

Centers for Medicare & Medicaid Services
COVID-19 Medicaid & CHIP All State Call

February 23, 2021

3:00 pm ET

- Operator: Greetings and welcome to the CMCS All-State Medicaid and CHIP call webinar. During the presentation, all participants will be in listen only mode. Afterwards, we will conduct a question and answer session. Participants can ask questions in the chat box at the bottom left of their screen and by phone by dialing one four. Should you require operator assistance at any time, please press star zero. As a reminder, this call is being recorded today. Tuesday, February 23rd, 2021. I would now like to turn the call over to Jackie Glaze. Please go ahead.
- Jackie Glaze: Thank you. Good afternoon everyone and welcome to today's all-state call and webinar, and thank you everyone for joining us. First up today, John Giles from our Disabled and Elderly Health Programs Group will provide some managed care updates. John will give an overview of a State Medicaid Director letter released in January 2021 that provides guidance to states on standards and documentation for Medicaid managed care state directed payments. He will also provide reminders on some of the operational information associated with vaccine administration outlined in our vaccine toolkit. After John's presentation, we'll take your questions. Then Shondelle Wilson-Frederick from our Children and Adults Health Programs Group (CAHPG) group will present on a new report issued by CMCS on Medicaid and CHIP beneficiaries with Sickle Cell Disease.
- Jackie Glaze: This report represents another innovative use of T-MSIS data and is the first ever comprehensive national and state level portrait of Sickle Cell Disease and Medicaid and CHIP beneficiaries. After Shondelle's presentation, we'll open up the lines for your general questions. I'll note that we will use a webinar for the second presentation today, so if you're not logged into the webinar platform, I would suggest that you do so now. With that, I'll turn things over to John Giles to start his presentation. John.
- John Giles: Thank you Jackie and good afternoon everyone. Today, we wanted to provide a couple of managed care updates related to recently published guidance. Specifically, we wanted to provide a brief update related to the managed care vaccine administration language that was included in the December 17th update to the vaccine toolkit. We also wanted to provide a brief overview of the recent state Medicaid director letter on state directed payment as well as the revised preprint that were both published on January 8th of 2021. First, I will start with the updates to the vaccine toolkit. In the December update, we included new language starting on page 23 of the toolkit that provides options for states to incorporate COVID-19 vaccine administration in their managed care programs. Generally reimbursement for vaccines and associated administration may be specified by the state in a Medicaid managed care plan contract, subject to the approval requirements for state directed payments in 42 CFR 438.6(c) or may be determined by the managed care plan.

John Giles: To the extent that Medicaid managed care plans are contractually responsible for covering COVID-19 vaccines for their managed care enrollees, they must cover only an administration fee for the COVID-19 vaccine. In the event the approved capitation rates are not sufficient to cover the cost of the vaccine administration, states may wish to pursue actuarially sound rate adjustments. States can amend their risk-based capitation rates to include an adjustment for these costs if such an adjustment is actuarially sound and subject to compliance with federal requirements for rate development. States can also pay for the administration of the COVID-19 vaccine outside of the Medicaid managed care capitation rates as a non-risk payment arrangement subject to the requirements for upper payment limits as specified in federal regulations, consistent with the requirements for a non-risk contract. States also have the option to carve this benefit out of Medicaid managed care program and contracts and pay for the administration of the COVID-19 vaccine under their fee for service programs. States should carefully analyze and assess whether this approach will necessitate any file submissions to CMS.

John Giles: This approach is similar to how coverage for COVID-19 vaccinations administered during calendar years 2020 and 2021 for Medicare beneficiaries enrolled in Medicare advantage plans will be provided by the Medicare fee-for-service program. As states consider these various approaches related to reimbursement of the COVID-19 vaccine administration, we strongly urge states to analyze and assess their current Medicaid managed care contracts and capitation rates for any necessary revisions or amendments. States should also consult with their actuary for any potential impacts to managed care plans capitation rates. States are required to submit all managed care contract actions, rate certifications, and state directed payment preprints to CMS for review and approval. As always, we will work with states to prioritize and expedite CMS's review and approval of any necessary changes to managed care contracts or rate certifications due to the COVID-19 public health emergency.

John Giles: Next I will provide a brief overview of the recent Medicaid managed care state directed payments guidance, including the revised preprint that we published in early January. As many of you know, state directed payments have become increasingly popular in Medicaid managed care contracts and capitation rates since we published the original regulation in 2016. To date, CMS has reviewed and approved more than 500 state directed payment arrangements across 39 states. During our review and approval of these payment arrangements, some common issues have arisen that we believed required additional guidance and clarification. Therefore in publishing the January guidance, we had a couple of goals in mind.

John Giles: First to clarify what is considered a state directed payment. Second to alleviate burden on states by proactively addressing common questions that arise during the preprint review process. Three, enhanced program and fiscal integrity in the use of state directed payments. And finally to provide important reminders about the quality related requirements associated with state directed payments. We also included a revised preprint form that has been updated to include more information in tables and checkbox format to make completing the preprint both easier and clearer. Much of this information was previously requested during the review process through follow-up questions. So we are hopeful that by including more information in the revised preprint,

that CMS can reduce processing times as well as the number of follow-up questions sent to states.

John Giles:

While much of the guidance should be familiar to states related to the federal requirements associated with state directed payments, there are a few areas to highlight. First, related to a clarification regarding which arrangements are considered state directed payments. This new guidance revisits previous guidance that was issued in November of 2017 and clarifies that general contract requirements for provider payments that provide or add an amount to the contracted payment rates, but the provider payments are not clearly and specifically related to the utilization and delivery of a specific service or benefit provided to a specific enrollee under the contract, must either be classified as state directed payments or pass through payment in accordance with federal requirements. We did provide several examples of these arrangements in the published guidance. CMS will begin applying this guidance for contract rating periods that began on or after July 1 of 2021.

John Giles:

Second, CMS provided guidance related to a new centralized mailbox for processing state directed payment preprints. We strongly encourage states to submit preprints for state directed payments at least 90 calendar days in advance of the start of the rating period that includes the state directed payments. The preprints should be submitted to the new mailbox, StateDirectedPayment@cms.hhs.gov. And as a reminder, the regulations do not permit new state directed payments for rating periods that have ended. Third, I would highlight the section on incorporating state directed payments into managed care capitation rates. While there currently remain two ways that states can incorporate state directed payments into capitation rates, either through adjustments to the base capitation rates as an adjustment to the rate or through a separate payment term, we are intending to require additional documentation and justification from states as to the rationale for incorporating state directed payments through means other than adjustments to the base capitation rate as part of the preprint review process.

John Giles:

Finally, in addition to the guidance, we've released the revised preprint. The revised preprint will be required for all state directed payments that require prior approval to contract rating periods that began on or after July 1 of 2021. States are welcome to use the revised preprint earlier to facilitate review of a state directed payment. Although the preprint is longer, it is much more structured and organized and we believe will greatly reduce the number of follow-up questions needed during the review process. One note, the preprint is now smarter in that as the preprint is completed, certain check boxes and tables will become available as required based on the information entered. So for example, only certain questions are required for a fee schedule arrangement while other questions will be required for quality-based payment arrangement. As always, if you have any policy questions related to state directed payments or require some technical assistance, please feel free to contact CMS directly using the new state directed payments mailbox. And with that, I am happy to conclude and start taking questions. Thank you. Jackie, I think I'll turn this back to you.

Jackie Glaze:

Great. Yes. Thank you John and thank you for your presentation. So as John indicated, we're ready to take your questions now on the managed care updates that he did provide. So we'll begin by using the chat function so you can begin submitting your questions now and then we will follow by taking a few questions over the phone line.

- Operator: And as a reminder to all, to register for a question over the phone lines, it is one four on your telephone keypad. You'll hear a three tone prompt to acknowledge that request and your line will then briefly be accessed from the conference to obtain information. Once again, one four on your telephone keypad for questions over the phone.
- Ashley Setala: So it looks like we have our first question in the chat box and it says, given the dynamic format of the preprint, will there be a version of the preprint available to states so we can see the full list of questions needed to prepare our submission in advance outside of the system?
- John Giles: Thank you for that question. So the preprint that is on Medicaid.gov is the entire preprint and you will be able to see all of the questions. One of the issues that we have heard from states is, sometimes they were going in and wanting to work on just certain sections of the preprint and they would find that the box may not be available to type into. And generally that's been because there needed to be a selection above that question such as selecting the fee schedule or selecting another checkbox that would then open that question up for being completed. So all of the questions are available and you can print the entire version of the preprint and see it in its entirety, it's just that the preprint is designed to be intuitive. So as you check boxes and complete components of the preprint, it then opens up additional questions that may be required because of the content that has been entered.
- Ashley Setala: Okay. Thanks John. And we have I think one more written question. It says, our state's exploring a couple of different ways in which we would like to provide incentive payments to our EPCCM and MCOs for performance on getting Medicaid members vaccinated for COVID. How can we get more information on this?
- John Giles: Sure. So I think there was a couple of things to unpack in that question. So I think I would just start by saying the federal requirements regarding incentive payments for PCCM entities and MCOs or other managed care plans do differ slightly so I'll broadly talk about them separately. So for managed care plans, so this is the MCOs, PIPs, or PAPs. The requirements found in 42 CFR 438.6(b)(2), so B as in boy two, would apply to those incentive arrangements under managed care contracts. And this would include requirements such as those incentive payments to those plans cannot exceed 5% of the approved managed care capitation rate and it would also include a few other requirements. So the contract must provide that the incentive arrangement is for a fixed period of time and performance needs to be measured during the rating period under which that contract would apply. The incentive arrangement needs to be available to both public and private plans using the same terms of performance.
- John Giles: And the incentive payments need to be for specified performance measures or quality-based outcomes as included in the state's managed care quality strategy. And of course, for these kinds of times of managed care incentive arrangements, states would need to include the incentive arrangement in both the managed care contract as well as the rate certifications and submit those to CMS for review and approval. Related to PCCM entities, slightly different. So the requirements are found at 42 CFR 438.3(r) as in rabbit, and those apply specifically to PCCM entity contracts. So a state that was interested in implementing an incentive arrangement with their PCCM entities, would

amend that contract and include the incentive arrangement and submit that contract to CMS for review and approval.

- John Giles: I think the thing to note for those contracts is that for PCCM entity contracts that include incentive payments, additional quality related requirements will be triggered during the review of that contract and that would include things such as quality assessment and performance improvement, including the submission of performance measurement data as well as requirements related to the development of a managed care quality strategy and external quality review. So there is a few extra quality requirements that would kick in based on that being a contract that would include an incentive arrangement. And of course we can give targeted technical assistance if needed for either one of those incentive arrangements.
- Ashley Setala: Okay. Thanks John. We have one more question that's come in through the chat and it says, it sounds like separate payment terms will remain an option but with additional documentation and justification requirements. Can you speak to what kind of justification reason CMS is looking for?
- John Giles: Sure. So I don't know that we have a list of acceptable rationale. I would note that I think the State Medicaid Director Letter does a fairly nice job of laying out some of the concerns that we have around separate payment terms, largely just driven off the basis that they're not completely consistent, at least from CMS's perspective with the nature of a risk-based contract and some of the other behaviors that could be attributed to separate payment terms. And so I think we described that in the State Medicaid Director Letter. I think at this point, correct, they are still a permissible way to incorporate and implement a state directed payment through the capitation rate.
- John Giles: I think CMS is really interested, because we have these concerns and because separate payment term do feel the removal of risk out of the contract, I think we're really interested in collecting that information from states so that we can better understand why states are continuing to use them as well as the uptick that we've seen. We've seen a lot more states moving in the direction of separate payment terms and I think we're trying to understand why that is. So I think that's the purpose for collecting additional documentation and rationale from states during the review process because we want see if some of that rationale might help inform our thinking moving forward.
- Jackie Glaze: Thank you, John. We'll check the phone lines to see if we have a question or two there and then we'll move on to the next presentation. Operator, will you open up the phone lines please?
- Operator: Yes. Thank you. We do have one question. It comes from Krisann Bacon. Your line is open.
- Krisann Bacon: Hi. I apologize. These are general questions that weren't related specifically to this section, but the first question, I had two, the first question is, a couple of weeks ago someone had mentioned that CMS was developing a crosswalk for these calls I think by topic and I was just curious if you're planning to release that anytime soon or is that still even a plan to have something like that?

- Jackie Glaze: Hi, this is Jackie Glaze and I'll try to respond to your question. We are asking for states to provide topics for future calls but we haven't actually developed a crosswalk as to what those topics would be. Ashley, is that something that you're working on or can you respond to that?
- Ashley Setala: Sure. So my memory is failing me a little bit but I will need to confirm with another staff member. I believe that we did send out a listserv that identified some of the topics that we discussed in the Q&A sessions over the last few months but we'll need to confirm that, and then are also thinking about whether we can make additional updates to our COVID page where the calls are posted to make it clear which topics were discussed on which days so more to come hopefully there in the future.
- Krisann Bacon: That's great. And I just had one other question about vaccine administration. So we've been discussing the cost sharing component and waiving the cost sharing component. And as our state looks to widen vaccine administration distribution, the question came up that with associated procedure codes such as an ENM, normally we would bundle the vaccine administrations into those. Is there a specific guidance on that? Should we be looking to waive copays for additional procedure codes like ENMs as maybe physician offices look to start administering vaccines or is there guidance on that?
- Jackie Glaze: Is Kirsten Jensen on the line or someone from the Division of Coverage and Benefits that can respond?
- Melissa Harris: I'm sorry Jackie, this was Melissa Harris. Kirsten is not on today. I'm sorry, would you mind repeating the question?
- Krisann Bacon: Sure. So as our state looks to widen vaccine distribution, potentially to physician offices in a few months, should we be looking at waiving cost sharing for associated ENM codes? I know we have to waive them for the vaccine administration codes and make sure that there's no cost sharing but we had the question come up, what about associated visits or things like that?
- Melissa Harris: Well, I've made you repeat the question and now I'm going to tell you I don't know the answer to it. I'm wondering if we have any of our colleagues from the Children and Adults Health Programs group on who can take the cost sharing question?
- Sarah deLone: I think we don't. I think we're going to have to take it back. I think we were not anticipating, we don't have the right subject matter experts on the call right now. So if you could send your question in to your state lead, we can be sure to get an answer back to you.
- Krisann Bacon: Okay. Thank you.
- Sarah deLone: Thanks.
- Jackie Glaze: Thank you for your questions. So at this time, we'll move on to the next agenda topic and Shondelle Wilson-Frederick will present on the report that was recently issued from CMCS on the Sickle Cell Disease. Shondelle.

Shondelle Wilson-Frederick: Thank you. So today I will describe two recently released innovative CMS data products that highlight adults and children living with Sickle Cell Disease enrolled in Medicaid and CHIP. These materials were developed in collaboration with the Centers for Disease Control and Prevention and Mathematica, and they can easily be used by states and stakeholders to better understand the Medicaid and CHIP population with Sickle Cell Disease. Sickle Cell Disease represents a group of inherited red blood cell disorders. A child gets Sickle Cell Disease when he or she receives two sickle cell genes, one from each parent. Sickle Cell Disease causes the body to produce blood cells shaped like crescents or sickles rather than disks. The sickle shaped blood cells are unable to properly deliver oxygen to body tissues and lead to extraordinarily painful and severe attacks known as crises. People living with Sickle Cell Disease often experience long-term health challenges such as stroke, acute chest syndrome, and organ damage.

Shondelle Wilson-Frederick: It is estimated that Sickle Cell Disease affects approximately 100,000 Americans. Sickle Cell Disease can impact all racial and ethnic groups. In the United States Sickle Cell Disease disproportionately impacts blacks and Hispanics. CMS is committed to raising awareness about special populations of Medicaid and CHIP beneficiaries such as those with Sickle Cell Disease. However, at present a national Sickle Cell Disease surveillance system does not exist. To address this gap and data availability and to improve the quality of care for people living with Sickle Cell Disease, CMS used the 2017 T-MSIS Analytic Files also known as TAF to produce national and state level Sickle Cell Disease prevalence estimates for adults and children enrolled in Medicaid and CHIP. The 2017 TAF version four data where the most currently available TAF at the time of production. In January 2021, CMS released the groundbreaking Medicaid and CHIP Sickle Cell Disease report. This report is the first ever comprehensive national and state level portrait of Sickle Cell Disease among adults and children enrolled in Medicaid and CHIP who are under age 76.

Shondelle Wilson-Frederick: It also provides detailed information on various demographic, health, and health care utilization characteristics among Medicaid and CHIP beneficiaries with and without Sickle Cell Disease. Beneficiaries with Sickle Cell Disease were defined as individuals with at least two claims with a Sickle Cell Disease diagnosis and 12 continuous months of enrollment with full Medicaid or CHIP benefits in 2017. Beneficiaries without Sickle Cell Disease were defined as individuals with no claims or only one claim with the Sickle Cell Disease diagnosis and 12 continuous months of enrollment with full Medicaid or CHIP benefits in 2017. Age was assigned using each beneficiary's age as of December 31st, 2017. The report consists of key findings and five sets of detailed data tables covering a specific aspect of beneficiaries with Sickle Cell Disease, including demographic and geographic characteristics, recommended care for Sickle Cell Disease, health care utilization, preventive care, and other health conditions.

Shondelle Wilson-Frederick: One of the signature features of the Sickle Cell Disease report is the amount of granular information presented at the state level and by age category for adults and children. In 2017, the national prevalence was 74 beneficiaries with Sickle Cell Disease per 100,000 Medicaid and CHIP beneficiaries. The State prevalence of Medicaid and CHIP beneficiaries with Sickle Cell Disease range from fewer than 50 per 100,000 beneficiaries in 24 states and Puerto Rico to 150 or more per 100,000 beneficiaries in five States; Alabama, Georgia, Louisiana, Mississippi, South Carolina, and the District

of Columbia and the U.S. Virgin Islands. 54% of Medicaid and CHIP beneficiaries with Sickle Cell Disease lived in eight states; California, Florida, Georgia, Illinois, Louisiana, New York, North Carolina, and Texas. Nearly 30% of Medicaid and CHIP beneficiaries with Sickle Cell Disease lived in the South Atlantic census division compared to 15% of beneficiaries without Sickle Cell Disease.

Shondelle Wilson-Frederick: Additionally, the report includes information on various health conditions that are most common amongst children and adults with and without Sickle Cell Disease by age categories. Among beneficiaries with Sickle Cell Disease, 19% of children had asthma, nearly a third of adults between the ages of 21 to 45 had fibromyalgia, chronic pain, and fatigue and half of adults aged 46 to 75 had hypertension. Whereas the most common health conditions among the beneficiaries without Sickle Cell Disease included; 4% of children having asthma, 14% of adults aged 21 to 45 had depression, and 31% of adults aged 46 to 75 had hypertension. The Sickle Cell Disease report includes detailed information on healthcare utilization stratified by age category for beneficiaries with and without Sickle Cell Disease.

Shondelle Wilson-Frederick: This slide highlights information on emergency department (ED) utilization. 23% of Medicaid and CHIP beneficiaries with Sickle Cell Disease had six or more ED visits in 2017 compared to 2% of those without Sickle Cell Disease. Children with Sickle Cell Disease between the ages of 13 to 20 have the highest rates of 20% of six or more ED visits compared to 1% of similar age children without Sickle Cell Disease. Adults with Sickle Cell Disease between the ages of 21 to 30 have the highest rate of 43% of six or more ED visits compared to 3% of similar age adults without Sickle Cell Disease. Transcranial Doppler (TCD) Screenings are used to identify children with Sickle Cell Disease who are at risk for stroke. Overall less than 40% of Medicaid and CHIP beneficiaries ages three to 16 with Sickle Cell Disease had at least one TCD screening in 2017.

Shondelle Wilson-Frederick: However, upon examination by age group, greater variability is observed. 41% of children aged three to five and 40% of children, age six to 12 received a TCD screening in 2017, however less than 30% of children between the ages of 13 to 16 received a TCD screening in 2017. Hydroxyurea is one of three FDA approved therapies for Sickle Cell Disease and the report includes information on hydroxyurea utilization by age and categories of 90 day utilization. Amongst children between the ages of 21 months to 20 years, 7% received more than 270 days of hydroxyurea compared to 9% of children ages six to 12 years and 5% of children between the ages of 13 to 20. Among adults between the ages of 21 to 75, 4% received more than 270 days of hydroxyurea compared to 4% of adults aged 21 to 30 and 6% of adults between the ages of 46 to 54.

Shondelle Wilson-Frederick: As shown on this slide, the sickle cell report includes the first TAF-derived national estimates on antibiotic prophylaxis in children with Sickle Cell Disease who are enrolled in Medicaid and CHIP. Antibiotic prophylaxis is recommended to decrease the risk of invasive pneumococcal disease. For this figure, the number of days of antibiotic prophylaxis reflects the number of calendar days in 2017 that a beneficiary was covered with the prescription for antibiotic prophylaxis. Our analysis shows that 11% of Medicaid and CHIP beneficiaries aged 15 months to four years with Sickle Cell Disease had 300 or more days of antibiotic prophylaxis in 2017. To our knowledge, the Sickle Cell Disease report is the first HHS-produced detailed report that solely uses TAF data

to highlight Sickle Cell Disease. It is also the first presentation of TAF-derived estimates for antibiotic prophylaxis among children with Sickle Cell Disease enrolled in Medicaid and CHIP.

Shondelle Wilson-Frederick: So in commemoration of national Sickle Cell Disease awareness month, CMS developed the inaugural at-a-glance Medicaid and CHIP beneficiaries with Sickle Cell Disease TAF 2017 infographic. This Sickle Cell Disease and for graphic was released during the September 15th, 2020 White House Sickle Cell Disease roundtable. The Sickle Cell Disease infographic highlights selected information from the Sickle Cell Disease report in a two page format, for example, 43% of Medicaid and CHIP beneficiaries with Sickle Cell Disease were over age 20, three and 10 beneficiaries with Sickle Cell Disease age 21 to 64 were dually eligible for Medicare and Medicaid, and nearly six and 10 children under the age of two received a pneumococcal vaccination in 2017. The Sickle Cell Disease infographic also includes information on recommended preventive care and children. More than half the children with and without Sickle Cell Disease have at least one health screening and dental examination. However, when these items are shown by age category, we can see in greater detail the potential for targets for improvement.

Shondelle Wilson-Frederick: As previously mentioned, the infographic includes information on utilization among beneficiaries with and without Sickle Cell Disease. On average, beneficiaries with Sickle Cell Disease had five times more ED visits than those without Sickle Cell Disease in 2017. On average beneficiaries with Sickle Cell Disease had nine times more hospital stays than those without Sickle Cell Disease, and among the beneficiaries, those with Sickle Cell Disease had more than twice the median of outpatient visits than those without Sickle Cell Disease. Both the Sickle Cell Disease report and infographic represents an important step to advance our understanding of the national prevalence and impact of Sickle Cell Disease since there is no national Sickle Cell Disease surveillance system.

Shondelle Wilson-Frederick: We look forward to partnering with you in advancing quality care for all Medicaid and CHIP beneficiaries, including those with Sickle Cell Disease. In closing, I would like to note that having Sickle Cell Disease increases one's risk for severe illness from COVID-19 according to the Centers for Disease Control and Prevention. It is especially important for people with medical conditions such as Sickle Cell Disease and those who live with them to protect themselves from getting COVID-19. This concludes my presentation. Thank you for your time today.

Jackie Glaze: Thank you Shondelle for your great presentation. We're ready now to take any general questions that you may have or questions you may have from the presenters today. So we'll begin by taking your questions through the chat function followed by the phone lines so you can begin submitting your questions at this point.

Operator: And as a brief reminder to all, if you would like to submit a question or register for a question over the phone lines, please dial one four. Thank you.

Ashley Setala: Okay. So we have a question for Shondelle on the sickle cell report and it says, how can the states use this report to drive improvements in quality of care?

Shondelle Wilson-Frederick: So thank you for that question. I think in particular tables one and two provide state-level information in terms of identifying count of beneficiaries that reside in your respective state with Sickle Cell Disease. I think that would be a key place to start just to get an idea of how many beneficiaries are living within their state with this condition. I think other parts of the report that may be also key features and useful for driving quality improvement would be around preventive screenings so the dental examinations that I mentioned or the preventive health screenings. In particular those two items, we're seeing numbers where we probably could be doing better for both beneficiaries with and without Sickle Cell Disease and so those are two areas in particular that come to mind. And then lastly for sickle cell specifically, there are sickle cell treatments that we've highlighted in the report; hydroxyurea utilization, Transcranial Doppler Screening, as well as antibiotic prophylaxis. So those are the areas that I would recommend as being starting points for states.

Ashley Setala: Okay, thank you. And then we have one other question for Shondelle and it says, are there other resources for states on Sickle Cell Disease?

Shondelle Wilson-Frederick: There are. Of course we have to sell our product so I would definitely start with the report and the infographic and we've included links to both of these products in the slide deck. But the National Academies of Science, Engineering, and Medicine released a Sickle Cell Disease blueprint that is a fantastic report loaded with information. That would be a great resource for states to consider revealing. Also there's different professional societies such as the American Society for Hematology who have recently released some new pain guidelines focused on Sickle Cell Disease which may also be a great resource. CDC has a wealth of information on Sickle Cell Disease. If you simply Google CDC and Sickle Cell Disease, those resources will populate for you as well as the HHS Office of Minority Health. They have a very rich landing page with information on Sickle Cell Disease.

Ashley Setala: Okay, great. Thank you. And then we had a couple of questions come in to our Medicaid COVID-19 email box this week that we wanted to address on the call today. So the first one is for CAHPG [Children and Adults Health Programs Group] and it says, on a recent CMS All-State COVID call, we discussed disregards of assets accumulated during the PHE, and CMCS mentioned states would have to submit a SPA in order to disregard assets, but also that CMCS was looking for information from states on what the disregard would look. Is the SPA that CMCS was referring to accrued SPA that states would have to amend to disregard assets? And if so, which one? Or a slide template that CMS will create based on feedback and information that CMS gets from states there. And if so, when would CMS be releasing this template?

Gene Coffey: Ashley, this is Gene Coffey from CAHPG. I think I can try to take that question and thanks for the question. We have for many months now had a number of states express some interest in disregarding resources that for one reason or another, for those Medicaid beneficiaries were the subject to a resource test has had resources accumulate during the public health emergency. And we are working directly with a couple of states right now in trying to get disregards approved under their state plan consistent with how they want to shape the disregard. But in terms of the particular process, for those States who are interested in incorporating such a disregard of resources that have accumulated during PHE or for any other reason, into their state plans. If a State wants

to limit the application of the disregard to the period of the public health emergency then the disaster SPA template would be the appropriate place for the state to document that particular resource disregard.

Gene Coffey:

If the state wants to extend a such a resource disregard beyond the end of the Public Health Emergency, well, in that case, a state would have to come in with a state plan amendment generally through our macro system and incorporate into the state plan amendment, the reviewable unit corresponding to those eligibility groups to which they want to apply the disregard. Regardless of which a state might choose either again to limit the disregard to the PHE in which the disaster SPA template would be used or to extend it beyond in which case there might be a little bit more work to do. For those states that are interested in either way, for us to provide the most I guess a specific tactical assistance, we just need from each individual state that is interested the parameters of the disregard that they want to apply.

Gene Coffey:

In other words information about how much they want to disregard, is it in a limited disregarded accumulated resources or only up to a certain point they just hypothetically up to \$10,000 or \$20,000. Is it any resources that have accumulated or is it exclusively those resources that accumulated because an individual did not experience a change in his or her post-eligibility treatment of income calculation, or for some other reason. We just need those specifics from each state that's interested in this disregard to help them shape it appropriately and I guess I would be one of the most appropriate people to reach out to for those states that still have any questions about how to incorporate and disregard this type into their state plans.

Ashley Setala:

Okay. Thanks, Gene. The next question then is for MCOG [Medicaid and CHIP Operations Group] and it says, our state has an approved 1135 waiver for provider enrollment provisions and is interested in ending the waiver provision related to the postponement of deadlines for the revalidation of providers. Currently for providers that had revalidation due since March 2020, about half has submitted their revalidation verification. But providers that have not submitted their revalidation verification remain enrolled and we would like to start sending out revalidation notices in accordance with the CMS guidance on resuming normal operations. We want to confirm that we can do this in the phased approach outlined in the state health official letter so resuming normal app operations after the end of the PHE even though we would be resuming the revalidation process prior to the end of the PHE.

Jackie Glaze:

Ashley, this is Jackie Glaze and I can take that one. So yes, in the SHO letter CMCS did recommend the states to consider transitioning back to normal operations in a phased approach. So as you determined that individual flexibilities are no longer needed to address COVID-19, you can begin phasing back and transitioning back to normal operations. So in this case, we did indicate in the SHO letter that states may delay the revalidation due dates by the amount of the time the public health emergency is in place plus six months to allow providers the notification of the new revalidation dates. So I would just suggest if you do determine that you're ready to start returning to normal operations, just notify your providers in advance of when their revalidation verifications are due.

Ashley Setala:

Okay, great. Thank you, Jackie.

Jackie Glaze: Sure.

Ashley Setala: Then we have a question that's come in through the chat for CAHPG on cost sharing and it says, we are preparing to implement the requirements to limit member cost sharing to 5% of family income. While overall, the changes being made are beneficial to members, we have identified instances where the sum of members' maximum monthly cap over a 12-month period may exceed that of our current annual pharmacy copay cap. It has been our understanding and we believe confirmed by the January 2021 FAQs that amendment to the state plan related to such cost sharing changes were permissible and presented no conflicts during the PHE. Could you please confirm if this is correct?

Sarah deLone: Hi, this is Sarah deLone. I don't know if we have Melissa Harris on the phone right now. That sounds like a very state-specific and pretty complicated question and I think that we really need to take that offline and provide some one-on-one TA. So if we can just capture that question or send it to your state lead, we can be sure to stay on the phone with you and provide you the TA that you need.

Ashley Setala: Okay. Thanks, Sarah. And then we have one more question that's come in through the chat and it is also for CAHPG on the COVID-19 testing group, and it says for the COVID-19 uninsured testing group, would CMS consider making SSN optional instead of required? Advocates have told us that requiring SSN creates a barrier and we are unsure if that was a policy decision that can be changed or if CMS does not have any flexibility around it.

Jessica Stephens: This is Jessica Stephens. I will note that the rules around provisions and verification of an SSN for the COVID testing group are the same as they are for any other Medicaid population. So they are required as they would be required outside of the context of the public health emergency and for any other population and for individuals who don't have a social security number, obviously that would not be required, as well as the processes to assist individuals to obtain a social security number and provide coverage in the meantime. So I wanted to clarify that point. And the reason why it is that way is that, this like any other Medicaid eligibility group has many of the same eligibility requirements, there isn't just a special provision carved out particularly for the COVID testing group. But if there are specific questions from a given state about an application that they're using, kindly share with your state lead and we would be happy to talk through them with you.

Jackie Glaze: I'll check the phone lines at this point to see if we have any calls coming in. So operator, can you open up the phone lines?

Operator: Certainly. There are no questions registered at present time. As a brief reminder to all to register, dial one four on your telephone keypad. Thank you.

Ashley Setala: And while we're waiting, we have one last question that's come in through the chat, again for CAHPG, and it says, during the PHE, if a member loses Medicaid eligibility that remains eligible for the Medicare savings program, are states permitted to allow the Medicaid eligibility to close?

- Gene Coffey: This is Gene Coffey from CAHPG. I guess I can try to take that. And Ashley did I hear the last part right? Is the question... Actually, could you just read that last part about the Medicaid closure please?
- Ashley Setala: Sure. It says if a member loses Medicaid eligibility but remains eligible for Medicare savings program, are states permitted to allow the Medicaid eligibility to close.
- Gene Coffey: Well, the answer is that an individual can simply be kept in the Medicare savings program (MSP) eligibility group. Now the MSP eligibility is in fact Medicaid eligibility. It's not just a technicality that the individuals under Medicaid eligibility is being maintained. However, what can be terminated is the individual's coverage in a separate eligibility group that the individual may have simultaneously been eligible under. In the example of individuals who are eligible in one of the Medicare savings program groups, which again are Medicaid eligibility group, such individuals actually can be eligible and involved at the same time in other eligibility groups.
- Gene Coffey: And again, as we've instructed in regulation relating to the maintenance of effort requirements where an individual may have been eligible in an eligibility group, the coverage for which constitutes minimal essential coverage, the individual can be terminated from that eligibility group and transition to a Medicare savings program group if the individual is in fact eligible for one or the MSP groups and by extension, if the individual was already eligible both for the categories in the group and an MSP group and the individual no longer meets the eligibility requirements for the categories in any group, the state can terminate the coverage for the category group provided the safety for the individual and the MSP group towards the individual meets the eligibility requirements.
- Jackie Glaze: Thank you, Gene. And I want to thank the questions from everyone today and also thank our presenters for their excellent presentations and the information they shared with us today. Looking forward, we will meet with you again soon, and the topics and invitations for the next call will be forthcoming. If you do have questions between the next call, feel free to reach out to us, your state leads, or bring the questions to the next meeting that we have. Thanks again for joining us today and hope everyone has a great afternoon. Thank you.
- Operator: And this concludes the conference call for today. We thank you very much for your participation and ask that you please disconnect.