Centers for Medicare & Medicaid Services COVID-19

Medicaid & CHIP All State Call

April 19, 2022
3:00 pm ET

Coordinator: Welcome, and thank you for standing by. At this time, all participants are in a listen-only mode. During the Q&A session, if you'd like to ask a question, you may press Star 1 on your phone. Today's call is being recorded. If you have any objections, you may disconnect at this time. I'd now like to turn the call over to Jackie Glaze. You may begin.

Jackie Glaze: Thank you, and good afternoon and welcome, everyone, to today's all-State call. I'll now turn to Anne Marie Costello, our Deputy Center Director, and she'll provide highlights for today's discussion. Anne Marie?

Anne Marie Costello: Thanks, Jackie. And hi everyone. And welcome to today's all-State call. Today, we have some updates on section 1135 waivers, and program news on Money Follows the Person, but we will spend the bulk of today's time on answering your questions, those that have come in previously, and new questions that you may have today.

Last Friday, we sent an email to Medicaid directors letting you know about an upcoming planned rescission of the section 1135 alternative settings blanket waivers that were issued in response to the COVID-19 public health emergency.

Today, we're joined by David Wright from CMS's Center for Clinical Standards and Quality, who'll provide an overview of the planned rescissions of section 1135 blanket waivers, and the implications to Medicaid section 1135 waivers.

Then Martha Egan from CMCS's Disabled and Elderly Health Programs Group, will provide an overview of a recently announced Money Follows the Person notice of funding opportunity and supplemental services notice. After Martha's update, we'll take your questions for both David and Martha.

Then Sarah O'Connor, and Sarah Spector, and subject matter experts from our Children's and Adult Health Programs Group, will provide responses to some frequently asked questions related to unwinding the continuous enrollment requirement.

Finally, we'll open the lines and take your questions on unwinding or any other topic. We use the webinar for today's Q&A sessions to help us capture all of the questions that come in through the chat. So, if you're not logged in to the webinar platform, please do so now.

With that, I'll turn things over to David to get his presentation started. David?

David Wright: All right. Thanks so much, Anne Marie, and I appreciate you teeing that up. So, I'm the Director of Our Quality, Safety and Oversight Group here at the Center for Clinical Standards and Quality, and we coordinate with Anne Marie's center, as well as the Centers for Medicare on the 1135 waivers.

And to be clear, a couple of broad points. One, the public health emergency is still in effect, and our 1135 authority remains in effect, but as the pandemic has gone on, we have continuously been reviewing the appropriateness and need for certain waivers, and especially as they have more or less relevance as the pandemic has progressed.

And so, what we announced on April the 7th was a termination within 30 or

60 days from that April 7th date, of some specific waivers that we had put into place that we no longer feel are necessary or appropriate.

There's still the opportunity if facilities or States or particular geographic areas believe they have a need for some of these waivers, to contact CMS and request that those waivers be issued on an individual basis, but what we're doing at this point is eliminating the blanket waiver status of these flexibilities. And again, it's really in response to kind of our progression through the pandemic.

So, I'll give you a quick overview of these waivers. They apply to different provider types, mainly to skilled nursing facilities or SNFs, nursing facilities, or NFs, ICF/IDs and inpatient hospice. Those are the ones that were basically covered under this April 7 notification.

And so, some of them that are ending within 30 days include - after 30 days, I apologize, include the wage requirement that allowed facilities to restrict in-person meetings of residents. So, that's been waived.

Certain physician delegation tasks, as well as physician visits within SNFs and also within NFs, we had allowed for certain delegations by physicians to other clinicians within a nursing facility or skilled nursing facility, and we've ended that, as well as the requirement that physicians physically present to do some of these visits.

We had waived the requirement under the quality assurance and performance improvement or QAPI requirement, that nursing homes do a full QAPI assessment to allow them to focus more on infection control and issues more relevant to the pandemic. So, that's being waived within 30 days of April 7th as well.

Some discharge planning provisions were waived during the pandemic that allowed nursing homes to not have to share as much information about post-acute care providers and helping to find placement outside of the nursing home. And we have waived that, and now those are back in place as well.

And certain clinical records requirements such as requiring that facilities provide a resident with a copy of the records within two working days, had been waived as well. And that is, again, going to go back into effect within the next - 30 days after the April 7 notice.

Some waivers that we ended or are ending 60 days post that April 7th declaration include some physical environment waivers. And these were things that allowed SNFs and NFs to expand their location into other buildings that weren't otherwise certified, and mainly to provide for isolation of COVID-positive residents.

So, we are ending that waiver, as well as a waiver that allowed for use of rooms in long-term care facilities that weren't originally designed or specified for residents. We're ending that as well.

We're finding that there's no longer the need or acute need for cohorting and movement of residents based on their COVID status given the high vaccination rate, especially in nursing homes.

And then a lot of the other waivers under this 60-day notice provision really deal with things like fire safety. So, mandated fire safety inspections and some equipment and maintenance that needed to be done.

Those had been waived again. So, facilities both could limit visitors into their

facility, as well as be able to, again, focus on their COVID response. In that same vein, we have waived the requirement for fire drills. And so, again, those will all be put back into place 60 days after April 7th.

We had waived the requirement to have an outside window or an outside door in every sleeping room for inpatient hospice, ICF/IDs and SNF, NF residents. Again, that would allow them to be placed in alternate rooms within a facility that otherwise may not be used for patient care, but we're going to eliminate that requirement - I'm sorry, eliminate that waiver and go back to that basic regulatory requirement as well.

And then the last thing is that we had waived the requirement for certified nurse aides to be able to work for more than four months without training and certification. And we are eliminating that waiver.

Again, we're eliminating it in 60 days, and that means that nurse aides who are working at facilities who haven't completed either the training or the competency requirements to be a nurse aide, will now have essentially six months from April 7th in order to complete those trainings and become certified nurse aides.

And this is one particularly important because we have seen over the course of the pandemic, a lot of care issues specifically related to the provision of care that's generally provided by certified nurse aides, and the diminishment of those quality standards.

We've seen weight loss. We've seen pressure ulcers and other things that we believe tie into this waiver of allowing for nurse aides to not have necessarily completed all of the required competencies. And so, that's why we're moving past this waiver as well.

A couple of things to reinforce, and then happy to take any questions that you all have after the next presentation. But again, those of you who are familiar with 1135s in the past before this pandemic, probably heard the message that our expectation is always for providers to only use the waivers when they're necessary, and they should always be working to get back to a state of operation that doesn't require those waivers and flexibilities.

So, this is kind of an extension of our normal practice to try to get everyone back to normal operations as quickly as possible. All of our regulations that are in place, especially for long-term care facilities and ICF/IDs and inpatient hospice are there because they have a direct link to patient and resident health and safety.

So, the ability to get back to kind of the full catalog of those expectations we believe is necessary to ensure the health and safety of those receiving care in these facilities.

And as we indicate, we'll continue to evaluate the need for additional blanket waivers that may be in place, and whether they need to be terminated prior to the end of the PHE.

All waivers that are in place at this time will expire, unless we terminated them earlier, do expire at the end of the PHE, unless there's some sort of explicit formal authority that allows us to continue their practice beyond the end of the PHE.

So, we want to try to kind of titrate down in terms of the waivers that are out there anyway so that facilities can get used to getting back into normal

operation where appropriate. And we believe, again, that this is important, especially for the health and safety of the residents that we all serve.

So, with that, I appreciate you all taking the time to be on the call today, and I'll turn it back over to Jackie.

Jackie Glaze: Thank you, David. So, next up would be Martha Egan, and she will provide an update on the Money Follows the Person funding opportunity. Martha?

Martha Egan: Thank you, Jackie. So, again, my name is Martha Egan, and I am a Technical Director in the Division of Community Systems Transformation, and we are division - in the Disabled and Elderly Health Programs Group.

And I am going to provide an overview of a recent announcement on two pretty exciting Money Follows the Person demonstration opportunities, one being a notice of funding opportunity, and the second being some changes to MFP or Money Follows the Person supplemental services.

So, I'll start with the notice of funding opportunity. So, the Money Follows the Person MFP demonstration, this is a longstanding grant-funded program that supports State Medicaid program with helping Medicaid beneficiaries who live in institutions, to transition to the community, and gives people with disabilities and older adults more choice in deciding where to live and receive long-term services and supports.

Currently, 34 States participate in the program, while two States are in the process of reactivating their programs as a result of the reauthorization of the MFP program. It was included in the Consolidated Appropriations Act of 2021.

And we recently released a notice of funding opportunity, a NOFO, to provide up to $5 million per State or territory - to any State of territory not currently participating in the program.

So, the NOFO makes funds available for a 16-month planning phase, with an anticipated start date of September 1st, 2022. And these funds will support initial planning and capacity building activities to help the State or territory to implement the MFP program.

And the funds can be used for a range of activities, including for things like developing community transition programs, for establishing partnerships with community stakeholders, for conducting an HCBS system assessment and gap analysis.

They can be used for establishing or enhancing Medicaid HCBS quality improvement programs for recruiting, transition coordination, and other HCBS providers, and also for securing technical assistance.

Now, successful applicants will also have the opportunity to submit an MFP supplemental budget amendment in fiscal year 2023 to request funding for an HCBS transitions and program implementation phase, during which States will be eligible for funding.

And this funding will be at an enhanced - MFP enhanced match rate for community transition services that can support eligible individuals to transition from institutions to community living, for 365 days of home and community-based services for eligible individuals post transition, and also for administrative and personnel costs to support the State or territory's participation in MFP.

A State Medicaid agency, again, not currently participating in the MFP demonstration, may apply for up to $5 million for planning and capacity building activities through the NOFO, no later than May 31, 2022. And the NOFO is available on grants.gov.

Now, CMS will be holding the second of two webinars to provide information on this funding opportunity, and also to answer questions from potential applicants. And this webinar will be held April 27th from 1:00 to 2:00 p.m. Eastern Time.

And please note that registration is required, and you may visit the Money Follows the Person page on Medicaid.gov for more information on this opportunity. And also, on this webpage is also a link to the registration for the webinar as well.

So, let's talk a little bit about the changes to MFP supplemental services. So, for States already participating in the MFP demonstration, we also announced that we are making several changes to the scope and reimbursement rate for MFP supplemental services.

MFP supplemental services, now, these have historically been defined as one-time services to support an MFP participant's transition to the community that are otherwise not allowable under the Medicaid program.

And they had been reimbursed through MFP grant funds at a State's regular FMAP rate. And recently, we notified MFP grantees that we are modifying the definition of MFP supplemental services from one-time services to short-term services to support an MFP participant's transition to the community, again, that are otherwise not allowable under the Medicaid program.

And with this change, we did notify grantees that the expanded definition of supplemental services for MFP participants includes the following; up to six months of short-term rental assistance and associated utility expenses to bridge the gap between when an MFP participant transitions to the community, and when federal, State, or local housing assistance is secured, food pantry stocking for up to a 30-day period for MFP participants, payments for services and activities to such as home accessibility modifications, vehicle adaptations, pre-tenancy support, community transition services, and case management prior to an individual transitioning from an institutional setting, and also other costs associated with securing a community-based home that are not coverable under Medicaid, such as apartment application and administrative fees.

Now, in addition, these services will now be 100% MFP grant funded, with no State share. And so, these changes to the reimbursement rate and the scope of MFP supplemental services, these are effective retroactive to January 1, 2022. And we have provided additional information on these changes to MFP grantees, and we also will be discussing these changes directly with grantees.

The notice is available on the Money Follows the Person page on medicaid.gov, and questions about these changes to MFP supplemental services, or about the NOFO that was released, can be directed to the MFP mailbox. And that mailbox address is MFPdemo@CMS.hhs.gov. And again, that's MFP demo, D-E-M-O at cms.hhs.gov.

So, that concludes the update on the MFP demonstration program. So, I will turn it back over to Jackie.

Jackie Glaze: Thank you, Martha. So, now we're ready to take the questions from today's presentations on the Medicare blanket waivers, and the Money Follows the Person presentations.

So, you can begin sending your questions, submitting your questions through the chat function, and then we will move to the phone line. So, we - I'll turn to you now, Ashley, to see if we have any questions.

Ashley Setala: Thanks, Jackie. It looks like we don't have any questions related to these first two presentations in the chat yet.

Jackie Glaze: Maybe we'll start with the phone lines first, and then I can circle back to you. So, operator, could you please provide instructions to the audience on how to submit their questions through the phone lines, and then we'll take questions there.

Coordinator: Yes. The phone lines are now open for questions. If you would like to ask a question over the phone, please press Star 1 and record your name. If you'd like to withdraw your question, press Star 2. Thank you. And I'm not showing any phone questions yet, but again, if you would like to ask a question over the phone, please press Star 1 and record your name.

Jackie Glaze: Okay. And I'll just circle back to you, Ashley. Do you have a question or two?

Ashley Setala: Sure. Yep. So, we have a few questions that have come in around Money Follows the Person. The first question says, some States have worked to translate supplemental services into their 1915(c) waivers. Would those States need to move them back to MFP to secure the 100% FFP?

Martha Egan: This is Martha. So, supplemental services are services that cannot be covered under the Medicaid program. So, they would - under MFP. So, they would not be - if they are being covered under a 1915 (c) waiver, then they would not meet that criteria for the MFP demonstration.

So, again, these are services and supports that are not covered under the Medicaid program. So, you would retain those services in your 1915 (c) waiver and not move them over to the demonstration.

Ashley Setala: Okay. Thanks, Martha. The next question says, can you confirm that when you said supplemental services can now include six months of rental assistance, that includes the actual rental costs of the residents?

Martha Egan: That is correct. That is part of the definition of the short-term rental assistance. It can be up to six months of rental assistance. And there is some additional criteria along with - that goes along with meeting the requirements for receiving the short-term rental assistance.

And we will be working there directly with our MFP grantees on that criteria. And there's some additional information in the notice that we did put out on what we mean by short-term rental assistance. But yes, that can include rental payments for up to six months of rental payments.

Ashley Setala: Okay. Then we have a question that says, will CMS be offering an operational protocol template for States to use when updating or adding supplemental services?

Martha Egan: Yes. CMS is working on an MFP demonstration operational protocol template. So, we will be working with States directly on supporting them with adding these supplemental services into their operational protocol, and also

working with States on adding these supplemental services to their current budgets.

Ashley Setala: Okay, thank you. Then it looks like we have a couple of questions that have come in on the blanket waivers. So, the first one says, I missed the connection discussed between the blanket waiver changes and 1135 waivers. Can you speak again to how the changes to blanket waivers impact 1135 waivers?

David Wright: Yes, thanks. So, this is David. The blanket waivers are 1135 waivers. So, with the 1135 waiver authority, we have the option of providing specific waivers, either for a specific facility or geographic area or even State, or we can do blanket waiver that can apply, again, to a geographic area, or in this case, the entire country which is covered under the 1135 authority.

So, what we're doing with the April 7th memo is, we are terminating some of the blanket waivers that we had put into place based on our evaluation of the current need.

The 1135 waiver authority, however, still remains in effect. So, if there's a belief that any of those waiver - blanket waivers that we are terminating, need to be instituted, again, either for a specific facility or area, you can just notify CMS and we will evaluate whether to provide that flexibility again under a, not blanket authority, but under just a specific targeted waiver, again, either for a facility or for a particular area. But the 1135 authority still remains in effect. We have just terminated some of the blanket waivers early.

Ashley Setala: Okay, thank you. Looks like we have one other question. It says, which waiver opportunities will be reviewed on a State-by-State basis based on the April 7 termination date?

David Wright: So, we won't be reviewing them on a State-by-State basis. if there's a belief within your State that you still need certain authorities or these authorities to remain, I would recommend that you work with your CMS location or office, with the 10 regional offices out there to convey those needs.

Ashley Setala: Great. Thank you.

Jackie Glaze: Thank you all. So, I think we're ready to move on to the next presentation. So, the Children's and Adult Health Programs Group team will share some of the responses from some of the frequently asked questions relating to the unwinding of the continuous eligibility requirements. So, I will begin with Sarah O'Connor. So, I'll turn to you.

Sarah O'Connor: Thanks, Jackie. Our first set of questions are related to the data reporting. And the first question, is could CMS clarify the different reports States are required to submit and when they are due?

Shannon Lovejoy: Yes. So, in addition to States regular reporting for (TMSIS) performance indicators and other data sets, there are two reports that are unwinding-specific. First, there is a one-time renewal report that details each State's plans for distributing renewals across the unwinding period.

The report also requests the State identify implemented and planned strategies to ensure continuity of coverage. This report is due 45 days before the end of the PHE. If the PHE ends on July 15th, 2022, for example, the renewals report will be due on June 7th, 2022. CMS will communicate a date once the end of the PHE is known.

Secondly, States will be required to submit data reports to CMS to

demonstrate States progress towards restoring timely application processing and initiating and completing renewals of eligibility.

There are two separate parts to this data reporting. There's a one-time baseline report due at the end of the month prior to the month in which the State's unwinding period begins.

And there is a monthly report that's due on the 8th of each month. As an example, if the PHE were to end sometime in July 2022, and the State elects to begin its unwinding period in the same month the PHE ends, the baseline data is due at the end of June 2022, and the first monthly report would be due on August 8.

Sarah O'Connor: Thank you. Our next question is, is there any flexibility with when the baseline on winding data report is due? States may not have complete information about the month the report is due until after the month has ended.

Shannon Lovejoy: I'll take this one as well. So, CMS acknowledges that the baseline report includes all pending applications received in the same month the report would be submitted.

So, States actually have two options. The first option would be for States to submit baseline data consistent with published guidance and then updated baseline report once they have the complete information.

The data reporting portal online has the flexibility for States to update its report. A second option is for States to submit baseline data to CMS by the 8th of the month the State begins its unwinding period.

States that select this option should send an email to

unwindingmetricsTA@Mathematica-npr.com. It's the same TA mailbox that's associated with all of the data reporting for unwinding.

CMS reminds States that we're available for TA, technical assistance, if you have any specific questions. We want to continue encouraging States to prepare in advance for these data reports so that the necessary processes and reports are ready for submission once unwinding begins. Thanks.

Sarah O'Connor: Great. And the next question is, what does CMS mean by a MAGI and non-disability application?

Shannon Lovejoy: Thanks, Sarah. So, regulations at 42 CFR 435.912 c3, outline the timelines standards for States to process applications and make a determination of eligibility for applications for which a determination of disability is required and for all other applications.

States should not exceed 90 days for applicants who apply for Medicaid on the basis of disability, and 45 days for all other applicants. This includes applications that are processed using MAGI rules.

This may include - may also include individuals being determined on a non-MAGI basis, but for which a determination of disability is not required to process the application.

While a MAGI-based determination will never require a determination of disability status, non-MAGI determinations may fall into either bucket, depending on whether a determination of disability is required.

For example, the 45-day limit applies to applications involving a determination based on being age 65 or older. We encourage States to use the

textboxes in the portal to explain the data submitted, including how a State's reported data may vary from the data specifications provided by CMS.

Sarah O'Connor: Great. And a follow-up to that question is, what does CMS mean by a disability-related application?

Shannon Lovejoy: Sure. So, a disability-related applications are applications for which the State requires a determination of disability to process the application. New applications are subject to the 90-day limit for processing applications at 435.912 c3i.

Again, we encourage States to use the textboxes in the portal to explain the data submitted, including how the State's reported data may vary from our data specifications.

Sarah O'Connor: Thank you. And the next set of questions relate to the 1902(e)(14)(A) flexibilities we outlined in our unwinding SHO. And the first one is, what can States expect in terms of effective dates for approvals? Is there an ability for CMS to make retroactive approvals?

So, as a reminder, at the beginning of April, States should have received 1902(e)(14)(A) waiver submission instructions and sample language through both E-TAG and an email to State Medicaid Directors.

Any State that did not receive that information or who has additional questions should reach out to their State lead. As part of the submissions, States are advised to propose an effective date on their request for CMS's review.

For States requesting a retroactive date, we will review those requests, but

please recognize we will need to work with the State to understand their need for the retroactive request.

That said, our goal is to approve these as quickly as we can when we receive them. For some context, we received four formal submissions last week, and approved one, and we hope to get the others out shortly.

Finally, we also recognize the MCO contract information flexibility is the most common request where States are seeking an early effective date. And we are trying to prioritize those approvals for States.

The next question is, will CMS reconsider the requirement that there be an attestation of $0 income that was verified within the last 12 months for that specific 1902(e)(14)(A) flexibility?

So, as described in the March unwinding SHO, the 1902(e)(14)(A) flexibility to permit ex parte renewals for individuals with no income, permits States to complete the income determination for ex parte renewals without requesting additional income information or documentation, if an attestation of $0 income was verified within the last 12 months, either at the initial application or the previous renewal, and the State has checked financial data sources in accordance with its verification plans, and no information is received.

After discussions with States and other stakeholders, CMS recognizes the need for additional flexibility, and will consider approving this e14 flexibility, as long as there is an attestation of zero income verified up to 12 months prior to the start of the public health emergency, rather than the last 12 months.

States interested in this broadened flexibility may continue to use the sample language we provided, but are requested to modify it with this amended

timeframe. For any additional questions or technical assistance requests, please contact your Medicaid State lead.

The next question is, will CMS be able to use the e14 authority to allow flexibilities beyond those identified in the SHO, such as allowing States to use SNAP data to support non-MAGI redeterminations?

CMS described in the SHO that based on the strong correlation between SNAP eligibility and MAGI-based financial eligibility for Medicaid, we determined that it would be appropriate for States to use e14 authority to renew certain individuals in MAGI Medicaid based on SNAP program income findings.

This authority permits States to renew Medicaid eligibility for SNAP participants under 65 years old, whose gross income as determined by SNAP, is under the applicable MAGI threshold for Medicaid eligibility, without conducting a separate MAGI-based income redetermination.

If a State's SNAP income eligibility level is above the State's Medicaid eligibility level for adults under 65 years of age, the State may use this strategy by comparing the individual's growth income determined by SNAP, to the applicable MAGI-based income standard.

If the individual SNAP gross income is at or below the applicable income standard, the State may complete the renewal of income using that SNAP gross income.

If the individual has SNAP gross income above the applicable Medicaid threshold, the State may not use SNAP information to determine Medicaid

eligibility, but must instead complete the renewal applying MAGI-based methodology.

The SHO also mentions that we will consider other strategies may want - the States may want to propose. I will note that there are some guardrails outlined in the SHO, including that CMS will not approve e14 waiver requests unrelated to the State's unwinding period, or requests that fail to protect beneficiaries.

In terms of non-MAGI, CMS may consider the use of the e14 SNAP strategy for non-MAGI population, but will need to work with States interested in the strategy to conduct an individual analysis of the State's non-MAGI eligibility criteria and rules, as compared to SNAP rules, such as income resources, household composition, and so on. States interested in this pathway should reach out for technical assistance.

So, switching gears, we have one question on ex parte renewals for individuals receiving SSI. The question is, States receive a daily SDX file with changes and updates to SSI individuals. It was announced on an all-State call that CMS is expecting ex parte renewals of the SSI individuals. Is it CMS's intention to include 1634 States in this requirement?

Shannon Lovejoy: Thanks, Sarah. So, there are no exceptions to the requirements to conduct periodic renewals of eligibility that are outlined in regulation 42 CFR 435.916, as these regulations apply to all eligibility groups.

And this includes the requirement to start the renewal process by attempting an ex parte renewal or renewing eligibility based on available information

without contacting the individuals as specified at 435 916 a2 for MAGI beneficiaries, and 4 35 916b for non-MAGI beneficiaries.

But it's our understanding that most 1634 States check the SDX file from the Social Security Administration on a monthly basis to verify ongoing eligibility. And so, practically speaking, renewal requirements for SSI beneficiaries in a 1634 State, would be satisfied through the monthly process that verified the beneficiary is still in receipt of SSI.

And so long as the individual continues, you know, to come over on the SDX file, the State could renew the eligibility on an ex parte basis.

Sarah O'Connor: Thank you, Shannon. So, with that, I will turn it over to my colleague, Sarah Lichtman Spector.

Sarah Lichtman Spector: Thank you, Sarah. I'm going to address one question today that came in about fair hearings. We've gotten a number, but we wanted to make sure that we addressed this one today.

The question is that if a State does not elect section e14 waiver authority for fair hearings, are the general fair hearing regulations in effect? Specifically, the State asked, would the State be expected to comply with fair hearing timeframes at 431.244, and also be permitted to seek recruitment in the circumstances for which it's permitted?

So, the answer is yes. Unless CMS grants authority under section 1902 e14 of the Social Security Act, our regular fair hearing regulations would be in effect, meaning that unless CMS grants a section e14 waiver to provide the State with additional time to take final administrative action on fair hearing requests beyond the regulatory timeframe, the State would be expected to follow

current Medicaid fair hearing regulations, and begin processing fair hearing requests timely when the continuous enrollment condition ends.

Some other key Medicaid fair hearing regulations that would be in effect, States must provide Medicaid beneficiaries benefits pending the fair hearing decision when the beneficiary requests the fair hearing before the date of an action. So, that would be the termination or suspension.

States may, it would be an option, reinstate benefits pending a fair hearing decision when an individual requests a fair hearing not more than 10 days after the date of an action.

And indeed, if the agency's determination is upheld in the hearing decision, a State agency may, again an option, seek to recoup from the beneficiary the cost of any services provided while the appeal was pending.

We recommend that in evaluating how the State is going to meet the anticipated increase in fair hearing volume resulting from the return to normal operations and the schedule of redeterminations that States are determining now, that they review the slide deck that we presented on the April 5th all-State call, and indeed is posted on medicaid.gov on the unwinding landing page, and the planning tool that we also issued in March, that can help States with the assessment of their capacity, the risk, and both tools outline potential strategies States can take.

We are available to provide additional technical assistance to discuss with States either the strategies to address their potential volume, and indeed if States would like to pursue an e14 waiver related to fair hearings. If States would like …

Woman: Oh, I didn't don't remember that, but yes. Okay.

Sarah Lichtman Spector: We recommend that States please contact your State lead and copy the unwinding mailbox. With that, Jackie, let me turn it back to you.

Jackie Glaze: Thank you, Sarah, and team for going through the questions with us. We're almost ready to take your questions, but I wanted to cover one of the questions that we received earlier regarding the Medicare blanket waivers.

And so, we did receive this question asking what the connection was with the Medicare blanket waivers and the Medicaid 1135 waivers. So, I wanted just to explain that a little further.

So, the physical environment Medicare blanket waiver that David referenced, is associated with the individual Medicaid 1135 waiver for the alternative care settings. And so, this is the waiver that will terminate 60 days from the issuance of the April 7th guidance.

So, all of the other Medicaid 1135 waivers that we've issued to the States and territories, will remain in effect unless there is, you know, additional guidance that may come out later. But for the time being, this is the only Medicaid 1135 waiver that is impacted.

So, the State leads will be following up with the States shortly after this, just to talk further with those States that did receive approval for this waiver so we can get a better understanding if you're still using this waiver and need it further. So, more to come on that.

So, for right now, we will move forward with the questions from the States.

And so, we do have a number of questions in the chat function. So, Ashley, I'll turn to you to go over those.

Ashley Setala: Great. Thanks, Jackie. So, the first question says, section 2e of SHO 22-001 states, given how long it has been since some individuals have been renewed, there is an increased risk that individuals who may be eligible for CHIP or Medicaid on another basis, may be terminated based on changes in circumstances related to a single factor of eligibility.

Consequently, during the unwinding period, prior to taking adverse action based on an identified or reported beneficiary change in circumstances, States must complete a full renewal for any beneficiary, unless a renewal was completed in the 12 months prior to the identified change.

Well, the first sentence specifically references termination. The second sentence refers more broadly to adverse action, which is identified at 42 CFR 435.917 as including denial, termination, or suspension of eligibility or change in benefits or services.

Would CMS please clarify whether a renewal must only be completed prior to terminating Medicaid, or whether a renewal must be completed prior to any adverse action, including reductions in benefits or services?

Shannon Lovejoy: Hi. This is Shannon in CAHPG. I can take that. So, it is - a full renewal is required for these individuals, and that is regardless of, you know, any potential outcome of an adverse action, which could include termination, but could also be a reduction in benefits because the individual has not had a renewal in the last 12 months

One, you know, eligibility will need to be verified for all factors of eligibility,

but then the State needs to make sure it is, you know, redetermining eligibility in all basis for individuals who may, you know, no longer qualify for the group that they were initially enrolled in.

Ashley Setala: Thanks, Shannon. The next question says, do we know if those being extended on Medicaid who now have Medicare and are not determined eligible in the redetermination, will have a step with Medicare?

Sarah DeLone: So, this is Sarah DeLone. That is an issue that that we, and more importantly, our colleagues at the Center for Medicare, are aware of and are working on. There is not currently a step that's available for those individuals, but it's a potential gap in coverage we're very aware of and are working on a solution, which hopefully we will be getting out.

Ashley Setala: Thanks, Sarah. The next question is around Money Follows the Person, and it says, could you speak to the requirements around administering the rental - the requirement that administering the rental assistance be administered by local housing partners? Why is this being required?

Martha Egan: So, yeah, I'm happy to - this is Martha Egan, and I'm happy to speak to that briefly. And I do want to remind you that we will be meeting directly with our MFP grantees to discuss more fully the supplemental services and the requirements around receiving the short-term housing assistance under the supplemental services program.

But the main reason that we are asking MFP grantees to partner with a State Medicaid - I mean, with their State housing finance agency or a State or local housing entity, is to really ensure that, one, that an MFP participant will have access to ongoing rental assistance once that six-month period has ended, and

also to support ways that our MFP grantees can continue to strengthen their relationships with their State housing providers and any local or State housing entities.

So, it really is sort of two-pronged, to really encourage those partnerships, to support those partnerships, and to make sure that people or individuals - MFP participants do - will have the access to ongoing rental assistance once the MFP portion of that concludes.

Ashley Setala: Okay, thank you. Then we have a question that says, due to the HHS COVID-19 Prep Act Declaration, our disaster SPA lists pharmacies, licensed pharmacists, pharmacy technicians, and pharmacy interns, as qualified providers of COVID-19 vaccinations.

Should we submit this language in a SPA under section 7 or B as a temporary extension without modification, or are we supposed to make it permanent? I'm not sure if or when the HHS COVID-19 Prep Act Declaration ends.

Kirsten Jensen: Sure. Hi. This is Kirsten Jensen, and there's a lot to unpack in that question, and I would maybe encourage the State to contact your State lead. We can have a very fulsome discussion about it.

The Prep Act is scheduled to end on October 1st of 2024. And so, the disaster relief SPAs will end at the end of the public health emergency. But we also have the ARP, the American Rescue Plan SPAs that added vaccine and vaccine administration coverage and testing and treatment.

And within those SPA templates, there is a checkoff box for compliance with

the Prep Act. And those SPAs go until approximately one year after the end of the PHE.

So, we would ask States to submit the ARP coverage templates that will incorporate the Prep Act requirements. And then we can, you know, depending on timing, figure out, you know, next steps after the end of the - approximately one year after the end of the PHE.

But if you'd like to discuss that further, and I'm sure, you know, there may be other specific questions for the State, please contact your State lead, and they'll reach out to the Division of Benefits and Coverage, and we can have a call.

Jackie Glaze: Thank you, Kirsten. Let's move to the phone lines now. Operator, could you once again provide the instructions for registering their call and their questions, and then we'll see if there's questions there?

Coordinator: Yes. I'm not showing any phone questions yet, but again, if you would like to ask a question over the phone, please press Star 1 and record your name. Thank you.

Jackie Glaze: No questions?

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

Jackie Glaze: Okay. All right. Thank you. Ashley, back to you then.

Ashley Setala: Okay. The next question says, if the State checks the SDX monthly for everyone, how would the State report the SSI Medicaid renewals in their renewal reports?

Shannon Lovejoy: This is Shannon in CAHPG. I think it would depend a little bit on the timing, but, you know, I think we have metrics in the renewal report. If this is talking about like the monthly and baseline data, you know, when they're checking - the month that they're checking the SDX, you know, because be the month initiated, and then, you know, if the individual continues to be in receipt of SSI, then that would be considered to be a renewal that was completed, you know, on an ex parte basis.

And so, it would fit into the appropriate categories depending on, you know, the timing of when the State's checking in and, you know, determining the individual still continues to be eligible.

In terms of, you know, the renewal distribution report, it's just they are part of the State's enrolled population, and would be included in the total numbers.

Ashley Setala: Thanks, Shannon. The next question says, in SHO 22-001 released March 3rd, 2022, CMS clarified that if a State uses the strategy to provide a reconsideration period following a denial for failure to provide requested information to verify eligibility at a change in circumstances, they would treat the verification submitted by the client during the reconsideration period as an application. The SHO further clarifies the State would need to obtain a signature from the client. Would this signature need to meet the requirements of 42 CFR 435.907F?

Shannon Lovejoy: This is Shannon in CAHPG. Yes, this would be, you know, the same signature that's required, you know, under penalty of perjury, similar to, you know, an individual that's submitting a full application.

Ashley Setala: Okay. And another question on signatures, it says, if the State has a signature on file from the applicant with an initial application or renewal application, would the State need to obtain a new signature?

Shannon Lovejoy: This is Shannon. I'm not sure if that was a follow-up to the last question or at what point in time the State is thinking they would need capture a signature. You know, signature is required with an initial application.

It's - you know, the individual is sent a renewal form in order to complete the renewal because a renewal cannot be done on an ex parte basis. Then the renewal form must be signed.

Ashley Setala: Okay. Then we have a question that says, for a fair hearing e14 waiver request, are there specific requirements for expectations related to when the waiver must be submitted? For example, may they be submitted after the PHE ends or a few months after the PHE ends?

Sarah Lichtman Spector: Hi, this is Sarah. I can take that one. There's no specific limitation. It can - it could be a waiver that's considered after and submitted after the PHE ends, and that is fine.

We understand the fair hearings are going to follow, in some cases, eligibility determinations and renewals, and are happy to work with States over periods of time and accept your waiver requests when you want to submit them.

Jackie Glaze: Thank you, Sarah. So, wanted to also thank everyone for your questions today, and thank you for our team for your presentations. Our next all-State call will take place on Tuesday, May the 3rd, from 3:00 to 4:00 p.m. Eastern Standard Time, and we will send the topics invitation shortly.

Of course, as your questions come up between calls, feel free to reach out to us, contact your State leads, or bring your questions to the next call. We thank you again, and we hope everyone has a great afternoon. Thank you.

Coordinator: This concludes today's call. Thank you for your participation. You may disconnect at this time.

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