HHS-CMS-CMCS

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2:00 pm CT

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 would now like to turn the call over to Jackie Glaze. Thank you. You may begin.

Jackie Glaze: Good afternoon and welcome, everyone, to today's All-State Call-In webinar. I'll now turn to Ann Marie Costello, our Deputy Center Director for Opening Remarks. Ann Marie?

Ann Marie Costello: Thanks, Jackie. Hi, everyone, and welcome to today's all-State call. We're dedicating today's call to discuss the CAA unwinding frequently asked questions that CMS released on May 12th. We'll also take any other unwinding or other questions that you have for the team.

Before we get started, I wanted to let folks know that we'll be using a webinar platform to share slides today. If you're not already logged in, I suggest you

do so now so you can see the slides for today's presentation. You can also submit any questions you have into the chat at any time during our presentation.

With that, I'll turn things over - I'm sorry. With that, I'd like to introduce today's presenters, Sarah O 'Connor, and Suzette Seng, Meg Barry, Marc Steinberg, Melissa McChesney, Gene Coffey, and Kitty Marx, all from our Children & Adults Health Programs Group. With that, I'm going to turn things over to Sarah O 'Connor. Sarah?

Sarah O 'Connor: Thank you, Ann Marie. As you mentioned, a number of us will be providing a brief overview of the topics addressed in the FAQs, which are now available on the Medicaid.gov unwinding page. Next slide, please. I'll begin with the returned mail portion of the FAQs, which are intended to assist States as they operationalize and implement the returned mail conditions in the CAA.

As States are already aware, the returned mail condition requires States to make a good faith effort to contact a beneficiary using more than one modality prior to terminating enrollment during unwinding. The FAQs explain how CMS defines a good faith effort in this context, and also address State flexibilities regarding the timing of conducting the attempted beneficiary outreach using more than one modality to satisfy the returned mail condition. Next slide, please.

Recognizing that mail may be returned to a State agency after a beneficiary's coverage has been terminated for failure to respond to the renewal, the FAQs explain how long after the termination States would be required to act on the returned mail, and also when a State would be required to reinstate a beneficiary's coverage, including the effective date of such coverage if a

beneficiary who has already been terminated responds to a State's outreach attempts.

There's also information on State agencies using managed care plans to conduct beneficiary outreach to satisfy the returned mail conditions in the CAA, and the timeframe States will need to implement the returned mail condition in order to claim the temporary FMAP increase. And with that, I'll turn it over to Marc Steinberg.

Marc Steinberg: Thank you so much, Sarah. So, I'm going to talk - next slide, please. I am going to talk about the resumption of premiums in Medicaid. We've covered a number of these topics orally on prior All-State calls. I'm going to slide some of the topics and then go into a little detail on a few that are more developed and will be presented.

Previously, we discussed in the past the general flexibility that the Consolidated Appropriations Act gives States to change individual premiums between now and the end of this year and still claim the increased FMAP. We've covered the effect at the end of the Secretary declared public health emergency on premium suspensions via disaster relief SPA and that any disaster relief SPAs are now sunsetting or have sun-setted as of May 11th.

And so, States should either resume the premiums under the State plan or take an alternative strategy. There's information on rescinding a disaster relief SPA, which is still (unintelligible) in case you're interested in the process. And then we articulate several strategies States can employ to further delay - let me - next slide, please. Got a little ahead of myself.

We discussed several of the strategies available to States to further delay reinstatement of premiums after the end of the public health emergency. I

want to talk a little bit more on questions 12 through 14 here. Question 12 talks about what beneficiary protections apply to resuming Medicaid premiums that had been suspended while also increasing premiums after April 1st.

States need, of course, to follow all the standard requirements identified in these questions like make sure the premiums are documented in your State plan, you have notice of fair hearing rights. Importantly, any determination of a premium has to rely on income determinations that have been made within the previous 12 months, which means that if the State completed a renewal for the beneficiary in the past 12 months, you can resume the premium without a new redetermination.

As we said before though, if you haven't completed that renewal in the past 12 months, you must complete a new redetermination before resuming or increasing the premiums for that beneficiary. The last two questions I want to spend a little more time on, a question we've gotten is, can a State claiming the temporary FMAP increase for the period between April 1st and the end of this year make changes to its premium schedule?

The answer is it depends. States can reduce their premium amounts or exempt additional populations. You do this via a regular SPA. States can adopt a new optional eligibility group and that group can have premiums. You can do that prior to January 1st, 2024, and still claim the increased FMAP. That's not new policy. That's been the case throughout this period.

But if you're claiming the temporary FMAP, you cannot increase amounts in your premium schedule over the amounts that were in place as of January 1st, 2020. Finally, we've gotten questions, can a State claiming the temporary

FMAP increase disenrolled Medicaid beneficiaries for failure to pay premiums? And the answer is yes, but with some limitations.

The continuous enrollment condition, as we all know, is no longer in effect. So, you can disenroll Medicaid beneficiaries who have not paid premiums for at least 60 days, provided that that is in your State plan, that you follow the normal Medicaid procedures, and that that policy was in place as of January 1st, 2020.

States cannot claim the new FMAP if they adopt a new policy, i.e., a policy adopted subsequently to January 1st, 2020, that would allow disenrollment of a beneficiary for failure to pay premiums. That would be a violation of the Section 6008(b)(1) of the FFCRA. So, again, if you want to continue to claim the FMAP increase, any disenrollment policies must be in your State plan as of January 1st, 2020.

And, as always, before any disenrollments, please, you must consider if the beneficiary is eligible on any other basis, (unintelligible), including a determination of an eligibility in disenrolling the beneficiary. And you must ensure that all beneficiary protections, including the determination of income I just mentioned and all the notice requirements fair hearing rights of a variety of beneficiaries are provided, and those are discussed in the FAQs.

One last point. You cannot disenroll beneficiaries for unpaid premiums accrued during the period when the continuous enrollment condition was in effect. States cannot count any days that occurred while the continuous enrollment condition was in effect toward the 60-day period of non-payment.

You can also not count any days that occurred during a period that Medicaid premiums were suspended by a disaster relief SPA. States can disenroll

beneficiaries for unpaid premiums that were incurred prior to the continuous enrollment condition taking effect on March 18th, 2020, as long as you're not counting any dates between March 18th, 2020, and March 31st, 2023, toward the minimum 60 days.

However, as we say in these FAQs, we encourage States not to count the days of non-payments that were accumulated prior to March 18th, 2020, because it's been such a long time, it's very difficult for an individual to document any payments that were made that long ago. That is the Medicaid premium section in a nutshell. I'm going to pass it to my colleague, Meg Barry.

Meg Barry: Thanks, Marc. Next slide, please. So, we included a few FAQs about CHIP premiums during unwinding. The bottom line of the CHIP FAQs is that States may resume the collection of premiums only for beneficiaries who have had a full renewal within the last 12 months, and a State may only terminate an individual's coverage for failure to pay those premiums during the unwinding period if the individual has had a full renewal within the last 12 months.

And then finally, we have an FAQ about the authorities States need if they wish to resume premiums or terminate individuals for failure to pay premiums, but they have not completed a renewal for all beneficiaries within the past 12 months.

And I'll give my usual plug that if you have any questions about these CHIP premium policies or the disaster authorities you need during the unwinding period, to reach out to your CHIP project officer and they can connect you with the right people. So, with that, I will turn it over to Suzette Seng.

Suzette Seng: Thanks so much, Meg. And this next slide, please. This next question, I think we've answered a number of times in many forums, so we're happy to be able

to provide an answer in writing, which is about renewals, SSI renewal requirements in 1634 States.

So, we just reiterate in our response that States do not have to take affirmative steps to renew Medicaid for individuals who continue to receive SSI in 1634 States. However, States should act on any changes and circumstances that are submitted through the SDX to the States and process those changes in accordance with our regulations.

So, again, we'll really happy to be able to put this one in writing for you all, and let us know if you have any questions. And with that, I will pass it to Melissa McChesney.

Melissa McChesney: Great. Thank you, Suzette. So, this one is about data sharing with enrolled providers. And as many of you know, enrolled Medicaid and CHIP providers receive, as a regular course of business, information about Medicaid beneficiaries so they can do things like verify enrollment and bill for services.

In the context of unwinding, several States voiced an interest in sharing additional data fields, such as a person's renewal date, with certain providers who want to support unwinding efforts by doing outreach to their clients about unwinding and renewals.

This FAQ clarifies that disclosures of beneficiary data to an enrolled Medicaid or CHIP provider to enable the provider to give information about renewals to their patients, is a purpose directly related to the administration of the Medicaid or CHIP State plan, and is therefore permissible.

Medicaid regulation 42 CFR 431.306(d), requires States to seek consent from beneficiaries before making a disclosure of beneficiary data to an outside

source. However, enrolled Medicaid or CHIP providers are not considered an outside source.

Therefore, in this context, prior consent is not required. States should review current agreements with providers to evaluate if they authorized the provider to use beneficiary data from the State to support beneficiaries in maintaining Medicaid or CHIP coverage, and to ensure they include applicable Medicaid and CHIP confidentiality requirements and restrictions on the use of information regarding beneficiaries.

I'll now turn the mic over to my colleague Kitty Marx to discuss data sharing with Indian healthcare providers specifically. Kitty?

Kitty Marx: Thank you, Melissa. Throughout the unwinding process, CMS has released tailored communication tools to support outreach to American Indian and Alaska Native Medicaid beneficiaries. We know that Medicaid revenues play a critical role in supplemental funding to Indian healthcare providers.

We also know that coastal delivery is limited on Indian reservations, and only about 50% of tribal households have internet access. Due to these broadband and coastal delivery limitations, Indian healthcare providers can play a critical role with helping American Indian and Alaska Native beneficiaries with the renewal process.

For these reasons, we've been encouraging States to share data enrollment and renewal data with Indian healthcare providers, and to date, seven States are sharing data. So, thank you to those States. And with this guidance, we hope other States will follow in sharing data, and we'll continue to engage with tribes and Indian healthcare providers throughout the unwinding process. Thank you, and let me go ahead and turn it over to Gene Coffey. Thank you.

Gene Coffey: Yes, hi folks. The next question is the very last question in the FAQs. Is Section 1115 authority needed to enroll individuals in the Medicaid State plan group for former foster care children who meet the eligibility criteria for the group but who turned 18 prior to January 1, 2023? And the answer is no.

And we say this because far more often than not, States will have to collect additional information from individuals they know to be eligible for this group to determine if they are eligible for a separate mandatory group. So, for that reason, we think it's impractical to require that States collect this additional information to enroll these individuals in the former foster care youth eligibility group.

Now, if a State knows such an individual to be eligible in a separate mandatory group, like the SSI mandatory group for individuals in States that do not have a 1634 agreement, yes, it's true, the State will have to enroll the individual in the SSI group.

Additionally, if the State does have information tending to show that the individual might potentially be eligible for a separate mandatory group, the State at least has to advise the individual that they may have a choice to make.

But again, ultimately, we think that it would be most practical for States and beneficiaries alike, for States to simply enroll in the former foster care youth eligibility group, individuals who might be eligible for the separate mandatory groups, but for whom the States would have to collect the additional information. And I'm not actually sure whom I'm turning this over to next.

Jackie Glaze: I think, Gene, you're turning it back to me if you're finished with your presentation.

Jackie Glaze: Gene Coffey: Yes, I am, Jackie. Yes, thank you.

Jackie Glaze: Great. Well, thank you, Gene, and thank you to the CMCS team for your presentation today. So, with the remainder of our time, we will just move to the question-and-answer portion of our discussion today. So, we'll begin with the chat function.

So, we'll ask that you go ahead and start submitting your questions through the chat, and then we will follow by taking questions over the phone lines. So, I'll just turn to you now, (Krista), because I see we do have one question at this point.

(Krista): I have one question in the chat. Based on the FAQs 19, can we treat the FFCC group regardless of aging out before or on or after 1/1 of 2023, the same in our system hierarchy above the most mandatory Medicaid groups?

Gene Coffey: And this is Gene again. Well, the answer is that there is still the hierarchy rule for the former foster care youth eligibility group for individuals who turned 18 before January 1, 2023. What we are saying in our FAQs, again, just to elaborate a little bit further on the answer I just gave, is that where the State knows that the individual, even if the individual turned 18 before January 1, 2023, if the State knows the individual is eligible for the former foster care youth eligibility group, but the State has to proactively gather additional information from the individual to determine if the individual might be eligible for one of the separate mandatory groups, the State can simply enroll the individual in the former foster care youth eligibility group, and 1115 authority is not necessary to do that.

Again, if the State knows, if the State does in some fashion, either through

proactively collecting the information or in some other way or manner, knows that the individual is in fact eligible for a separate mandatory group, be it the pregnant individuals group or as I suggested before, maybe in a non-1634 State, the SSI group, it is true that the State will have to enroll the individual in that separate mandatory group.

But again, it's the State - I'm sorry to say like multiple times, if the State has to proactively collect that additional information, it is okay to enroll the individual in the former foster care youth eligibility group, even if the individual turned 18 before January 1.

Jackie Glaze: Thank you so much. I am seeing one additional question in the chat. Will States be allowed to make changes to the plan for full compliance with redetermination requirements after it is approved?

Jessica Stephens: This is Jessica Stephens. And yes, so I think the idea is for States to submit that plan, which we do six months after you receive your approval letter for your mitigation strategy. And then we'll want to have a conversation with you all to get to a final approval of that plan.

We anticipate, we know that there are things that come up, and I think we'll talk about sort of a monitoring strategy and how to stay in touch on whatever changes that may need to be made, although ideally, we would want to go down a path towards full compliance at that point and identify what changes might need to be made.

Jackie Glaze: Thank you, Jessica. I'm not seeing any additional questions in the chat, so I think I'll return to you, (Ted). If you could please provide instructions to the participants for registering their questions, and if you could open up the phone lines, please.

Coordinator: Sure. 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 again, if you would like to ask a question over the phone, please press Star 1. I'm currently showing no phone questions at this time.

Jackie Glaze: Thank you, (Ted). Back to you, (Krista). Are there any additional questions?

(Krista): I'm not seeing any additional questions in the chat at this time.

Jackie Glaze: Okay, so we'll wait another minute or two and see if we have any questions that come through, and then (Ted), if you could monitor the phone lines and let us know if you have any questions.

Coordinator: Okay. Again, to ask a question over the phone, please press Star 1.

Jackie Glaze: (Krista), I'm seeing one question, actually two.

(Krista): Yes, I just saw a couple of new ones come in. The first one here is, has there been any written guidance provided on how to handle return mail of an AREP/guardian? If so, can you please provide us with that information?

Suzette Seng: Hi, this is Suzette. I think we may have answered - let us take that back. I know we answered a similar question verbally. We answered an authorized rep question, which may be in the transcript of the all-State calls. But if the State has a specific question, please feel free to send it to the unwinding mailbox and we're happy to answer.

(Krista): Great. And there's one additional question here in the chat. Can you please restate the information you provided regarding providing renewal information to Medicaid and CHIP providers? Does there need to be an agreement with them?

Melissa McChesney: Hi, yes, this is Melissa McChesney. And what we stated was that States should review what agreements they already have with the provider to ensure that they authorize the provider to perform the additional outreach and the enrollment support and that they include Medicaid and CHIP confidentiality standards as are required.

But that may be included in current provider agreements. And if that is not included in current provider agreements, then those may need to be amended.

Jackie Glaze: Thank you. (Ted), I'll turn back to you and ask if there are any questions through the phone lines.

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

Jackie Glaze: Okay. (Krista), I'm not seeing any additional questions. Are you?

(Krista): I did get a few questions just about posting the slides. And so, I did just want to remind folks that the slides and the transcript of this call will be posted on Medicaid.gov following the call.

Jackie Glaze: Thank you. I'm not seeing any additional questions, and it sounds like we have no additional questions through the phone lines, so I think we will close early today. So, I would like to thank our team for their discussion, and also looking forward, the topic and invitation for the next call will be forthcoming.

If you do have questions before the next call, please feel free to reach out to us, your State leads, or again, bring your questions to the next call. So, we do thank you for joining us today, 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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