3-4pm ET. We expect it to be valuable for states through the implementation of this important extension of Medicaid eligibility, so we invite you to include your eligibility and system staff. We've sent out registration information through our Eligibility Technical Assistance Group (ETAG) and state system staff, and we'll also be sending the registration and information to our Medicaid updates listserv. If you'd like to participate and don't have registration information, please contact your state lead. Finally, I wanted to announce that beginning with our next call, which will take place on May 11th, we'll be transitioning to a new webinar platform for our All State Call series. In the invitation to the May 11th call, we'll include instructions for joining the new platform. So please be on the lookout for that in the coming weeks. With that, I'll turn things over to Melissa to start her presentation.

Melissa Harris: Thank you, Anne Marie. I am really happy to be here to discuss a topic that seems all too relevant to each of us, either because we have been touched personally by it, or we hear on the news about how communities and families are being so impacted by it. Today we're going to walk through various Medicaid coverage categories and how they can be used by states as part of violence intervention strategies. As we get started, I'll first reiterate what you've likely already heard in terms of violence intervention being a key priority of the Biden administration. We have links on this slide to two fact sheets released by the White House, both of which call out this webinar as an initial action to be taken by the administration to prioritize investments in community violence intervention. Moving to the next slide. The first bullet on slide four shows just one statistic to illustrate the importance of this topic and why we're having this conversation today. The universe of individuals and in our context for this conversation, the universe of Medicaid beneficiaries who are directly impacted by acts of violence is quite large. So let's talk about how Medicaid can provide services to help. We all know that the

Medicaid program has a lot of inherent flexibilities and a lot of options for states to craft programs and models of care based on state demographics. Here we have a reminder about the key role Medicaid can play in the delivery of violence intervention services, particularly given the statistic in the second bullet about the number of victims of gunshot wounds who are either on the Medicaid program or who are uninsured.

Melissa Harris: So we'll start off by talking about a violence prevention program that can be implemented in the treatment setting we most often associate with people who have experienced violence, and that's the hospital. If you look at the Medicaid statute, you won't find any reference to a hospital-based violence prevention program, but this is a model of care that states can set up across the state or in targeted locations to be on scene when individuals who have experienced violence come to the hospital for treatment. The use of a multidisciplinary team and a focus on a continuum of care are both nods to the importance of whole person care, not just treatment of a specific injury sustained in a violent act. Making sure individuals have linkages to counseling services, for example, and to professionals who can help an individual be safe at home and in the community are often just as critical and can be components of these hospital-based programs.

Melissa Harris: Let's look at some of the other benefit categories under the heading of mandatory Medicaid services that can be part of the state's violence intervention strategies. Besides the services that you see here, I'm going to flag some new coverage mandates of medication assisted treatment that was included in the Support Act and the mandatory assurance of non-emergency medical transportation codified in the Consolidated Appropriations Act of 2021. All of these services can be used by states to offer access to services provided by qualified professionals who can treat a range of physical, behavioral, emotional conditions, including in the context of violence prevention and in response to acts of violence. Looking now at some of the optional services in Medicaid, just like the mandatory services on a previous slide, the optional benefit categories are very broadly defined in statute and regulation, and can also authorize a wide array of intervention.

Melissa Harris: We'll spend the next few slides looking at these categories in more depth, but I want to spend a minute on the final bullet here, the case management benefits. This is a service that is more administrative than medical in nature, linking beneficiaries to needed medical, social, educational, financial, or other types of needed services. While Medicaid might not pay for the underlying services themselves, sometimes making the connection to a needed source of care is just as critical. States can also target these services to groups of individuals who share a particular condition or

characteristic. For example, a state could provide case management services to individuals who have experienced violence or are at risk of experiencing violence, and to require providers of case management services to those individuals that have a particular skillset relevant to their needs. And then we're going to walk through some of the other benefit categories. The other licensed practitioner benefit is very broadly defined, and you can see in the first bullet that we have a quote from what's in the regulations. And basically this benefit places the importance on the licenser category of the practitioner. We've included here some examples of licensed individuals who might be the most relevant for conversations around the violence intervention program, but really the door is very widely open based on the type of licensure categories within a state. And so because an individual possesses a license, what that individual is now licensed to provide becomes a Medicaid coverable service, as long as the state's Medicaid state plan references these individuals as part of the state's Medicaid qualified provider pool.

Melissa Harris: And obviously because we are talking about licensed individuals, it kind of raises the question around the role of unlicensed individuals. You can see here in the last bullet that services of unlicensed practitioners can also be covered under this benefit if they are working under the supervision of the licensed practitioner, and that supervision is within the scope of practice of the licensed practitioner recognized in the state plan. So most states have a varying array of licensed practitioners listed in their state plan. So we encourage you to take a look at the provider pool that you already have capped in your state plan to see if there are any missing licenser categories that you think could be relevant and helpful to this conversation.

Melissa Harris: And you'll hear throughout this presentation, that CMS is available to provide technical assistance. Switching now to preventive services and you'll see the very broad definition here also on the first bullet. There's really an awful lot of interventions that can be authorized under this benefit category, including many that could fall under the heading of violence prevention or a violence intervention. In the state plan, the state would need to describe the types of violence prevention services, or other types of services that they are seeking to cover, along with who the practitioners are of these services. Because licensure is not required in the preventive services benefit, we do ask states to include a description of the qualifications of the providers.

Melissa Harris: Licensed individuals certainly can be reflected under the preventive services benefit, but certainly non-licensed individuals can be as well. And

in that case, we just asked, like I said, for the state plan to include a statement about what those qualifications are.

Melissa Harris: Spending another minute with the preventive services benefit will flag that the Affordable Care Act included an option for states to claim a 1% increase in the federal matching percentage if they provide without cost sharing certain types of benefits. Some of those benefits are those services that have a grade A or B by the United States Preventive Services Taskforce, and all vaccines and their administration that are recommended by the Advisory Committee on Immunization Practices. One of the grade B United States Preventive Services Taskforce recommendations is for intimate partner violence screening for women of reproductive age.

Melissa Harris: So we put that as a flag here, even a state that has not to date implemented this option under the Affordable Care Act, may do so now. And again, you can request technical assistance of CMS to add this benefit component to your preventive services state plan. And then also talking about the rehabilitative services benefit. This is where you'll find an awful lot of the mental health and substance use disorder services authorized in the state plan. This provides an array of services defined as medical or remedial services recommended by a physician or other licensed practitioners for the maximum reduction of physical or mental disability, and restoration of a beneficiary to his or her best possible functional level.

Melissa Harris: Because this is such a broad service category, again, we ask for states to define the actual service interventions and the qualifications of the practitioners that the state is recognizing to deliver these services. Licensure is not required, but again, licensed individuals can certainly be included in your rehabilitative services benefit.

Melissa Harris: And again, an awful lot of room here for services to be provided to address acts of violence in individuals who have experienced acts of violence, individuals who are at risk of experiencing violence, et cetera. We have here on this next slide a couple of services that we thought might be particularly relevant for this conversation. A lot of them are in the mental health and substance use disorder realm, and I'll focus your attention on peer support services. We have links here to a couple of pieces of guidance that CMS has issued over the years on peer support. This is a really important service that can be provided by individuals who have lived experience with either a mental health diagnosis or a substance use disorder diagnosis.

Melissa Harris: And sometimes the ability to really empathize between someone who was providing some counseling services and someone who's in need of

counseling services can really make a big difference in fostering a connection and really letting the therapeutic regimen take root. We also clarified that there is the ability for a parent of a child who has a mental health diagnosis or substance use diagnosis to receive peer support services as well. So do take a look at that as you are having conversations around ways to increase your menu of services under this category.

Melissa Harris: Okay. Moving on to another state plan option. This one is Health Homes, which was added to the array of state plan services in the Affordable Care Act. This is for individuals with a chronic condition and states have a lot of flexibility in selecting the chronic conditions that will be the focal point of a Health Home. And you can see that individuals with a serious mental illness, individuals with a substance use disorder can be a target group of Health Home services. Health Homes is akin to targeted case management in that at its heart is a coordination and linkage focus to make sure individuals have the right kind of connections to resources in the community that can be so helpful for a whole person focus that a strategy for violence intervention requires. And so we have some information on this slide about how Health Homes could be helpful.

Melissa Harris: As an aside, states receive a 90% federal match for the first eight quarters of Health Home implementation. This timeframe can be increased to 10 quarters of 90% federal match for Health Homes targeting individuals with a substance use disorder. We know a lot of states have made good use of this Health Homes authority, but if this is of interest to you as something you'd like to add to your Medicaid program, you can certainly reach out to us.

Melissa Harris: Moving now into the category of long-term services and supports because we know that individuals who are recovering from a violent act or who have experienced or are at risk of experiencing an act of violence sometimes need more than acute time limited treatment. And so we'll talk briefly here about the Home and Community-Based Services (HCBS) authorities. You can see some examples here of how the 1915(c) waiver and the 1915(i) state plan options can be used in violence prevention or intervention programs.

Melissa Harris: A word about the last bullet and its reference to the social determinants of health, there's a lot packed into that statement and it could be the topic of its own dedicated conversation. As the Medicaid program engages in national and state specific conversations about equity in access to healthcare and ways to achieve improved beneficiary health outcomes, the social determinants of health naturally become front and center. CMS issued guidance on social determinants of health a few months ago,

walking through the various ways in which Medicaid can reimburse for activities like housing support, supported employment, nonmedical transportation, the HCBS authorities feature prominently in any conversation around the social determinants and in the context of preventing or responding to violence. It goes without saying that the social determinants of health would play a critical role.

Melissa Harris: Two components of the HCBS benefit categories that deserve to be mentioned here is the incident management system. You often hear CMS talk about an incident management system in the context of detecting and preventing beneficiary abuse, neglect, or exploitation. So it's a natural fit as part of this conversation, as violence can take many forms and to be inflicted by people playing a variety of roles in the lives of our beneficiaries. So we point out on this slide, the role of the incident management system, and particularly, the 1915(c) waiver program, as really a key element to detect and respond to information that indicates that there has been a critical incident that needs investigation. Okay. And then the last authority we'll talk about is the 1115 demonstration authority. This authority authorizes Medicaid federal reimbursement for services not otherwise covered and can be used to convey Medicaid eligibility to people not otherwise eligible. You'll see examples on the slide of national demonstration initiatives to assist in mental health and substance use disorder reform activities, but states may also submit proposals based on their own assessment of specific needs and gaps in their service systems. If states identify a role for an 1115 demonstration to play in the context of violence prevention or intervention, we certainly would want to hear it.

Melissa Harris: So let's start to wrap up, reducing acts of violence and improving the services provided to people who have experienced or witnessed violence is in the best interest of every single person in this country. While Medicaid cannot fill every gap and is not the solution to all issues, we know how pivotal the Medicaid program can be in providing critically needed services in the immediate aftermath of violence, in the longer term healing process, and perhaps more importantly, in the prevention of violence in the first place. We've really only touched on the tip of the iceberg in terms of how the coverage categories highlighted here can be used as part of a larger, comprehensive strategy by our state partners. We are happy to do a deeper dive with you on an individual state basis based on your specific demographics and your current systems.

Melissa Harris: And we'll end here with some links to guidance published on medicaid.gov that you might find helpful as you think about ways to enhance your violence prevention and intervention programs. Take a look at them and let us know how we can be helpful to you in determining your

next steps. And with that, I'm going to stop and turn it back over to Jackie Glaze. Thank you.

Jackie Glaze: Thank you, Melissa, for your presentation. So we're ready to take your questions now and we will start with the chat function. So you can begin submitting your questions at this time, and then we'll follow by taking your questions over the phone line and the operator will provide instructions at that time. So I'll turn it over to you, Ashley.

Ashley Setala: Thanks, Jackie. And while states are submitting questions through the chat we have a couple of questions that were submitted by email to our Medicaid COVID-19 box for the call today that we wanted to start with. So the first question is for our Financial Management Group, and it says, "Do you have any information on the CMS-64 coding related to that American Rescue Plan (ARP) Act 100% FMAP? Will new lines be created on the CMS-64 for these, and when will states find more information?"

Rory Howe: Hi, Ashley, this is Rory Howe with the Financial Management Group. So as we've talked about on the past few calls, we're working to provide states with information on the ARP provisions that relate to increased federal matching. And included in that information, we hope to provide helpful information regarding expenditure reporting on the CMS-64 and changes to the form itself and the process, that will come both with that guidance and after. So once that information is out, we do intend to offer training and technical assistance to states on CMS-64 reporting and hope to have that information to states as soon as possible.

Ashley Setala: Okay. Thanks, Rory. Then the other question that we wanted to address is for our Children & Adults Health Programs Group. And it says, "In the State Health Official Letter (SHO) number 20-004 released in December, 2020, Which is CMS's unwinding SHO, CMS provided guidance that states do not have to redetermine eligibility for individuals if they were determined ineligible within six months of the last day of the month when the public health emergency ends. The state must ensure that coverage is not denied until after the adverse action period expires, and the household is notified of hearing rights, but additional information is not required from the household prior to denial at the end of the public health emergency. Do States have the flexibility to redetermine eligibility for these households determined ineligible within six months of the PHE ending by repeating renewal or requesting verification if we choose to? In other words, can the state set a shorter timeframe than six months to identify those ineligible households, and will reevaluate eligibility for at the end of the PHE?"

Jessica Stephens: This is Jessica, the answer is yes. That is not a requirement, the six month period is not a requirement in the current guidance. And states may choose to complete the redetermination or verification, the full process, as soon as the public health emergency ends for any individual.

Ashley Setala: Okay. Thanks, Jessica. Then we have a couple of questions that have come in through the chat. The first one is for Melissa on today's violence prevention presentation. And it 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 the requirement, is consideration being given to these types of scenarios?" And sorry, I actually said this would be for Melissa, but I think maybe our Children & Adults Health Programs Group may want to weigh in.

Sarah deLone: Yeah. Hi, this is Sarah deLone. I can give a little bit of a stab, but I think we're going to want to take this back and talk about it more with everybody on the team who are our subject matter experts on MAGI household composition. But we have had situations, just for say, in general, where somebody maybe doesn't know what their tax filing status will be. In this particular scenario it would be difficult for this person, I think this hypothetical was a woman, to be sure about what her abuser was planning to do, and so there would be flexibility for the state to treat her as a household of one, but I want to take that back and talk with our team about it and would love to have that... I think, Ashley, that question's already written out, so it would be great if you could forward that to us so we make sure we have all the details.

Ashley Setala: Sure, absolutely. Then we have a couple of questions that have come in around when CMS may release guidance related to various recent legislative provisions. And the first one says, "When can we expect that CMS will release guidance on section 9811 of the American Rescue Plan Act?"

Melissa Harris: Thanks, this is Melissa. And we have so many pieces of guidance in development, you would not believe it. And so our goal is to get all of them out as quickly as possible. We know that all of you are waiting with a lot of interest on a lot of these legislative provisions. So specifically around the NEMT provisions and the information associated with the planning grants in particular for clinical trials, we definitely have guidance in the works. We also know that you all are very interested in the guidance

on the American Rescue Plan provision around increased FMAP for home and community-based services. And so we are moving all of those documents through our queue as quickly as possible, and really appreciate your patience as we work to get these out on a flow basis. In the meantime, if you've got a particular question about a specific scenario or specific legislative provision, you can certainly feel free to contact us. We might be able to give you an answer or we might have to tell you that that answer will be addressed in upcoming guidance.

Ashley Setala: Thanks, Melissa. And you actually covered the next question as well, because that was going to be around whether we were releasing guidance on NEMT and the clinical trial provision. So then we have another question that came in around the processing of Medicaid renewals after the public health emergency. It says, "In the SHO Letter dated December 22nd, 2020, CMS stated the following: CMS acknowledges that the need to process all renewals pending at the end of the PHE within six months may lead to an uneven distribution of renewals concentrated in the month following the month in which the public health emergency ends, which could impact timely processing of renewals in future years. CMS is available to provide technical assistance to states and territories seeking to ensure renewals are distributed evenly over the course of the year to ensure a manageable and sustainable renewal workload in future years. Can you confirm that states will be permitted to evenly distribute all renewals over a 12 month period post-PHE?"

Jessica Stephens: This is Jessica. I cannot confirm that part at this time. However, additional guidance is forthcoming that should help with the initial point that the questioner asked about challenges redistributing renewals, and the balance and concerns about long-term renewal bulges.

Ashley Setala: Okay, great. Thank you.

Jessica Stephens: And that too is coming soon.

Ashley Setala: Then we have a question that says, "On page seven of the COVID-19 vaccine toolkit," I'm sorry, "Page seven of the COVID-19 vaccine toolkit says that CMS will be providing more information regarding whether beneficiary incentives will be permitted in connection with COVID-19 vaccination during the PHE. Can CMS provide an update regarding whether states can provide incentives to encourage beneficiaries getting their COVID-19 vaccine? When can states expect updated guidance related to this?"

Rory Howe: This is Rory Howe with the Financial Management Group. So I think this is certainly a question that we've heard before and we've been working on internally, and hopefully we'll have more information for states soon, but don't have much more than that to share at this time. And again, we recognize the importance of the question and the time sensitivity, but it is something that we're working on.

Ashley Setala: Thanks, Rory. Then we have a question that says, "Does the mandatory coverage of vaccine administration for limited benefit plans include emergency Medicaid?"

Melissa Harris: This is Melissa. We understand really the state interest in having an answer to that question, and we hope to be able to have a formal answer for you very quickly. We do not have one right now, but it is under active discussion, and we will have a more comprehensive answer for you as quickly as we can. We appreciate the question.

Ashley Setala: Thanks, Melissa. It looks like we've covered all of the questions that have come in through the chat at this point.

Jackie Glaze: Thanks, Ashley. Operator, could you please provide instructions for the callers to submit their questions through the phone?

Operator: Thank you. If you would like to register a question, please press the one followed by the four on your telephone keypad right now. You will hear a three tone prompt to acknowledge your request. Your line will then be accessed from the conference to obtain your first and last name. If your question has been answered and you would like to withdraw your registration, please press the one followed by the three. And one moment please, for the first question. As a reminder, to register for a question, press the one followed by the four on your telephone keypad right now. There are no questions on the phone at this time. I will now turn the presentation back to the speakers.

Jackie Glaze: Thank you. So we'll give it another minute or two to see if we do have any further questions through the chat or through the phone. So, if you do have additional questions, we're waiting for them from you.

Operator: And as a reminder to participants on the phone, press the one followed by the four on your telephone keypad to register for a question.

Ashley Setala: So it looks like we have one more question that just came in through the chat. It says, "Does CMS expect the guidance for rolling back flexibilities at the end of the PHE to change at all before the end of the PHE?"

Jessica Stephens: This is Jessica. I can chime in, and then I'll ask others to chime in as well if there's more to say. I think as many states know, we have had a number of conversations with states to understand any challenges that they may be facing and provide technical assistance. Of course, the information that you all have been sharing with us has been really helpful to provide the technical assistance that is needed. Right now, the guidance is the guidance, but given the conversations and information that states have shared with us, we are looking to see if there's additional technical assistance we might be able to provide, including what I referenced earlier related to challenges that states have expressed with respect to potential bulges in renewals and how states can address that. Would anybody like to add anything else? Okay, then I think we're good.

Jackie Glaze: Thanks, Jessica. I think you covered it well. Thank you. So I'll check back with the operator. Do we have any questions in the queue?

Operator: As a reminder, to register for a question, press the one followed by the four on your telephone keypad. As a reminder, to register for a question, press the one followed by the four. There are no questions on the phone at this time.

Jackie Glaze: Thank you. Anne Marie, shall I turn to you for closing?

Anne Marie Costello: Sure. Thanks, Jackie. I want to thank everyone for joining us today. I, in particular, want to thank Melissa for her excellent presentation, information, and to all of the staff that provided answers to today's questions. Looking forward when we meet with you again on May 11th. The topic invitation instructions for joining our new webinar platform will be forthcoming. Of course, as questions come up between these calls, feel free to reach out to us, your state leads, or bring the question to your next call. If you'd like to pre-submit a question for the open Q&A portion of our next all state call, you can email them to MedicaidCOVID19@cms.hhs.gov by one o'clock Eastern on the day of the call. Thanks again for joining us today, and hope you have a great rest of the week. Bye.

Operator: And that does conclude today's conference. Thank you for your participation and I ask that you please disconnect your line.