Centers for Medicare & Medicaid Services

COVID-19 Medicaid & CHIP All State Call

October 29, 2020

3:00 pm ET

Operator: Ladies and gentlemen, thank you for standing by and welcome to the CMCS All-State Medicaid and CHIP Call webinar. At this time all participant lines are in a listen-only mode. After the speaker's presentation, there will be a question and answer session. To ask a question during the session, you will need to press star one on your telephone keypad. Please be advised that today's conference is being recorded. If you require any further assistance, please press star zero. I'd now like to hand the conference over to Jackie Glaze. Thank you, please go ahead.

Jackie Glaze: Thank you, and good afternoon everyone and welcome to today's all-state call and webinar. I will now turn to our acting center director, Anne Marie Costello, and she will share highlights for today's discussion. Anne Marie.

Anne Marie Costello: Thank you, Jackie, and welcome and thanks to everyone for joining us today. We moved our call this week so that we could share with you some important information regarding an interim final rule released yesterday that impacts Medicaid and CHIP programs. So I'm really glad you all could adjust your schedule to join us.

Anne Marie Costello: I'll note that in addition to the interim final rule we released, a toolkit on vaccine coverage payments and administration under Medicaid CHIP and the Basic Health Program. The toolkit is now available on medicaid.gov, so we encourage you to take a look at it. The toolkit will also be the focus of our all-state call next Tuesday.

Anne Marie Costello: But turning to today's presentation, the Interim Final Rule (IFC) released yesterday ensures that individuals covered by group health plans, health insurers, and participants in CMS programs, like Medicaid and CHIP, have access to U.S. Food and Drug Administration (FDA)-authorized or approved COVID-19 vaccines at no cost. It also includes provisions designed to provide more flexibility to states on the Maintenance of Effort requirements included in the Families First Coronavirus Response Act, or the FFCRA.

Anne Marie Costello: To help orient you to this new rule, CMCS staff will discuss two key provisions that impact Medicaid, CHIP, and BHP beneficiaries. Melissa Harris, the acting director of the Disabled and Elderly Health Programs Group, will discuss COVID-19 vaccine coverage for Medicaid, CHIP, and BHP beneficiaries during and after the public health emergency. This information is outlined in the preamble of the IFC. Then Sarah deLone, the group director of the Children and Adults Health Programs Group, will discuss an IFC provision that updates CMS' policy related to maintaining Medicaid enrollment during the public health emergency.

Anne Marie Costello: As you all are aware, section 6008 of the FFCRA authorizes states to claim a temporary 6.2 percentage point FMAP increase if certain conditions are met. The IFC provides additional flexibilities related to maintaining Medicaid enrollment during the PHE that is intended to assist states in managing their programs.

Anne Marie Costello: After Melissa and Sarah's presentations, we'll open up the lines to your questions on the IFC, as well as your general questions. I will note that we are using slides for today's presentation, so if you are not logged into the webinar, I recommend that you do so now. The slides will also be posted to Medicaid.gov shortly after the call. With that, I'll turn things over to Melissa Harris to start the IFC presentation. Melissa.

Melissa Harris: Thank you, Anne Marie. This is Melissa, and we will now be moving to the second slide in the deck. And Anne Marie mentioned that the regulation that we issued yesterday was an interim final with comment, and there were many different provisions in that document. Medicaid had two of those provisions and they're highlighted here for you in red font.

Melissa Harris: The bulk of the other provisions in the interim final applied to the Medicare program and to the commercial market, and so we encourage you to peruse that document to understand all of the new provisions issued across the program that CMS administers, but we are going to focus the rest of our conversation today on the two Medicaid provisions that you see highlighted in red.

Melissa Harris: And so what I'm going to talk about is the vaccine coverage information for Medicaid, the Children's Health Insurance Program, and the Basic Health Program, and we will start with the coverage provisions that apply during the public health emergency.

Melissa Harris: In the piece of legislation passed earlier this year called the Families First Coronavirus Response Act, there is a provision that authorizes states to receive an extra 6.2 percentage points of federal match for Medicaid expenditures, and that extra match is conditioned on the state doing several things, and you see the four conditions that are laid out here.

Melissa Harris: And for this purpose, I'll call your attention to the four sub-bullets, covering without the imposition of cost sharing, testing services and treatments for COVID-19, including vaccines, specialized equipment and therapies. So as we delve more into the vaccine coverage provisions during the public health emergency, understanding that all states, to our knowledge, are pursuing the extra 6.2 percentage points of federal match, it's incumbent on states to provide without cost sharing access to a COVID-19 vaccine.

Melissa Harris: And so we structured some of the preamble language and some of the information that you see in the vaccine toolkit yesterday, from the vantage point of both what's happening inside the public health emergency and what's happening outside. It's a fairly cohesive discussion during the public health emergency, in terms of who is receiving coverage in Medicaid because of this provision of the Families First Coronavirus Response Act.

Melissa Harris: And so, as we move to slide three, there's a lot of content on this slide, but it provides really the meat of the information that was conveyed in the interim final yesterday. So again, here's some bullets that talk about the span in which the Families First Coronavirus Response Act provisions are in effect. They run not only through the public health emergency declaration itself, but they technically run until the last day of the calendar quarter in which the public health emergency expires. And so that technicality, in terms of the timing of when states are expected to abide by the conditions for receiving that enhanced match, are pretty critical as we're talking about when there is coverage for the vaccine and when we move into the post public health emergency period.

Melissa Harris: The only individuals who will not have coverage for the COVID vaccine are people who are receiving limited benefit packages. And these are people who, either by statute or by an existing 1115 demonstration, are receiving a defined set of benefits that don't typically include vaccine coverage. Here, we could be talking about individuals receiving family planning benefits, or tuberculosis-related services, or individuals who are in the optional COVID testing group who received testing services but not treatment services. Those are the people whose coverage for the COVID vaccine is not guaranteed.

Melissa Harris: You'll see in the toolkit that states certainly can take action to provide vaccine coverage to those individuals through the 1115 demonstration avenue, and certainly CMS is available to provide technical assistance with those limited benefit individuals who are in a different category from the rest of Medicaid eligible, in terms of receipt of the COVID vaccine during the public health emergency.

Melissa Harris: I will say, spending a couple of moments to segue outside of the Medicaid program to the Children's Health Insurance Program, separate child health programs are required to cover Advisory Committee on Immunization Practices (ACIP)-recommended vaccines without cost sharing for individuals under the age of 19. Coverage of uninsured pregnant women in a separate CHIP program is optional.

Melissa Harris: It's important to note that the Families First Coronavirus Response Act provisions do not apply to CHIP, and they don't apply to basic health benefits or Basic Health Programs, but there are some other provisions in CHIP and BHP that are in effect during the public health emergency that allow for coverage of the vaccine to an awful lot of individuals in those programs.

Melissa Harris: The Basic Health Program, which is currently available in New York and Minnesota, provides benefits that include the 10 essential health benefits defined under the Affordable Care Act, and those also include all ACIP-recommended vaccines, and those vaccines would be provided without cost sharing.

Melissa Harris: One of the changes in the interim final rule published yesterday in the commercial market that has applicability both to the Basic Health Program and the Medicaid Alternative Benefit Plan program for the adult group, is that there needs to be coverage with no cost sharing for what's called qualifying coronavirus preventive services, which includes the COVID vaccine, and the

important point of that coverage is it is required regardless of whether the vaccine is delivered by an in network or out of network provider.

Melissa Harris: This was, again, a change that happened in the commercial market regulations, defining the preventive services essential health benefits, but those essential health benefit (EHB) categories have meaning for both the Basic Health Program and in Medicaid, the Alternative Benefit Plans. And so those protections in yesterday's IFC represent really the only change in operations for vaccine coverage in Medicaid and Basic Health.

Melissa Harris: So we will go to the next slide. And so after the public health emergency, or to be more precise, after the period in which the conditions around the Families First Coronavirus Response Act expire for enhanced match, we then revert to traditional coverage requirements in the Medicaid program. And here, it becomes a little more of a mixed bag in terms of who has mandated coverage for a COVID vaccine and who has optional coverage, and you see a lot of that spelled out here.

Melissa Harris: So for children under the age of 21, through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) parameters, all of those children would receive an ACIP-recommended vaccines and their administration at no cost sharing. They also, even after the public health emergency has expired, would continue to receive the COVID vaccine. Same thing for any individual who is in an Alternative Benefit Plan because again, those benefit packages are based off of the essential health benefits, which include ACIP-recommended vaccines.

Melissa Harris: Additionally, adults in states who are receiving an extra one percentage point of Federal Medical Assistance Percentages (FMAP) for preventive services, based on section 4106 of the Affordable Care Act, are also required to receive the COVID vaccine because that extra 1% of FMAP is conditioned on the preventive services benefit also including ACIP-recommended vaccines.

Melissa Harris: And so, those are the populations for whom coverage of a vaccine would be mandated outside of a public health emergency. Beyond those populations, states have the option to cover vaccines for other Medicaid eligible groups, and by now we're talking about other adults. So individuals who were eligible on an aged, blind, and disabled basis, or other bases to come into the Medicaid program. They have the option for the state to provide them coverage.

Melissa Harris: For the Children's Health Insurance Program, for CHIP, coverage is the same both during and after the public health emergency, and so the expiration of the public health emergency declaration does not have any bearing on the benefit packages or cost sharing experienced by CHIP enrollees. And then in the Basic Health Program, states have to continue providing those enrollees with the vaccine at no cost sharing, again, because of the essential health benefits structure.

Melissa Harris: It's important to note that after the public health emergency is no longer in effect, for both the Medicaid alternative benefit plans and the Basic Health Programs, the provision in yesterday's interim final regulation, that vaccines need to be

covered by either in network or out of network providers, are no longer in effect. That provision is only applicable to the period of the public health emergency.

Melissa Harris: So with that, I am going to turn it over to Sarah deLone to walk through the other Medicaid provision in yesterday's interim final regulation, but I will be around for questions at the end. So thank you very much. And Sarah, I'm going to hand it over to you.

Sarah deLone: Great. Thank you, Melissa, and hello, everybody. As Melissa mentioned, to claim the 6.2 percentage point increase in the FMAP that was authorized by section 6008 of FFCRA, states have to satisfy four conditions, and the IFC provides, the interim final rule, provides the long-awaited additional guidance on the third condition in section 6008(b)(3) of FFCRA, under which states must maintain beneficiaries' coverage through the end of the month in which the public health emergency, or PHE, for COVID-19 ends.

Sarah deLone: So just by way of reminder, note this is the one condition that actually expires at a different time than Melissa mentioned for the vaccine, the coverage requirements, and the other conditions, which goes to the end of the quarter in which the PHE ends, this requirement goes just until the end of the month in which the public health emergency ends.

Sarah deLone: So the interim final rule reinterprets this condition in 6008(b)(3) to provide states with greater flexibility in managing their programs, while also ensuring important safeguards for beneficiaries. So by way of reminder, under our original interpretation, which was set forth in a series of FAQs earlier this year, to receive the increased FMAP, states were required to keep beneficiaries enrolled in Medicaid, if they were enrolled, as of or after March 18th, 2020. That magic date is the date of the enactment of FFCRA, again through the end of the month in which the PHE ends.

Sarah deLone: Along with this maintenance of enrollment, beneficiaries had to maintain access to the same amount, duration, and scope of benefits. In addition, they couldn't be subject to any increase in cost sharing, or beneficiary liability for long-term services and supports during the period in which this condition is in effect. Those are the beneficiary liability under the post-eligibility treatment of income (PETI) rules.

Sarah deLone: So this original interpretation, and we heard from any number of you that this original interpretation prevented you from implementing changes that you needed to in order to manage your programs and the cost in your programs. For example, reduction in the number of covered visits, or prior authorization requirements, that would restrict the amount, duration, and scope of benefits available to somebody who was already enrolled in the program.

Sarah deLone: The only cost-controlling measure that has been available in practice, under the original interpretation, was a reduction in provider rates to the lowest level permitted under the provider access standards. And so you all raised, as the PHE continued, you all raised concerns about the lack of flexibility that was available to you under this interpretation. So can we go to the next slide.

Sarah deLone: So as I said, this interim final rule reinterprets this provision of the law, and it establishes a new section 433.400 in 42 CFR of the Medicaid regulations. Under this new provision, in order to claim the temporary FMAP increase, states must continue to maintain the Medicaid enrollment of validly enrolled beneficiaries in one of three tiers of coverage through the end of the month in which the PHE for COVID-19 ends.

Sarah deLone: So let's break that down in the next couple of slides to sort of unpack what that actually means. Next slide, please. Okay, so, as I said, 433.400 requires state to main coverage of validly enrolled beneficiaries. What exactly does that mean?

Sarah deLone: So as a general rule, most beneficiaries are presumed to be considered validly enrolled. So, for purposes of really understanding the rule, it's easier to think about who would not be considered validly enrolled. And the rule specifically identifies two groups of beneficiaries, those who received an erroneous determination of eligibility, and those who were erroneously granted eligibility because of fraud or abuse.

Sarah deLone: And also I want to note, and I'm going to go into each of those two groups in a moment, but also want to note that individuals receiving services during a period of presumptive eligibility because they've just been determined presumptively eligible by a qualified entity, their hospital or another qualified entity, those individuals are not considered validly enrolled for purposes of 6008(b)(3) in this condition, because the determination was not made by the state. You can go to the next slide, please.

Sarah deLone: So, first, let's spend a moment on those beneficiaries who were enrolled due to agency error. So these are beneficiaries who received an incorrect eligibility determination due to an error made by the state agency that determines Medicaid eligibility. For example, we heard from one state that stopping the $600 disregard of the unemployment compensation bump that individuals were given wasn't able to be turned off right away, and so there were many applicants who were erroneously given that disregard, even though that $600 was actually no longer being received by them. That would be an example of an erroneous determination by the agency, and those people would not be considered to be validly enrolled, and the state could terminate those individuals, after, of course, advance notice is provided, proper advance notice is provided, and fair hearing rights also would have to be provided.

Sarah deLone: And to note that this provision will apply both to initial determinations of eligibility that are made on new applicants that come on or after March 18th, as well as people who had a determination, either at initial application or a renewal that occurred before March 18th, 2020, that was erroneous. Those are the time spans that this would apply to. If somebody's validly enrolled as of March 18th, 2020, they keep that. There's no way to undo that, just reverse that valid determination. So if we can go to the next slide.

Sarah deLone: So, similar to the agency error carve out from who's considered to be validly enrolled, a beneficiary under the rule also would not be considered validly enrolled if the beneficiary was erroneously granted eligibility due to fraud,

beneficiary fraud, as evidenced by fraud conviction or due to a finding of beneficiary abuse, which would have to be determined following the regulations, following a complete investigation and a formal finding of abuse, which is the process for that, and the regulations for that are provided in 42 CFR 455.15 and 16.

Sarah deLone: And just by reminder, again, for both of these situations, before anybody is terminated, the agency would have to comply with the advance notice and other due process requirements, advance notice and fair hearing rights. Next slide, please.

Sarah deLone: Okay, so again, the regulation provides that to claim temporary FMAP increase, the state must maintain enrollment of validly enrolled beneficiaries in one of three tiers of coverage. So let's talk now about the three tiers of coverage. So, tier one is coverage that meets the definition for minimum essential coverage, or MEC, and that's most Medicaid coverage. Tier two includes coverage that is not MEC, but does include COVID testing and treatment services. So an example of that would be, in a few states, pregnancy-related coverage is not considered MEC. It doesn't quite meet that standard for certain beneficiaries, but it is going to include coverage of COVID testing and treatment services, so that would be an example of a tier two coverage group.

Sarah deLone: Tier three is truly limited benefit package. So tier three is neither MEC nor includes coverage of COVID testing and treatment services, and so an example of that would be coverage of family planning services only, or coverage under the optional COVID testing group. Slide 12.

Sarah deLone: So, by establishing three tiers of coverage, what we accomplish is an ability to give states greater flexibility, but also ensure that beneficiaries who have one of the more robust tiers, their coverage is protected. So somebody can't be transitioned without their consent from a more robust tier to a less robust tier. So, can't go from tier one to tier two, or from tier two to tier three. Can always go up the ladder, but can't go down the ladder.

Sarah deLone: So for example, if a beneficiary has tier one coverage as of or after March 18th, 2020, they must be maintained, they must maintain access to tier one coverage through the end of the month in which the PHE ends. If they no longer meet the eligibility requirements for a tier one group, but they become eligible for a different tier one group, they could be transitioned into that new group. And this includes, I'll note, beneficiaries who become eligible for a Medicare Savings Program group.

Sarah deLone: So for example, an adult in the adult group who becomes eligible for Medicare and is no longer eligible for the adult group, but is eligible as a qualified Medicare beneficiary of QMB or SLMB or one of the other MSP groups, could be transitioned to that group. They'll still be getting MEC through the Medicare program, and they'll get their premium and cost sharing wrap that's available through the MSP program.

Sarah deLone: On the other hand, if a beneficiary with tier one coverage loses eligibility for that group, and became eligible for a tier two group, the state would not move that person to the tier group. That would be to a less robust coverage group, and that would be prohibited for a state claiming the 6.2 percentage point FMAP increase.

Sarah deLone: The same basic rule applies to tier two coverage, with the exception that, as I mentioned before, a beneficiary can be transitioned from tier two to tier one. So, for example, if in a state where the coverage for pregnant women is not matched, so it's a tier two group, and that pregnant woman becomes eligible after her postpartum period is over, she becomes eligible for the adult group, the state would move the woman into the adult group, which would be tier one coverage, or into a parent caretaker relative group if that was the appropriate group for her.

Sarah deLone: If somebody in a tier one or tier two coverage loses eligibility for that coverage group, and doesn't meet the eligibility requirements for any other group, they keep with the same coverage that they were getting under their original group. Next slide, please.

Sarah deLone: So the rule for tier three is a little bit different, and that's because tier three coverage really spans a much wider range of benefits than either coverage that might fall into tier one or tier two. And so for example, could be a 1115 demonstration project using expenditure authority that provides a pretty good, either it's disease or condition specific or it's some other targeted, and it's a limited benefit package, but not super targeted, as contrasted to an 1115 demonstration, which some states, they'll have to cover family planning services only, or the family planning group, which covers a very narrow range of benefit package.

Sarah deLone: But the rule under the regulation is that beneficiaries receiving tier three coverage, of course, they would need to be transitioned to tier one or two, if they become eligible for tier one or tier two coverage, which is more robust. That's the same as the rule for tier one and tier two. However, if the person loses eligibility for one tier three group, and obtains eligibility for another tier three group, the beneficiary must be continued in the original tier three group, unless they voluntarily say, "No, I want that other coverage. I want to move to the other group that I'm eligible for, the other demonstration that I'm eligible for."

Sarah deLone: So that's the basic difference. Tier one and tier two, states can move you within the tier or move you up a tier. Tier three, you can move up, but states can't move somebody within tier three unless they agree to the change because it provides a benefit package that's actually going to be better for them. Next slide, please.

Sarah deLone: Okay, so as I mentioned earlier, when talking about individuals who are not validly enrolled, there are some cases in which a beneficiary's enrollment can be terminated before the end of the month in which, who are validly enrolled, beg your pardon, without impacting the state's ability to claim the temporary FMAP increase.

Sarah deLone: So the exceptions under the regulation to the requirement to maintain somebody's enrollment in Medicaid is one, the individual is no longer a resident of the state;

two, the individual dies, the beneficiary dies; or three, the individual requests a voluntary termination. An important reminder again, is that even with these exceptions, states have to provide advance notice and fair hearing rights before terminating an individual's eligibility. Next slide, please.

Sarah deLone: So, related to the state residency exception, we recognize, and a number of states have asked us what to do in the situation of an Interstate

Public Assistance Reporting Information System (PARIS) match, which may identify beneficiaries who are enrolled in a public benefit program in more than one state, and what should states do in that situation?

Sarah deLone: So, I think some of the uncertainty arises, rightfully so, because a PARIS match does not actually provide definitive evidence that a person lives in one state or another. We know that they live in one of the two states, very, very high probability they live in one of the two states, but PARIS match doesn't tell you which state the person still lives in and which state they may have recently moved from. So under existing Medicaid regulations, when a state receives an Interstate PARIS Match indicating potential residency in another state, the state must follow up with a beneficiary to determine whether in fact the individual is still a state resident.

Sarah deLone: The interim final rule addresses a situation in which beneficiaries who fail to provide information needed by the state to confirm state residency following a PARIS Match. So what should a state do when it gets the match, don't know what state, if this person still in my state, reach out to the person, ask for some proof of state residency, and don't get anything back?

Sarah deLone: Under ordinary circumstances, absent the FFCRA conditions, that person would be terminated for failure to provide information needed by the state to make a determination of state residency. Here, the state has a lack of information, doesn't know which state the individual actually lives in. And so under the rule, the rule provides that for purposes of section 6008(b)(3) of the FFCRA, they can consider a beneficiary to be a nonresident, for purposes of that exception, allowing you to terminate enrollment in the following situation.

Sarah deLone: So first, three things have to be present. First, the beneficiary has been identified through PARIS, has enrolled in a public benefit program in another state. Second, the state has taken other reasonable steps available to it to attempt to verify the individual's residency, but has been unable to do so. And third, the state has asked the beneficiary for information but the beneficiary has not responded to the state's request for additional information to verify residency. In that case, for purposes of section 6008(b)(3), the state can consider the person no longer a state resident, and terminate their enrollment.

Sarah deLone: However, if a beneficiary's eligibility is terminated in this situation, and the state later obtains, or the beneficiary provides information verifying their state residency, the beneficiary's enrollment needs to be reinstated back to the date of termination. And once again, as with all situations where somebody's eligibility is being terminated, using the address that you have on file, or if it's through

electronic notification, if that's been the person's election, you have to provide advance notice and fair hearing rights. And next slide, please.

Sarah deLone: Last but not least, it's important to emphasize that effective with this interim final rule, which we understand is likely to be effective tomorrow, is when we hear it, it will probably be on display tomorrow, but we'll need to confirm the effective date later as soon as that's actually happened. But as soon as the rule is effective, states are permitted to make changes to beneficiary coverage.

Sarah deLone: So for example, eliminating optional benefits or moving, if somebody moves from one group to another that involves a change in a loss of benefits, again, that's fine. So, states can make changes that impact beneficiary coverage, cost sharing, beneficiary liability for institutional or long-term services and support under the PETI rules, without violating the continued enrollment condition in FFCRA 6008(b)(3), provided that the person stays in the same tier or better tier of coverage. And also obviously, those changes have to be otherwise permitted under the Title 19 and implementing regulations. And these same rules also apply to somebody whose coverage is in through a section 1115 demonstration, or a waiver authorized under section 1915 of the Act. And that is all I have, so thank you very much.

Jackie Glaze: Thank you, Sarah, and thank you, Melissa, so much for your very helpful presentation today. So now we're ready to take questions on the IFC or any other questions that you may have for us today. So, since we're using the webinar platform, we'll start by taking your questions through the chat function first. And I already see some questions now, so those of you that would like to use this function, you can send your questions to us now. And then we will follow by taking any questions over the phone line. So we'll begin by taking the questions now from the chat.

Ashley Setala: Okay, great. So we have a few questions that have come in so far on the MLE provisions of the IFC. And the first is, "If a state evaluates that renewals were done at agency error since March 18th, will the state be subject to return FMAP for the time period that the beneficiary should have been terminated from services?"

Sarah deLone: So if a renewal was done after March 18th, 2020, if I'm understanding the question correctly, the state should not be terminating that people there's no correct or incorrect renewal at that point, for purposes of the continuous coverage requirement. That person would have been correctly enrolled as of March 18th, as of whatever the prior renewal or the initial application determination, and the state would need to retain that person's coverage. If they have been terminated erroneously, the state should reinstate that person's coverage so that they can claim the 6.2 percentage point bump.

Ashley Setala: Okay, great, thanks. And then the second question is, "Our Medicaid program provides tier one coverage, and currently we are keeping children who have become adults during the public health emergency in a children's program, but are understanding that they can now move them to an adult program that is also a

tier one, even though they will no longer receive EPSDT services. Can you confirm that that's correct?"

Sarah deLone: Yes, that is correct. So an EPSDT, so yes, as soon as they... I mean, I would say also an individual who is in the adult group, maybe at age, which is not going to be common, but who's under 21, once that person hits 21, the EPSDT benefit will no longer be available to that person. But the scenario painted, yes, move them from the children's group to the adult group, as long as the individual is now 21, right. They keep EPSDT if they're in the adult group and under 21, but if they have hit the age 21 mark, EPSDT would no longer be available.

Ashley Setala: Okay, great. And then the next question is, "Is buy-in only, such as QMB coverage, included in tier one, and can someone go from having full Medicaid coverage to having buy-in MSP only?"

Sarah deLone: Yes, that is permissible. That person actually continues to have MEC through the Medicare program, and I'll also note that buy-in coverage in the MSP groups is not coverage that's carved out of being considered MEC under the IRS regulations. So they actually have MEC still under Medicaid and they have MEC through Medicare, but importantly, they continue to have full coverage that meets the definition of MEC through Medicare, and they are getting their Medicaid wrap. So that's premium with cost sharing, and so that is permitted. Yes.

Ashley Setala: Okay, great. Here is a vaccine question. "Can you clarify coverage of the COVID vaccine? Will states be covering the actual cost of the vaccine or is it going to be covered by federal funding?"

Melissa Harris: Thanks for that. This is Melissa. In the provisions of the interim final rule and in the toolkit that we released yesterday, we're talking about provisions for the administration of the vaccine. So we're talking about the services of a pharmacist, or a physician, or whoever in the state is actually delivering the vaccine. And so we're reimbursing for the time of the professional to do that.

Melissa Harris: We are operating under the premise, as has been made public in multiple press releases, that the cost of the vaccine itself will be covered by the federal government. And so that is why the information that you saw get released yesterday includes many, many references to the administration of the vaccine, because that is the perspective of the coverage information that we're talking about.

Ashley Setala: Okay, great. Another question, "If the current PHE ends on January 20th, 2021, and in accordance with the MLE requirement, when can we reinstate the cost sharing provision?"

Sarah deLone: So the cost sharing can be reinstated effective, the date that the interim final rule is effective. So and as I said, that date will be when it goes on display, which it has not happened yet, but should happen shortly.

Ashley Setala: How about if-

Sarah deLone: Just a note, one note, is for the COVID testing and treatment services, that cost sharing needs to, you need to continue that exemption under the 6008(b)(4) provision, but that's a separate condition for receipt of the 6.2 percentage point. I'm sorry, Anne Marie.

Anne Marie Costello: I'm sorry, just give me a sec. Ashley, maybe you could just say the question again. I thought it was tied to the end of the public health emergency, and maybe Sarah, that's where you were going? So can we just double check?

Ashley Setala: Yes, it was. Yes, it was. It was tied to the PHE ending.

Sarah deLone: Oh, so the PHE ending, so the question is about the cost sharing waivers for COVID testing and treatment services under 6008(b)(4). That condition to claim the increased FMAP goes through the end of the quarter, in which the PHE and the calendar quarter. So if the PHE ended at the end of January, as currently scheduled and it's not extended, then that requirement would go through the end of March, and cost sharing for those services could begin, again, effective April 1st.

Ashley Setala: Okay, and then another question, "Can you confirm that members who were enrolled erroneously due to the member's inaccuracy or reporting error, but who are not convicted of fraud and do not have a formal abuse finding, must be maintained?"

Sarah deLone: Yes, they must be maintained. If a person makes an honest mistake, and they haven't been either convicted of fraud or suspected foul play and gone through a process and found that they've actually intentionally sort of abused the Medicaid program in that way. If they've made a mistake, the state has verified that information in accordance with its verification plan, that person is validly enrolled, and their coverage must be maintained in the tier that they were enrolled in, or a more robust tier, if their circumstances change through the end of the month in which the PHE ends.

Jackie Glaze: Ashley, do you want to take one more question and then we'll move to the phone lines?

Ashley Setala: Sure. Here, "If a state is providing a Medicaid member with premium assistance for ESI, is it permissible for the state to end the PA if the member becomes eligible for Medicare?"

Sarah deLone: It's going to depend on a regular premium assistance program. There's different premium assistance programs, so to give a comprehensive answer, can we make sure to get that person's name so we can circle back and find more about their particular premium assistance program?

Ashley Setala: Sure we can do that.

Sarah deLone: Thanks.

Jackie Glaze: Okay, thank you. So let's move now to the phone. So operator can you provide instructions to the audience on how to ask their questions, and then open up the phone lines, please?

Operator: Absolutely. As a reminder, to ask a question over the phone, you will need to press star followed by one on your telephone keypad. Again, that is star one. To withdraw your question, just press the pound key. Your first question comes through the line of Patrick Beatty. Your line's now open.

Patrick Beatty: Yes, this is Patrick Beatty from Ohio. Quick question. If you've got a premium assistance member who loses their Medicare eligibility, what does the state need to do in that case, there's no premiums to pay.

Sarah deLone: So you've got somebody who's Medicare, and they're in a QMB group, let's say, or they're in a whatever group, and they lose eligibility for Medicare, you would need to... So I want to differentiate potentially two different scenarios. One, say that's the group that they were in when March 18th, 2020 rolled around, or that's the initial group that they were enrolled in after that date. You would need to keep that person, in the event that they become eligible for Medicare again, and we're still in the period covered by 6008(b)(3), so through the end of the month in which the PHE ends, then you would need to have that person still in your system to begin the Medicare premiums and cost sharing again.

Sarah deLone: So there's nothing, you're right, there's nothing for you to provide because there's no Medicare coverage for you to wrap with the premiums or benefits, but if they become eligible for Medicare again, then it would resume. Does that make sense?

Patrick Beatty: Yeah, yeah. Thank you.

Sarah deLone: And I think it makes, in the case, I think this is probably a highly unlikely scenario, but where somebody say, went from a full Medicaid group into an MSP category and then lost their Medicare, this is probably a blue moon, less frequently than that, then they should go back to their tier one coverage that they were in before as a regular Medicaid beneficiary.

Patrick Beatty: Okay, that sounds good.

Operator: Your next question comes through the line of Goyal Arvind. Your line's now open.

Arvind Goyal: Yes. Thank you very kindly. Arvind Goyal, a medical director, Illinois Medicaid. My question is specific for COVID-19 vaccine distribution. You did say in your comments, I believe, that providers do not necessarily have to be enrolled within the program to be able to administer the vaccine, and if I misheard it, please correct me, but my question is that, COVID-19 vaccine distribution on a fast pace might require use of new providers, such as pharmacists, community health workers, et cetera, who may or may not be enrolled within the Medicaid program. So is there any guidance on that?

Melissa Harris: Thank you. This is Melissa Harris, and I will clarify that in order to be reimbursed in the Medicaid programs, individuals who would be administering the vaccine to Medicaid beneficiaries do need to be enrolled as a provider and have a valid and executed program agreement or provider agreement with the state.

Melissa Harris: We have a little bit of information about that in the toolkit that was released yesterday. There was some language about some flexibilities that a state can use that are available at all times, particularly for providers who are enrolled in the Medicare program. There are some flexibilities that a state can bring to enrolling such providers to not repeat some of the screening activities that the Medicare program has done. CMS is also available for state-specific technical assistance on ways to streamline the enrollment of providers. There's also a fair amount of discretion at the state level in terms of who or what cohort of providers a state wants to authorize to deliver the COVID vaccine.

Melissa Harris: You probably have seen some guidance around pharmacists, pharmacy techs, pharmacy assistants, being able to deliver the COVID vaccines. There might be some additional clarification coming out about that soon. But in addition to the traditional providers that states have been using to deliver immunizations in some of the more primary acute care settings. So certainly, we're encouraging states to cast a wide net, to make sure they have enough providers at the ready to be able to deliver the COVID vaccine to as many people as possible, but all of those providers will need to have a provider agreement with the state and be enrolled.

Melissa Harris: There's also some information in the toolkit about whether a state plan amendment is necessary, both during the public health emergency and after the public health emergency, to make sure your state plan is all set up and established to correctly describe the providers and the practitioners that you are authorizing to deliver the vaccine.

Arvind Goyal: Thank you very kindly.

Operator: Your next question comes to the line of Jessica Drenning. Your line is now open.

Jessica Drenning: Hello, Jessica Drenning from Health and Human Services in Maine. If we have individuals who are enrolled in tier one coverage, who then become ineligible, but eligible for tier one coverage with a fee, can you confirm if it's okay to move them to that tier one program?

Sarah deLone: So, the fee is a premium, there's a different requirement and there's a different condition that we didn't talk about today that's in 6008(b)(2) and that prohibits imposing a higher premium on somebody. So the answer, in terms of being able to apply a premium, you can move them to the new coverage group, but you could not apply a higher premium to them without violating. You'd be fine under 6008(b)(3), but you would not be okay under 6008(b)(2). So higher cost sharing would be okay, but not the premium.

Jessica Drenning: Thank you.

Sarah deLone: You're welcome.

Jackie Glaze: We can take one additional question. Thank you.

Operator: If anyone wants to ask a question, please press star one. Speakers, I am seeing no further questions in the queue, please continue.

Jackie Glaze: Thank you. So, appreciate all the questions today. I will now turn to Anne Marie Costello for closing remarks. Anne Marie.

Anne Marie Costello: Jackie, I just need one minute.

Jackie Glaze: Sure.

Anne Marie Costello: So I'm not sure if there's anything in the chat that you want to go to.

Jackie Glaze: I know that we do have a few more questions in the chat.

Ashley Setala: Sure, we can do a couple of others.

Anne Marie Costello: We have five minutes.

Ashley Setala: Okay, so, "on the MLE provisions, for the changes within tiers you say permissible, is it permissible or required?"

Sarah deLone: It is required. It is required. There's nothing to override as a federal, regulatory or statutory matter, there's nothing to override a change. So if it, I'm sorry, let me back up and say it differently. So if the regular Medicaid rules would require that you shift somebody, then you must do that, as long as they're within the tier one or within the same tier. So that is the case. And we recognize that some states have, there may be complexity, operational complexities for states in beginning that, and so that's what states should certainly be working towards, but if you have that situation, then you should reach out. But as a policy and legal matter, what you should be doing is, it's a must. Move that person to the other coverage for which they are eligible.

Ashley Setala: Okay, and then "with regard to CHIP, if the person has aged out and is over 19, would we move them into regular Medicaid now, or would we need to keep them there?"

Sarah deLone: So, the 6008 FFCRA conditions do not apply to separate CHIPs. So when a child ages out of CHIP, they should be terminated and if they are eligible for Medicaid, they should absolutely, for example, they might be eligible under the adult group, or a disability group, or any other number of groups, they should be transitioned to that Medicaid coverage group, but the 6008 does not apply to separate CHIPs.

Ashley Setala: Okay, and then, "does this mean that states that find that individuals ineligible for 1915(c) benefits can terminate eligibility for waiver benefits without a penalty and redetermined under another category now?"

Sarah deLone: Yes, as long as somebody remains in the same tier, they can be shifted into another category. I'll note, and I don't know if, I know Gene Coffey was not able to be on today, I don't know if Ralph Lollar is on. So even under the original interpretation, if somebody doesn't, the services, they no longer meet the level of care need for, say, for 217 group, and they don't meet their plan of care, the services that they were getting, they don't actually need them anymore, the states were not obligated to continue to provide coverage of services, which were not available to the person.

Sarah deLone: If there's no other tier one group to move, let's say a 217 group person into, who's eligible for the 1915(c) waiver, they need to keep them in that 217 group. The question is, what services are they going to get? If there's another tier one group that that person becomes eligible for, absolutely, that person should be moved into that other coverage group.

Ralph Lollar: And Sarah, this is Ralph, I concur with what you've just said.

Sarah deLone: Great, thanks, Ralph. It's always to have an endorsement from the real expert.

Ralph Lollar: Yeah.

Anne Marie Costello: Great. And I think we'll close now. Okay. So I really want to thank everyone for today. I especially want to thank Melissa and Sarah for their excellent presentations and really great questions that came from the audience. I think after hearing today's presentations, reviewing the slides, reading the IFC, you all in the audience may have more questions. We'll use a portion of next week's call to answer any of those questions.

Anne Marie Costello: And just as a reminder, you'll soon be receiving an invitation to our next all-state call, where in addition to answering any follow-up questions from today, we'll be discussing CMS' newly released vaccine toolkit. So of course, if questions come up between these calls, reach out to us, to your state leads, or bring the questions to next week's calls. We're here to assist you. Thank you for joining us today, and have a great afternoon.

Operator: Ladies and gentlemen, this concludes today's conference call. Thank you for participating. You may now disconnect.