HHS-CMS-CMCS

March 7, 2023

2:00 pm CT

Coordinator: Welcome and thank you for standing by. I'd like to remind all parties that the lines have been placed in a listen-only mode until the question and answer session of today's conference call. I'd also like to inform you that this call is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the meeting over to Jackie Glaze. Thank you. You may begin.

Jackie Glaze: Thank you, and good afternoon, and welcome everyone to today's all state call. I'll now turn to Dan Tsai, our Center Director, for opening remarks. Dan?

Daniel Tsai: Thanks, Jackie. Good afternoon and good morning, everybody. Welcome to today's all state call. We are actually going to do a very Q&A-focused, discussion-focused all state call, because we've had so much back and forth; we've had a ton of presentation-heavy all state calls recently. We are in individual discussions with - lined up with all of the states on what I believe most of you are familiar with, for mitigation plans and getting to approve mitigation plans to claim enhanced funding within the Omnibus, or all the unwinding work, etc., etc.

All I would say is thank you all. There's a ton of work as I always say, on the ground underway. I think we all feel it. And there - the silver lining here is a

chance for us to both help manage an orderly set of redeterminations that maintains and preserves coverage for folks, whether it's through Medicaid or other forms of coverage, and also helps us all make progress, recognizing state operational realities on the ground, with the regulations that are on the books for what folks are entitled to, for Medicaid applications and renewals.

So that is a ton of work underway with individual state discussions. So if you have questions for our subject-matter experts on unwinding or a range of things, feel free to start entering them into the chat now, so that we have time to get into that. Before we go into the Q&A, I'm going to turn it to Sarah O'Connor from our Children and Adult Health Programs group, who will go through proactively, a few of the frequently asked questions, FAQs, we've been getting from states around returned mail, and some of the CAA requirements, the Omnibus requirements, which is of great interest to folks. So we'll do that.

We'll have one other important walk-on item of note that you'll hear about. And then we'll go into open questions and dialog. So with that, thanks all for being here in the trenches with everybody. And I'm going to turn it over to Sarah O'Connor. Sarah?

Sarah O'Connor: Thanks so much, Dan. And yes, so what we'd like to do today is to provide some - hopefully some clarification around some confusion surrounding a state's obligation to act on returned mail that's returned after a beneficiary has been terminated for failing to respond to the renewal. And the first thing we'd like to address is how long after a beneficiary's coverage has been terminated for failure to respond to the renewal, are states required to act on returned mail to meet the condition in the CAA?

The answer is that states will be required to take the steps to attempt to contact beneficiaries using one or more modalities for mail returned within 30-days of termination. And at state option, this timeframe can be extended up to 90-days. We've also received some questions asking us to clarify the expectations to reinstate coverage if mail is returned within 30-days of a beneficiary's coverage being terminated for failure to respond to the renewal. So the first step states would need to take would be to attempt to contact the beneficiary through more than one modality.

So this is a scenario where a beneficiary's coverage has been terminated, mail is returned within 30-days, and the state attempts to contact the beneficiary. If the beneficiary responds to the state's outreach, the state must promptly reinstate the beneficiary's coverage effective on the date that contact is reestablished, or back to the first day of the month in which the contact is made.

After the state obtains up-to-date contact information and the beneficiary has been reinstated, it must provide the beneficiary with an opportunity to furnish information needed to complete the eligibility determination. If the state needs to send a new renewal form, the state must provide MAGI-based beneficiaries with 30-days and non-MAGI beneficiaries a reasonable period of time to respond. If the individual returns the information and is determined eligible, the state must reinstate coverage back to the date of termination.

So I know we've received some follow-up questions to this guidance in general, and we want you to know that we're working through those questions as quickly as we possibly can, and we're looking forward to receiving additional questions today, if there are any, and really appreciate your input and feedback, in particular your concerns about operationalizing this, because that helps inform the policy in general and the guidance as we try to work

with you to implement these policies. So with that, Jackie, I'll turn it over to you.

Jackie Glaze: Thank you, Sarah. So before we start our portion of the Q&A session, we will turn to Stephanie Bell from our Children and Adult Health Programs group. And she would like to provide a quick update. So Stephanie, I'll turn to you.

Stephanie Bell: Thanks, Jackie. I wanted to let you all know that CMS will be sending a letter today to each state Medicaid director, to inform them of a court order that was issued in CAR v. Becerra on March 2, 2023, and the actions that HHS is taking to comply with it. As I'm sure you recall, this is a case concerning the interim final rule that was issued by HHS in November 2020, which interprets Section 6008(b)(3) of the Families First Coronavirus Response Act.

In the March 2nd order, the court clarified its January 31, 2023 order. That January 31st order - within it the court certified a class that consists of all individuals who are enrolled in Medicaid in any state, on March 18, 2020 or later. And as a result of the adoption of the IFR on November 6, 2020, either had their Medicaid eligibility reduced to a lower level of benefits and were determined to be eligible for a Medicare savings program, or will have their Medicaid eligibility reduced to a lower level of benefits and be determined to be eligible for a Medicare savings program prior to a redetermination conducted after March 31, 2023.

The January 31st order also directed HHS to refrain from enforcing the challenged portion of the interim final rule with respect to members of that certified class. And it ordered for HHS to reinstate its previous guidance with respect to the class members. In the March 2nd order the court directed HHS to take the same positions as those reflected in the frequently asked questions that were in effect prior to the interim final rule. These frequently asked

questions were attached with the letters that we sent to state Medicaid directors regarding the January 31st order, and they will also be attached to the letters sent to each state Medicaid director today.

The court's order observed that among those frequently asked questions is the following answer provided by the Secretary. This is question 7 from the April 13, 2020 FAQ. It reads, if a state has already terminated coverage for individuals enrolled as of March 18, 2020, what actions should the state take? Must those individuals have their coverage reinstated? And the answer in the published FAQs reads, to receive the increased FMAP, states may not terminate coverage for any beneficiary enrolled in Medicaid during the emergency period effective March 18, 2020, unless the beneficiary voluntarily requested to be disenrolled or is no longer a resident of the state.

States that want to qualify for the increased FMAP should make a good faith effort to identify and reinstate individuals whose coverage was terminated on or after the date of enactment for reasons other than a voluntary request for termination or ineligibility due to residency. At a minimum, states are expected to inform individuals whose coverage was terminated after March 18, 2020, of their continued eligibility, and encourage them to contact the state to re-enroll.

Where feasible, states should automatically reinstate coverage for individuals terminated after March 18, 2020 and should suspend any terminations already scheduled to occur during the emergency period. Coverage should be reinstated back to the date of termination. We continue to encourage states to all consult with their own counsel. And I'm sure you all have additional questions, and you're welcome to include them in the chat, and we will take them back for consideration. Thanks.

Jackie Glaze: Thank you, Stephanie. So we're ready to take your questions now. So we'll begin by taking questions through the chat function. So you can begin submitting those now. And then we'll follow by taking questions over the phone line. So (Ashley), I will turn to you at this point.

(Ashley): Thanks, Jackie. We have a few questions that have been submitted so far. And the first one says, can you provide additional guidance and/or examples of extraordinary care vs ordinary care, as it relates to a spouse providing paid services to their spouse enrolled in a waiver?

Melissa Harris: Hi (Ashley), this is Melissa Harris in DEHPG, and I'm going to - I happen to have the 19159(c) waiver technical guide in front of me, which is handy. And there is a language in the technical guide that defines extraordinary. And it says by extraordinary, CMS means care exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization.

So this boils down to care above and beyond and what that individual, in this case the spouse, would be expected to provide. And so there is some room there, now that we are moving past a period where Appendix K flexibilities and other HCBS flexibilities are going to be in play. There is some room to continue using family members as paid caregivers, and we would encourage states to come talk to us with your specific questions as we're dealing with children or, you know, individuals receiving HCBS under the age of 21.

Obviously that conversation takes on some additional nuances depending on the age of the child. But there's a lot of room there for states that want to

continue that flexibility. And we're available to provide technical assistance. Thanks.

(Ashley): Thanks, Melissa. The next question says, when a beneficiary's enrollment is terminated due to death, moving out of state, or via requested discontinuance, where should they be counted on the monthly unwinding report?

(Kirsten): This is (Kirsten) in (CAP). I wanted to acknowledge that we have this question in-house, but I think we'll have to follow up in writing. And we'll do that as soon as we can.

(Ashley): Okay. Thanks (Kirsten). The next question says, is the state required to implement the returned mail procedures by April 1 in order to claim the increased FMAP?

Sarah Delone: Hi, this is (Sara Goat) with - was someone from (unintelligible) getting ready to jump in? No? So this is Sarah Delone. So a state needs to not - cannot terminate somebody. The earliest terminations can happen in April. And a state needs to not terminate anybody based on returned mail, without complying with that condition.

So while you wouldn't have to - let's say you get a piece of returned mail in March or you got one in late February, you wouldn't have to complete that condition in February or March. But you're going to have to satisfy that condition prior to terminating anybody based on the returned mail. So I think the short answer is yes, but it could happen, you know, in April.

(Ashley): Thanks, Sarah. The next question says, if states terminate the COVID-19 testing group on April 30th and anticipate their first eligibility closure to be

effective May 1st, does this timing allow states to exclude the COVID-19 testing group from the eligibility cascade evaluation required prior to closure?

(Shannon): Hi, this is (Shannon) in the Children and Adult Health Programs group. So there may be two things going on here. So, you know, many states, for those who are enrolled in their optional COVID group, that population who are already enrolled in that group, we know many states have followed a special notice process for ending coverage and satisfying the requirement to redetermine eligibility in all bases.

That guidance on those notice requirements and how a state can use this alternative notice process, is in a guidance deck we released in October. And as long as the state is following those notice requirements, then the state can, you know, send that final notice of advanced termination for those who are already enrolled in the optional COVID testing group.

Now there is another issue for states that may have their first termination going into effect for, you know, across Medicaid enrollees before May 11th. If we're assuming that the public health emergency ends on May 11th, there is no authority for the optional COVID testing group. So for states that offered the optional COVID group who are doing renewals, and think that they will have terminations, their bulk terminations, before May 11th, there is still the obligation to redetermine eligibility in all bases and consider coverage in the optional COVID group and either move those individuals to the optional COVID group.

We can also discuss with states different strategies because we know that operationally that could be pretty challenging for a state to move over large groups of individuals who are not eligible on any other basis in Medicaid, into

the optional COVID group. And can certainly work with states on some of those strategies if they might need an alternative strategy.

(Ashley): Okay. Thanks, (Shannon). We have a question on the CAR ruling. And it says, does the ruling also apply to those presumptively enrolled, and those enrolled in error; or only those validly enrolled?

((Crosstalk))

Woman: Okay. I think this - thanks for the question. We appreciate your asking, you know, any and all questions that you have. We'll need to take them back and do our best to get back answers to you when we can. So we can just (Ashley), get that from you after the call. That would be great.

(Ashley): Sure. We have a question asking if the answers to the FAQs discussed today will be posted online later. And yes, we do always post transcripts from the calls. So the transcripts from today's call will be available in the next week or so, likely. The next question says, do extraordinary care services by the LRA, remain not eligible for FSP?

Melissa Harris: Hi, (Ashley), this is Melissa. And so I would imagine that's asking about the legally responsible individuals. So, you know, when we are talking about extraordinary care that's provided under a 1915(c) authority, to the extent that the waiver allows for that family member or legally responsible adult maybe, or legally responsible individual, to be a provider of service, and if the services that are being provided really do fit under the umbrella of extraordinary care, then FSP is available for those services that are provided.

But as always, we would want to have state-specific conversations with you to make sure that all the paperwork is correct, outlining the services that we're

talking about, and making sure the providers and the family members in this case are described accurately, so there's no room for misunderstanding at the state or federal or provider levels. But certainly FSP is available for those extraordinary services or extraordinary care provided in the form of a covered waiver service, you know, when all of that paperwork is done correctly.

(Ashley): Okay, thank you. The next question is around the hub and Equifax. It says, we understand the CMS hub offers states free wage data from Equifax as the work number. But the data have to meet 12 of 12 fields to be available from the CMS hub. Has CMS considered relaxing its threshold of 12 of 12, in order to make Equifax as the work number wage data readily available to states during unwinding?

Jessica Stephens: This is Jessica Stephens. I think we're going to need to take that - I mean appreciate - I think it's sort of an ask for us to consider. I don't think we have all the right people on at the moment. So we will take that back and get back to you. Thank you.

Jackie Glaze: Thank you, Jessica. I think what we'll do now is transition to the phone line. So (Calvin), I'll ask if you could provide instructions for registering the phone - for the - questions over the phones. And then if you could open the phone lines, please, thank you.

Coordinator: Thank you. At this time, we will begin the question and answer session. If you would like to ask a question, please press star 1 on your telephone keypad. Please ensure that your line is unmuted and record your name at the prompt. Again, that is star 1 if you would like to ask a question.

Jackie Glaze: (Calvin), do we have any questions? (Ashley), I'll transition back to you while we're waiting.

(Ashley): Okay. The next question says, does the returned mail provision for supplying an additional 30-days apply only to the renewal form? Or does it also apply to any subsequent verification request if we receive returned mail while processing the received renewal form?

Woman: Hi, this is - oh, go ahead. Sorry, were you going to answer?

Woman: Oh, yes. I'll start and then you can chime in if needed. But, yes, so it applies to the renewal form and it also applies to any additional information request needed to complete the renewal.

(Ashley): Great. The next question is around unwinding data reporting. And it says, our state's renewals begin on April 1, 2023 and the first round of terminations would be effective May 31, 2023. CMS said our first report is due the 8th of the month following the report month. Can CMS clarify if our report would be due by May 8th or June 8th? It should be noted, our termination processes don't occur until the 10th of the renewal month, May 10th in this example. So we wouldnt have a good set of data to report on May 8th.

(Kirsten): (Ashley), this is Kirsten. I'm sorry I couldn't hear much of what you said because there was some phone noise. So if you could repeat the question, that would be helpful.

(Ashley): Yes. The question says, our state's renewals begin April 1, 2023, and the first round of terminations would be effective May 31, 2023. CMS said our first report is due the 8th of the month following the report month. Can you clarify if our report would be due by May 8th or June 8th? It should be noted our termination processes don't occur until the 10th of the renewal month, so May

10th in this example. We would not have a good set of data to report on May 8th.

(Kirsten): So maybe it would help if the state is initiating their first renewals on April 1st then the baseline data would be due by April 8th. And then the first monthly report would be due by May 8th. And then, of course, we acknowledge that by that point the state wouldn't likely have a good set of data to report on or renewal dispositions to report.

(Ashley): Okay. Thanks, (Kirsten). The next question says, assume a member's coverage is terminated on January 31st for failure to respond to the renewal request. We contact the member via two modalities in February. The member doesn't respond until August, 6-months after we conducted outreach via two modalities. Are we required to reinstate coverage? And is there a time limit on how long the member has to respond to the returned mail?

Sarah O'Connor: So the policy that we were explaining today was to clarify that states are obligated to track, if you will, returned mail received within 30-days of a person's coverage being terminated for failure to respond to the information needed to complete the renewal. So I think that answers the question. In this scenario the person has reached back out to the state agency and the returned mail provision would not apply because that person reaching out was 6-months later.

So again, the state would be required to reinstate if contact is made within 30-days of the mail being returned to the state agency.

Jackie Glaze: Thank you, Sarah. We'll transition back to the phone lines. And (Calvin), could you please provide instructions once again for the participants to register their questions, and if you could open the phone lines?

Coordinator: Thank you. Yes. Once again, if you would like to ask a question, please press star 1 on your telephone keypad. That is star 1 to ask a question. Please stand by for our first question to come in. And I'm showing no questions at this time.

Jackie Glaze: Thank you. (Ashley), back to you.

(Ashley): Okay. The next question says, if a person was receiving HCBS waiver services under 1915(c), had a 30-day break in services since April 30, 2023; if the person does not complete their unwinding renewal and is terminated as of June 30th, and then re-engages with the state within 30-days of their termination, what program would the state reopen, since based on the person's income and spouse's resources they would not be eligible for another medical program without HCBS waiver services. Should the state reinstate the medical coverage and request a current assessment?

(Suzette): Hi, (Ashley). This is (Suzette). I think that combines a number of areas and subject-matter experts. So why don't we take that one back, and we can come back with an answer?

(Ashley): Okay. Thanks, (Suzette). We've gotten a couple of questions asking, when will CMS release written guidance on returned mail?

(Suzette): Hi. Again, this is (Suzette). Thank you, (Ashley). So we are working on hopefully being able to put out some of our responses in writing. We know that would be very helpful to states. So we hope to be able to do so very soon. I would say in the interim, the transcripts from these all state calls where we've answered a number of questions, are available to states.

(Ashley): Okay. The next question says, does the two modality rule apply when we have closed coverage due to failure to return a renewal and then receive returned mail with an out-of-state forwarding address?

Sarah O'Connor: This is Sarah. And the answer is yes. So the two modalities - that requirement does apply in that scenario. The January 2023 CAA (SHO) explains the modality requirement or how to meet that modality requirement based on returned mail. And it also has - there's a brief discussion on how to meet that modality requirement based on the type of address that comes back on the returned mail envelope. But essentially for purposes of meeting this requirement, it doesn't matter if it's an out-of-state address or an in-state address.

And so I would direct you to that (SHO) for a discussion on the types of addresses and types of mail that can come back and how the state can meet the modality requirement with the information that it has available to it.

(Ashley): Okay. Thanks, Sarah. The next question says, if mail is sent to both the applicant and their authorized representative at different addresses and mail comes back for one but not both mailings, does this need to be treated as returned mail?

(Suzette): Thank you. So we know this is a pending question with us. We are working on a response and hope to get it to you all soon.

(Ashley): Thanks, (Suzette). The next question says, can CMS advise how states should handle renewals returned within the renewal month, but after the termination has been processed? For example, termination notice sent June 10th and effective June 30th. The renewals returned on June 29th. What is the state required to do in this scenario?

Woman: Hi, (Ashley). Sorry, can you repeat the question again?

(Ashley): Sure. It says, can CMS advise how states should handle renewals that are returned within the renewal month but after the termination has been processed? So, for example, a termination notice is sent on June 10th and would take effect on June 30th, but then the renewal form is returned on June 29th. What is the state required to do in this scenario?

(Shannon): This is (Shannon). So I can answer that. So any time, and this is not specific to unwinding, this is any time a state is processing a renewal. If an individual returns their renewal form or the requested information that was needed and requested for the renewal process, as long as they return that information prior to the date that the individual is terminated, the state needs to keep the person enrolled and process the information they received.

So in this case, even though the state sent advance notice on June 10th, if the person responded and provided information on June 29th and termination was supposed to go into effect on June 30th, the state would need to consider that information to determine eligibility before they effectuated the termination, and at that point, then send out a new notice of termination if the information the person returned would - still shows that they are ineligible for coverage, or they would start a new eligibility period if, based on the information they, received the person's eligibility would continue.

(Ashley): Thanks, (Shannon). The next question says, can you review the timeline for returned mail again?

Sarah O'Connor: Sure. So the scenario that we're speaking of is where the state has sent the information needed for the renewal and the individual has been terminated for

failure to respond to that request for information or the renewal. And the timeline that states will need to track any mail that's come back after the beneficiary's termination, is 30-days.

So after that point, if the mail is returned, the person that's been terminated for failure to respond, the mail is returned, the state will be required to reach out through two modalities, if available, and reinstate coverage as of the date that contact is made, or back to the first day of the month in the month that contact is made.

And I'll stop there. And (Ashley), if this person has a follow-up question, I'm happy to take it. But that was the first part of the timeline.

(Ashley): Okay. Thanks, Sarah. The next question says, can you clarify - we don't need to reinstate coverage if the person is out-of-state when we reach them by two modalities, correct?

Sarah O'Connor: So the purpose and the point of reaching the person through the modalities, is to establish contact with the beneficiary. If at that point the state has information, you know, indicating a change in residency, then the state would follow its typical process once it has that information, to establish that residency has changed. So no, if the person satisfies, you know, the state's request to verify residency that they're no longer a state resident, through that outreach, through that contact, through that modality, and establishes that they're no longer a state resident, then the state would go through its typical process to terminate on that basis.

(Ashley): Thanks, Sarah. The next question says, on a prior all state call, CMS said they would get back to us on how states should process individuals returned via a (pairs) match after the continuous coverage provision ends, so after April 1st.

What are states permitted to do with this information? And can CMS provide explicit guidance on this issue?

(Suzette): Sure. So I could generally say, you know, states would use the policy that was in place prior to the public health emergency. But to say if - when a state receives (pairs) information, it's receiving third party information that the state must verify with the beneficiary prior to taking any adverse action. So if there is indication on the (pairs) match that the individual may no longer be a resident, the state would need to confirm with the individual. Or let me say they would need to verify residency for that individual prior to taking any action.

So it would be a change in circumstance that the state would need to address. It would be a potential change in circumstance that the state would need to address.

(Ashley): Thanks, (Suzette). The next question says, is there a script available for acceptable language for phone messages that qualify for the second modality?

Sarah O'Connor: This is Sarah. And I can say no, there's no specific script. I think states, you know, what we have said is that if the state conducts this outreach through one or more modality at the same time as, or prior to, mail is returned to the state agency. And if that's the case, in that circumstance then the state would, through its outreach through more than one modality, would need to provide specific information about the beneficiary's renewal.

And it would have to contain information about how the benefit - to alert the beneficiary that the renewal has been sent, and how to complete the renewal, and to provide instructions on how to reach the state agency for assistance through all available modes, such as online, or through a number that the state

provides in that outreach. So that level of detail or guidance that we've provided, is in response to states' request to clarify whether these outreach attempts can occur prior to receipt of the returned mail.

And other than that, the attempt to reach out to a beneficiary after mail is returned, would be specific to the circumstances. But we don't have a specific script or language that states can use. They have discretion to implement that as they deem appropriate.

Jackie Glaze: Thank you, Sarah. We'll transition one final time today to the phone lines. So (Calvin), if you could provide instructions once again for registering the questions, and then if you can open the phone lines, please.

Coordinator: Thank you. Once again, if you would like to ask a question, please press star 1 on your telephone keypad. Please ensure your line is unmuted and record your name at the prompt. Again, that is star 1 to ask a question. And I'm showing no questions at this time.

Jackie Glaze: Thank you, (Calvin). (Ashley), I'll return back to you.

(Ashley): Okay. The next question says, if the baseline report was February for renewals due in April, on March's first monthly report should the state report about redeterminations that occurred during the reporting period initiated in December and completed in February, even though those are not subject to the unwinding provisions and still fall under the PHE requirement? Or should we mark those sections as no data until we have information about the renewals that were initiated as a part of unwinding?

(Kirsten): This is (Kirsten) in CAHPG. So maybe I could take a step back. The monthly report will include renewals initiated for that particular month, so the month

of February. And then of the renewals due in the month of February, the dispositions of those renewals. So it would not include information pertaining to renewals from a prior month. Did that get to the question?

(Shannon): This is (Shannon). I can jump in as well. Yes. I think we recognize that in the first few monthly eligibility and enrollment unwinding reports, you know, the states reporting on their unwinding renewals. And for those first few months it may be a lot more information about renewals that are initiated or that are still in progress. And recognize that, you know, a few months in we'll see some more information about the outcomes of those renewals because we recognize that, you know, states have a process of, you know, 60 to 90-days or so on average, to process renewals for a cohort.

(Ashley): Okay. Thanks to both of you. The next question says, earlier in the call, you mentioned that coverage must be reinstated when an updated address is provided within 30-days of discontinuance. Are states required to reinstate coverage when we are made aware of an out-of-state address, either by USPS returned mail with an out-of-state address, or the consumer contacts the agency to provide the address? Or is the requirement to reinstate fully when the updated address is in-state?

Sarah O'Connor: Go ahead.

(Suzette): I was just going to say, I think Sarah tried to clarify this before, but maybe we could just say states need to reinstate individuals once they have made contact with that individual. And then once you've made contact with the individual, you would take the steps to, you know, either send a new renewal form to that individual or obtain information from them in order to complete the redetermination, including verifying whether or not that person continues to meet residency.

So I think if you're able to confirm that that person is no longer a resident of your state, then you would not need to either reinstate or if you've reinstated, to terminate that individual once you've made that verification that they are no longer a resident of the state. Sarah, anything to add to that?

Sarah O'Connor: No. That's correct.

Sarah Delone: (Suzette), this is Sarah Delone. Just to further clarify - so in the two specific examples given in the question, if the only information the state had was the piece of returned mail with a forwarding address that was out-of-state, I think what I'm hearing you say, and please correct if this is wrong, that's not confirmed. That's not - the state needs to take additional steps in an effort to verify that with the beneficiary. That alone wouldn't be enough. Right? They need to take additional steps.

In the case of actually reaching the beneficiary, let's say that was a verbal, you know, phone contact and the person said yes, I'm now living in this other state, then it would be no requirement to reinstate.

(Suzette): Correct.

(Ashley): Okay. Then we have a question around the date to which states need to reinstate coverage. So it says, do states have the option to reinstate coverage after a discontinuance due to returned mail, and a new in-state address is received within 30-days effective back to the date of the contact, or to the last day of the person's coverage? Or can states reinstate back to the first day of the month in which the contact was made?

Sarah O'Connor: So states can reinstate as of the date that contact is made with the individual, or they have the option to reinstate back to the first date of the month, the first day of the month in which that contact is made.

(Ashley): Okay. The next question says, if an agency mails out a notice prior to mailing renewal forms to alert people that their renewal is coming, and this is sent 5 to 7-weeks before the renewal paperwork is mailed, and includes information on how to update your contact information, let's people know their renewal is coming, informs them of how to contact their agency, can this be considered one of the modalities if later the agency gets returned mail related to the renewal form?

(Suzette): Yes. Thanks, (Ashley). No. I think we've clarified that for the modality - well, it would count as the state attempting to obtain up-to-date contact information, which is also a condition of the CAA for states to claim increased FMAP. But it would not count for the returned mail condition. So states would need to attempt to contact the individual after the renewal is sent, but prior to returned mail being returned. And again, it would have to meet the criteria contained - the information that Sarah went through before.

Woman: I didn't get that. Could you...

(Ashley): Okay. The next question says, my understanding is, after the state reaches out via two modalities, if the member responds within 30-days, coverage must be reinstated. If the member responds more than 30-days after the state reaches out, the state does not need to reinstate coverage. Is this correct?

(Suzette): That is correct. The CAA condition would not apply to that returned mail. But we obviously encourage states to take, you know, any additional action to act or to contact that individual. And maybe I can also clarify from the question

before - if the state receives returned mail with an out-of-state address, that in and of itself, is not a contact. It would be if the person responded to the form, either sending it back or making a phone call based on that new outreach, based on the return mail.

Jackie Glaze: Thank you, (Suzette). I think we'll try the phone lines one additional time. So (Calvin), can you please provide instructions once again, and then open the phone lines?

Coordinator: Thank you. Once again, if you would like to ask a question, please press star 1 on your telephone keypad. That is star 1 to ask a question. Please ensure your line is unmuted and record your name at the prompt. One moment for our first question to come in. We do have a question from (Jessica Pearson). Your line is open.

(Jessica Pearson): Good afternoon. I was the one who asked the question earlier about the reinstating with the out-of-state address. So I just wanted to make sure I clarified the response that I heard. Understanding that we sent the renewal form to the consumer, we gave them the 30-days; they did not return it, so the case was closed. Their coverage was discontinued. But then after the 30-days, they're already discontinued, we are then made aware by returned mail or what, be it, that they are now out-of-state.

I just want to make sure I heard that if it's just based on the returned mail and they've already been denied for failure to provide, we're to reinstate them. After attempting to do the two modalities, and we can't get a hold of them, we reinstate them; send a letter to confirm residency out-of-state.

(Suzette): No. You only reinstate them if you make contact with them.

(Jessica Pearson): Okay. That - okay, thank you. That's what I wanted to confirm. I did not hear that correctly then. Thank you.

(Suzette): Sure.

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

Jackie Glaze: Thank you. (Ashley), I think we have time for one more question.

(Ashley): Okay. The last question says, during unwinding, the eligibility system pings electronic data sources to verify information, including income, as required by regulation. The eligibility system then determines if the income information received from electronic data sources, is reasonably compatible with the information we have in the case record, which is information the client has provided to us.

The information in the case record indicates the member notified the agency of income that puts them above the FPL for any Medicaid category. And the ping of electronic data sources confirms that the member is still over income at unwinding. Can the state deny eligibility based on the fact that both are compatible? Or is the state required to reach out again to the individual to ask them about their current income information?

(Suzette): Sure. So I think if the state is attempting an ex parte determination and cannot renew based on information either contained in the record or returned from a data source, the state must send a renewal form.

Jackie Glaze: Thank you, (Suzette). So in closing, I'd like to thank everyone for all of the great questions today and also thank our team for the update. Looking forward we will follow up with the topics and the invitation for the next call. If you do

have questions before we speak again, please feel free to reach out to us, to your state leads, or bring the questions to the next call. So again, we thank you for joining, and we hope everyone has a great afternoon. Thank you.

[End]