HHS-CMS-CMCS

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2:00 pm CT

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 miss (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.

Dan Tsai: Hi everybody. Thanks for joining our all state call, regularly scheduled. We'll spend most of today on updates related to Mpox, and obviously also the end of the COVID 19 PHE. We're all tracking the May 11th date, and certainly in our work with you all, the work on redeterminations renewal from winding, has really kind of begun full swing.

So I continue to thank folks for the amount of work and effort underway, even as we think about closing out one chapter, and really moving on to not only the many other parts of the Medicaid and CHIP programs we've been working on together, but also for making sure we have a successful and orderly

transition for Medicaid renewals to help keep people covered. So thank you all for that. And I think we'll see many folks next week from the state side, in Minneapolis, for a set of meetings in person, which will be really a wonderful thing.

So I will introduce shortly, colleagues that we have from the White House Mpox National Response Team, who will go through some updates for all of you, and our state colleagues, on Mpox. And then I will turn it to - we will turn it to Perrie Briskin who is Senior Policy Advisor here at CMCS, and Maria Tabakov, from our Medicaid and CHIP Operations group, who will go through an overview of a center informational bulletin we released yesterday on the upcoming end of the PHE - dates, timeframes, when vary authorities expire, the things that we've been in close dialogue on for quite some time, but certainly extends to many of the pieces and flexibilities and authorities that go far beyond the eligibility renewal topic, and that you all have been very engaged on.

So we look forward to that in the Q&A. I will be using the webinar platform today. So if you're not already logged in, you can do so to see any of the slides for today's presentation. And you can also submit questions in the chat, during the presentation, with that feature. And so before we get started, I just wanted to again, acknowledge the end of - the outcome again, of the COVID-19 PHE, which is set to expire in two days, on the 11th. And I think having been on the other side, the state side when this all started, I think COVID really set a different precedent for how CMS and the states work together under incredibly challenging circumstances.

But really as joint federal and state partners, and running and operating the Medicaid program and CHIP program. So that level of collaboration, I think we have maintained, and that's for the benefit of the program and the close to

90 million - over 90 million people that we together serve now. So thank you for that. And I know our all state calls and other forms of engagement and the countless dozens of hours of meetings each week around the Medicaid renewals and other pieces, will continue.

So one step the team pulled that just expresses how much work has happened and how fast folks pivoted, I think we counted somewhere between 1400 and 2000 different waiver and other flexibility that you all at the state level, submitted, to CMS, during the pandemic, all in the name of trying to help support individuals, consumers, beneficiaries, providers, plans, and kind of the rest of the delivery system and safety net, which is really quite incredible.

And together, I think CMS and the states and others forward some new flexibilities and authorities that we will carry on, as other pandemic approaches come up. And certainly, some of the things that states outlined, including the really tremendous shift to telehealth, we - it's an authority specific to the pandemic, and we hope and anticipate use of that will continue. So we could spend a lot more reflecting on the past three years in all the various roles, but all that just to say, thank you, and, you know, it's gratifying to be able to work together.

I'm sure the - all our federal and state colleagues feel the same and service over 90 million people we serve. So with that, I'm going to turn things over to Demetre Daskalakis, who is the Deputy Coordinator of the White House National Mpox Response Team, and Nikki Romanik, who is the Senior Policy Advisor, also at the White House National Mpox Response team. So, Dimitri and Nikki, over to you.

Dr. Demetre Daskalakis: Thank you so much. And again, thanks. We are really enthusiastic over here at the White House Mpox National Response Team, to have a

chance to come to you and speak on Mpox and the role of vaccine, and where we need your help. So we're going to give you a break from your previously scheduled programming, talking about the COVID PHE, and talk a little bit about Mpox for a couple of minutes. Next slide, please.

So first, I'll start with a situation update. The data are going to be updated later this week, so on Wednesday. But as of April 26th, there have been 30,361 and Mpox cases in the United States. You can look at the map; the darker the jurisdiction the more number of cases were diagnosed in that jurisdiction. To date we have 42 total deaths, which gives us a depth rate of about 1.4 for 1000 cases. We're displaying the epi curve here. Again, the epi curve is from April 26th. We are actually seeing a few cases in Chicago, which will likely mean that we are going to break our trend of less than one case per day for the last several weeks.

But we are still moving in overall, a very good direction, compared to the peak on our busiest day, of almost 800 cases in one day at the US. Next slide, please. Along with the surveillance that we have using case based reports, the CDC also has released wastewater surveillance that gives us a sense of the fact that there is in fact still Mpox activity even in parts of the country where we're not detecting cases. And so this is the update as of May 3rd. That shows that there is consistent detection in one part of Virginia, and that there is intermittent detection actually in three sites in Texas, all clustered around Dallas, Memphis, as well as Southern Maryland.

So we continue to see evidence of disease activity both by a small increase in cases in Chicago, as well as some wastewater data that implies that Mpox is still among us. Next slide, please. It's important to note that we have an effective medical countermeasure that addresses Mpox. There's a two-dose vaccine known as Jynneos; I'm going to call it MVAVM vaccine, to keep it its

generic name. This vaccine has been demonstrated to be safe and effective. So I know your slides are very small, but the message is that two-dose vaccines have an effectiveness of about 70%.

A single dose which is not the recommended regimen, is about 30-ish percent. There are more data that are coming from CDC in the next week or so, that really tracks very closely, to this, that a two-dose regimen is about in the same ballpark. So those data are forthcoming. I can't share all the details yet. But it is not a surprise or different than what we have seen to date. There are also safety data that come from many different sources, both the - multiple vaccine safety data databases, including a database per individuals less than 18 years old.

This resulted in CDC advisors at ACIP. They were in the use of Mpox vaccine in the setting of an outbreak, which we continue to be embroiled in today. Next slide, please. In terms of who needs the vaccine, the estimated population is less than 2 million people. It's about 1.7 million people. So first, let me tell you how this is estimated. Looking at the population of individuals - gay, bisexual, other men who have sex with men who are potentially candidates for HIV pre-exposure prophylaxis, as well as gay, bisexual, and other men who have sex with men, who are living with HIV in the United States.

That comes up with the denominator of just about 1.7 million. That then leads to the recommendation of who needs to be vaccinated based on current CDC guidance. The guidance is that men who have sex with men, and other gay/bisexual men, as well as transgendered individuals who have demonstrated risk in the last six months, should be vaccinated. And CDC recommends a couple of markers of that, including having had one or more

sexually transmitted infections in the last six months, or self-identifying as having more than one sex partner in the last six months as well.

They also recommend vaccination for people who have had interactions in a geography with Mpox transmission, or specific types of venues, and for people living with HIV or other immunocompromised; any one of those folks that has recent or anticipated exposure qualifies for a vaccine. On top of that population, there is also sex partners of people who have had indications for vaccine that I talked about.

In fact, that 1.7 million estimate includes a 25% increase of the population that I've described, to actually deal with the additional numbers of humans who may be partners of the individuals who are the primary target of vaccination. Next slide, please. There's really important modeling that comes from CDC that makes it really clear that our work is not yet done vaccinating. So I'm going to share, shortly, how many vaccines were administered in the US. But what we know is, that there's an inverse relationship between immunity in the population, and the risk for recurrent outbreak.

So the more immunity, the less likely we are to have an outbreak. We also know from the CDC modeling, that there is a threshold, about 35% coverage, under which the modeling says that not only will we potentially be at risk for an outbreak, but an outbreak that is of equal or larger size to the one that we experienced in 2022. So that's the second panel. So again, really ways to enter our awareness that this is potentially a costly scenario and could be much larger than what we've experienced to date so far, unless we achieve a higher level of vaccination among our communities at risk. Next slide, please.

We also publish - CDC published vaccination rate state by state, including some jurisdictions from larger cities, that are directly funded. And overall,

what we've got for the United States, is that we're squeaking by at about 37% coverage for one dose. Remember, that has a significantly lower effectiveness, and only about 23% of the population who could benefit from vaccine, has been fully vaccinated, to achieve the higher level of vaccine effectiveness that we need, to prevent a future outbreak.

And again, though this is small and hard to see on the CDC Web site, if you're interested there is a state by state breakdown of vaccine rates estimated, using the denominator that I referred to before. Next slide, please. So we need your help to make sure that we can continue to contain Mpox. And the real ask is we definitely are - ACIC has opined on the fact that this is an important in the setting of outbreak. And so we are really asking for you all to review your coverage and really see if this vaccine is covered. And if it's not, please do cover it.

So many reasons for that - so covering of vaccine for the limited population at risk protects the whole country, and may prevent death and prolonged hospitalization in very vulnerable individuals. I actually will share one piece of data that I think is important when you think about hospitalization. That of the 57 people who reported early on to have hospitalization 42 of them actually passed away. The average length of time between their diagnosis and death, was 68 days, most of which was spent in the hospital.

Coverage of the vaccine is critical to help us accelerate integration of Mpox vaccination into routine clinical services in the populations who could benefit. We have been talking to many providers around the country, both traditional and non-traditional pharmacists, and coverage ends up being one of the key feature that is important to them, to be able to bring the vaccine into their normal practice. And so really making sure that there is coverage for the

vaccine in the Medicaid space, is so important for us to be able to extend vaccine access to populations who could benefit.

Also as I just implied, coverage also means that new providers may agree to administer vaccine. So pharmacies cite coverage as one of their major barriers to implementing Mpox vaccination programs. We know from COVID, that vaccines in pharmacies tend to have a very deep reach into communities that we can't always get in standard or clinical public health environments. That's a really important opportunity for us. And making sure that there's coverage in your state would be really important for us to move that forward.

Our community has also asked that we accelerate access in new settings, to increase access equity. And again, in our voyages with many types of providers, this continues to be one of our major barriers. And something that is not new to you, is that private industry follows what you do. You all are the leaders in this space. Private insurers will follow your lead. And also, like I said, not only does it give us the opportunity to get this into more spaces for provider who could provide vaccines, but also Medicaid coverage really helps us to open the door to commercialization of vaccines.

At the moment, the vaccine is distributed through the strategic national stockpile. Until it's commercialized, it will continue to move to the US government, and will be limited where we are able to actually implement vaccination programs. So the step to commercialization supported by coverage being a piece of what we can negotiate, means more willingness by the company to move forward in commercializing the vaccine, so we can improve access across the nation. Next slide, please.

That is the end of my presentation. And we're going to hang around in case you have questions. So thank you very much for letting us visit your meeting.

(Jackie Glaze): Thank you, Demetre. So next, Perrie Briskin and Maria Tabakov will walk through the CMCS informational bulletin that was released yesterday, regarding the end of the Public Health Emergency. So I will turn now to you, Perrie and Maria.

Perrie Briskin: Thanks, (Jackie). Hi, everyone. So as (Jackie) mentioned, yesterday we released a new informational bulletin. Next slide, please. Here we go. Informational bulletin entitled End of the COVID-19 Public Health Emergency, and the COVID-19 National Emergency, and Implications for Medicaid and CHIP. Next slide, please.

As background, on April 10, 2023, this last month, President Biden signed into law a joint resolution of Congress that ended the presidentially declared COVID-19 national emergency on April 10th. The COVID-19 National Emergency is separate from the COVID-19 Public Health Emergency or "PHE", declared by the Secretary. So in February, as announced in February, it is expected that the Secretary of Health and Human Services, Xavier Becerra, will let the COVID-19 PHE expire on May 11th, this coming Thursday.

This said that we released describes end dates of certain COVID-19 related Medicaid and CHIP coverage, flexibilities and enhanced federal funding, tied to both the COVID-19 national emergency, and the COVID-19 PHE. CMS has previously provided information through past all state calls and other resources, all posted on Medicaid.gov, on how states can continue many of these flexibilities beyond the COVID-19 PHE, if permissible.

It's also important to note that this (SIB) does not provide any additional information about the end of the continuous enrollment condition, which

ended the - which the CAA ended on March 31st. So anything around unwinding, this (SIB) does not provide any updated information there. Next slide, please. As many of you know, the American Rescue Plan implemented a series of new coverage options for states, and additional funding.

So that is covered in this (SIB). The first is the ARP Sections 9811 and 9821, which is coverage of COVID-19 vaccines, vaccine administration, testing and treatment, in Medicaid and CHIP. Since the ARP, the American Rescue Plan, was passed in March 2021, states have been required to cover COVID-19 vaccines and their administration, testing and treatments, without any cost sharing.

Under the ARP, these coverage requirements end on the last day of the first calendar quarter that begins one year after the last day of the COVID-19 PHE. That is a mouthful. But what our (SIB) clearly states is that if the COVID-19 PHE ends as expected, on May 11, 2023, this ARP overage requirement will end on September 30, 2024. Similarly, for other ARP Sections 9811 and 9821 around enhanced matching funds, for vaccines and their vaccine administration, so the ARP authorizes 100% FMAP for state expenditures for medical assistance for COVID-19 vaccines and their administration.

Similarly, to the previous coverage requirements, the 100% FMAP also ends on the last day of the first quarter that begins one year after the last day of the COVID-19 PHE. So if the COVID-19 PHE ends on May 11th, as expected this 100% FMAP will end on September 30, 2024. Next slide, please. The Family First Coronavirus Response Act provides states with authority for coverage to a new optional COVID-19 Medicaid eligibility group for uninsured individuals, and gave states 100% federal (maps) for their expenditures. So this has been in place since 2020.

As of the publication date of this (SIB), 15 states and three territories have opted to provide coverage to this optional COVID-19 group. For those states and territories that have adopted the optional COVID-19 group, the coverage and related federal matching funds expire on the last day of the COVID-19 PHE, which is expected to be May 11th. Next slide, please. I will now turn it over to Maria Tabakov, to walk through the Section 1135 waivers.

Maria Tabakov: Thank you, Perrie. Since 2020, states submitting a Medicaid disaster relief file for COVID-19, have been able to request Section 1135 waivers or modifications of the applicable federal expected date, public notice, and tribal consultation requirements. The end of the COVID-19 National Emergency on April 10, 2023 ended CMS's authority to issue new perspective, Section 1135 waivers related to the COVID-19 pandemic.

Section 1135 waiver authority to waive or modify SPA submission requirements for Medicaid disaster relief SPAs submitted on or after April 10, 2023, is no longer available. Medicaid Disaster Relief SPAs related to the COVID-19 pandemic, can remain in effect until the end of the PHE, unless the state has tied the end of the SPA to the end of the COVID-19 National Emergency or an otherwise specified effective earlier end date on the SPA. Now I will turn it back to Perrie, to cover the telehealth flexibility.

Perrie Briskin: Next slide, please. We also call out in the (SIB), to remind states about telehealth flexibilities. Telehealth flexibilities under Medicaid and CHIP, are not tied to the COVID-19 PHE. The flexibilities that cover Medicaid and CHIP services when they're delivered via telehealth, was available prior to the COVID-19 PHE, and will continue to be available after the COVID-19 PHE ends. States have a great deal of flexibility with respect to covering Medicaid and CHIP services provided via telehealth.

Generally, a state does not need to submit a State Plan Amendment to describe when it will cover or pay for already covered Medicaid services when they are delivered via telehealth, unless it wants to cover or pay for the services differently, when the services are delivered via telehealth. Next slide, please. So I will not read through this entire chart, but this is an example of what is included in the (SIB). We have provided a table for key dates for expiration of Medicaid and CHIP COVID-19 flexibilities or requirements.

You can see in the first column authority and provisions, and then about their expiration date. So we try to very clearly state when the different flexibilities are expiring and are again open to provide technical assistance to states to help them understand or extend certain flexibilities. And with that, I will turn it back over to (Jackie).

(Jackie Glaze): Thank you, Perrie, and thank you, Maria. So we're now ready to take your questions. So we'll begin by taking your questions through the chat function. So you can begin submitting them now. And then we'll take questions over the phone line. So if you have any questions today, about today's presentations or any other questions, please ask them now. So we'll now look for your questions through the chat function, and then again, we'll transition to the phone lines. Okay, I'm not seeing any questions through the chat function. Are you (Krista)?

(Krista): I am not (Jackie).

(Jackie Glaze): Okay. So why don't we transition and see if we have any questions over the phone line. So (Missy), if you could provide instructions to the participants to register their questions. And then if you can open the phone lines, please?

Coordinator: Yes, ma'am. If you would like to ask a question over the phone, please press star followed by 1. Please make sure your phone is unmuted and record your name 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. I'm not seeing any questions coming in yet, ma'am, over the phone.

(Jackie Glaze): Thank you, (Missy). And I'm not seeing any questions either, over the chat function, so we're going to give everyone a few minutes to see if they do want to ask questions today. And then we may finish early. And (Missy), if you see any questions that come through the phone line, if you could just alert us, that would be helpful.

Coordinator: Yes, ma'am.

(Jackie Glaze): Hey, (Krista), I believe we have one question?

(Krista): Yes. I have one question here in the chat. Can Appendix Ks still be submitted through the end of the PHE on Thursday? So Maria and Perrie, I think this one is for you or for anyone else who might be on the line.

Melissa Harris: Hi. This is Melissa Harris in the Disabled and Elderly Health Programs Group. And yes, Appendix Ks for 1915(c) home and community based services waivers, can still be submitted up to Thursday and even after Thursday. But we would really encourage states to submit their last Appendix Ks as quickly as possible. Thanks.

(Krista): Thank you so much, Melissa. I'm seeing one additional question in the chat. When will written guidance for forwarding addresses, be sent through?

(Alice Weiss): Hi. This is (Alice Weiss) from (CAP). I'll take that question if that's okay. I just wanted to share that we are in the process of trying to finalize that guidance, and we are hopeful that that written guidance will be forthcoming soon. So stay tuned.

(Jackie Glaze): Thank you, (Alice). (Missy), I'll follow back with you to see if we've received any additional questions through the phone lines.

Coordinator: Not At this time, ma'am.

(Jackie Glaze): I'm not seeing any additional questions either, through the chat function. So I think we'll give everyone back time on your calendars today. So again, I'd like to thank our presentations today, our presenters. And looking forward, we will follow up with the topics and invitations for the next call. If you do have questions before the next call, please reach out to us, your state leads, or bring your questions to the next call. So we do thank you for your participation today. And we hope everyone has a great afternoon. Thank you.

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

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