Centers for Medicare & Medicaid Services
Medicaid & CHIP All State Call

August 28, 2021

3:00 pm ET

Coordinator: Welcome, and thank you for standing by. At this time, all participants are in a 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 Jackie Glaze. You may begin.

Jackie Glaze: Thank you, and good afternoon, and welcome, everyone, to today's all-State call. I'd like to turn now to Daniel Tsai, and he will provide opening remarks. Dan?

Daniel Tsai: Thanks, Jackie. Thanks, folks. I think for today's all - so this is Dan Tsai, the Director of the Centers for Medicaid and CHIP Services, along with other colleagues from CMCS on the phone. And I know we have quite a number of State colleagues and related folks on the phone.

So, I think we're going to do a slightly different all-State call today, and just give a - take a step back, since we've all been running on a bunch of pieces. And I wanted to highlight some of the overall priorities and direction that, at least from the federal standpoint, we see for the Medicaid program - Medicaid and CHIP and partnership of States, and then highlight a few specific items of note, and really just open it up to hear from folks and have some dialogue together.

And I want to start out, as always, with just a thank you to the States and staff on the ground. I am now almost three months removed from being the Medicaid director in the State. And, you know, the work that folks do in a

very challenging environment to help maintain coverage and get services and manage a program and deal with budget and operational and other items is - you know, that's where the glory is, and the glory of the federal government all at the same time.

So, I think the - as I've been going around having chats with individual State Medicaid directors and programs, you know, it's a really strong partnership and dance that we have the opportunity of going through together to collectively serve and improve the program and strengthen coverage for right now, about 80 - a little over 80 million individuals enrolled in Medicaid.

So, and I think it's really important to emphasize, as we have in discussions with NAMD and other associations and such, the importance of collaboration and partnership with States. We all have various roles. It's been very interesting for me to take my State hat and put on a federal hat on that which warrants many discussions over some sort of adult beverage at some point.

But I - we really appreciate the partnership with States and what folks are having to do on the ground to run and manage individual Medicaid programs. So, a few overall policy priorities that kind of are the umbrella over a lot of the work underway from the CMS standpoint.

And the administrator Chiquita Brooks-LaSure, did put out not too long ago, six overall policy or strategic pillars and priorities for CMS, and the CMCS, the Medicaid and CHIP pillar is kind of all very well underneath that. And so, three areas we're focused on. Number one, coverage and access. Number two, equity. And number three, innovation and whole-person care.

And those three dimensions pretty much span the landscape of quite a number of things, including things that we have been in very live discussion and

partnership with States around, including HCBS, including how we think about measuring and stratification of a range of outcomes for race, ethnicity, and other factors when it comes to baselining and making progress on equity.

And so, each of those different priorities kind of, again, coverage and access, equity, and innovation, whole-person care, are shaping kind of where we are putting emphasis with our various policy levers and where we're encouraging States to kind of think about where policy priorities are, et cetera.

Two or three things I just wanted to note. The ongoing response to the pandemic, which we are still very much in. we again echo the thanks to folks on the frontlines. We sent out information, I think, not too long ago, around some of the booster dose pieces, which I know there's a lot of discussion around, and any technical assistance for things folks need to highlight that we need to help put on the table.

From a CMS standpoint, we would love to hear and know. So, want to continue to acknowledge all the work underlying there, which is kind of related to the discussions underway with quite a number of States in the NAMD workgroup around how we collectively are preparing for, responding to, and thinking about unwinding from the public health emergency, when that does end, with a lot of operational policy and fiscal considerations that States have all raised.

And so, that will continue to be a very important area of partnership and focus. And so, we look forward to that continued dialogue. And I think we'd love to just hear, there's been a lot of work with States around the HCBS spending plans, which there is a tremendous amount of funding available, and the desire for us all to kind of be able to move the system forward.

I've heard a range of thoughts and perspectives from State colleagues on that and where folks are going and such. So, I just wanted to put a placeholder to invite thoughts and comments on that piece. And finally, other things and realities on the ground that from a State standpoint, you all want to make sure we from the federal standpoint, have in mind and are helping to solve to and think through in partnerships.

So, let me just pause there. And I think, Jackie, we are able to open it up just live for thoughts or questions or other comments from our State colleagues. Is that correct?

Jackie Glaze: Yes. thank you, Dan. So, as Dan indicated, we want to give you all the opportunity now to ask him questions about any of the agency priorities, if you'd like more detail there, any questions you may have about the work we're doing to work with States and territories down the line and flexibility.

So, we just want to give you the opportunity now to ask questions. So, I'll ask the operator to open the phone lines and so you can ask your questions verbally. If you prefer, we'll also have the chat function open, if you would like to send the questions in that way as well.

So, once we finish this part of the discussion, we will do our regular Q&A session at the end. So, I'll ask the operator to provide instructions now so that you can begin asking your questions. Operator?

Coordinator: Yes. 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.

Daniel Tsai: And I know - it can be both questions, exhortation, things that you don't like, things that we need to hear. States usually aren't shy, so we'll see how this goes.

Coordinator: There is a question in the queue from Mary Brogan. Your line is now open.

Mary Brogan: Hi. Are you able to hear me?

Daniel Tsai: Hi, Mary.

Mary Brogan: Hi. Quick question. Early on in the process for the ARPA spending plans, it was mentioned that for those initiatives that require a waiver amendment or I guess a State plan amendment, that there would be a - I guess you would call a streamlined process for review for those specific things that are ARPA spending plan related. And I was wondering if that is still the case and when those - that advice would be issued. Thank you.

Daniel Tsai: Thanks. Jackie, are we - do you want to answer this or should I just answer.

Jackie Glaze: Dan, you - I'll just ask you to take the questions you can, and then if you want to defer to someone else, that's good too.

Daniel Tsai: I'm chuckling because that means I can say anything.

Anne Marie Costello: I was going to say, Ralph is on the line, Dan, if that's helpful.

Daniel Tsai: So, Ralph, I think for - that's a great question. I think as - and I remember being on the Stateside not too long ago, I was thinking about some of these pieces. The goal with the spending plans is to make sure that we're getting

approvals or partial approvals or the ability to draw down the FMAP as quickly out to States.

I think we are - soon should be on track to having completed review of all the 50 States and D.C. that have submitted spending plans. And so, folks should be well on the way to begin to draw down pieces. As you indicated, to the extent that some of the use of the enhanced funding would be for things that could draw down FFP through standard Medicaid and other vehicles, they would go through the regular processes.

We are trying to make sure there is as streamlined and crystal process across any of those items as possible. I think it has - generally, there are a common set of things that many States are exploring for that. So, Ralph, if you're on the phone, do you want to comment at all on the particulars of the - any of the fee waivers or other amendments?

Ralph Lollar: Sure. Can folks hear me, first of all?

Daniel Tsai: Yes.

Ralph Lollar: Okay. Essentially, we're working as quickly as we can. And as we've stated in previous all-State calls, making sure that you alert us to the fact that using 9817 funds, putting it in the application itself, and limiting the application to just the activities you're taking on 9817 assists in expediting that review and that process as we crosswalk it to the spending plans that have been sent in.

So, the process we're expediting first starts with the State declaring when they submit the application, whether it's a SPA or a C or what is the disaster relief application that they are going - that their intent is to use 9817 funds, and then

to keep that application as clean as possible so that it can be expedited and concentrate solely on the 9817 activities.

Daniel Tsai: Okay. So, operator, I think - do we have another question or thought or comment?

Coordinator: I'm not showing any other questions at this time. But again, if you would like to ask a question over the phone, please, press Star 1 and record your name.

Daniel Tsai: If we hear silence, the conclusion will be, we're completely in line with States on every topic. So, now is the opportunity. Any takers?

Coordinator: I'm showing no phone questions at this time.

Daniel Tsai: All right. Let the record show that we are alignment with States on all topics, so. Okay. So, folks should feel free to press whatever the buttons are to raise other items. Jackie, are there other Q&A items that we want to switch to on the chat, if there are any?

And again, I would encourage folks not to be shy in sharing your thoughts. They're not just questions around our, you know, policy direction reviews and things, but also what, from a State standpoint, is really important that you want to make sure we're thinking about together, have on the table and are working through.

Jackie Glaze: I'm not seeing any questions right now on the chat. I know that folks do like to use the chat function. So, I'll just encourage you, if you have any questions, comments, anything that you would like to cover today, please start submitting those and then we'll certainly address those.

So, we'll give folks a few minutes if they'd like to submit their questions. Do you have any questions, Ashley, that you received through the mailbox that we can ask at this point?

Ashley Setala: Yes. And we have some questions that came in through the mailbox. And there actually are some policy questions that have come in through the chat. So, Dan, we do have one that I guess you may want to address. It says, when will we hear when the PHE will end?

Daniel Tsai: So, we can start a pool on that. So, I think we've been very transparent from a CMS standpoint of sharing with States what we know when we know it. I think folks are aware, publicly the general indication had been through the end of the year. There's been no formal changes to any of that.

And so, what we have indicated, there has been commitment of, whenever the end of the PHE would be, that States would have at least 60 days' notice for that. It's a dynamic situation. I think, especially in the context of all the unwinding discussions, I think we all would love as much lead time and offertory together as possible so that so we also recognize the 60-day piece is - still triggers in a lot of things that have to happen in rapid order.

I would say that there's been - it's been - we've been reminded multiple times, multiple discussions, that the way the enhanced FMAP works from a statutory standpoint, that the FMAP continues to the end of the quarter in which the public health emergency ends. And so, whereas kind of the renewal and redetermination process from the Medicaid standpoint starts on a slightly different timeframe.

So, folks are well aware of that sequencing that many States have wanted to

make sure is on our radar. All I can say is that there are - we are keeping folks abreast of things as soon as we know it, and planning for a range of different scenarios. All of that comes down again to a lot of collaboration with NAMD unwinding workgroup and States on how individual States are managing the operational and other pieces from a winding standpoint.

In those discussions, we've been really clear. We wanted, and folks probably have seen the various estimates that are out there in terms of implications for coverage. We want to do everything possible to both support States from an operational standpoint, recognizing a lot of the intensity and various factors on the ground, while making sure that we're doing everything to preserve coverage for folks.

So, that includes folks who are at renewal, no longer eligible for Medicaid and might be eligible for highly subsidized care on the marketplace, how we collectively are working together and with partners like health plans to try to make sure folks successfully transition to other coverage options.

It also means working together off a punch list of operational and other policy items that are intended to max - or minimize the amount of procedural and administrative churn that would otherwise happen where folks are indeed still eligible for Medicaid, but potentially at risk of losing coverage for a handful of months due to turn because they did not get a renewal notice in the mail, that sort of thing.

So, those are things that we want to spend a lot of time together with in support of States, recognizing the many dynamic needs and issues on the ground, and some of the broader policy goals that we're trying to achieve. So, that's a longer answer than I think the question was. All that to say, every one of those factors links to the end of the PHE. And as soon as we have any

additional inkling, we will let States in this group and NAMD and others know.

Ashley Setala: Okay. I will flag that we did get a comment in the chat that says, I think CMCS goals are aligned with most States, including Hawaii's, so.

Daniel Tsai: Thanks, Hawaii.

Ashley Setala: Then we have the question that says, is there an issue related to no federal budget and how States continue Medicaid due to the PHE? I assume this is in reference to the end of the fiscal year.

Daniel Tsai: So, I appreciate that. I think that, you know, dynamics around the stuff certainly are well publicized for folks and on many folks' minds. I don't know if other colleagues from the CMCS side want to jump in on this. I know we have received quite a few incoming inquiries from States on this exact topic. So, anyone, or Anne Marie, or others, you want to jump in on this topic?

Anne Marie Costello: So, I'd defer to Karen Shields, if she's on the line.

Daniel Tsai: But we - as far as we can tell, when we look at the timing of various payment cycle loads and things of that sort, I think, you know, and CMS colleagues have been through this sort of thing more than once over the past number of years, we think we're seeing a fairly comfortable path.

I think if any particular State, and a few examples have come up as of late, or territories, have any immediate cash flow or other issues, I would just say, please let us at CMS know as soon as possible, including your other - your State contacts for FMG. Where those issues are coming up, the team is trying

to make sure that we are partnering and figuring out how to maintain as much continuity on the ground as possible.

So, if anyone has specific concerns or deadlines or timing things, or cash flow issues or others, please do reach out to make sure that that is on our - that we have awareness of that. Okay

Ashley Setala: Okay, great. Then we have a couple of eligibility and enrollment-related questions that have come in. the first one says, for Medicaid enrollees who have been enrolled for 12 or more months and are overdue for renewal, and who have failed to respond to requests for post eligibility verifications, or whose whereabouts become unknown during the public health emergency, are States expected to conduct an ex parte renewal, issue a pre-populated renewal form, and provide 30 days to respond after the PHE ends prior to terminating Medicaid?

Jessica Stephens: Hi. This is Jessica, and the answer is yes.

Daniel Tsai: Great, Jessica. Thank you.

Jessica Stephens: Yes. Sure. The answer is yes to everything that was laid out. So, consistent with our most recent guidance, States needs to conduct a full renewal for individuals, whether they were found ineligible during the public health emergency, or they did not respond to information if the State attempted a renewal or a redetermination and did not respond to requests for additional information. And that includes all of the things that the questioner asked.

So, first, attempted ex parte renewal, so renewal based on available information. If not able to do so, send a form, a pre-populated form for MAGI

individuals, and provide the beneficiary with a minimum of 30 days to respond.

Ashley Setala: Okay. Thank you, Jessica. The next question says, the CMS FAQS dated January 6th, 2021, indicate States can't terminate eligibility for Medicaid beneficiaries who are eligible based on receipt of supplemental security Income. Does this apply when the State receives a notification from the State data exchange interface, or SDX, indicating the client is deceased or has moved to another State?

Daniel Tsai: Jessica?

Jessica Stephens: I know that we addressed this question. I am going to have to take this one back - potentially come back to it before the end of the call. I think the right person to answer it is not on the call at the moment. So, if you just give us one moment, can we circle back to the question?

Daniel Tsai: All right.

Ashley Setala: Okay. So, the next question relates to the Section 9817 HCBS spending plans. And it says, previously, CMS indicated that they would provide feedback or responses to all States regarding their ARP HCBS spending plans by the end of the month. Are we still on track for that?

Jennifer Bowdoin: Hi. This is …

Daniel Tsai: We are - oh, go ahead.

Jennifer Bowdoin: Oh, go ahead, Dan.

Daniel Tsai: I was going to say, they were all done yesterday. We're on track, or very, very close to on track. So, I think someone from the team was just about to jump in on that.

Jennifer Bowdoin: Yes. Hi. This is Jen Bowdoin. Yes, we are on track and the expectation is that all States will have received a formal response to their initial spending plan narrative submissions by September 30th.

Daniel Tsai: So, a two-day sprint?

Jennifer Bowdoin: Yes. That's right.

Ashley Setala: Great. Then a couple of other 9817 questions. The first one says, when reviewing the personal approval response letters to States regarding the ARP plan, it is a bit unclear what items are or are not approved in the plan. Is it safe to assume that unless CMS specifically raises concerns or asks for more information about an item in the spending plan, it is approved for implementation?

Daniel Tsai: Jen?

Jennifer Bowdoin: Hi. This is Jen again. So, yes, if we did not identify an activity as not approvable or asked any questions about it, the State can assume that it is approved and that the State can begin implementing the activity.

Ashley Setala: Okay. the next 9817 question says, can you please clarify that the Section 9817 State assurance to maintain provider reimbursement rates at the rate in effect on April 1st, 2021, applies to fee-for-service rates and the rates paid to providers by the managed care organizations?

Daniel Tsai: Jen, do you want to try to tackle that?

Jennifer Bowdoin: Yes. So, I don't think we've previously addressed this on an all-State call, but, you know, the expectation is that it would be all rates. But Dan, do you want to jump in more, because this is …

Daniel Tsai: I think that's understood. I mean, it's a great question. On the fee-for-service side, that is extremely clear relative to fee schedules and what's approved in the SPA and things of that sort. I think the spirit and intent of this is to maintain the same on the managed care side.

I think we are cognizant of differing levels of detail that States have with various plans construct. So, but I think very much the spirit of that is to maintain such. If any other colleague from CMCS want to jump in, please do so. Okay.

Ashley Setala: Well, okay.

Daniel Tsai: That's a great question though.

Ashley Setala: Okay. Another 9817 question. It says, if States are using the HCBS funds to increase waiver slots, does community-based State plan services not listed in Appendix B, include physical health services that these beneficiaries would be eligible for?

Daniel Tsai: Ralph, do you want to take that? I know this has come up in the context of a few States.

Ralph Lollar: Sure. Can you ask the question again? I want to make sure I get the nuance.

Ashley Setala: Yes. It says, if States are using the HCBS funds to increase waiver slots, does community-based State plan services not listed in Appendix B, include physical health services that these beneficiaries would be eligible for.

Ralph Lollar: It depends and it depends - and the answer is that if the individual is already eligible for Medicaid when they enter the waiver, the State is already funding the State plan services for that individual that are not waiver-related. If the individual is not currently eligible, and is only eligible for Medicaid services, as a result of their waiver eligibility, then those services are able to be funded through 9817 fund. Jen, please correct me if I got any of that wrong.

Jennifer Bowdoin: No, that's right, Ralph. And we did cover this previously on an all-State call, as well as in some other stakeholder calls. And I can just repeat the response that we've shared previously. So, if a State increases the number of Section 1915c waiver slots and enrolls additional individuals who are not already Medicaid-eligible into the waiver program as a result, the State will have an increase in non-ACDF 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 B, for individuals who become Medicaid eligible because of the State increase in the number of waiver slots as part of a State's activity to enhance, expand, or strengthen HCBS under ARP Section 17.

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, essentially, if the individual is not already Medicaid eligible, the State can - basically the State

could use the funds to pay for any services other than institutional expenditures, which we would interpret to - institutional to include hospital expenditures.

Daniel Tsai: I did want to make a broader note and also folks should, I don't know, start - wonder whether if they want to comment on this live, and I'd ask for folks to consider that. So, on the 9817 HCBS piece, and I've had a number of discussions, we've had a number of discussions with States as of late on this, I think it's - to reemphasize it, certainly for everyone, it is a very large amount of investment, with a level of flexibility and also statutory intent that is unprecedented.

And so, we want to be figuring out how to best support States as an overall collective set of partners, try to both deal with a lot of immediate near-term things that are certainly, you know, rates and workforce issues that are very acute in nature and have been acute overall, certainly have an exacerbated pandemic, but also to think about how to use that funding to fundamentally expand capacity in the HCBS system.

And so, for some States, those waitlists for 1915c waivers, we'd love to figure out how to help folks get to the ability to expand waiver slots for those that - there are few States that have recently thought about some very cool, creative ways to try to expand HCBS LTSS services beyond their traditional HCBS 1915c waiver population.

We'd love to partner and to see kind of how best to support States on that. for any State, and we've seen less of this, for example, but we're actually using the ARP funding for capital investments not as a payable, but still funded from the enhanced FMAP, as a starting point to actually build out additional community residential settings that are compliant with the settings rule.

We would love to support and do that. And those are things that require capital cost and time and are always issues and typically have no source of federal funding for. And so, anything along that continuum that has the net effect of getting more individuals access to HBCS services, or sustainably building out capacity or other workforce development trajectory type things, I just want to emphasize our goal to help support States on that.

So, I'd appreciate hearing from folks. If that resonates with the intent of what all of you on the ground and what stakeholders are currently trying to work through and wrestle with, are there things that you would say, great, CMS, that's a great set of goals. If only you would help think about X, we could do that even more, that would be helpful to hear generally from folks on the ground at the State level.

Jackie Glaze: Dan, I'll ask the operator now to check the phone line to see if anyone has comments on what you just shared. So, Operator, could you open the phone lines, please?

Coordinator: Yes. I don't see any comments yet, but again, if you would like to ask a question or make a comment, please press Star 1 and record your name. Thank you.

Ralph Lollar: Dan, this is Ralph. While we're waiting for comments, if I can add here, any State that's having difficulty figuring out how to factor into the budget the amount of money that would be for the individuals who were not Medicaid eligible and the individuals who are Medicaid eligible, that data or the source for the data is available in the States own 372s, and in their appendix J in their waiver document.

We would be happy to walk folks through that. All they have to do is contact their regional office and they'll ship that information up, and we'll tell you where the date is.

Daniel Tsai: Thanks, Ralph.

Jackie Glaze: Operator, any questions?

Daniel Tsai: So, were there any thoughts from folks?

Coordinator: I'm showing no questions or comments at this time.

Jackie Glaze: Okay, Dan, we'll …

Daniel Tsai: All right. I'm going to get a job at an auctioneer after, unsuccessful auctioneer …

Jackie Glaze: Dan, we'll return to the chat box, but then we'll come back again to see if we have any questions. So, Ashley, I'll send it back to you.

Ashley Setala: Okay. so, one of our 9817 question that has come in and it says, regarding 9817 funded services for newly eligible persons, we understand that community-based State planning services can be paid for with funds attributable to the enhanced FMAP, but not institutional services. Are outpatient hospital services considered community-based services?

Ralph Lollar: Sure. This is …

Daniel Tsai: So, I would generally probably say that doesn't strike me as what we think about for HCBS, but others can jump in, Ralph, Jen, others, if there's any nuance or proposals from States you want to comment on.

Jennifer Bowdoin: This is Jen. We have not received, I would say, any proposals from States that get into this level of detail, at least that I'm aware of. But Ralph, is there anything you'd want to jump in with?

Ralph Lollar: I just think it's a really good question, because there are a couple of ways to view that, and I'd like to take that back for consideration.

Daniel Tsai: Right. Thanks, Ralph.

Jennifer Bowdoin: Okay.

Ashley Setala: Yes. Thanks, Ralph. So then, I think we want to return to the question that we couldn't answer earlier, and I think Jessica has an answer. But just to restate the question, it said, the CMS FAQs dated January 6, 2021, indicate States can't terminate eligibility for Medicaid beneficiaries who are eligible based on receipt of SSI. Does this apply when the State receives a notification from the State data exchange interface or SDX, indicating that the client is deceased or has moved to another State?

Jessica Stephens: Sorry for my hesitation earlier. The answer is that, yes, it does apply. It means that even for information received from the SDX interface, that might indicate that the individual is no longer a resident or deceased, that the State needs to reach out to the individual to request additional information to verify.

And if the individual at that point does not respond, that in itself is not sufficient basis to terminate eligibility for the beneficiary during the public

health emergency due to the FFCRA provisions in order to continue receiving the increased FMAP. So, that is not an exception to the FFCRA continuous enrollment requirement.

Ashley Setala: Okay. Thank you, Jessica. Then we have a question that says, will the Medicaid provider revalidation pause continue through the end of the PHE?

Jackie Glaze: Dan, would you like for me to take that one?

Daniel Tsai: That would be perfect. Thanks, Jackie.

Jackie Glaze: So, yes, the answer is yes. And so, if States pause revalidation for providers with the validation due dates that fall during the public health emergency, the State would then recalculate the provider's revalidation due date by adding six months, plus the length of the public health emergency, to the provider's original revalidation due date. So, we have included that within a set of FAQs that we have issued. Ashley, back to you.

Ashley Setala: Thanks, Jackie. Great. Then we have a question that says, will the individuals who were found ineligible for MAGI during the PHE, but their eligibility was continued, qualify for transitional Medicaid upon their redetermination after the PHE ends?

Sarah Lichtman Spector: Hey, Ashley, this is Sarah Lichtman Spector. I'm in the Division of Medicaid Eligibility Policy. I can take that one. The easy answer is yes. So, a State when it does its redeterminations at the end of the PHE per our unwinding guidance, is going to determine an individual eligible for TMA were it to meet the criteria in the way that it would in any other context.

As a reminder, TMA is mostly for adults and the parent caretaker relative

group, and sometimes for kids enrolled in the mandatory children's group. In the context where a State might have - be doing renewals in the middle of the PHE, but not acting on those determinations, the State would consider TMA as appropriate during this tenancy of the PHE.

Ashley Setala: Okay. Thank you, Sarah. Then we have a question that has come in around vaccines. And it says, for the vaccine strategy that was released a few weeks ago, does CMS have any guidance on how CMS will review vaccine administration rate increases or direction on guardrails around physician incentives?

Daniel Tsai: I'd say, I think - and then I'd ask Anne Marie or others to jump in. I think we would love to hear from States if you have a particular proposal or an idea, to let us know. I think the goal is to try to figure out how we can support States in creatively doing what they need to do to help increase uptake of vaccines with the Medicaid population. So, I would say that's an overarching thought. Team, anything you want to comment on?

Jeremy Silanskis: Hey, Dan, this is Jeremy. And I would say that, you know, what the letter speaks to is the overarching requirement of economy and efficiency. And so, you know, as Dan alluded to, you know, what's the basis and rationale behind increasing the rates? What sort of information do you have to say that, hey, we need to do this in order to more effectively deliver back to the administration within our communities? I think that's the kind of explanation that we'd be looking for.

Daniel Tsai: In other words, we'd like to partner together to help in the context of the pandemic support to get where they need to get to on these pieces, what the various statutory and other requirements we have.

So, I think it's less about us putting out a bunch of parameters and guidance, than offering and indicating very clearly our desire to provide support in this way, and then seeing kind of where States want to go on some of these pieces.

Ashley Setala: Okay. Then we have a question that has come in around over-the-counter COVID testing for Medicaid recipients. And it says, regarding the coverage of over-the-counter COVID testing for Medicaid recipients, is this coverage retroactive back to March 11th, 2021? And is the 100% FMAP applicable for over-the-counter COVID tests?

Daniel Tsai: Anyone on the team want to jump in on that?

Melissa Harris: This is Melissa Harris in the Disabled and Elderly Health Programs Group. So, we should - I should clarify first, and I'll ask my FMG colleagues to be kind of on standby. The 100% FMAP attaches to COVID vaccine administration, not COVID testing. The only difference there would be testing provided to the individuals in the optional testing group that has all of their services reimbursed at 100%.

But that's an important distinction to keep in mind. Vaccines for everyone in Medicaid is at 100%. Other services, including testing, is a regular FMAP, unless we're talking about individuals in the optional COVID testing group. So, over-the-counter testing is part of the mandate that the American Rescue Plan put out.

And we are happy to provide technical assistance to States to make sure they are accurately accounting for over-the-counter testing. Now, the information that we released in the State health official letter for testing, was effective as of that date of issuance moving forward. So, it was all prospective.

We understand that even though the ARP was effective back in March, the

nuances of the guidance that we had to provide to States, were such that it only made sense to implement or have the effectiveness of those provisions on a prospective basis. So, States would have an understanding of what their CMS expectations were moving forward.

So, beyond that, we are happy to have a State-specific technical assistance conversation with you, but I would say that's the overarching point that I would make. FMG colleagues, any amendments that you need to make to my references of the 100% FMAP?

Jeremy Silanskis: Hey, Melissa, this is Jeremy, and I'll just verify that what you said is accurate and true. So, thanks.

Melissa Harris: That's great. Thank you.

Ashley Setala: Okay, great. Then we have a question - oh, go ahead, Jackie.

Jackie Glaze: Ashley, shall we try to check the phone lines? I did see a question from a State, and she's asking for instructions on how to go off mute and ask her question. So, I'll ask the operator if you can share the instructions one additional time, and hopefully we can take that question.

Coordinator: Sure. If you'd like to ask a question over the phone, please press Star 1 and record your name. And we do have one question in the queue, if you'd like for me to open their line.

Jackie Glaze: Please. Thank you.

Coordinator: Sure. Sam (Herwig), your line is now open.

Sam: Hi. This is Sam (Herwig) from Nebraska. Can you hear me?

Daniel Tsai: Yep. Hi, Sam.

Jackie Glaze: Yes.

Sam: Hey. So, I wanted to ask a question about the school-based screening testing guidance provided in SHO letter 21-03. The guidance outlines out, States could reimburse schools via their school-based service programs through cost - cost reconciliation methodologies, apologies.

In Nebraska, our HCBS program is limited to a subset of the Medicaid enrolled student population who are in individual education programs or individual family service plans. And for the schools to be reimbursed for HCBS, those services have to be required by their IEPs or IFS fees.

That said, however, the guidance in the show letter on this point appears as if it's intended to encompass all Medicaid enrolled students. And I guess where we're seeking clarification on, it's mandatory for States to provide testing services in schools and whether the guidance applies to all students or just school-based populations.

And I guess the overarching question is, is it CMS's intention for schools to be reimbursed through HCBS for providing testing to students who are not a part of the actual school-based services population?

Daniel Tsai: Ralph, can you just say more about what - where from a State standpoint your head is on that.

Ralph Lollar: Yes. so, at first, Nebraska, we had originally interpreted this section to mean that we can pay schools through school-based services, our program through cost reconciliation, the fact that it points to using the cost report to record tests as a medical supply and as administration.

But our school-based program itself is limited IN so far as only students who have IEPs or IFSPs can receive school-based services and schools can be reimbursed for those services. And I guess, we're just trying to determine whether or not this is the means by which CMS is intending States for schools to provide testing to Medicaid eligible or enrolled students. And if so, how we can possibly overcome our school-based services being limited to a subset of that population.

Daniel Tsai: Maybe - I appreciate that question. Maybe it's - Sam, if you wouldn't mind following up with us on that so we can understand a little bit more of your context and how to support on that. So, Jackie - folks, Jackie Glaze can help be the conduit for that to get to the right folks.

I would say overall, this is an invitation for anyone else on the - there are a number of discussions that have been happening just around how we, from a Medicaid standpoint, especially going into this fall and where things stand with kids and schools and so on, we want to find a way within our statutory, regulatory, and other requirements to be as supportive and helpful as possible relative to, you know, what can be done through Medicaid and funding sources through schools during this time.

So, that's an overall goal, with obviously quite a bit of nuance under it, as folks should recognize. So, Sam, I appreciate you raising that. We'd love to put our heads together to see where we can support you all on that, if you wouldn't mind following up directly.

Sam: Great. Yes. We'll be sure to be in contact.

Melissa Harris: And Dan, this is Melissa Harris. The only thing I would add upfront is that your larger issue in Nebraska about only reimbursing for services that are specifically noted in the child's IEP or IFSP, if you are interested in broadening that universe beyond reflection and services reflected in those two plans, we also can provide technical assistance on that point.

And that does not have to be limited to just testing or just during the public health emergency. On our website, we have a letter to State Medicaid directors from December of 2014 where we talk about revisions to the policy around free care, and I put free care in quotes, that basically says that Medicaid will authorize reimbursement for any Medicaid covered service provided to a beneficiary in the schools, whether or not the service is specifically listed in an IEP or IFSP, as long as some basic program requirements are met, and these requirements are detailed in a bulleted list in the State Medicaid director letter.

So, that's not a mandate, but it is certainly a flexibility. If you are looking to grow the universe of covered services that receive reimbursement federally when provided in the schools, that might help you in this case to be able to more leverage the schools in a wider way to provide coverage of testing.

But absolutely, we are happy to provide some State-specific context to not only the free care provision, which has broader applicability than just one specific service or one specific timeframe, but certainly how that can fit in with maximizing the testing provisions as well. Thanks.

Sam: Thank you. I appreciate all this, and we'll be sure to look into that 2014 letter and check out.

Coordinator: There is another question or comment in the queue.

Daniel Tsai: Please. Thank you.

Jackie Glaze: Okay.

Coordinator: From Judy Mohr Peterson. Your line is now open.

Daniel Tsai: Judy.

Judy Mohr Peterson: Hi, Dan. How are you?

Daniel Tsai: Great. Can we come visit you in Hawaii?

Judy Mohr Peterson: Of course you can. We think we're opening back up, but you still have to register with the Safe Travels Program, et cetera. So, we highly recommend that you come vaccinated. So - but yes, please do come visit. But my actual question - I actually have two, but the question is regarding the optional pregnant women, expanding it to the 12 months' time period.

So, we're preparing for our budget session, getting our budget requests ready. And we had a question, and I know a couple of other States have, and it's relative to - I think it's more relevant for States that expanded, but today, you know, when a woman, you know, reaches that 60-day postpartum, then we evaluate for other categories of eligibility.

And oftentimes, they may be eligible for either the pediatric relative or the expansion adult population.

So, given that the match rate is, of course, different and we are considering that 12-month expansion, but from a budget perspective, depending on whether we evaluate at that 60 days versus the 12 months for if they're eligible for other categories, becomes sort of a critical budget question, because if we do it at the 60 days, then, of course, the delta for the additional dollars that we would need is considerably lower than if we have to do it at the 12-month time period. So, my question is, are you guys coming out with guidance or not and responding to that or not?

Daniel Tsai: Yes. Judy, thanks for that. So, I think we would love to work with as many States as possible to have folks take up the 12-month postpartum option that you're referencing. There is guidance that the team is working on that should - that we hope to be getting out relatively soon.

That includes this exact topic, which some of the States who have been involved in some of the earlier 1115 discussions have been quite involved in. And so, that has been the primary kind of operational piece that we have been working through with States. So, I'd ask the team to comment on that.

And the guidance also will help encourage folks around different elements of how to improve care and maintain strong care for folks in that period as well. But anyone from the team want to give a quick thing? I know we're about up in time. We can also defer this for future discussions.

Sarah DeLone: Sure. This is Sarah DeLone, Dan. I can jump in. just to sort of reiterate, Judy, we are - that is definitely a question that's front and center, I mean, just to sort

of - you know, a number of these individuals we know post 60-day period would be determined eligible for coverage in the adult group if you're an expansion State.

And a good number of those would be unique and newly eligible criteria. And so, that is definitely - but at the same time, you'd have to do a full redetermination in order to really know for sure whether many of them would meet that criteria. So, we are actively working on that issue.

We're aware that that's really important for you all to - that's a budget impact. And, you know, from a policy perspective, you certainly shouldn't have to take that financial "hit," if you will, for making a decision to expand coverage to all the extended postpartum coverage to beyond those - that 60-day period.

So, actively working on it will definitely be in the guidance and sort of hopefully that can provide some more definitive information soon.

Judy Mohr Peterson: Great. Thank you so much. I appreciate that. And only after - it's a quick sort of comment and that's around the technical budget pieces on the 9817, the home and community-based services and how it is that States claim or get that sort of freed-up general funds or State funds, or that enhanced - that percentage point.

That is also proving to be a little bit of a down-in-the-weeds technical challenge and difficulty, at least for our State, in that we don't get to carry over general funds or State funds from year-to-year, and yet we have three years to spend this.

So, we have some ideas, if you guys want to talk to us about if you were still working on your guidance, we would be happy to express our idea that would

make our lives at least much, much easier. I don't know about you guys' lives. So, that's it for me. Thank you.

Daniel Tsai: Thanks, Judy. I think you'll have the last word on this. But Jen, and Melissa, and Ralph, and team, could we - could you all follow up with Judy's team - Judy and team on this? That's a good point, Judy.

Jennifer Bowdoin: Yes. This is Jen. Yes, we'll definitely follow up. Thank you.

Daniel Tsai: Great. All right. Well, I think with that, Jackie, I think we're up on time.

((Crosstalk))

Jackie Glaze: Yes that is it right there.

Daniel Tsai: What's that?

Jackie Glaze: So, Dan, we'd like to thank you for joining us and participating in the call today. Very helpful. And we'd also like to thank the States for the questions that they posed today. So, looking forward, we'll meet with you again on Tuesday, October the 12th. So, we'll be sending out the topics and the invitations.

If you do have questions before the next call, you know how to reach out to us or your State liaison or bring your questions to the next call. You can also resubmit your calls in advance to us for the Q&A portion of the next call. And you can email them to MedicaidCOVID-19@cms.hhs.gov up by 1:00 pm Eastern Time on the day of the call. So, again, we thank you, and we hope you all have a great afternoon.

Daniel Tsai: Thanks, guys. Take care. Bye-bye. Thanks, team.

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

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