Centers for Medicare & Medicaid Services COVID-19
Medicaid & CHIP All State Call
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3:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time I'd like to inform all participants that today's call is being recorded. If you have any objections you may disconnect at this time. All lines have been placed in a listen only mode for the duration of today's conference. I would now like to turn the call over to Jackie Glaze. Thank you, ma'am. You may begin.

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

Daniel Tsai: Thanks, Jackie. Good afternoon, folks or good morning, wherever folks are. I just wanted to open up with a few highlights and thank you. I like to say thank you every time, there is - it's hard to fathom the amount of work, progress, and operational stuff happening across 56 states and territories for medicated shift in BHP.

So I - it's just - it's very impressive to see and also as much as we are on the receiving end and seeing a ton of proposals and work and operational things coming in, and discussions of all sorts of topics, that is all coming from front line states and along with your colleagues and the plan provider and advocacy space. So I just want to acknowledge that.

And I'm sure folks feel it, are tired. Some moments are very exciting. Some moments are quite daunting. And so thank you as always. We're all in the same place together trying to make good stuff happen for - I think we're about

86 million people now covered. I also just want to give a quick shout out I guess, to - so the CMS Administrator, Jon Blum and myself, just two or three weeks ago, were out with two of our states, in Illinois and Ohio, with state teams and others on a range of roundtables and site visits kind of seeing a range of things happening on the ground.

In Illinois around health equity, around some of the things that the state is trying to really advance, nursing facility reforms for quality and staffing and such. And in Ohio around a whole ton of stuff for maternal health, for lead and in both places seeing really exciting, interesting collaboration between the state, local entities, providers, advocates around the table.

So it's a good reminder of how much state innovation is happening across the country; how much we have the roles from the federal standpoint, in helping to support, shape, give a view on policy. But ultimately, stuff only happens on the ground with our state partners and your partners, really trying to figure out how to advance stuff. And our strong hope is to be able to support and help enable many of the really exciting things that are happening.

And it's also nice to see other human beings from a state standpoint and local provider standpoint. I'm meeting some beneficiaries, enrolees but it's always a really good reminder why we do what we do. I also want to acknowledge there's going to be a portion at the end of the agenda today, for unwinding. We have been engaged both in structured and individual discussions as I think all of you are aware of, and involved in, on a range of unwinding topics whenever the PHE.

And as folks have been asking, you know, around timing when the end - we have no new messages except to say we realize and recognize that clarity and advanced notice is of utmost importance. The Secretary has reiterated HHS

and the Administration's commitment to at least 60 days notice prior to the end of the PHE with, you know, ideally as much notice as possible.

And May 16th is the date as of now, that is 60 days prior to the end of the current PHE timing. So I'm sure folks all are tracking that. But we certainly very much are, as well. So with that, I think there is a lot of other work, really exciting policy work, important operational work and other topics that we look forward to covering with folks in engaging on in the coming months and quarters.

And today we have a range of very specific topics, some of which touch on unwinding, some of which get to other topics like community health workers and other topics we've been getting some questions about and want to give highlights on. So with that, I'm going to turn it to Anne Marie, to walk through the agenda. Thanks.

Anne Marie Costello: Thanks, Dan. And hi, everyone. Welcome to today's all state call. We have a few topics to cover on today's call. First up, Michael Tankersley from our Disabled and Elderly Health Programs Group, will provide an overview of Medicaid coverage and reimbursement at Community Health Worker Services. We've received many questions on how community health workers can be supported through Medicaid and hope this presentation answers many of those questions.

Also, as we've been working together if you will, to prepare for unwinding, many states have asked the question about what happens to the individuals who do not sign up for Medicare timely, and may be subject to a penalty. To address this issue, Kim Glaun from CMS's Medicare and Medicaid Coordination Office, will provide an overview of the new proposed rule that would create a new Medicare Special Enrollment Period, to individuals losing

Medicaid eligibility once normal operations resume after the end of the Public Health Emergency and who did not enroll in Medicare on time.

Then Sarah Spector and a series of subject matter experts, from our Children and Adult Health Programs group, will provide responses to some frequently asked questions related to unwinding the continuous enrollment requirement. Finally, we'll take your questions on unwinding or any other topics. We'll use the webinar for today's call. So if you're not logged into the webinar platform, I suggest you do so now.

Before we start today's presentation, I want to give two updates. First, CMS has updated its existing 1135 waiver portal so that state Medicaid agencies can submit Section 1135 waiver requests and public health emergency related inquiries through this portal. This is the same portal that has been used by providers to submit 1135 waivers. My office will be sending an email to all state Medicaid directors the end of this week, about the portal and links to how to submit a waiver.

For those states and territories that have historically been impacted by national disasters, our state leads will send an email to their state contacts to reinforce the availability of the portal. The links to the Quick Reference guide and YouTube video can be found on the CMS Emergency Preparedness site on May 6th. We are hopeful that the portal will reduce administrative burden on state Medicaid agencies, and will expedite CMS's approval process. This is critical during natural emergencies and natural disasters.

State Medicaid agencies should use the 1135 portal for future or new public health emergencies and natural disasters, and not the current COVID-19 public health emergency. Before we start - before we get started with our presentation, I'm going to turn things over to Stephanie Bell for a quick

minute, to share some information of work being done by CMS, the Department of Health and Human Services, and the FCC on use of text messaging and other communication methods, in support of unwinding. Stephanie?

Stephanie Bell: Thanks, Anne Marie. So I just wanted to give you a breaking announcement, which is that in response to all the requests we've received from all of you for TA on the use of text messaging as an unwinding tool, on Friday, last Friday Secretary Becerra and Administrator Brooks-Lasure, submitted a letter to the FCC requesting their opinion on the use of text messages and automated calls, to beneficiaries as states are resuming their regular operations at the end of the public health emergency.

So the letter was submitted on Friday and today the FCC opened a two-week public comment period on the issues raised in the request, specifically whether these text messages and automated calls relating to Medicaid, CHIP and other health coverage programs, are permissible under the Telephone Consumer Protection Act.

Comments can be filed electronically through the FCC. They have a system called the Electronic Comment Filing System or ECFS. And if you go to FCC.gov you'll see the ECFS link right in the middle of the page. And if you click on that you can search for the Secretary's and Administrator's letter the FCC's public notice. You have to put in proceeding number 02-278. I will repeat that in just a second.

That is the rules and regulations implementing the Telephone Consumer Protection Act. And if you look for that proceeding number, 02-278, you will see the first two things that pop up are the Secretary's letter and the public notice announcement. And all of these details, if you didn't get that written

down, will be about how to submit comments and how to find the letter and the public notice, will be provided in a listserv announcement that's coming out tomorrow.

So a big thanks to everyone who has requested information and flagged this as an issue. And now I will turn it over to Michael Tankersley.

Michael Tankersley: Thanks, Stephanie. And hi, everyone. Before I turn to the slides I wanted to just take a moment to frame the discussion on community health workers, by saying, you know, broadly speaking states have significant flexibility to authorize a range of practitioner types, ranging from licensed practitioners to individuals that meet certain state requirements such as training, prior experience, or educational requirements.

Today I'm going to discuss how this flexibility and other specific benefit flexibilities can be leveraged to cover and reimburse community health workers. I'll start with a quick overview. Community health workers are front line public health workers who are trusted members and have an understanding of the communities they serve. This enables the community health worker to serve as a liaison or intermediary between health and social services, to the community to facilitate access to services, and improve health knowledge and self-sufficiency for beneficiaries. Next slide, please.

Community health workers are typically laypersons with knowledge of local healthcare systems with cultural competency in the communities they serve. As you see here, community health workers can have a variety of titles such as community health advisors lay health advocates, outreach educators, and so on. Next slide, please.

Okay. Turning to Medicaid coverage and reimbursement - services of community health workers can be covered and reimbursed under several benefit categories, and we'll talk about those in just a minute, as long as the services they provide and the community health workers themselves, meet the requirements of the respective benefit category.

You'll see here, here are a few examples of the type of community health services may include health promotion, health coaching, health system navigation and resource coordination service. This is by no means meant to be an exhaustive list. Just some examples of the type of community health worker services that can be covered under the state plan. Next slide, please.

The first benefit category I want to talk about is preventive services benefit. As you see here, this is authorized under Section 1905(a)(13) of the Social Security Act, and 42 CFR 441.30(c). That's the statutory and regulatory requirement. The services must be recommended by a physician or other license practitioner of the healing arts within the scope of authorized practice under state law, to prevent disease, disability, and other health conditions or their progression, prolong life, and promote physical and mental health and efficiency.

As you can see, this benefit is really broadly defined like many other Medicaid benefits. So states have a significant flexibility here to both the, you know, to authorize a wide range of services under this benefit. And again, back to my earlier comment, they also have significant flexibility to identify the particular practitioners as well as their qualifications for providing preventive services. And that can include community health workers. Next slide, please.

Services of other licensed practitioners - as you see, it's authorized at 1905(a)(6) and 42 CFR 440.60. And they can include medical care and any other type of remedial care, other than physician services provided by obviously licensed practitioners, within the scope of practice as defined under state law. This benefit can also include unlicensed practitioners such as a community health worker, that are working under the supervision of a licensed practitioner, can be included under the state plan. So this is another benefit category that can be leveraged for community health workers. Next slide, please.

Physician services - 1905(a)(5) and 42 CFR 440.50 is where you can find the requirements for this benefit. And this is obviously services medicine practice defined within state law. I think again, this is another benefit that can be - states can utilize to authorize unlicensed practitioners that are working under the personal supervision of a physician's license under state law, to practice medicine.

So again, just like the - similar to the OLP, other licensed practitioner benefit, the physician services benefit can be utilized authorized services of community health workers that are working under the personal supervision of a physician. And for state plan purposes, we would not expect states to identify all of the unlicensed practitioner types that are authorized by your states. Next slide, please.

Rehabilitative services - 1905(a)(13) and 42 CFR 441.30(d) is where you can find this specific requirement. Rehabilitative services include any medical or remedial services recommended by a physician or other license practitioner of the healing arts, when the scope of practice under state law. For the maximum reduction of physical or mental disability and restoration of a beneficiary to his/her best possible functional level.

Similarly to the preventive the services benefit, under this benefit states can both identify the types of practitioners that are authorized to provide rehabilitative services, and states could also determine their qualifications for providing those services. And so you - this is another benefit where you could have a range of practitioners - licensed, unlicensed, different training, educational requirements. And this could include community health workers as well. Next slide, please.

I'll talk for a minute just about payment. States have the same flexibility to pay for services provided by enrolled community health workers as they do for other providers within the Medicaid program. This means that payments to community health workers (CHW) must be consistent with economy and efficiency, and assure quality and access to care. And of course, states must have a state plan method that comprehensively describe how states pay for community health worker services within the approved Medicaid state plan.

So nothing unique to CHW is I think the standard requirements related to mitigate payments, would apply to services provided by community health workers. And next slide. Quickly, related to managed care - states must ensure that their manage care plans comply with 42 CFR 438.12 which prohibits provider discrimination and follows their written policies and procedures for the selection and retention of network providers as specified in 42 CFR 438.214.

States and managed care plans can also design and implement managed care payment strategies, to encourage managed care plans to consider specific community health worker initiatives, such as the states get to pay for performance incentive arrangements for Medicaid managed care plans,

subject to the requirements at 42 CFR 438.6(b)(2), to incentivize specific community health worker activities or community health worker contracting.

States could also utilize Medicaid managed care state directed payments under 42 CFR 438.6 to contractually require that managed care plans implement specific payment arrangements with community health workers to better support state goals and objectives. That is it for me. So I am going to I think turn this back over to Jackie.

Jackie Glaze: Thank you, Michael. So next, Kim Glaun will provide an overview of the proposed rule that will create a new Medicare special enrollment period for those individuals losing Medicaid. So I'll turn now to you, Kim.

Kim Glaun: Thanks so much. Last week CMS published a proposed rule that includes several provisions that impact states. And the federal register link is included on the screen. And we encourage states to submit comments that are due to CMS by no later than June 27, 2022. We'll describe all of the proposal effective dates initially during the May 18th (DTAG) call and their operational implications at a later date on an (STAG) call.
For example, the rule includes proposals related to states' payment of Medicare premiums for Medicaid beneficiaries, and implements certain provisions of the Consolidated Appropriations Act of 2021 or the CAA. Today though, we'd like to take a few minutes to highlight our proposal to create a new special enrollment period or SEP, for individuals to meet Medicaid eligibility.

The proposal starts at page 2509 in the Federal Register posting that's 2509. As some background, the CAA allows the Secretary of the Department of Health and Human Services to create SEPs for Medicare Parts A and B for exceptional conditions. The proposed regulations include five new SEPs under

this authority, including one helping individuals to (lose) Medicare coverage entirely after becoming eligible for Medicare.

While, many individuals stay eligible for Medicaid after they qualify for Medicare, other individuals, namely those in the adult group, may lose Medicaid eligibility entirely. And since the start of the current public health emergency, advocate state health insurance assistance programs have shared their concerns that individuals may have missed their Medicare enrollment period either because they did not understand the need to enroll in Medicare on time, or because they could not afford to do so.

Should these individuals lose Medicaid entirely after their states resumes regular termination once the public health emergency ends, individuals will need Medicare to maintain continuous coverage. But they may be unable to enroll in Medicare if they have missed their Medicare initial enrollment periods, and the general enrollment period has passed.

The general enrollment period is January through March each year. Further, when they eventually are able to enroll in Medicare, they may incur a late enrollment penalty. This proposed SEP aims to abate gaps in coverage by allowing individuals a chance to enroll in Medicare following the loss of all Medicaid eligibility once states resumed regular terminations after the public health emergency ends. The SEP also removes any applicable late enrollment penalties.

Under the CAA, the soonest the SEP can start is January 1, 2023. So individuals must wait to use the SEP until then. The SEP generally starts when the individual receives notice of an upcoming termination of Medicaid eligibility and ends six months after the Medicaid termination. However, if the public health emergency and an individual's Medicaid ends before January 1,

2023, they can select a start date for their Medicare coverage back to the first day of the month they lost Medicaid in 2022, as long as they agree to pay back premiums.

Further, their SEP lags until June 30, 2023. The proposed SEP is not just for those who missed enrolling in Medicare on time during the public health emergency. It would also be available on an ongoing basis to individuals who newly qualify for Medicare and then lose Medicaid entirely once states resume routine terminations of eligibility after the public health emergency ends.

We note that individuals who remain eligible for Medicaid, including a Medicare savings program, and have not received notice of an upcoming Medicaid termination, are not eligible for this SEP. That's because states already enroll Medicaid beneficiaries, under their buy-in agreements with CMS, at any time of the year, without regard to Medicare enrollment period and late enrollment penalties.

I'm happy to take questions during the Q&A or later. But I just want to remind folks that none of the points raised will be viewed as formal comments to the proposed regulation. To ensure consideration against we encourage states submit comments in written form, using the instructions in the Federal Register document. Thanks. I'll turn it back to Jackie.

Jackie Glaze: Thank you so much, Kim. So next, Sarah Spector and the team from the Children and Adults Health Programs Group, will address some of the FAQs related to the unwinding and continuous enrollment requirement. So Sarah, I'll turn to you.

Sarah Spector: Great. Thanks, Jackie. First, I'm going to turn to Mark Steinberg to ask the first few questions. Mark, are you with us?

Mark Steinberg: I am. Can you hear me?

Sarah Spector: Wonderful. Terrific. So the first two questions I tried piggyback off Kim's presentation, that we have questions are about the Medicare Special Enrollment Period. Is there a Medicare Special Enrollment Period available for Medicaid beneficiaries who became eligible for Medicare during the public health emergency, but who did not enroll in Medicare during their initial enrollment period?

And similarly, may states delay a redetermination of eligibility for such beneficiaries until the next Medicare general enrollment period, which would be January 1 to March 31, 2023?

Mark Steinberg: Thanks, Sarah. So I mean obviously this question came into us before this new proposed rule was published last week, but I think it's a great opportunity to clarify where we are and what the state of affairs is here. So it's quick. As of right now, while this proposed rule is still a proposed rule, there is no Medicare Special Enrollment Period for someone who loses Medicaid coverage.

This new NPRM that Kim just discussed, would create a new Special Enrollment Period for people in that situation, for people who - it would be for someone who loses Medicaid coverage; they could enroll in Medicare effective on or after January 1, 2023. And as Kim said, we certainly encourage states to review the NPRM and submit comments.

But if you are talking to say Social Security and I know I heard from the states that said Social Security staff said well, there is no SEP right now. And that's true. Until this rule is - were to be finalized as propped took effect, there is not an SEP right now. The related question - may a state delay a redetermination of eligibility until the new Medicare General Enrollment Period, which runs January to March, the answer is yes.

States do have discretion to schedule renewals of individuals during the unwinding period, to coincide with the Medicare General Enrollment Period, even if under other circumstances, that person's renewal was scheduled to come up in a different month. And in fact, do review the March 3rd state health official letter from this year, look on page 21, we say that we actually encourage states to take into account Medicare's enrollment period when they're scheduling renewals for people who may have been affected by becoming Medicare eligible during the PHE and may not have enrolled in Medicare.

Sarah Spector: Great. Thank you so much. So if you can stick with us, I know that you're going to answer a few more questions later, in just a few minutes. Turning now, switching gears to Gene Coffey, are you with us? I have the next few questions for you.

Gene Coffey: Yes, Sarah. Can you hear me?

Sarah Spector: Terrific. Hello.

Gene Coffey: Yes. Hello.

Sarah Spector: So we've gotten a few questions about the state plan amendments, the disaster relief state plan amendments that a number of states have submitted related to

disregarded assets. For those states that have submitted disaster relief state plan amendments, disregarded assets for non-MAGI beneficiaries during the public health emergency, can a state continue to disregard these assets for non-MAGI beneficiaries after the public health emergency ends?

Gene Coffey: Okay. Good question. And hi folks, this is Gene Coffey, Technical Director in the Division of Medicaid Eligibility Policy. The answer is yes. But we do want to clarify the appropriate method by which states can actually continue these particular disregards. Income and resource disregards that were implemented through the use of disaster (SPA)s will actually not be effective once the PHE ends.

But states will have two options if they want to continue application of any such income or resource disregards after the end of the PHE. First, states that want to extend such disaster disregards for a state's temporary period of time after the PHE, should submit an extension date addendum (SPA) to add a subsection 7.4(b) to their state plans. And in case anyone is wondering what that is, we're going to refer for now to the directions we provided in our all state call on February 15th, on such an addendum (SPA).

Separately, and alternatively, states that want to add the disaster related income or resource disregard to their state plan more permanently, in other word without a pre-stakes end date, may choose to submit (SPA)s through the regular (SPA) submission process, generally through our MAC Pro system. These disregards can apply to beneficiaries and any eligibility group to which disregard authority under Section 1902(r) 205, which, you know, as basically indicated in the question, dissolved or some non-MAGI eligibility groups.

So, you know, those would be the two particular methods for states that wanted to extend these particular disregards. We note however, that many

disaster related payments that beneficiaries may have received during the pandemic, are already disregarded from income and resources at least under a design methodology. The Social Security Administration has actually published guidance and I think we've talked about this before, but SSA has published guidance on the SSI methodologies with regard to the particular types of pandemic related assistance.

And the general permanent income and resource disregard of them. And for reference, the SSA guidance is as follows. And before I read this out, we'll be happy to circulate this after the call if someone misses it, but it is SSA Emergency Message 20014. That's EM-20014 RE Victor, or V as in Victor 4. And that's available on the Social Security Administration's Program Operational Manual System page, which is otherwise referred to as the POMS, which is the inventory of SSA's policy guidance on the SSI program.

But that's where you will see again, described at least for those people who are subject for purposes of Medicaid, the SSI methodologies, the descriptions of the pandemic assistance that based on SSI methodologies, should be disregarded independent of an R2 (SPA), from income and resources. And we'd be happy to provide any additional technical assistance or guidance that any states need on this point.

Sarah Spector: Great.

((Crosstalk))

Sarah Spector: Thanks for that, Gene. So shifting gears, we know we've gotten a number of gears from states around moving individuals to different eligibility categories. Can you tell us what are the best practices for moving beneficiaries to different categorical levels?

Gene Coffey: Okay, good. And thanks again, for this question. And we just want to say ahead of our answers here, that we're interpreting this question to, you know, as Sarah mentioned, we have gotten this question or at least how we're interpreting it, from other folks. But if we are misinterpreting the question here, the state that initially asked us, should let us know, and we'd be happy to answer the appropriate question, again if we missed it.

But assuming and interpreting this question referred to the best practices related to switching individuals from one Medicaid eligibility group to another, after the end of the month in which the PHE ends, at which point the continuous coverage provisions of the Family First Coronavirus Response Act, or FFCRA, will have expired. The standard rules relating to proper eligibility group placement for individuals eligible for Medicaid, will apply.

For example, an individual should be enrolled in a categorically needy group over medically needy group if such individual happens to be eligible for both. Likewise, where an individual is eligible for two different optional categories of meeting eligibility groups, the individual should consistent with our regulation at 435.404, be offered the choice of which group in which to enroll.

Additionally, in states that have adopted the adult group, an individual should not be enrolled in the adult group if the individual is eligible for other mandatory eligibility groups, such as the mandatory parent and caretaker relative group, the mandatory kids group, and the mandatory pregnant individuals group. Again, CMS is available to provide any technical assistance necessary to help states determine after the PHE, the appropriate eligibility groups for Medicaid-eligible individuals. And I think that wraps up that question too, Sarah.

Sarah Spector: Thanks, Gene. So can you tell us, will the enhanced (FMAP) be extended beyond the end of the public health emergency to help provide more financial support for states during the unwinding process?

Gene Coffey: Yes. Good. The short answer is no. The availability of the 6.2 percentage point increase in (FMAP), authorized in the FFCRA, will expire under the terms of FFCRA at the end of the quarter in which the PHE ends. Now at present, there isn't separate authorization for enhanced (FMAP) for states beyond that point, for continued coverage during the unwinding period.

You know, if such, you know, enhanced (FMAP) becomes available or authorized, we'll certainly advise states ahead of time or, you know, when it happens, of the availability of it. But again, for now, at the end of the quarter in which the PHE ends, the enhanced (FMAP) that was authorized under FFCRA, will likewise end.

Sarah Spector: Right.

Gene Coffey: And that's it.

Sarah Spector: Thank you for that, Gene. So if you would...

Gene Coffey: Yes.

Sarah Spector: ...stick around we've got one more for you at the end. Turning back to Mark Steinberg, I've got two questions for you about fair hearings. A number of questions related to the flexibility we're providing and describing in our March 3rd State Health Official letter about the 1902, I'm sorry, 1902(e)(14) waiver related to fair hearings.

If a state elects the waiver flexibility for fair hearings, can the state retain their typical time period under which a member needs to request a fair hearing, to have benefits continue pending a decision? Can states elect to change that initial period to request a fair hearing through their (e)(14) waiver?

Mark Steinberg: Sure. This question has come up a couple of times. So yes, the 1902(e)(14) fair hearing waiver does not impact how long an individual has to request a fair hearing. They're two separate questions. The timeframe to request a fair hearing must be reasonable under our regulations, and could not exceed 90 days from the notices that the action - that the Notice of Action is mailed, and that's 42 CFR 431.221(d) as in David.

When we come to the end of the PHE states can use - can revert or can use the same fair hearing request period that they had in place prior to the PHE, or they can adjust that timeframe provided that the amount of time is reasonable and does not exceed the 90 days in our regulation. Note, you do not need a state plan amendment to change the time period to request a fair hearing.

We've gotten a related question from some states about whether they can use (e)(14) authority to extend the timeframe to request a fair hearing beyond the 90 days that is allowed under our regulation, once we get to the end of PHE and beyond. We are in the process of reviewing these requests and we will be in touch with those dates and we will let states know what our next steps are in that area.

Sarah Spector: Great. Thanks, very much, Mark. And then a question around provider hearings. Do the CMS consider provider hearings to fall under Medicaid's umbrella for the purposes of (e)(14) waivers, or will they be distinct from fair hearings that and individual might file?

Mark Steinberg: Good question. Provider hearings are distinct. We are - they are outside the scope of the beneficiary fair hearing flexibilities that we've been contemplating under Section 1902(e)(14). But in the unwinding period our provider hearings are not regulated under 42 CFR subpart E. So they are a separate question. If there's a state that has questions or interest in flexibilities around provider appeals, we're happy to talk to the state and connect them to another part of CMS that works with provider appeals.

Sarah Spector: Great. Thanks, very much, Mark. So my next question is from Meg Barry. And this question is, do the (e)(14) authorities also apply to CHIP, to the Children's Health Insurance Program?

Meg Barry: Thanks, Sarah. In general, yes, 1902(e)(14) does apply to CHIP in the same way that it applies to Medicaid. I will say however, that there were some (e)(14) authorities that we suggested to states and some of those don't actually really make sense. For CHIP - so there are two that really do. Those are partnering with managed care plans to update beneficiary contact information and extending automatic re-enrollment into Medicaid managed care plans up to 120 days.

The other authorities that we suggest at the states don't really make sense for CHIP, either because the rules that would be waived don't apply to CHIP, so that's things like (ADF) and fair hearings, or because the relevant conditions really just don't apply to CHIP enrollees. They're not typically in the SNAP income range and they really never have zero income.

But I also know that states have been suggesting innovative ways to use this authority in Medicaid and if they have ideas about how to use it CHIP, the authority does apply in CHIP. Back to you.

Sarah Spector: Great. Thanks very much, Meg. Turning to Shannon Lovejoy, we have a question about changes in circumstances. Can CMS provide additional information on the changes in circumstances and renewals, specifically clarifying when a state may act on a known change in circumstances during the post-public health emergency redetermination period?

Shannon Lovejoy: Thanks, Sarah. Yes, so generally, under federal regulations, states must periodically renew eligibility for all beneficiaries and promptly act on changes in circumstances that may affect eligibility in between renewals. So during unwinding, if a beneficiary had been determined eligible or their eligibility was renewed, they were granted a new eligibility period and they are still within that eligibility period when the state would go to act on the change in circumstance.

In this case the state can choose to go ahead and act on the change in circumstance during the unwinding period as they ordinarily would, consistent with our requirements at 42 CFR 435.916(d). However, if this is an individual whose eligibility has not been renewed so either the state's been delayed in getting to their renewal, or the individual had a renewal but they were determined ineligible or didn't respond to their renewal paperwork during the PHE, and therefore they're not in a new eligibility period.

For these individuals, the state must conduct the full renewal during the unwinding period, rather than only act on a particular change in circumstance.

Sarah Spector: Great. Thanks very much, Shannon. So, Gene Coffey, one last question for you before we end this portion of our - of the call. There's a question here that really melds the categories of eligibility and the tiers with fair hearing. So can CMS confirm that an adverse action as described in the State Health Official letter 22-001, that's the one we issued on March 3rd about unwinding, does

not refer to any movement within a tier as defined in the November 2020 regulation, additional policy, and regulatory revisions in response to the COVID-19 public health emergency?

That was the regulation that we issued in November of 2020 setting out the various tiers that were possible, of movement during the public health emergency. Gene?

Gene Coffey: Yes, right. Thanks for that clarification, Sarah. Yes. I mean we understand that Sarah just said tiers to refer to the level of medical assistance that states have had to maintain for Medicaid enrollees, under FFCRA's continuous coverage provision, as implemented in our temporary - interim regulations during PHE in order for states to be eligible for the enhanced (FMAP) that FFCRA authorized.

The tiers will effectively become irrelevant at the end of the month in which the COVID-related public health emergency ends. States will no longer be required at that point, to comply with the continuous enrollment requirement. However, we know that an adverse action as referenced in SHO letter 22-001, is called an action in federal regulations. And an action is defined in our regulations at 42 CFR 431.201, to include a termination suspension of reduction in covered benefits or services or a termination suspension of or reduction in Medicaid eligibility, or an increase in beneficiary liability.

So to the extent a state proposes after the PHE, a reduction in covered benefits of services, or to the extent of proposed to cause an increase in beneficiary liability, such a proposal would be considered an action and subject to advanced notice and fair hearing requirements. That's it.

Sarah Spector: Great. Thank you. So, Jackie, that ends - concludes this part of the question and answer and I'll turn it back to you.

Jackie Glaze: Thank you, Sarah and the CAHP team. I appreciate the questions and answers. So now we're ready to take questions, the state questions that you may have at this point. So we'll begin with the chat function and followed by taking your questions over the phone. So I do see a couple of question, so I'll turn to (Ashley). And then just continue to submit your questions, and then we'll go from there.

Ashley Setala: Thanks, Jackie. So the first question is about the Medicare Special Enrollment Period. And it says for the Medicare Special Enrollment Period, do states need to issue a proof of coverage for the individuals to provide Medicare? What documentation does the individual need to get Medicare coverage back to the dates when Medicaid coverage ended?

Kim Glaun: So I can take that question. This is Kim Glaun. Again, we can't really speak beyond what the proposed rule says. But in the proposed rule we do specify that the state advanced notice of termination will serve as proof of the - their - an individual's eligibility for the Special Enrollment Period. We do not comment on any other form of again, proof for the individual's loss of Medicaid. But, so we do recognize though, that documentation of the advanced notice is actually sufficient. One source of proof that the person does qualify.

Ashley Setala: Thanks, Kim. Our next question says page 20 of the State Health Official letter issued on March 3rd suggests that states consider COVID-19 PHE demonstrations to provide for an extension of the Reasonable Opportunity Period beyond the 90-day timeframe required under Section 1902 of the Social Security Act. Guidance on page 19 of the December 2020 SHO

indicates that COVID-19 PHE Section 1115 demonstration ends no later than 60 days after the conclusion of the PHE.

States seeking to extend ROP to help manage redeterminations will need this flexibility for the duration of the 12-month unwinding period. Will CMS extend the duration of the COVID-19 1115 demonstration authority so that program flexibility may extend through the duration of the unwinding period?

Sarah Spector: Yes. (Ashley), this is Sarah Spector. I can take that one. We are - we've gotten a number of questions around the Reasonable Opportunity Period and the 1115 flexibility. We're working very closely between us and our colleagues in the state demonstrations group, to work out all the details. And I will say we will be coming back to all of you at a theater near you, soon with more details. So I think I'd ask if we can pend that one. But I think I can safely say we are working very, very actively on that issue internally, and we'll come back.

Ashley Setala: Okay. Thanks, Sarah. The next question says in regards to moving beneficiaries to different categories, should states ever require an individual to submit a new application? For example, individuals that transition out of MAGI when turning 65, the state likely needs additional information to make a determination of eligibility resources requirement to run ADS, etc.

Shannon Lovejoy: This is Shannon in CAHP. I can maybe start but others should jump in. I mean in general, if you have someone who is enrolled in Medicaid and you need to complete a renewal or redetermine eligibility on all bases, it is possible that you need to collect additional information to complete the redetermination and may need to, you know, send that request out. But it should not be a full new Medicaid application.

Gene Coffey: Shannon, this is Gene. And I don't have anything to add to that. It would be fundamental from the MAGI to non-MAGI switch that there is likely to be additional information that is necessary for a state to collect, in order to confirm non-MAGI related eligibility, especially given that in many non-MAGI eligibility groups there is a resource test that applies that of course does not apply to any MAGI group.

So again, fundamentally, there would be additional information to collect. But, you know, as Shannon said, an additional application should not be necessary or it just should not be requested.

Sarah Delone: And this is Sarah Delone. Just by way of reminder, the person should not be terminated in this situation, until an effort has been made to collect that additional information and process it.

Ashley Setala: Okay. Thanks, all. The next question says if a state's determined someone eligible for prior months' Medicaid but the person is not eligible for ongoing months, does the state need to maintain the person's Medicaid eligibility through the end of the month when the PHE ends?

Gene Coffey: This is Gene Coffey again. I think I can tackle that one. I don't have it on my screen. So I think, although I may, well let me just stop there. Could you read that again, please, (Ashley)?

Ashley Setala: Sure. It says if a state determines someone eligible for prior months' Medicaid but the person is not eligible for ongoing months, does the state need to maintain the person's Medicaid eligibility through the end of the month when the PHE ends?

Gene Coffey: The answer is yes.

(Suzette): Yes. Thank you, Gene.

Gene Coffey: I'm sorry. Go ahead, (Suzette).

(Suzette): No, no, yes. The answer is yes. If somebody is, as per the FFCRA continuous enrollment provision, if an individual is found eligible in the retro months but not prospectively, the statement still, based on that retro enrollment, keeps a person on until the end of the public health emergency.

Ashley Setala: Thank you. Jackie, it looks like that's everything in the chat at the moment.

Jackie Glaze: Thank you, (Ashley). Operator, would you please provide instructions so that participants can know how to register their questions, and then if you could open the phone lines?

Coordinator: Yes, ma'am. If you would like to ask a question over the phone, please press star followed by 1. Please make sure that your phone is unmuted and record your name clearly when prompted. If you wish to withdraw your question, you can press star 2. Please allow a moment for questions to come in. Thank you. First question comes from (Pat). Your line is open.

(Pat Curtis): Yes. This is (Pat Curtis) from Illinois. I have a question about the disaster (SPA) for Title XXI. Has there been guidance that I certainly may have missed but I've been looking for it, on how to submit the extensions we want for the Title XXI (SPA)? I mean the Title XIX was so easy because it was in a, you know, a very abbreviated format. Is there a similar format for extensions for the Title XXI (SPA)?

Meg Barry: Hey, (Pat). This is Meg. That's a very well-timed question. Your project officer should be sending you an email in the next day or two with instructions.

(Pat Curtis): Okay. Thank you. Can I ask another real quick one, and this is about the extension of the disaster verification plan? We heard in a separate meeting last week, that there is serious consideration that we will be allowed to submit a MAGI disaster verification plan, and I'm just wondering is there a format for that or how should we submit it?

Sarah O'Connor: Hi, (Pat). This is Sarah O'Connor and I can address that question. And yes, we will be allowing states to extend their disaster verification plans during the unwinding period. States may also submit a new addendum to - specific to the unwinding period. And any state that is interested in adopting these flexibilities or continuing on through unwinding, should just reach out to your state lead or otherwise reach out the way you normally would, submit changes to a disaster verification plan.

(Pat Curtis): Thank you.

Coordinator: There are currently no other questions in queue at this time.

Jackie Glaze: Thank you. I'll switch back to (Ashley). I believe we have one additional question in the chat.

Ashley Setala: Yes. We have a question that says CMS stated prior that a certification period may be extended as part of the PHE unwinding, but may not be short (mooned). When does the state's ability to adjust a certification period end? At the end of the PHE; the end of the month the PHE ends; or the end of the 12-month unwinding period?

Shannon Lovejoy: This is Shannon Lovejoy in CAHP. So, you know, states that, you know, during the public health emergency and the unwinding period, for a variety of reasons we know that, you know, during the PHE states have been maintaining continuous enrollment for individuals. And then during unwinding will have to, you know, do quite a bit of work on renewals for a total caseload. And so the option to adjust when you picked up a case for renewal and extend out, you know, a renewal beyond someone's current recertification period, goes through the 12-month unwinding period.

So as long as that renewal ends up being initiated by the end of that 12-month unwinding period, that's how long that flexibility is to, you know, essentially not be timely in initiating and completing the renewal.

Ashley Setala: Thanks, Shannon. And we have one more question that has come in. And it says how should states handle members losing Medicaid due to losing SSI? Should we only ask for information needed to make a determination?

(Suzette): Hi, this is (Suzette) and I can - I think we've addressed this before. I think the question is like what - how does a state do an ex parte renewal for SSI-eligible individuals? And the answer is while renewals - there is no exception to annual renewals. States already check the (SDX) or should be checking the (SDX) on a monthly basis to ensure that the individual continues to be in receipt of SSI.

So they could continue their process as long as during the renewal months the individual continues to be eligible for SSI and the state is getting that information through the (SDX), the person should be considered renewed.

Sarah: (Suzette), this is Sarah. I think they may be asking but what happens if the person loses SSI.

(Suzette): Oh, I'm sorry.

Sarah: So they check the (SDX) and this person is not in receipt of SSI, what next steps should the state be taking?

(Suzette): Right. Thank you, Sarah. So the state must determine eligibility on all bases prior to terminating that individual. So sort of back to the question that was asked earlier, the state may need to collect additional information. The state would send either a renewal form or a request for that additional information the state needs, to determine eligibility on all bases prior to terminating.

And the state would continue to provide coverage to that individual until that determination of ineligibility is made.

Sarah: And you could imagine, depending on the state I think (Suzette), right, it could be that this person if they're under 65 might be eligible for the adult group. It could be that they remain disabled and maybe if the state covers the 100%, you know, federal poverty level group of, you know, people age 65 and older or disabled, they might be eligible for that group.

So there might be either a MAGI or a non-MAGI eligibility group that this former SSI recipient may well remain eligible for.

Gene Coffey: Sarah, (Suzette), I would also just want to add that if the person was receiving SSI on the basis of disability, and lost SSI for financial reasons, the state should in all but limited circumstances to certain 209(b) states, the state would have to consider that individual to maintain a disability and determine the

individual's eligibility for potentially disability-related groups based exclusively on the individual's financial eligibility.

Woman: So lots of complexities here, and I'm going to offer a technical assistance from members of the CAHP team for any state, who needs some assistance on those kinds of cases.

Jackie Glaze: Thank you, Sarah, (Suzette), and Gene. So in closing, I'd like to thank the team for their presentations today. Our next call will take place on Tuesday, May 17th, from 3:00 to 4:00 pm Eastern Standard Time. We will be sending the topics and the agenda forthcoming. So of course if you have questions between the next call, feel free to reach out to us. You can contact your state leads or you can bring your questions to the next call.

We thank you again, for joining us today. And we hope that everyone has a great afternoon. So, thank you.

Coordinator: That does conclude today's conference. You may disconnect at this time. And thank you for joining.

[End]