HHS-CMS-CMCS

February 14, 2023

2:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time I'd like to inform all participants that today's call is being recorded. If you have any objections, you may disconnect at this time.

All lines have been placed in a listen-only mode for the duration of today's conference. I would now like to turn the call over to Ms. Jackie Glaze. Thank you, ma'am. You may begin.

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

Dan Tsai: Thanks, Jackie. Hi, good afternoon plus good morning plus good day to everybody. I think folks are all well aware that we, as the administration announced last week, are both a renewal of - the last renewal of the PAG with an intention to end the PHE on May 11.

And as folks know, with a lot of work we've had ongoing with all of you as our state colleagues, the omnibus had already separated out the Medicaid redetermination piece from the end of the PHE.

So we spent a lot of time recently and weekly and every day, many, many, many meetings on the Medicaid redetermination component. We're going to take some time today given the May 11th announcement to go over some of the other - what needs to happen with Medicaid disaster relief laws, Section 1135 waivers, things of that sort when they expire.

And this is really part of a series of discussions that we are going to have over the last few weeks for preparing for resuming normal operations when the PHE ends. We've had discussions with you all and our state colleagues over the past year, but given the focus on May 11, we're re-upping those and we're getting questions and starting to really pin down what's next on that.

So you'll hear from Maria Tabakov and Tannisse Joyce from our team, from our Medicaid and CHIP operations group, specifically today about some of the disaster SPAs and 1135 waiver flexibilities.

Before we do that, you'll hear from Sara Harshman from our Disabled and Elderly Health Programs Group about some quick updates on monkeypox, and the PREP Act.

For the transitions, I just want to - for unwinding more broadly, I just want to note what we put out in the fact sheet last week. It's a lot of work. We're here together to work through as we have been for the past year and a half plus how to transition in as orderly a way as possible.

The different authorities during the PHE, as you all know, have different time implications and such of when things end. Some things may end immediately. Some things have a longer runway. Those are all the topics that we're going to start talking through and reiterating again today and in the coming weeks.

Some things that notably do not change, I think folks that are joining us here probably all know, but it's worth reemphasizing. First, the telehealth flexibilities that exist in Medicaid separate from how things are from a statutory standpoint for Medicare. On the Medicaid side, those flexibilities are not linked to the PHE or the end of the PHE or PHE-specific authorities.

States have and continue to have substantial flexibility in the use of telehealth. Almost every state broadly expanded and took up telehealth during the pandemic. And we've seen a lot of really - continuing things from an access standpoint.

We are hoping that folks can continue on usage of telehealth, including telephonic modalities and other sorts, especially for clinical areas like mental health and other things where everything from workforce to equity and all that, that's a really important tool. And we recognize states will be evaluating kind of a range of policies around it. So that's one thing.

Another thing that does not end right away is coverage with no cost shared for Medicaid enrollees for COVID treatment, testing and vaccinations and such. So just a few notes there, but we're looking forward to - I don't know if looking forward. But we're in it with you all to go through the next level of detail now to prepare for May 11.

Finally, the last thing I just wanted to mention before we jump in. We've had quite a bit of outreach on this. On last week's all state call, we briefly discussed a court order that was issued on January 31 of this year in the case of Carr vs. Becerra. This is a case concerning the Interim Final Rule issued by HHS in November of 2020, which interprets Section 6008(b)(3) of the FFCRA.

And so I sent a - my office sent out a note to every state Medicaid director based on that court order explaining the steps that CMS is taking to comply with the court's order to share the letter to Medicaid directors, inform the states of the court's order and actions HHS is taking to comply with it.

Several states have raised a set of nuanced questions about the court order and how to best interpret the direction of the court. And for those questions at this time, we advise you to consult with your own counsel.

So with that pleasing thought, I will turn things over to Sara Harshman for an Mpox update.

Sara Harshman: Great. Thank you, Dan. As we've discussed on previous calls, HHS PREP Act declarations can affect which providers are qualified to provide certain Medicaid-covered services for purposes of the Medicaid free choice of provider requirement.

We've also released written guidance on the Medicaid implications of the HHS PREP Act authorizations in the Mpox Frequently Asked Questions for Pharmacy Providers FAQ and in the CMCS COVID-19 Vaccine Toolkit. You can reach out to CMS for links to that guidance if needed.

As you all likely know, the federal Mpox PHE ended January 31, 2023. And although the federal Mpox public health emergency has ended, other state, regional, or local emergencies related to Mpox might still be issued or in effect.

In the case there is a new or ongoing federal, regional, state or local Mpox declaration of emergency, the authorizations under the HHS PREP Act

declaration for smallpox, Mpox and Orthopoxvirus medical countermeasures still apply.

For example, if a federal, regional, state, or local Mpox emergency declaration is issued or still ongoing after the end of the federal Mpox public health emergency, certain persons, including certain pharmacists, pharmacy interns and pharmacy technicians are covered under the HHS PREP Act declaration to administer countermeasures in the area of the emergency until December 31, 2032 or the end of all federal, state, regional or local emergency periods, whichever is first. That means that the Medicaid implications of these HHS PREP Act authorizations also apply.

If there is no applicable federal, regional, state or local emergency in effect, then certain providers authorized under Section 5 of the PREP Act declaration are no longer covered under the declaration. That is, their authorizations under the declaration will end and so will the related Medicaid implications, including those for certain pharmacists, pharmacy interns and pharmacy technicians.

Please see Sections 5A, 5D, 5E and 12 of the HHS PREP Act declaration for smallpox, Mpox and Orthopox medical countermeasures for more details.

We would also like to stress that this information is only relevant to the end of the Mpox public health emergency, not the COVID-19 public health emergency. We will provide guidance on the effective time period of COVID-19-related PREP Act authorizations in the near future.

And please, as always, feel free to reach out to CMS for any technical assistance on this topic. And with that, I'll turn it over to Jackie. Thank you.

Jackie Glaze: Thank you, Sara. Next, Maria Tabakov and Tannisse Joyce will share guidance on preparing to return to routine operations with expiration of the public health emergency. Maria, I'll now turn to you.

Maria Tabakov: Thank you, Jackie. Good afternoon, everyone. Over the past year, we have been working with you to help you prepare for the return to routine operations at the end of the PHE.

Today we will recap a few presentations we previously conducted, highlighting key dates for PHE flexibilities and options for states to continue state plan provisions before the end of the PHE.

As Dan mentioned earlier, the administration announced its intent to end the national emergency and the public health emergency declarations related to the COVID-19 pandemic. Last week Secretary Becerra sent a letter to governors specifying the renewal of the PHE for an additional 90 days.

Based on current trends regarding COVID-19, HHS is planning for this to be the final renewal and for the PHE to end on May 11, 2023. This announcement allows for 90 days' notice before the end of the PHE.

Next slide. On this slide, we list various flexibilities and their expiration dates as we approach the end of the PHE. Medicaid disaster relief state plan amendments will expire at the end of the PHE or any earlier date requested by the state and approved by CMS.

CHIPS disaster COVID-19 SPAs will expire at the end of the PHE. Evergreen disaster SPAs will expire at the end of the state declared emergency or the end of the PHE, whichever is later. Both of these SPA types may also expire at an earlier date at the state's discretion.

Common community-based services Appendix K and Attachment K will expire no later than November 11, 2023. Medicaid and CHIP 1135 waivers expire at the end of the PHE.

Section 1115 COVID-19 demonstrations generally expire no later than 60 days after the end of the PHE, unless otherwise noted in the approval documents. Some demonstrations will end before the end of the PHE. We advise states to contact their project officer with any questions related to the expiration of COVID-19 1115 demonstration.

The optional COVID-19 group expires at the end of the PHE. No federal financial participation is available for any state expenditures on services for this group, including coverage of COVID-19 vaccinations, testing and treatment after the PHE ends.

The mandatory coverage of COVID-19 vaccinations, testing and treatment without cost-sharing and the increased FMAP and eFMAP for coverage of COVID-19 vaccines and administration will end on September 30, 2024.

Next slide. For flexibilities approved under Section 1135 waiver authority, CMS recommends that state review approved Section 1135 waivers to determine any actions needed for returning to routine operation.

The December 2020 state health officials letter indicates that states must provide a 10-day advance notice to Medicaid beneficiaries before ending certain Section 1135 waivers as required by regulation.

They should also inform providers of upcoming changes related to the expiration of 1135 flexibilities and evaluate necessary changes to systems

and/or processes, financial reporting and managed care operation. They should also consider program integrity risks and try to mitigate them to the extent possible.

Finally states have additional time to complete some actions related to the expiration of 1135 waivers after the PHE ends. Examples include completing initial HCBS level of care determinations, completing provider screenings and finalizing provider enrollment.

Next slide. For Medicaid disaster relief SPA flexibilities, states have the following options. States can let the provisions expire at the end of the PHE with no action needed.

States can end their approved provisions before the end of the PHE by submitting a rescission law. States can temporarily extend the provisions beyond the end of the PHE or states can elect to indefinitely continue the provisions by submitting a regular SPA.

Next slide. Now I will turn it over to Tannisse Joyce for a detailed overview of the state plan options.

Tannisse Joyce: Thanks, Maria. As Maria described, states have several options for unwinding disaster relief SPAs, either before or after the PHE ends. And based on your state's needs, you may decide to rescind an existing disaster relief provision before the end of the public health emergency.

Removing a provision from a disaster relief SPA or ending that provision earlier than originally approved is considered a reduction and therefore cannot be done using the Medicaid disaster relief SPA template.

Next slide. To end approved disaster release provisions, states should create a new subsection in Section 7.4 of the state plan entitled 7.4.A. Rescission SPAs are subject to all federal review requirements including submission, effective date, public notice and tribal consultation as applicable.

Next slide. So after reviewing approved disaster relief SPA provisions, a state may also decide to extend a provision temporarily after the end of the public health emergency, either without any modifications, meaning those provisions states would like to extend exactly as written in the approved disaster relief SPA with modifications, meaning a state would make changes to some of the details of the approved disaster relief SPA provision or states may identify additional new provisions that were not part of an approved disaster relief SPA, but may be needed temporarily to help transition to routine operations.

Next slide. So last year we also introduced the option to create new state plan Subsection 7.4.B and 7.4.C that can be used for these time-limited provisions aiding in the return to routine operations.

I'll emphasize here that all of the SPA options we're presenting on today are subject to the regular SPA submission requirements, including the effective date requirements, public notice and tribal consultation. Section 1135 SPA process flexibilities are not available for these types of SPAs.

I'll also pause to highlight a few other things. States can use one SPA submission that includes all of the temporary provisions, either with or without modification. However if there are different effective periods, we do ask that you include the provisions on separate pages with the proposed expiration date for each provision or group of provisions.

Secondly, these SPA submissions should not be combined with a template disaster release SPA. And if a State intends to have the provision or provisions in place for longer than a year, we recommend submitting these changes in the applicable state plan section.

Next slide. There are three types of SPAs that have a public notice requirement. The timing and the content of each provision are described in the regulations. It's important that you plan in advance to ensure public notice is conducted timely so as to avoid possible interruption in current authority.

First, public notice is required for any Medicaid state plan change that substantially modifies alternative benefit plans, or ABPs, and must be completed prior to SPA submission.

Second, cost-sharing public notice requirements require that states complete public notice prior to submitting any SPAs substantially modifying premium or cost-sharing policies. And public notice is also required prior to the SPA's effective date for any significant proposed change to methods and standards for setting payment rates for services.

Let's move on to tribal consultation. Next slide. States must also ensure applicable tribal consultation requirements are met in states where one or more Indian Health Programs or urban Indian organizations furnish healthcare services.

Soliciting advice is required for any Medicaid SPA change that is likely to have a direct effect as defined in each state plan on American Indians, Alaska Native, Indian Health Programs or urban Indian organizations.

Similar to public notice, timing is key here as well as some states have specific tribal consultation timelines in their approved state plans that need to be followed. For example, conducting tribal consultation 60 days prior to SPA submission. So depending on the type of SPA that you want to submit, you may then need to build in time to do tribal consultation.

Next slide. Okay. Now we'll move into the submission and review process of the temporary SPAs. For SPAs that will temporarily extend disaster relief provisions without any modification, states will establish a new state plan subsection, Subsection 7.4.B. The pages will directly follow the disaster relief SPAs in Section 7.4 and any disaster relief SPA rescissions in Section 7.4.A.

Next slide. We asked states to begin section 7.4.B with the following introductory language included on this slide. And as you can see, it's slightly modified from what we've previously presented since we now know the end date of the PHE.

This introductory paragraph should include the approval date and the disaster relief SPA number where the provision or group of provisions were originally approved. Then you'll just cut and paste the approved disaster relief SPA language into section 7.4.B.

Next slide. And here you can just see a sample of what that Section 7.4.B would look like. You have a SPA page title, then the introductory paragraph with the sunset date, followed by the approved disaster relief SPA language exactly as it was approved in the original SPA.

Next slide. To streamline the review and approval of SPAs temporarily extending a disaster relief SPA provision without any modifications, we will

rely on the policy review conducted as part of the initial approval. And we anticipate the review of these SPAs to be handled in an expedited manner.

During our review, we'll confirm the language is exactly the same as it was approved in the disaster relief SPA. A sunset date is included for all the provisions. The effective date of public notice and tribal consultation requirements are met. And lastly, where applicable for ABP alignment states, we'll confirm that the State also included an assurance that the extension also applies to ABP.

Next slide. All right. Now we'll move on to temporary extension SPAs with modifications and SPAs adding new temporary provisions not previously included in the approved disaster relief SPA.

For these SPAs, states will submit State Plan Section 7.4.C. And as a reminder, these SPAs must also comply with effective date requirements, public notice and tribal consultation.

One thing to highlight here is that for states modifying an approved disaster relief SPA provision, a rescission SPA is also required and can be submitted in the same SPA submission package.

Next slide. Next slide. For modifications to provisions already included in the disaster relief SPA, we ask states to use the introductory language included on this slide. And states will then also cite the disaster relief SPA number where the provision was originally approved and that SPA's approval date and then you'll just add the modified SPA language.

Next slide. In Section 7.4.C, states can also temporarily amend the state plan with additional new changes not already approved in a disaster relief SPA.

These changes should be directly related to the state's COVID-19 PHE unwinding efforts and should be different than what's currently approved in any of the state's disaster relief SPAs. On the SPA page, we ask that states then use this introductory language identified on the slide for these types of requests.
Next slide. And here is a sample of what the Section 7.4.C page could look like. At the top there's a SPA page title followed by the introductory paragraph where the state will include the effective and the sunset date and then the newer modified SPA language is added.

Next slide. All right. Lastly, if a state intends to make a disaster relief SPA provision or provisions permanent in the state plan, the states would just submit a regular SPA. The SPA can either have a requested effective date of May 12, 2023, which would be the day after the end of the PHE, or the state can request an earlier effective date if needed.

CMS will review the SPA following the standard processes including SPA review timelines and ensuring that public notice and tribal consultation is conducted as applicable.

Next slide. All right. This slide is a summary of the SPA options that we presented today. And I think, I truly hope, that it will be a helpful tool for states to understand what state plan section or sections should be submitted as well as the operational actions states need to take, including compliance with SPA submission requirements and the informing of providers and beneficiaries depending on the provision being modified or ended.

There may be other unique scenarios not included on this slide and we, you know, recommend reaching out to your state lead about these options for

technical assistance or, you know, other changes that you want to make that the state is thinking about.

Next slide. And on this slide, we've just included some links to relevant all-state call presentations and guidance references. Those presentations that we hope you will find helpful. And with that, I'll turn it back to Jackie.

Jackie Glaze: Thank you so much, Tannisse and Maria. So we'll begin taking questions now. I will turn to you first, (Ashley). I think you have a few questions that you'd like to cover and then we will begin taking questions through the chat. So begin submitting those questions and then we'll follow by taking questions through the phone line. So I'll turn to you now, (Ashley).

(Ashley): Yes. Thanks, Jackie. We have a number of questions that have come in. The first one says, my state is working on plans for unwinding flexibilities at the end of the PHE. We have not disenrolled members from our 1915(c) waivers throughout the pandemic and we are seeking clarification on when a member can be disenrolled without impacting the MOE requirements?

What would be the earliest date that a member can be disenrolled from a waiver in the following scenarios? One, individuals who no longer meet the level of care based on the annual reassessment and two, individuals that maintained waiver enrollment but no longer meet waiver criteria because they've moved to a setting excluded from the waiver? These members may not be actively receiving waiver services.

Melissa Harris: Hi, (Ashley). This is Melissa Harris, DEHPG. I'm going to answer this question from the vantage point of the 9817 MOE that is attached to the provision of enhanced match for HCBS services. So I'm not going to adjust this from the FCRA or the CAA MOE, just from 9817.

And from that perspective, the actions that a state needs to be the most mindful of in terms of MOE are state actions that would impact a program, not individual actions based on an individual's eligibility.

So, for example, if a state was taking an action to make it harder to qualify for institutional level of care for a particular waiver then that would run afoul of the 9817 MOE. But assessing a beneficiary to no longer meet your existing institutional level of care is not going to run afoul of any of the 9817 MOE requirements.

So these beneficiary level changes are based on a change in circumstance of the beneficiary or a change in your second example, a setting in which a beneficiary is receiving HCBS. Those actions are fine to take in the context of your day-to-day operations of your HCBS programs without running afoul of the MOE.

Again it would be kind of program-wide decisions, using a new assessment tool, changing level of care, reducing the service package, reducing payments to providers. Those are the kind of things that we would want to talk to you about to make sure they did not tip off an MOE concern. But these beneficiary-level decisions are just fine to make, answering this question again through the lens of 9817.

Thanks, (Ashley).

(Ashley): Then we have gotten some questions asking if we have any updates on a number of returned mail questions that have been pending that I believe the team is ready to answer.

So, Suzette, can I turn things to you?

Suzette: Yes. Thank you so much, (Ashley). So we are very happy to be able to answer some of the questions that a lot of states have been asking us since we released the SHO on the CAA. So we are happy to be able to answer most of those questions for you today.

I know you all may have more questions in addition to the ones you have been asking already. So we are happy to talk through these and then when we get to the open Q&As, please ask us anything else that's on your mind.

So we have one of our subject matter experts, (Sarah O'Connor), is going to help us answer some of these today. So (Sarah), the first question in our outstanding questions is, can a state conduct outreach through one or more modalities before return mail is received in order to meet the return mail condition in the CAA?

(Sarah O'Connor): Thanks, Suzette. Yes, beneficiary outreach conducted at the same time as or after the state sends the renewal form but before the state receives the returned mail may count as a good faith effort to contact the individual through one or more modalities if the outreach provides information specific to the beneficiary's renewal and the attempted contact would be duplicative of the state's attempts to contact the beneficiary after receiving the returned mail.

Outreach conducted before the mail is returned must include information explaining that a renewal notice has been sent by mail, provide information on how to complete the renewal and provide instructions on how to reach the state agency for assistance through all other available modes such as instructing the beneficiary to go to the online portal to contact the state or to call the state's 1-800 number.

Suzette: Thank you, (Sarah). Another question we received from many states is how are states expected to act on returned mail received after a beneficiary's coverage has been terminated for failure to respond to a renewal notice?

(Sarah O'Connor): So for beneficiaries whose renewal is initiated during the state's unwinding period, if mail is returned after a beneficiary's coverage is terminated for failure to respond to a renewal notice, a state must attempt to contact the individual using one or more modalities, including by phone, email, text or a forwarding address provided on the returned mail.

If the beneficiary responds to the state's outreach, the state must promptly reinstate the beneficiary's coverage effective on the date that the contact is reestablished.

CMS will provide guidance on the length of the period of time after a person's coverage is terminated during which time these requirements would apply.

Suzette: Thank you, (Sarah). And then can you speak more to the actions a state must take if mail is returned after a beneficiary's coverage has been terminated for failure to respond to a renewal notice and what actions a state must take to reinstate that individual?

(Sarah O'Connor): Sure. After a state obtains up-to-date contact information from the beneficiary, it must provide the beneficiary with an opportunity to furnish information needed to complete the eligibility determination. If the state needs to send a new renewal form, the state must provide MAGI-based beneficiaries with 30 days and non-MAGI beneficiaries with a reasonable period to respond.

If the individual is determined eligible, retroactive coverage back to the date of termination must be provided if they receive Medicaid services at any time during the retroactive period and would have been eligible for Medicaid at the time they received the service consistent with 42 CFR 435.915(a).

Suzette: Thank you, (Sarah). Switching gears a little bit, we have received a lot of questions from states about MCOs and the role that they can play in satisfying the CAA return mail condition.

So, (Sarah), can an MCO conduct a beneficiary outreach through more than one modality in place of the state agency to meet the return mail condition in the CAA?

(Sarah O'Connor): Yes. A Medicaid Managed Care Plan has flexibility to provide information and conduct outreach to beneficiaries about the eligibility renewal process when the outreach to beneficiaries is not marketing or marketing activities within the scope of the Medicaid Managed Care Marketing Regulations at 42 CFR 438.104.

They may allow managed care plans to conduct outreach to beneficiaries whose mail is returned and have that count as outreach to meet the returned mail conditions.

There may be some considerations states must take in terms of the type of outreach that is being conducted and how that might affect state contracts and/or claiming. CMS will provide more guidance on this in the near future.

But for general information on how managed care organizations can help with the renewal process, we ask you to please refer to the slide deck at the CMS

unwinding page on engaging managed care plans that was last updated on January 6, 2023.

Suzette: Thank you, (Sarah). And our last question, at least in these prepared questions, is, is the returned mail condition triggered when an individual has been approved through the ex parte renewal process and the approval notice for that renewal is returned? Would the state then need to attempt to verify the address depending on any in-state or out-of-state forwarding addresses?

(Sarah O'Connor): So the notice sent to a beneficiary whose eligibility is renewed through an ex parte renewal is an eligibility determination notice and not a renewal form and therefore is not subject to the returned mail condition in the CAA 2023.

If such a notice is returned, the state would need to follow guidance in the March 2022 SHO at Appendix C on treatment of returned mail with an in-state, out-of-state or no forwarding address.

The SHO explains that states are strongly encouraged to attempt to locate beneficiaries whose mail is returned by checking the accuracy of the address on the returned mail against the address the state has on file and attempting to contact the beneficiary through other modalities such as phone, email or text messaging and by checking other data sources such as MCOs and the National Change of Address Database or other state agencies for updated contact information.

The SHO further provides that states may not terminate coverage when beneficiary mail is returned with an in-state forwarding address, even if the individual does not respond to confirm the new address.

If mail is returned with an out-of-state address, states must make a reasonable attempt to locate the beneficiary and send notice to the address on file for purposes of confirming continued state residency and eligibility.

If the beneficiary does not respond or the information does not establish continued state residency, the state must provide advance notice and fair hearing rights.

If no forwarding address is provided and the beneficiary cannot be located, the state may terminate coverage but must reinstate coverage if the person's whereabouts become known prior to the originally scheduled renewal date.

Suzette: Thank you, (Sarah). And we know states may have additional questions, but for now we will turn it back to (Ashley).

(Ashley): Thanks, Suzette and (Sarah). We have a number of questions that have come in. The first one says, please confirm the timeline for making provider enrollment re-validation current. At one time, it was suggested that states would have six months to resolve any backlog and return to normal provider re-validation operations.

Has that been extended to 12 months to match other allowances? And if not, what time frame has been established specific to Medicaid provider enrollment re-validation efforts?

Jackie Glaze: This is Jackie, and we're not aware of any new guidance. So the guidance that we provided in the December 2020 SHO letter is the guidance that we're continuing to use. But we can certainly do some additional checking to see if there are any changes, but this is where it is at this time.

(Ashley): Thanks, Jackie. The next question says our state submitted our baseline unwinding report on February 8, 2023. The state's unwinding period began February 2023.

Should the first monthly unwinding report be submitted by March 8, reporting on the first month of the unwinding period or February 2023, or by May 8, reporting on the first month when unwinding era re-determinations come due and routine terminations apply, so April 2023?

(Kirsten): Hi. This is (Kirsten). I think it's quite a long question, but I think the answer is March, March 8.

(Ashley): Okay. Thanks, (Kirsten). The next question says, has the enhanced FMAP rates for (KIP) and money follows the person been issued yet? Do we have anyone from our financial management group on? No? Okay. Well, I think that we'll take that question back then.

The next question says, if a state never implemented a particular 1135 waiver, are they still required to issue a provider notice? Thinking especially of those issued under the blanket waivers. But even if a state requested a flexibility and ended up not using it, is a provider notice required?

Jackie Glaze: This is Jackie, and I'll take that one also. So if an 1135 flexibility was not implemented, noticing is not required. We'll also refer you back to the December 2020 SHO letter.

And we also recommend that states inventory each of the flexibilities that they implemented and to make plans to inform affected providers and beneficiaries when the Section 1135 waiver is in. So again, take a look again at the December 2020 SHO letter.

Tannisse Joyce: And this is Tannisse. I will just follow up with that. If it's related to HCBS, states really need to be thinking about that and reviewing the prior guidance on these topics, including the ARC Section 9817, maintenance of effort requirements.

So we just recommend that you reach out to your state or contacts at CMS to discuss it further if you have those specific questions.

(Ashley): Thanks, Jackie and Tannisse. The next question says, if a state wants to put a new rate for all of Q1 and Q2, so January 1 through June 30, 2023, would they need to submit a disaster SPA and a streamlined SPA?

Maria Tabakov: This is Maria. So if the state has conducted public notice for those rates, they could submit a regular SPA by the end of this quarter with an effective date of January 1, and it could include an end date to the provision on that SPA if you use Section 7.4.C.

Those will be the new provisions that the state wants to temporarily implement but that will require public notice to be conducted before the effective date of the SPA.

If the state has not conducted public notice and the provision meets the requirements under the Medicaid disaster relief template, then they could submit a DR SPA and then they will submit a temporary extension SPA until the end of June when they would like the provision to end.

(Ashley): Thanks, Maria. The next question says, if a state wants to continue a COVID rate at the same rate, do we need to do the one-day public notice prior to May 12 or since it's not a change in rate, is public notice not required?

Maria Tabakov: This is Maria again. An extension will be considered something that will require public notice. So we advise that the state conducts public notice before the effective date of the SPA.

Jackie Glaze: Thank you, Maria. I think we're ready to move to the phone lines so I'll ask Missy if you could provide instructions for submitting the questions and then also if you can open the phone lines. Thank you.

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

Our first question comes from Tim. Your line is open.

Tim: Hello. Thank you. Earlier you said that if we received returned mail after the person had lost eligibility, we needed to restart their coverage the day they contacted us if I followed your answer correctly. I wanted to know if there was a time limit associated with that. Like if they contact us six months after their eligibility ends or something to that effect.

(Sarah O'Connor): Thank you for that question. We are still considering that, but hope to have guidance on that period, the length of the period of time a state has to triage for returned mail for this EA condition. So we hope to have an answer for you very soon.

Tim: Okay. I do have kind of a secondary part of that question.

(Sarah O'Connor): Sure.

Tim: The way our legacy MMIS system is built out, starting coverage a day other than the first of the month is a potential issue for us. In that guidance, can that be accounted for? I have to assume we're not the only state in that boat right now.

(Sarah O'Connor): Sure. So I think the consideration you're asking us to think about is that you can only have first of the month - you begin eligibility on the first of a month.

Tim: That's correct.

(Sarah O'Connor): Okay. All right.

Tim: Thank you.

(Sarah O'Connor): Thank you.

Jackie Glaze: Let me see. Do we have additional questions through the phone lines?

Coordinator: Yes. The next question comes from John. Your line is open.

John: Hi. Thank you. We plan to submit a disaster SPA to continue the suspension of premiums that we've had in effect during the PHE. So those regulations concerning public notice for premiums talks about it only in terms of changes in premiums. So since we're just going to continue the suspension, it's not really changing anything. Would we still need to submit a - or have a public notice for that SPA?

Maria Tabakov: This is Maria again. Yes, we are expecting that states conduct public notice for temporary extensions for anything related to premium and cost sharing. Even if you're not modifying it, it's continuing the way it was during the PHE.

John: Okay. Thank you.

Coordinator: Thank you. I'm showing no other questions on the phone at this time.

Jackie Glaze: Thank you, Missy. Back to you, (Ashley).

(Ashley): Okay. The next question says, are MCOs allowed to share information on maintained individuals with Medicaid providers who would like to conduct outreach activities?

Sarah Lichtman Spector: Sorry, (Ashley). Can you repeat that one? This is Sarah Lichtman Spector. I think I may be able to answer that one.

(Ashley): Yes. It says, are MCOs allowed to share information on maintained individuals with Medicaid providers who would like to conduct outreach activities?

Sarah Lichtman Spector: So I think we probably need our managed care colleagues on that. Let me see if any of them are on the phone or otherwise. We may need to take that one. Okay. It sounds like we may need to take that one back.

(Ashley): We have a number of questions asking if the recording of this presentation will be available. And the answer is yes. The recording and/or written transcript of the call will be posted to Medicaid.gov in the next week or so.

The next question, let's see, says, if an individual contacts the agency to report a new address but there is no mail, do states have to grant an additional 30 days based on the date we send the new renewal form or does the initial 30 days from the date the original renewal form was sent stay in place?

Suzette: Thanks (Ashley). So I think the question, you know, is based on the individual not receiving the renewal form but reporting a new address. So yes, the state needs to provide - if the individual never received the renewal form and they have changed their address, the state needs to provide a new 30 days for them to respond to the renewal form.

(Ashley): Thanks, Suzette. The next question says, if the re-determination form is received after the certification has ended but a re-determination cannot be made as information is still missing, does the start of the new certification period start from the date the agency receives the information that enables a re-determination to be made?

(Shannon): Hi. This is (Shannon). So it sounds to me like this question is asking what happens when information is potentially returned during what we call the reconsideration period.

So if an individual loses coverage because they failed to return their form and later comes in and returns their form and, you know, the state may or may not need to reach out to collect additional information based on the information returned.

But if that is the case, then during the reconsideration period, the state acts on the information without requiring the individual to fill out a new application then the state would follow its general practices for processing applications in terms of if the person is found eligible.

They would make coverage based on how they apply the effective date of coverage, whether it's the date the person returns the form or the first of the month in which the form is returned. Retroactive eligibility would apply and the state would need to process the information according to the time standards for processing applications.

(Ashley): Thanks, (Shannon). The next question says a client was renewed in September 2022, but we knew they were not eligible due to resources. If a client reports an unreported change in April 2023, do we have to wait to address the known eligibility factor resources until the next review in September 2023 and just work the newly reported change or can we work all changes in April 2023.

(Shannon): This is (Shannon) again. I think the one part of the question I didn't fully get was whether or not the person's eligibility was in fact renewed at the beginning of the situation.

If the person's eligibility was not renewed, but their coverage has been maintained then the state will need to conduct a full renewal and take into account the change that maybe came in afterwards with the renewal.

If this is a case where the state has successfully renewed someone, meaning all factors of eligibility were considered and the state was able to complete the full renewal process, states have the option during unwinding to act on the change in circumstance during the unwinding period if new information comes in or to wait and address everything with the renewal.

But it sounds to me in this case this was not a person whose eligibility had been renewed in 2022. In that case, the state would need to conduct a full renewal during the unwinding period.

Jackie Glaze: Thank you, (Shannon). We'll move back to the phones to see if we have any questions there. So, Missy, if you could provide instructions once again for registering your questions and then open the phone lines, please.

Coordinator: Yes, ma'am. Again, if you would like to ask a question over the phone, please press star followed by one. Please make sure your phone is unmuted and record your name when prompted. If you wish to withdraw your question, you can press star 2.

Our next question comes from (Edie). Your line is open.

(Edie Meishu): Hi. I was the one that asked - hi. Good morning, everyone. This is (Edie Meishu) in Hawaii. And I had asked that question about the re-determination form, but you answered it.

So basically, if it's turned in after the certification period has ended, we're using our re-determination form instead of an app. We treat it as an app. And so it's from the date we get it. And then if we need follow-up information, we can just follow-up with the client like we do for an application. So you confirmed that for me so thank you.

(Shannon): Yes, that is correct.

(Edie Meishu): Thank you.

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

Jackie Glaze: Thank you, Missy. (Ashley), I see we have additional questions. I think there's one.

(Ashley): Yes. And we'll acknowledge we've gotten a couple of follow-up questions on HCBS and the Section 9817 MOE, but we believe that our subject matter expert needed to drop a little early from the call so we can bring those back next week.

But we do have a question that says, if a state offers a reinstatement period, is CMS saying that the returned mail supersedes that process? Wouldn't the customer be eligible to have their entire lost coverage period reinstated if they responded within that reinstatement window and not just after the date we received the undeliverable mail or is the new guidance meant to imply for undeliverable mail the requirement to reinstate goes even longer?

Suzette: Let me try and talk through the steps. And I think in some scenarios it could go longer than the reconsideration period of 90 days if that is what the state has elected depending on sort of the trajectory of when the state makes (unintelligible).

So what we have said is if the state receives returned mail after the individual has been terminated for failure to respond, then the state must, in order to meet the requirements or the conditions of the CAA, must attempt to reach out through more than one modality at that point.

If the state makes contact with the individual, then the state should reinstate that individual prospectively as of the date that they made contact. The state should then attempt to update contact information and resend a renewal form. If the state finds that the individual is eligible, then the state would reinstate coverage back to the date of termination.

So in some instances, again, depending on when the mail is - when the state receives the returned mail, it could be more than - span longer than the 90-day reconsideration period.

(Sarah O'Connor): Suzette, can you clarify on the retro coverage back to the - you know, if the individual is determined eligible, like once they've made contact and provided all information, and then you said they would reinstate back to the date of termination, is that regardless of - like is that only if they received services during that retroactive period and would have been eligible or is that in all instances?

Suzette: I think we can definitely talk to states about how to operationalize. I think it would be, you know, the state would need to reinstate, but how the state then operationalizes it could be done by the state letting the person know that they had coverage and that if they have bills, that they can submit them to the state.

(Sarah), I'm not sure if that's where you were going.

(Sarah O'Connor): Yes, yes, that's where I was going. Thanks.

Suzette Sure.

Jackie Glaze: Thank you, (Sarah) and thank you, Suzette. So in closing, I want to thank our team for their presentations today. Looking forward, the topics and invitations for the next call will be forthcoming.

If you do have questions before the next call, please reach out to us or your state leads or bring your questions to the next call. We thank you for joining us today, and we hope that everyone has a great afternoon. Thank you.

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

END