# Centers for Medicare & Medicaid Services
## Medicaid & CHIP All State Call
## August 19, 2021
## 3:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time all participants and listen-only mode. During the Q&A session if you'd like to ask a question you may press Star 1 on your phone. Today's call is being recorded. If you have any objections you may disconnect at this time. I'd now like to turn the call over to Miss Courtney Miller. You may begin.

Courtney Miller: Good afternoon and welcome to this CMCS All State Call. CMCS Director, Dan Tsai will kick us off with some opening remarks. Take it away Dan.

Dan Tsai: Thanks Courtney. That was a very professional voice you have there to go to. Hi folks. Hi everybody. So I think we've got two agenda items I wanted to highlight that are particularly salient. Pretty much every discussion I - we have been having with Medicaid directors and teams these two topics have been coming up.

The first is on unwinding from the PHE and MOE requirements. Some recent guidance we've put out, etcetera, that we'll talk about in a second is a little bit more on the 10% enhanced funding with - HCBS. And the piece that I just want to note on that, you know, we've been hearing quite substantially from states over time around the need for additional time to thoughtfully, and in an operationally manageable way, start to move out of the MOE whenever the PHE ends, Maintenance of Effort that has been in place as a result of the pandemic from an eligibility standpoint and many of those processes for renewals and such.

So we are - we both heard that and from a policy standpoint we want to collaborate with states and others to make sure we do everything we can to maximize coverage, retention for folks whether it be through Medicaid and CHIP or through the marketplace QHPs if folks are eligible for that or employer coverage, Medicare, et cetera. And so we put out guidance very recently that as we've been signaling affirmatively extends the period in response to a lot of outreach we've gotten for when up to 12 months for when folks have to actually go through the various renewal processes and such.

And our strong hope is to work together with states and other partners in spreading the work out reasonably over that time making sure that there are a lot of operational things related to both the eligibility and other pieces coming out of the PHE that we are able to do that thoughtfully, that we can help partner with states on where we can maximize continued flexibility for folks to help minimize some of the administrative churn where some might come off enrollment for a short period of time only to come back on.

That's challenging from a health standpoint and administratively for states and all of us. So we look forward to this kind of kicking off a lot of very close back and forth and partnering with states. I think there - MAMD will be helping to facilitate a workgroup around some of these items. And we very much intend to also - I just popped off, several of us some of us just popped off a call with CCIIO colleagues and the marketplace thinking through some of the transitions also from Medicaid to marketplace and so on.

So it's a topic that I know is very front and center with directors, and colleagues and many else - others in the community. And we look forward to working together on that. And we're glad we finally were able to get out of this guidance last week that formally extends the period to 12 months and highlights a few other things.

So that's the first piece. And the second on the HCBS spending plans -- of which we are continuing to make progress on -- we - we've said this on a few calls but I think it's worth emphasizing. It is a life changing amount of funding that is potentially on the table for states here. We really want to be partnering with folks in creating flexibility policy wise to help states be able to invest in expanding capacity in HCBS.

And certainly there are a lot of things to deal with on short term workforce issues and others that will merit great enhancements in the short term and many states are indeed proposing that. We are also very excited about and want to encourage states to contemplate how to use that funding in ways, whether it be around capital investments to build new. you know, community settings that are compliant with the Setting Rules to actually add capacity or to help be able to reduce wait lists for folks for 1915(c) waivers or a range of other things.

We want to provide that flexibility even for things that are traditionally FFP able for how folks can use one time the funding and we're open to many other ideas as well. But that is an area that is both exciting that allows us to collaborate together and I would be remiss if I didn't note that behavioral health would fall very much within how we're thinking about some of this as well.

So we know states have been doing a lot. We're trying to get through some of that stuff and we also anticipate finding a way to post and sign posts for others kind of what the various approvals are so folks can have the benefit of seeing what that looks like across states.

So those are two things I wanted to just note. Again we are committed to being responsive and to thinking together about how best to achieve those various pieces. We look forward to a lot of that. I'm going to turn that - this over to I think (Judith) now. So (Judith)?

Judith Cash: Thanks Dan.

Dan Tsai: And thank you all. Thank you all for what you all are doing on the front lines. Everything we just mentioned is an intense amount of work operationally with state staff, with other agencies, with advocates in the community so thank you for all that. And hopefully we will help make life simpler and easier together. And yes (Judith) over to you. Thank you.

Judith Cash: Thanks Dan and hi everyone. I'm not sure anybody on this call excepts CMS to make things simpler and easier but we will certainly keep trying.

Dan Tsai: (Judith) you can definitely make that happen. I know it.

Judith Cash: Yes indeed. So as Dan mentioned, we do have a few things we want to cover on today's call so I want to get us there as soon as possible.

So first of all Shannon Lovejoy from our Children and Adult Health Programs Group is going to join us. And she's going to present an overview of the State Health Official Letter that Dan referenced and that we released last Friday. As I'm sure many of you are aware Friday's letter updates some other specific eligibility and enrollment guidance that we had initially given to states in a December 2020 State Health Official Letter that provided guidance on planning for what will be the eventual resumption of normal operations for Medicaid CHIP and BHP after the end of the COVID-19 Public Health Emergency.

That of course has not happened yet. And we do not have any information as to whether, you know, that is going to happen any time before the end of the year which is what we're all expecting. But we know at some point it will end and we want to be able to provide as much information as soon as possible to states as we know that you are planning for that ultimate and eventual return to normal operations.

After Shannon Lovejoy's presentation Jen Bowdoin, from our Disabled and Elderly Health Programs Group, is going to present some information from the other topic that Dan referenced of course which is Section 9817 of the American Rescue Plan Act.

As we discussed in fact multiple times on this call this provision provides states with that temporary 10 percentage point estimate bump that is available for certain Medicaid home and community based services from April 1 of this year through March 31 of next year. And then of course after Jen's presentation we will as always open the lines and look forward to your questions.

We will use a Webinar for Shannon Lovejoy's presentation today so if you're not already logged into the Webinar I suggest that you do so now. Before though we jump into those presentations I do want to raise two important pieces of information one a reminder and one perhaps new information based in a reminder.

So first of all regarding HCBS and the availability of retainer payments for calendar year 2021. We are hearing from states that there's an ongoing need to support HCBS providers during the COVID-19 Public Health Emergency.

And we certainly understand that and certainly respect that need for ongoing support.

In fact, as you might recall, we published a state Medicaid director letter back in May of this year that provided states the option to offer up to three additional 30 day periods of retained payments in this calendar year of 2021. To date though we've received only three requests to exercise this option for providers of 1915(c) waiver services in Appendix K.

So we just want you to know it's not too late to offer those retainer payments. These additional days can be made - payments can be made retroactive effective to the first of the year. And if states interested in doing that we encourage you to submit whether it's the Appendix K, the Section 115 Demonstration Attachment K, the last Disaster Relief State Plan template or an amendment of demonstration depending on where your HCBS authority lives to implement any of those additional days of retainer payments. And indeed if you have any questions please reach out to your HCBS lead and we can provide you with whatever support and technical assistance you need.

The second thing I wanted to touch on is really some very timely information regarding Medicaid eligibility for Afghan and Iraqi individuals who have assisted the US government overseas and are in the process of relocating to the United States in the coming months. As you may know for their service to the US government in Afghanistan and Iraq certain Iraqis and Afghans are granted special immigrant status by the Department of State and the Department of Homeland Security.

And these individuals are treated in the same manner as refugees. They are considered qualified non-citizens and are not subject to the five year waiting period for Medicaid and CHIP. They're also eligible for Office of Refugee

Resettlement Benefits and Services. And so if you're interested in learning more there's additional guidance about that on the Office of Refugee Resettlement Web site.

In the coming months I think we can expect more Afghan individuals to be coming to the United States. They'll be processed through Fort Lee, Virginia and relocated to any number of places in the US. Based on historical trends we expect that most of these individuals would be resettling in California, Texas, Washington, Virginia and Maryland but in fact may be relocated to any state.

And due to the urgent nature of their arrival we want to make sure that you're aware these individuals will receive special immigrant parolee status. These individuals and future arrivals are part of (unintelligible) will have lawful permanent resident status or special immigrant parole that meets the immediate requirement for certain government benefits including Medicaid and CHIP and again without the application of the five year waiting period.

So again if you have questions about this please reach out to your state lead. Happy to provide follow-up information, technical assistance if needed. And again we'll answer questions at the end of the call today if you have any questions about this area or any other.

So with that I am delighted to turn things over to Shannon Lovejoy to start her presentation. Shannon Lovejoy?

Shannon Lovejoy Thank you (Judith). Yes and just to echo the comments I think as CMS we are just as eager to finally be able to get this additional guidance out to states and territories on operational planning for the end of the Public Health Emergency as I think you all have been to hear from us. And really what we hope is that

the letter that was released on Friday is really the next step in continued guidance and resources to assist you all in your efforts to plan for the eventual end of the Public Health Emergency.

So, the letter that was released on Friday really updates two key pieces of eligibility and enrollment guidance that were initially provided in the December 2020 State Health Official (SHO) Letter that CMS released. The first change is that it extends the timeframe for states to complete pending eligibility and enrollment work from six months, which was the original timeline, up to 12 months now after the month the Public Health Emergency ends.

The second update is that states will need to conduct a redetermination of eligibility after the Public Health Emergency and for all individuals prior to taking any type of adverse action. And while the SHO updates these two specific areas of guidance and, you know, these changes will certainly have implications for your eligibility and enrollment planning operations it doesn't modify other aspects of the December letter and many of the policies and procedures that were outlined in that December letter still remain in effect and you should still refer to that letter for that guidance.

Next slide please. So under the new guidance states can take up to 12 months after the month in which the Public Health Emergency ends to complete any pending post enrollment verification, redeterminations based on changes in circumstances and renewals. As you all know Medicaid and CHIP enrollment is at an all-time high. And when the Public Health Emergency ends there will be a lot of work that states need to go through and there will be individuals who will become eligible for other sources of coverage.

And this 12 month timeframe is really intended to relieve some of the pressure that you all may have been feeling before to rush through all of that work and increase the risk that, you know, individuals might be inappropriately terminated and lose coverage. But it also provides an opportunity to really have a thoughtful and orderly approach to resume routine operations over the course of the year that really helps promote coverage for individuals.

And with this 12 month timeframe we, you know, hope that states really have the time now to conduct outreach and implement strategies to maintain coverage. And this includes adopting strategies that states can streamline enrollment processes, you know, ones that you're familiar with like continuous eligibility or enrollment strategies that rely on data from other programs like the Supplemental Nutrition Assistance Program or even just to change some processes like extending timeframes for individuals to respond to renewal forms or other requests for information.

And really this timeline provides a better opportunity to really manage the coverage transitions that we know will come after the Public Health Emergency ends but also allow you all to make sure that you're distributing workload over the year in a manner that will really be sustainable in future years.

In the December 2020 letter we provided states an option to align work on pending post enrollment verification and changes in circumstances with an individual's renewal if the renewal was due during that initial six month post PHE period. We wanted to confirm that that option will still remain available to states except now with the extended timeframe the states can align that pending work with the renewal that is due within the entire 12 month post PHE period.

The other important thing that we wanted to point out with this timeline is that this timeline does not affect the timeframe in which states must resume timely processing of all applications. States continue to have up to four months after the month in which the Public Health Emergency ends to resume timely processing of all applications as was outlined in the original December letter.

Next slide please. And the second key piece of guidance that was updated in this letter is that states will now need to make sure that they're conducting a redetermination in accordance with renewal requirements at 42 CFR 435916 prior to taking any adverse action with respect to any individual after the Public Health Emergency ends. And this includes, you know, individuals who might have been determined ineligible during the Public Health Emergency or who you have attempted to renew their eligibility but they didn't respond to a request for information and perhaps these are individuals that have been identified for their coverage to be terminated, you know, pretty soon after the Public Health Emergency ends.

So now these individuals will need another redetermination after the PHE. And so essentially this change removes the option that was in the December letter that would have - where states could avoid completing another redetermination for certain cases if all of the actions were completed within six months of when the individual is expected to lose coverage.

And when we talk about a redetermination, again after the Public Health Emergency, what we are really meaning is going through the entire process. There's no change to how a state should conduct the redetermination that's different from what's already expected under federal requirements. And so even if someone was determined ineligible during the Public Health Emergency the state would take the case back up again at some point in the year following the end of the PHE and start the process from the beginning,

including, you know, checking available information and data sources to attempt the redetermination without contacting the beneficiary.

And of course if you're not able to review eligibility at that point requesting documentation or sending out a renewal form to obtain whatever information is needed to complete a determination as appropriate. And if states have any questions or need additional resources on how to conduct renewals of eligibility we also wanted to remind you that in December as well we had also released a CMCS informational bulletin on Medicaid and Children's Health Insurance Program renewal requirements that really walks through the process to conduct renewals and redeterminations of eligibility based on changes in circumstances.

Next slide please. So we know that with these changes that, you know, even though the State Health Official Letter released on Friday doesn't really change how states should approach their planning it will certainly have implications for the plans that are put in place and states will certainly want to rethink these plans. So you all are still expected to adopt a risk based approach to complete pending work and make sure that these plans are being documented.

And if you remember in the December letter we identified a risk based approach as kind of the method in which states are prioritizing and planning to, you know, conduct their work in the post PHE period. And there were four specific risk based approaches that were identified in that letter.

The first was a time based approach where a state could prioritize actions based on the length of time that a case has been pending. There was a population based approach which states could prioritize work based on population, a hybrid approach which allows states to use a combination of,

you know, the age of the case plus type of population to determine a prioritization schedule. And then states could also use another state identified approach to complete their pending work.

They funded - these approaches haven't changed at all and states must continue to develop and document their plans to resume routine operations. And we will note that we did provide a resource for states back in December. It was a planning template that states could use either to help think through how they would prioritize their work or as a way to document their plans. And we do intend to update that planning template based on the guidance that was released on Friday. So look forward to that in the coming months.

And given the changes that were being made with this letter that was released on Friday we are strongly encouraging states to really reassess their risk based approach and make adjustments to their operational plans as they're thinking about how they're going to resume operations when the Public Health Emergency ends. And we really want states to take this opportunity to really think how they can distribute the workload across the 12 months, now that there's more time, and how this process to distribute the work can minimize churn and maintain eligible beneficiaries while also promoting seamless transition of coverage.

Next slide please. So even though we don't know when the Public Health Emergency will end and we know that there's a lot of work that's going to place, you know, to plan for when the Public Health Emergency does end, there are certainly strategies that states can start taking now to set themselves up for success down the road. So states should think about and start prioritizing actions now that insure eligible individuals are able to enroll in coverage and remain enrolled in coverage.

This includes making timely determinations of eligibility for new applicants and this also means that states should really think about how they can complete as many redeterminations and verifications as possible now to help limit the backlog of actions that need to be completed after the Public Health Emergency end. And certainly this includes trying to, you know, renew coverage for as many people as possible based on the available information, you know, to help set up this process where renewals are already staggered for you in the post PHE period.

This is also a good opportunity for states to really think about how to re-engage beneficiaries. We know that, you know, from the feedback we've heard from many of you that it's been hard to maintain contact with beneficiaries or because the normal communication process has been disrupted based on changes that you've put in place during the Public Health Emergency that, you know, now would really be a good time to start thinking about a strategy to really re-engage individuals and make sure they have updated contact information to increase the likelihood of success of maintaining eligible people on coverage after the Public Health Emergency ends.

This is also a really good time for states to review the authority either that were adopted during the Public Health Emergency or additional authorities that can be adopted to help streamline eligibility and enrollment processes. And really now is a great time to start thinking about what steps need to happen in order to adopt or extend certain authorities and flexibility. And this might include, you know, this PHE period now permitting state plan amendments for updating verification plans or even just updating your own internal policy documents and process documents.

And of course, you know, states should also be really looking at their staffing assignments and work flow now as well as making sure that their workforce is prepared and knows about any changes that you're making at this point in time as well as they know what to expect when work really starts to resume in earnest after the Public Health Emergency ends.

Next slide please. So I know we've talked a little bit about strategies to streamline and maintain enrollment for individuals. And we are certainly encouraging states to really consider in their planning efforts not only how they're going to distribute their work but really what they can do to look at other options that will help make the workload more efficient and reduce the burden for individuals who are covered as well as for states to really maintain continuity of coverage for eligible individuals.

And we've included, in the next couple of slides which I'll walk through, you know, some suggested strategies but certainly this is not a comprehensive list. And we'll, you know, are certainly looking forward to providing, you know, more resources for states that are looking for additional strategies.

So these types of strategies can include things like adopting or extending streamlined enrollment and retention options. And these I feel are some of the more classic options that many states have taken up already but could certainly extend or adopt if you haven't done so already such as providing continuous eligibility or using express lane eligibility.

And then there's also some other options such as, that streamline renewal processes such as adopting policies that are already required for individuals who are eligible based on modified adjusted gross income for their non MAGI population. So you think pre-populated renewal forms, having a minimum day

- minimum of 30 days to return information, you know, those kinds of policies.

States can also look at strategies to invest in process improvements. So using data and certainly, you know, looking for ways to help minimize work for your eligibility and workforce teams but as well as make it easier for individuals to come in and complete their enrollment process. So encouraging online and telephone applications and then also looking at just your own strategies on how you're handling things such as returned mail and other strategies that you're implementing to avoid unnecessary combinations of coverage.

Next slide please. And some additional strategies include improving beneficiary outreach and communication. This includes like looking at the modalities that you're using to reach out to individuals but as well as also looking very closely at the documents and the information you're putting out to individuals to make sure that the messaging is conveying the critical messages and it's in plain language.

And also thinking, you know, creatively about strategies to help make anything that you are sending out to individuals a little bit more noticeable and trying to make sure that you're actually, you know, able to reach individuals with your communications. And of course beneficiary assistance will be very critical especially in the post-PHE period.

And this not only includes, you know, making sure that your eligibility and enrollment workforce is well trained and well prepared for the changes that you're implementing now to mitigate coverage losses but as well as making sure that they just have, you know, a well-prepared to have accurate information. So when they're speaking to individuals and they're the first, you

know, contact that, you know, an individual may have had with the Medicaid agency for quite a while that, you know, the beneficiaries are getting accurate and complete information up front to prevent any confusion down the road that could lead to coverage losses.

But then, you know, this also includes looking at ways that you can better use navigators, or application assisters or connect with other individuals to help make sure that when an individual does come in that they have the assistance that they need to complete any kind of redetermination or renewal paperwork.

And then of course, you know, you will want to look at creating approaches for monitoring and evaluating, not only making sure you have the tools that you need to evaluate and monitor eligibility enrollment actions, but that you also have, you know, a plan in place on really how to address and tackle emerging issues and be able to, you know, course correct if anything seems to be going in a direction that could put individuals at risk for losing coverage.

Next slide please. So I just wanted to end that we do have some resources out that you might find helpful. Of course there's a two State Health Official Letters that we've been talking about. There's also, as we mentioned earlier, the informational bulletin on renewable requirements.

But we also wanted to point out that recently we held Webinar series on ensuring continuity of coverage and preventing inappropriate termination. And those slide decks have a number of strategies that states may find useful to help mitigate against coverage losses.

And I know that we will turn it over to questions at the end of the call so in the meantime I will turn it back to Courtney to continue with our agenda.

Courtney Miller: Thank you Shannon Lovejoy for your presentation. Next up is Jen Bowdoin to provide you with addition frequently asked questions related to Section 9817 of the American Rescue Plan Act. Jen?

Jen Bowdoin: Thanks Courtney and hello everyone. Hope you all are doing well. So I'm going to address some of the questions that we've received, as Courtney and Judith mentioned, related to Section 9817 of the American Rescue Plan. And as a reminder Section 9817 provides states with a temporary ten percentage point increase to the federal medical assistance percentage for certain Medicaid home and community services.

So the first question I'm going to answer is actually a two part question. And it has to do with establishing a new TEFRA group with ARP Section 9817 funds. So the first part of the question is, "Can states use the funds attributable to the increased FMAP to establish a TEFRA group commonly referred to as the Katie Beckett waiver?" And then the second question is, "Can states use the funds to pay for all Medicaid expenditures for individuals who qualify for the new TEFRA group?"

So the answer to this is, is yes. So CMS strongly encourages states to expand eligibility and increase access to HCBS for children in the TEFRA group as part of the activities to enhance, expand and strengthen HCBS under ARP Section 9817.

The TEFRA group is established to provide eligibility for children who but for services available through Medicaid would otherwise be residing long term in institutional hospital settings. Absent the combination of HCBS coupled with additional Medicaid state plan services a child served under TEFRA would otherwise be placed long term in a hospital or other institutional setting offering intense medical support and services.

Therefore states can use the funds attributable to the increased FMAP to establish a new TEFRA eligibility group and pay for all Medicaid expenditures for individuals in the TEFRA group. However states must either ensure that individuals in the TEFRA group are moved to another eligibility group if they have a long term hospital or other institutional stay of 30 days or longer or they must not pay for long term hospital or other institutional expenditures for these individuals using the funds attributable to the increased FMAP if the individuals remain in the TEFRA group.

The second question has to do with using ARP Section 9817 funds to increase the number of waiver slots. So the question is, "If a state increases the number of Section 1915(c) waiver slots as part of its activities to enhance, expand or strengthen HCBS under Medicaid can the state use the funds to pay for all Medicaid expenditures for individuals who gain eligibility when they enroll in the waiver program?"

So CMS strongly encourages states to increase access to HCBS and reduce or eliminate HCBS waiting lists by increasing the number of Section 1915(c) waiver slots as part of their activities to enhance, expand and strengthen HCBS under ARP Section 9817. If a state increase in the number of Section 1915(c) waiver slots and enrolls additional individuals who are not already Medicaid eligible into the waiver program as a result of that increase the state will have an increase in non HCBS Medicaid expenditures as a result of the increase in waiver program enrollment.

In this situation states can use the funds attributable to the increased FMAP to pay for community based Medicaid expenditures including community based state plan services not listed in Appendix C for individuals who become Medicaid eligible because of the state increase in the number of waivers slots

as part of the state's activities to enhance and expand or strengthen HCBS. However states cannot use the funds attributable to the increased FMAP to pay for institutional services for those individuals as this would be inconsistent with the intent of ARP Section 9817.

So the next question is another two part question. This question has to do with changes that support compliance with the home and community based settings regulatory criteria homestead implementation or other community integration activities. So I'll take the - I'll take them one at a time.

So the first question is, "Does the provision in the FMDL that require states to preserve covered HCBS including the services themselves and the amount, duration and scope of those services in effect as of April 1, 2021 prohibit states from implementing efforts to support compliance with the home and community based settings regulatory criteria homestead implementation or other community integration activities?"

So we actually addressed this topic previously on the June 29 All State call. So the language in the FMDL should not be interpreted to prevent the provision of HCBS to enhance individual autonomy and community integration in accordance with the home and community based settings criteria, homestead implementation or other rebalancing efforts. For example, if states are reducing reliance on a specific type of non-residential facility based service and increasing beneficiary access to non-residential services more integrated into the community CMS will not interpret such action as conflicting with the requirement to preserve covered HCBS.

So the second part of this question is, "What kinds of activities can states implement to promote community integration activities and support compliance with the home and community based settings regulatory criteria

and homestead implementation?" So in particular we strongly encourage states to implement activities under ARP Section 9817 that expand access to non-disability specific settings as part of the states HCBS option.

As we noted on the July 27 All State call states can use the funds attributable to the increased FMAP to support long term investment in HCBS infrastructure including grants or loans to explore, encourage or build affordable senior housing and capital financing for affordable housing development. As a reminder states must demonstrate how capital investments would expand, enhance or strengthen HCBS in approval of capital investments in ARP Section 9817 Spending Plans and Narratives does not authorize such activities for federal funding until participation. In addition, we remind states that all new settings must be in compliance with the funding’s criteria in order to receive federal reimbursement of HCBS as the transition period does not apply.

And then the last question I'm going to answer has to do with the implementation of managed care. So the question is, "Can states convert an HCBS delivery system from fee for service to managed care without violating the maintenance of effort requirements for Section 9817?" So the answer to this is that the language in the FMDL should not be interpreted to automatically prohibit a state from implementing a managed care delivery system prior to fully spending the funds under ARP Section 9817.

However, states will need to demonstrate that implementation of managed care will not result in reductions or restrictions related to eligibility, rates or covered benefits that were in place as of April 1, 2021 as described in the FMDL for Section 9817. CMS is, as always, available to provide technical assistance on this and other issues related to compliance with the requirements of ARP Section 9817.

And with that I'm going to turn the call back over to Courtney so that we can open up the call for questions. Courtney?

Courtney Miller: Thank you for the update Jen. At this time we will invite your questions to the chat box.

Ashley Setala: Okay, and we have a number of questions that have come in through the chat already. I wanted to start - we've gotten a few questions asking whether the recording or the slides for the call will be made available. And the answer is yes we will post the audio recording, the written transcript and the slide deck to our COVID page on medicaid.gov.

So if you visit medicaid.gov in the lower left there is a link to our COVID page. And if you scroll down to the bottom of the page you will find all of the audio recordings, transcripts and slide decks from our All State call series. And we will have the slide deck up in the next day or so and the recording in probably the next week or so.

So with that we will jump in to the questions we received. And the first question is on retainer payments. And it says, "Can the retainer payments be retroactive and if so to what date?"

Melissa Harris: And thanks (Ashley). This is Melissa Harris. And yes they can be retroactive back to January 1 of 2021. And that retroactive date can be effectuated either through the Appendix K for retainer payments to 1915(c) waiver providers or through a disaster related SPA 1915(i) or 1915(k) providers or through the Attachment K for providers delivering services authorized through an 1115.

And we're certainly available for technical assistance to map out exactly what a specific state needs to do. But yes retroactively available back to January 1. And just as a final reminder all of the guardrails that were contained in the FAQs released last summer I think the end of June 2020 discussing retainer payments those would continue to apply for any new retainer payments authorized in 2021. Thanks.

Ashley Setala: Thanks Melissa. The next question is around PARIS and Section 1135 waivers. And it says, "In light of the new wave of infections and hospitalizations that states are currently experiencing largely due to the Delta variant and the virus has CMS considered allowing states to suspend PARIS assessment a second time under Section 1135 waiver ?"

Melissa Harris: This is Melissa...

((Crosstalk))

Melissa Harris: Oh sorry go ahead.

Courtney Miller: I was asking if you could answer that one.

Melissa Harris: That, you know, that's something a question that we will take back. I know we have used 1135 waiver authority in the earlier days of the Public Health Emergency to authorize I believe a 30 day delay in conducting the PARIS required assessments and screens. And so I guess the question is asking if there would be either a second round of 30 days or if the waiver that we had originally approved under 1135 still remains in existence?

Let's take that question back. Certainly understand the dynamic nature of the Public Health Emergency and we want to provide you with the right amount

of flexibility. But let us put our heads together specifically around PARIS and 1135 and get back to you. So I appreciate the question.

Ashley Setala: Okay, then we have received a number of questions about the unwinding guidance that was released last Friday. And the first question says, "The recent letter states that redeterminations can be completed after the end of the PHE. Does that mean a redetermination can result with the termination of coverage on the last day of the month in which the PHE ends if the beneficiary no longer qualifies or doesn't provide necessary information or verification?"

Shannon Lovejoy So the requirement in the (SHO) is that a new redetermination is required after the Public Health Emergency. And given the 12 month timeframe along with this requirement, you know, we would not expect to see any terminations occur immediately or aligned with the exact end of the Public Health Emergency because that new redetermination is required.

Ashley Setala: Okay, the next question says, "Are states required to send out renewals right now since all cases have to be reviewed after the PHE anyway?"

Shannon Lovejoy So...

(Jessica): I can jump...

Shannon Lovejoy ...you know, there...

(Jessica): Go ahead.

Shannon Lovejoy ...sorry (Jessica) are you jumping in?

(Jessica): Go ahead.

Shannon Lovejoy I was going to say that, you know, the requirement to conduct periodic renewals of eligibility hasn't gone away. However, we understand that for a variety of reasons due to the Public Health Emergency including because of the continuous enrollment requirement that is in effect in Medicaid as a condition of receiving an increased FMAP we know that a lot of states have not been able to fully complete the renewal of redetermination process during the Public Health Emergency either, you know, because the - in order to prevent terminations of coverage that would not be allowed under the continuous enrollment requirement.

So, you know, while that requirement is still in place we certainly understand that states have been - have only been able to reach certain states such as only completing for example renewals based on available information during the Public Health Emergency.

(Jessica): And Shannon Lovejoy if I may just add that on top of everything that Shannon Lovejoy just said we encourage states to do work now that can be done. So you may not be able to complete a full enroll because you would need for somebody who is would otherwise be determined ineligible you would need to start that process again after the end of the Public Health Emergency.

It may be still be individuals whose eligibility you can redetermine based on available information for the (unintelligible) process. And doing that and identifying areas where you might have missing information or need to follow-up it may be important now to reduce the amount of work and follow-up that would be needed later on. And those individuals would then have 12 months of eligibility and so you would not need to do their renewal until 12 months later.

Ashley Setala: Okay, the next question says, "Someone who is ineligible but that does not become known until a later date within the 12 months is it correct to assume there is no FMAP available to the state for that individual past the quarter in which the - or past the end of the quarter in which the PHE ends?"

(Jessica): This is (Jessica) again. Let me - I'll say what I think the question is asking, and that is a state may not be able to complete renewals now and so they will complete - when they complete the renewal they will find that the person is ineligible but may have information for example to indicate that the person might have become ineligible earlier in their eligibility period or during the Public Health Emergency.

That - there's no expectation for any state to go back and figure out when a person became eligible during the eligibility period within or outside of the context of the Public Health Emergency. And FMAP is available, continues to be available until the person is determined ineligible for coverage for Medicaid.

So if the - if a state makes the determination of ineligibility hypothetically, I'm making up a date here of January 2023, even if that person had become ineligible in, I don't know June of 2022, the state continues to receive FMAP until that person's coverage has been - has ended. Of course that is not in a general sense sort of give states a pass for conducting renewals in a timely manner but generally speaking FFP is available until that determination of ineligibility is completed.

(Sarah): And (Jessica), this is (Sarah), if I can just add on just to complete in the context of the PHE and the unwinding period . For purposes of this discussion what would be considered timely is the renewal that's completed within that

12 month, you know, unwinding period, 12 months after the end of the PHE, right?

(Jessica): Correct.

Ashley Setala: Okay great. The next question says, "Would a risk based approach that handles all individuals who are 65 plus in the first post PHE months without a redetermination be allowed?"

Shannon Lovejoy This is Shannon Lovejoy. No, a redetermination of eligibility is still required even if an individual turns 65 and may no longer be eligible for the group in which they're enrolled states still have the obligation to determine eligibility on all basis prior to making a determination of ineligibility.

Ashley Setala: Okay, then there's a second part to that question. And it says, "Would a risk based approach that handles PARIS alerts with an additional redetermination of eligibility for those backlogs in bulk during the first or second post PHE month be allowed?"

(Jessica): This is (Jessica). You might want to understand the hypothetical a little bit more over the conversation with the state so kindly reach out .But I think what this part of the question is asking is the state maybe has been identified PARIS matches for individuals who are duly enrolled, potentially enrolled in more than one state during the Public Health Emergency.

And the question is whether the state can sort of do all of that work in the first month. I think first to note that what - after the end of the Public Health Emergency what a PARIS match would have indicated as potential enrollment in another state.

And in a state that is conducting renewals during the Public Health Emergency the first thing to do would be to make sure that you would not be conducting a renewal that is fewer than 12 months after the prior one. I think it might be helpful if we could have a conversation further about this particular scenario offline and then maybe come back to the larger group if we can help clarify. Thank you.

Ashley Setala: Okay, the next question says, "Are we required to sign a renewal form if the member was a PARIS match and potentially getting benefits in another state?"

(Jessica): Maybe let me clarify as it relates to PARIS that PARIS in match the PARIS - let's see outside of the context of the Public Health Emergency. A match with PARIS is an indication that an individual may be - may no longer be a resident of the state meaning that there is a change in residence, a change in circumstances with respect to residency.

The ordinary process when a state has a PARIS match would be to first see if the state has any additional information. And this is outside of the context of the Public Health Emergency, sorry just to clarify that, that see if there is additional information that the state might have that might explain the potential PARIS match, so for example the individual has just moved to the state.

And then to follow-up with the individual to request information to verify residency in the state. And if the individual verifies that they continue to be a resident of the state there is no additional action that should be taken because you have resolved the change in circumstance with respect to residency.

If this is a scenario that we are talking about where a person would otherwise have a renewal after the Public Health Emergency and the state is trying to

align changes in circumstances with the full renewals or redeterminations then they would conduct the renewal process in that process make sure that you verify residency. But otherwise following-up on a PARIS match or a change in circumstance would not require a separate renewal form.

Ashley Setala: Okay, thanks (Jessica). So operator, could we open the phone lines and see if there's anyone that has a question over the phone?

Coordinator: Sure. The phone lines are now open for questions. If you would like to ask a question over the phone please press Star 1 and record your name. If you'd like to withdraw your question press Star 2. Thank you. There is a question in the queue from (Erin Noble). Your line is now open.

(Erin Noble): Hi. My name is (Erin). I am from Nebraska. And my question has to do with noticing requirements. With the change allowing for 12 months after the PHE ends to complete eligibility redetermination how does this impact noticing requirements for beneficiaries who are determined ineligible during the PHE but remain open in states that are claiming the enhanced FMAP?

For example if someone is determined not eligible for September due to income or failure to provide information but they remain open are states required to send a notice to the beneficiary now that they were determined ineligible but that they remain open due to the OHE provisions?

Shannon Lovejoy: Hi. This is Shannon Lovejoy. You know, I think we can take back a little bit more specifics. We know that states have taken different approaches on how they want their notices to look. Because, you know, while individuals do need to be notified that they - of an eligibility determination I know states have also been trying to be mindful that they're letting people know that coverage, you know, does continue during the Public Health Emergency. So we can take

back because I know we want to think about how, you know, how we're - how states can put together notices that make the most sense for the individual that's not confusing about that.

Coordinator: Next question in the queue is from (Pam). Your line is now open.

(Pam Wenzel): Hi. This is (Pam Wenzel) from Illinois. My question is related to the redetermination of eligibility and how that applies to HCBS waiver participants who might have lost their waiver eligibility through the PHE are we required to do a redetermination of eligibility for waiver services prior to any adverse action?

(Jessica): This is (Jessica). Are you referring to like a redetermination of baseline eligibility or...

(Pam Wenzel): Yes for annual redetermination if for some reason they became ineligible for the waiver.

(Jessica): Oh well yes. like no - so generally speaking you would still - you would ordinarily be required to redetermine eligibility to see if an individual was eligible on another basis. So if that has not occurred well that would need to occur after the Public Health Emergency even if that occurs during the Public Health Emergency and you find that they are not eligible because they are potentially eligible afterward.

(Pam Wenzel): Okay.

(Jessica): Sorry that was a little circular.

(Pam Wenzel): Okay.

Coordinator: Next question is from (Henry Lippman). Your line is now open.

(Henry Lippman): Thank you and thank you for the briefing today. I appreciated the outline of the example of the application of FMAP and I think the example that was illustrated was someone who became ineligible in June of '22 and it wasn't determined until March of '23.

Was that assuming the Public Health Emergency ended some time before the March, original March date is my question?

(Jessica): Yes it was but actually that would not change even if the public health - well what would change is that you wouldn't be terminating eligibility but it would not change the answer even if the Public Health Emergency were still in place. In short the state would continue to receive FFP for individuals who are enrolled until the state terminates eligibility for them. And that would have to be after the end of the Public Health Emergency in the majority of circumstances.

(Henry Lippman): Thank you.

Courtney Miller: Thank you (Jessica). I want to thank Shannon Lovejoy and Jen for their presentations and updates today. Looking forward we will meet with you again on Tuesday, August 31. The topic and invitation 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 questions to our next call.

If you would like to pre submit a question for the open Q&A portion of our next All State call you can email it to medicaidcovid19@cms.hhs.gov by 1:00

pm Eastern on the day of the call. Thanks again for joining us today. And take care.

Coordinator: This concludes today's call. Thank you for your participation. You may disconnect at this time. Speakers please stand by.

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