Centers for Medicare & Medicaid Services

COVID-19 Medicaid & CHIP All State Call

June 16, 2020

3:00 pm ET

Operator: Greetings and welcome to the CMCS All State Medicaid and CHIP call webinar. Through the presentation, all participants will be in a listen only mode. Afterwards, we'll conduct a question and answer session. If you have a question, please press the one followed by the four on your telephone. At that time, your line will be accessed to obtain information. You may also ask questions in the chat box at the bottom left of your screen. If at any time during the conference you need to reach an operator, please press star zero.

Now as a reminder, this call is being recorded Tuesday, June 16, 2020. I would now like to turn the conference over to Jackie Glaze. Please go ahead.

Jackie Glaze: Thank you. Good afternoon and welcome everyone to today's All State call. I'd like to begin by walking through the agenda and that we begin with Calder providing welcome and introductions for today's discussion. The focus of our call today will focus on the key dates for termination of the COVID-19 flexibilities. We will also talk about retaining Medicaid state plans flexibilities adopted during the public health emergency after the emergency ends. We will follow with a discussion with questions and answers on the Medicaid state plan flexibilities and your general questions.

So at this time, I'd like to turn to Calder, and he will provide opening remarks for today's call. Calder?

Calder Lynch: Thank you, Jackie. Thanks and welcome everyone for joining us today. As Jackie said, this afternoon we're planning to begin a series of conversations with states regarding the process of unwinding the flexibilities that have been adopted during the public health emergency and beginning planning efforts around that.

So what we're going to have today is going to focus on Medicaid state plan authority and what states would need to do to retain some of the flexibilities or program changes that they've adopted during the public health emergency after it ends. Next week, we'll plan to cover CHIP state plan authorities. We do plan to post today's slides soon, hopefully later today, so they'll be available for your reference, but our staff are going to be onto provide steps that you'll need to make in order to retain some of these changes in the areas like Medicaid eligibility, enrollment, cost sharing, benefits, pharmacy and provider reimbursement.

We'll also review some of the requirements to keep in mind around public notice, tribal consultation and state plan submission timelines that are going to be

important if states want to ensure that there's no interruptions in the authority tied to some of these program changes. Then we'll, of course, open up the lines for any questions you have on this topic of retaining flexibilities. After those, we'll go to more general state questions. At the end of our call, John Giles, the director of our division of managed care policy is going to share a general reminder about state directed payments and some timelines associated with submission.

Before we get started, I do have a couple notes to share with you. As everyone should know, Health Resources and Services Administration (HRSA) is administering the Provider Relief Fund on behalf of the department and is currently working with providers on funding specifically targeting Medicaid providers. We know that there's a lot of questions that you're probably fielding from providers in your states about that process and what they need to do. So HRSA is planning on conducting webinars for providers on this particular distribution of the Provider Relief Fund. They're in the process of giving the details and timing of those worked out, and as soon as we have it we will be sharing that with you so that you can also share that through your provider communication channels in your state.

But now, let's turn to our topic for today, which is retaining the Medicaid state plan flexibilities adopted during the public health emergency. The first thing I'm going to cover before handing it over to staff is just a couple of the key background points and context that's important to keep in mind. A lot of the flexibilities that we've been able to provide states around adoption of disaster state plan amendments and then as we get into further of these for future weeks, 1135 waivers, et cetera, are tied to the links of the public health emergency. So I want to begin with the discussion and just a reminder about what that is and what some of those corresponding timelines mean.

As folks are probably aware, the secretary of HHS, under section 319 of the Public Health Services Act may determining that a public health emergency exists when there is a disease or disorder present or that there's a public health emergency. So he has that power to make that declaration. These declarations are made in periods of 90 days, at which time they can be renewed.

So when we're talking about this specific public health emergency as it links to COVID-19, the secretary first declared a public health emergency existed effective January 27th, 2020. On April 21st, he renewed that public health emergency with an effective date of April 26th, 2020. Therefore, this current public health emergency that we're operating under would have to be renewed again effective July 24th, 2020 or it would expire at that point. So that's the current timeline. As soon as we have any indication about further extensions or steps related to the public health emergency, we would of course share that, but right now that's the operational reality that we're operating under.

Now what does that mean for Medicaid, and let's turn to the next slide. There are some key dates, and again these slides are going to be available to you afterwards. So you don't have to rush to write any of this down. But there's some key dates related to the various Medicaid and CHIP flexibilities, many of which link back to the public health emergency. Some of this content may look familiar to you. It's been included in some of our prior FAQs that we've issued, but we've expanded on it a little bit to add some additional dates to consider such as when the date for the enhanced Federal Medical Assistance Percentages (FMAP) itself actually ends under the Families First Coronavirus Response Act (FFCRA).

I want to remind states generally that you don't have to wait until these dates are approaching or to the end of the public health emergency to take steps to either begin transitioning away from some of the program changes you've enacted or take steps to make permanent or retain some of the flexibilities or program changes that you've enacted. That's what we're going to begin talking about today.

So the CMCS team is Stephanie Bell, Melissa Harris, and Amber MacCarroll are going to be begin that dialog in greater detail. So I'm going to turn it over to Stephanie now.

Stephanie Bell: Thank you. Hi, this is Stephanie Bell. I'm a senior policy advisor in the children and adult health programs group in CMCS, and as you review all the different flexibilities that you've been using during the public health emergency, you may find that it would be helpful to extend temporarily some of the provisions or even retain some of the provisions permanently that you have found to work really well.

So we've put together a helpful tool, hopefully it'll be helpful to you, that walks through each of the different provisions in the disaster relief SPA and provides the information that you'll need if you want to continue that provision. We thought this would be a good opportunity to do a little refresher, both for you and for us on what is the regular standard SPA requirements that we all need to be following when we move past the disaster period, and we wanted to make sure that you had built in enough time if you wanted to submit a regular SPA.

So this first slide here is a snapshot of the public notice requirements for submitting a Medicaid state plan amendment. These are the requirements for regular, traditional standard State Plan Amendment (SPA). The timing and the content of each provision are described in the regulations. You'll see there are only three types of SPAs that have a public notice requirement. So premium and cost sharing SPAs, alternative benefit plan SPAs, and all the SPAs containing any payment provisions.

In some cases, the public notice is required prior to submitting, and in other cases it's required prior to the effective date. So if you're thinking about doing any of

these types of SPAs, like sending any of the temporary authorities you have in these areas, I encourage you to take a closer look at the regulations and make sure you're thinking about that as you consider the timing.

Next slide please. This is another reminder about tribal consultation requirements. So in those states where tribal consultation is required, the policy will be described in your approved state plans. Depending on the type of SPA that you want to submit, you may again need to build in time to do tribal consultation. Whenever it is required, the tribal consultation has to occur prior to submission. So, again thinking about building it in time.

I also want to note here just the quick note at the bottom, just a reminder that the CMS 179 form must be included with every SPA submission. If you're doing a submission in macro or in Medicaid Model Data Lab (MMDL), it's built into the system, but if you're submitting a traditional SPA via email to the SPA mailbox, make sure you include the 179 form. Also, don't forget to put in the fiscal impact when you're doing it.

The last reminder here I think is the most important, and this is the effective date requirements for SPA. So Medicaid SPAs must be received by CMS no later than the last day of the fiscal quarter in which the SPA will be effective. For the disaster relief SPAs, we have flexibility still under section 1135 to waive this requirement and allow for an earlier effective date, but once we get past the public health emergency, we're going to have to revert back to the rules of the effective date. So we have to pay close attention to make sure that, for example, if you wanted to have a SPA effective on August 1st, 2020, then you would need to make sure that it was submitted to CMS no later than September 30th, 2020. So just something else to think about building into your timeline.

As you're thinking about the different provisions that you may want to extend, just in general keep in mind will public notice be required, if yes, do I have to do it before I do my submission, do I need to build in time for tribal consultations and then what is the latest date that I can submit and still receive the effective date that we want.

Okay. Let's go to the next slide. So here is the first slide of this handy tool that we've put together. We've broken it out by category. So this first section is all about eligibility, my personal favorite. No offense to the other important parts of Medicaid. What we've got here is each provision in the disaster relief state plan amendment, the page in the current state plan where you would find that provision if you want to extend it in your state plans, the submission pathway, and then a reminder is public notice required or not.

So here in eligibility, you see most of the provisions are going to be submitted through MACPro the exception of post eligibility treatment of income, which hasn't been transitioned over yet. You'll find it on attachment 2.6A, and it should

be around Section B if you're looking for the right page to use to extend any changes to the personal needs allowance. But let's say, for example, you had a disregard in your disaster relief state plan amendment for a state supplement for the public health emergency. That disregard was applied to the ticket to work basic group. So if you wanted to extend that disregard you would need to go into MACPro and start a new submission with the optional eligibility group's reviewable unit, and you would add the ticket to work basic group. That's where you would find the options to include the disregard for that eligibility group.

I want to note the little asterisk on the optional groups. Just noting that the COVID-19 testing group does expire at the end of the public health emergency along with any renewals of the public health emergency. So there is no option to retain that group after the disaster period ends.

Next slide. Okay, these are the enrollment provisions that are in the disaster relief state plan amendment. We've got presumptive eligibility, hospital PE, continuous eligibility, renewal and applications and similar to eligibility, most of these will be found in MACPro, with the exception of continuous eligibility which you would submit through via email to the SPA mailbox in attachment 2.2A of the state plan right now.

So just to give a quick example here. Many states elected to add the Medicaid agency as a qualified entity for determining presumptive eligibility. So let's say you've added that authority for both pregnant women and children, presumptive eligibility. To extend it in your state plan, you would again go into MACPro and you would select a presumptive eligibility (PE) reviewable unit, and you would add PE for pregnant women and PE for children. Then within those reviewable units you would find the option to establish the state as a qualified entity.

Next slide please. All right, last but not least for me is cost sharing and premiums, and you will see all of the cost sharing pages are submitted through MMDL. Premium pages are submitted through the SPA mailbox. So if, for example, you had temporarily suspended all cost sharing for the public health emergency period, and you wanted to continue that temporary extension for a period of time to help people transition back into the regular routine of things, you would submit one of these pages, one of these PDFs, a G2a, G2b or a G2c pages through MMDL. So depending on did you have cost sharing for categorically needy, do you have it for medically needy, and if you have any targeted cost sharing, you would also submit the G2c page.

I want to flag here that public notice is required for any cost sharing or premium SPAs, anything that's substantially modified premiums or cost sharing. So for example, suspending all cost sharing would be a pretty substantial modification. It would require public notice or any change that related to the consequences for non-payment would also require public notice.

So I'm going to stop there and turn it over to Melissa Harris to pick up with benefits.

Melissa Harris: Hi. Thanks Stephanie. This is Melissa. I'm going to walk through the benefits section. This happens to be my personal favorite. I've never been able to understand really anything about eligibility. So I find comfort in really diving into the provision of care. So let's talk about this slide. You'll see a lot of variations on a theme here and I'll provide a couple of examples of the types of actions that a state might want to take. So let's say you have added a benefit during the public health emergency and you want to retain that new benefit in your state plan. An example of this could be a clinic benefit or a particular type of clinic. You would amend your state plan at either the 3.1A or B page. The 3.1A pages are for services provided to individuals who are categorically needy and the 3.1B pages are for services provided to medically needy individuals.

So depending on whether you want to provide those services to both or just the categorically needy, you would submit an amendment to your 3.1A or B pages. With the exception of alternative benefit plans, which we'll get to in a second, all benefit state plan amendments are submitted through the SPA mailbox. For adding an optional benefit, you don't need to do any public notice requirements, but note the double asterisk here. This will apply to a lot of benefit actions. If there is a change in payment for a particular service, then there will need to be a public notice for those payment provisions, and my FMG colleagues will solidify that point in a minute.

So let's say that you wanted to incorporate an adjustment that you had made to an optional benefit providing more hours of a service or providing a different amount or duration or scope of a service, the instruction would be the same. You would note that new provision, we have that new parameter in the appropriate 3.1A or B page. You'd also submit that through the SPA mailbox. The same public notice standard goes. It's only required if there is a change in the payment for that service.

For alternative benefit plans, these are for the services authorized under section 1937 of the Social Security Act. These services are provided to all individuals in the new adult group and if state options some other individuals as well. This SPA form has a template and these are submitted through the MMDL. So be aware of that difference between Alternative Benefit Plans (ABP) amendments and amendments to other benefits. So you would note any changes on the ABP form five and submit those through MMDL.

Note here that there are specific public notice requirements for alternative benefit plans, and these public notice requirements must happen before the submission of an ABP plan if you're either establishing a new plan or making an amendment to substantially modify an existing plan. If you have any questions about whether a particular change you're envisioning would count as a substantial modification

and therefore require public notice, we can certainly walk you through that in the form of some technical assistance.

So let's say that you have incorporated telehealth into your state plan and you want to continue with the provision of telehealth as you have it now in the public health emergency. It could be that you don't need to do anything in terms of submitting a state plan amendment. You'll want to look at what you currently have spelled out for telehealth in your section 3.1A or B pages. It could be that you have nothing at all about telehealth, and in that case, you don't need to submit any kind of an amendment.

If you have some limiting language in your 3.1A or B pages restricting a particular service from being provided under telehealth or prohibiting a particular provider from delivering services under telehealth and you want to remove those restrictions, then you'll want to submit those pages, again through the SPA mailbox, and we will review those amendments to your 3.1A or B pages. Again, no public notice is necessary unless you're making changes to payment provisions associated with those telehealth changes.

If we can go to the next slide. I'll spend a moment on pharmacy benefits, and you'll notice here that all pharmacy changes are submitted through the SPA mailbox, and they don't have any public notice requirements associated with them. There are a couple of different types of actions that a state could be making to their pharmacy benefit. It could be that you want to modify the day supply or a quantity limits for your covered outpatient drugs or you want to change your monthly prescription limits or you want to change your prior authorization parameters. You'll want to look at what you currently have in your state plan in your 3.1A or B pages, and if you're wanting to modify something that's already there, then you would need to submit those pages as an amendment, again through the SPA mailbox.

We can go to the next slide please. I'm going to focus on the second row for a minute. The same goes for exceptions to the preferred drug list. You only need to make an amendment there if there is existing language that you want to change. But if you are making an adjustment to the professional dispensing fee. This would be a change in your 419B payment pages for your pharmacy benefit. You'll note that there is a public notice requirement here and that public notice must happen prior to the effective date of a new SPA. So that's something that you'll definitely want to pay attention to.

If you'd like to change your coverage of investigational drugs, you'll also want to change your attachment 4.1B for payment pages and, if necessary, amend your attachment 3.1A and B pages for the benefit descriptions if there's existing language that you need to modify. Again here, note that there are public notice requirements that must occur prior to the effective date of the state plan amendments.

So we can go to the next slide and then I'm going to turn it over to Amber MacCarroll in the financial management group. Thanks.

Amber MacCarroll: Thank you, Melissa. Hi. This is Amber MacCarroll. I'm a senior policy advisor in the financial management group. I'm going to briefly cover the requirements for submitting reimbursement or payment SPAs. As you can see on the slide, we give some examples of when the state might want to submit a payment or reimbursement SPA or when it would be required. For example, if you had increased provider payment rates during the public health emergency (PHE) and want to continue paying providers at those higher rates, you would need to submit a regular state plan amendment. Or if you had added optional benefits and want to continue to provide those benefits after the end of PHE, then you would also need to submit the applicable payment pages for those benefits.

Just for general reference, I want to just highlight that we had... CMS has developed the SPA submission resources that are available on Medicaid.gov. These resources can be found under the resources for states dropdown menu on the Medicaid.gov landing page, and by clicking on the Medicaid SPA toolkit link. So if you're new to the SPA process or just need a refresher, there's a lot of good information within that toolkit.

As you can see from the slide, generally, all reimbursement SPAs are submitted through the SPA mailbox. The only exception is the home health SPAs and those are submitted through MACPro. All reimbursement SPAs should include the standard SPA package which includes the SPA transmittal cover letter, the completed form CMS 179 and the new SPA pages. For the reimbursement SPAs, I think the biggest takeaway that I want folks to remember is that when submitting a reimbursement SPA, public notice and when applicable public process must occur prior to the effective date of the new SPA. Although the regulations allow a state to make a reimbursement change effective back to the first day of the quarter in which the SPA is submitted, that change may only be effective one day after the public notice is issued.

As usual, as we go back to our normal processes, states should plan to include the responses to the five funding questions and any applicable Upper Payment Limit (UPL) demonstrations with their SPA submissions and both the funding questions are available and information on the UPL demonstrations is available on the toolkit that I highlighted earlier. The language of the SPA must be comprehensive and fully describe the service payment methodology in order for CMS to approve it. If you have any questions about a particular methodology or you're planning to submit a SPA that's particularly complicated or you need just help in understanding the federal requirements, please reach out to us and we're happy to assist you, and the more we can work with you on the front end, the easier the SPA approval goes on the back end.

That's all I have on reimbursement pages. I think the next slide is questions. So I'll turn it-

Jackie Glaze: Thank you.

Amber MacCarroll: Back over to Jackie.

Jackie Glaze: Yes. Thank you, Amber, and just thank you to all of our speakers for your remarks today. So we will begin by taking your questions now and those would be specific to the discussion that you just heard on the retaining flexibilities. So the format that we will follow, we will begin by taking your questions through the chat function first, and then we will follow by taking your questions over the phone. So for those of you that would like to use a chat function, I ask that you submit your questions at this time.

Calder Lynch: Jackie, it looks like we may already have some questions if we want to start.

Jackie Glaze: Yes. We're ready. So Barb, are you ready?

Barbara Richards: Yes. So our first question, and Calder I think this is more to you, is are you going through this because you're not planning on extending the PHE?

Calder Lynch: Yeah. So as I mentioned earlier, the decisions around extending the public health emergency are made at HHS and not CMS. I don't have any particular insights into what factors go into that or when or how that decision would get made, but whether it expires in July as according to the current timetable or it's extended in the future, it will end at some point and with it, there will need to be transitions because some of these authorities will expire with it. So we think it's prudent to begin planning now.

States also may need to be thinking now about some of the things they already know they want to make permanent or flexibilities that they no longer need to have in place as the situation on the ground changes. So we think it's all worthwhile exercise to begin working through that so that whenever the public health emergency ends it's a smooth transition for states, but most importantly for beneficiaries.

Barbara Richards: Great. Thanks, Calder. We also have another question that says, I think this is more to our colleagues in disabled and elderly, will telehealth flexibilities go back in full to pre-COVID policy status?

Melissa Harris: So this is Melissa Harris, and I will say that states are largely in the driver seat there. In the Medicaid program, there's an enormous amount of flexibility for states to determine how telehealth is used in the provision of Medicaid services. States may have, during the course of this public health emergency, uncovered

that there were some state level limitations that they've had to quickly work around to ensure maximum use of telehealth. So it might be that there's more work to be done at the state level to ensure that those flexibilities are retained after the public health emergency. We are certainly available to states to answer any questions that they might have.

In terms of the state plan accounting for telehealth, there's really only federal approval necessary if a state needs to walk away from a restriction in their current approved state plan or change the methodology for paying for services that are provided in telehealth. Otherwise, there's really no federal approval that you would need, and it might just be working to understand what kind of state level restrictions that might need to be exceeded on a permanent basis beyond the purview of CMS. That's something we can certainly walk through with you.

Barbara Richards: Great. Thanks, Melissa. So our next question might be a bit technical, but I'll just turn this back to our disabled and elderly colleagues and you can let us know whether you want to answer it or follow-up. The question is where does CMS recommend that states put COVID-19 specimen collections by pharmacist?

Melissa Harris: This is Melissa, and that is a technical question, and we will be speaking to that shortly. We've got a couple of options that we want to solidify and some operational state plan and guidance about how to reflect the role of pharmacist and the state plan is one of those issues. So if we can ask for your patience for just a little bit, we hope to have something out in the near future. So thank you.

Barbara Richards: Great. Thanks, Melissa. We have another question that's... the question is can states begin to submit SPAs before the PHE period ends so that they're effective right after the PHE ends?

Calder Lynch: So the answer to that is yes, and that's part of why we're beginning this conversation now is that you don't have to wait until the end of the public health emergency to make decisions about changes that you might want to make permanent in your program nor do you have to wait until the end of the PHE to begin taking down some of the changes that you made if they're no longer needed or appropriate.

So the answer is certainly yes, and we can work with you on the precise effective date of the given changes within the parameters we've outlined to make sure that there's no interruption if that's the state's desire.

Barbara Richards: Great. Thanks, Calder. So we have a premium cost sharing question I think for CAP. Please confirm that if a state will resume monthly premiums under its disaster SPA? Sorry, the questions keep moving. It's a little hard to read. Please confirm that if a state will resume monthly premiums requirements... I think we should come back to this one. It's long. We'll come back to this one. Sorry about that.

So we do have another question in the chat box asking if we need CMS approval to begin taking down flexibilities granted under the 1135 authority? Jackie, can you answer that?

Jackie Glaze: Sorry. We're going to have to follow back up. I think we're still doing research on that, but we will certainly follow back up with guidance on that.

Barbara Richards: Great. Thank you, Jackie. It looks like we have another telehealth question, and we've been asked if can you confirm if the term telehealth includes audio only? And can our colleagues in DE perhaps address that please?

Melissa Harris: Hi, it's Melissa. The question was whether telehealth in audio only is allowed? Is that it?

Barbara Richards: Yes. If the term telehealth includes audio only.

Melissa Harris: That's an interesting question. So there's an answer right now and an answer that will apply after the public health emergency. So right now our colleagues in the Office of Civil Rights have issued some enforcement discretion guidance that indicates that they are not enforcing typical prohibitions on the use of audio only telephonic modes of telehealth. Typically the use of the telephone violates HIPPA privacy provisions, and I'm speaking as a lay person here. So forgive me if I'm getting some of the technical nuances wrong.

So if we were not in a public health emergency, there would be no opportunity for telephonic usage to be used as the mode of telehealth. That flexibility is available right now during the public health emergency because of the Office of Civil Rights' enforcement discretions. That agency, OCR, will need to determine what's happening with that enforcement discretion after the public health emergency concludes. So they will need to be speaking one way or the other to that point, but there is telephonic ability right now during the public health emergency.

Barbara Richards: Great. Thank you.

Jackie Glaze: We'll take one more question. We'll take one more question through the chat line and then we'll open up the phone lines.

Barbara Richards: Okay. It looks like we have one more. This is more general question, and Calder maybe this is for you. When would states know if the PHE will be extended after the July 2020 date?

Calder Lynch: Yeah, so what we've seen in the past is that when they're renewed, that notification would come a few days in advance of the 90th day which is sort of the deadline after the last renewal. So as soon as we have any indication of that

or see that, we'll push that out of our listservs as we did last time to make sure folks are aware or if there's a decision made about further extensions, we'll make sure that that gets shared as soon as we know it. But I would expect there to be sometime getting close, which is why I think it's important to begin thinking through some of these efforts now.

Jackie Glaze: Thanks, Calder. So operator, we're ready to open up the phone lines at this point. Can you provide instructions to the audience on how to submit their questions?

Operator: Thank you so much. If you would like to register a question, please press the one followed by the four on your telephone. You will hear a three tone prompt to acknowledge your request. Your line will be accessed from the conference to obtain information. If your question has been answered and you would like to withdraw your registration, please press one three. One moment please for the first question.

Once again, to queue up for a question, please press one four on your telephone keypad. There are no questions on the line.

Jackie Glaze: Thank you. We'll wait another minute or two and then we will open up the chat function again to see if folks would like to submit additional questions, general questions that they may have. Are there any other questions through the phone line?

Operator: Once again please press one four. Yes, we now have a question from the line of Bill Logan. Please go ahead.

Bill Logan: Yes. I have a question with regards to some guidance that came out a while back with regards the maintaining individuals' eligibility for benefits in order to keep the enhanced FMAP. Specifically, the guidance that was provided indicated that... it related to waiver services that the state needed to still retain the ability to make determinations based upon the need of the individual and adjusting what services they were receiving. My question is whether or not that same flexibility applies to determinations as to medical need for state plan services. For example, if we made the determination that an individual needed a reduction in perhaps in-home nursing hours, whether those determinations are permissible and would allow the state to continue to receive the increased FMAP.

Barbara Richards: Melissa, are you going to jump in?

Stephanie Bell: So, this is Stephanie-

Melissa Harris: Okay. Hi, this is Melissa Harris and I'll take a shot at it and ask my colleagues to jump in as well. So what you're asking about is guidance that we issued a while ago on the maintenance of effort (MOE) requirements under the Families First

Coronavirus Response Act. I'm pretty sure I have that acronym correct, and it spelled out several requirements that states had to undertake in order to qualify for the enhanced 6.2% FMAP bump.

So it's safe to say that we've gotten some questions based on that guidance and we are taking a looking at if there are alternate questions or alternate answers that we can provide. So we are hopeful that we will have something else in the coming days and will be able to have a more fulsome conversation about that and answer questions about we waive individuals receiving services in 1915C, homeless community-based services waivers, individuals receiving services under the state plan, what happens if there's a change in someone's financial eligibilities, what happens if there's a change in someone's functional status. We're happy to walk through all of those questions and we're hopeful that guidance will be on the street as quickly as possible. So appreciate your patience there.

Barbara Richards: Great. Thanks, Melissa. So I think we've got a question for Stephanie Bell or her colleagues in CAP around premiums and cost sharing. The question is if a state wants to resume a monthly premium requirement for a program which it waived premiums under its disaster SPA does it need to submit a SPA or not?

Stephanie Bell: This is Stephanie. I will take a start and then others can jump in and add to it, but the waiver of the premiums in the disaster relief SPA is set to automatically sunset at the end of the public health emergency. So whatever was in your state plan before will automatically go back into effect at the end of the public health emergency unless you submit a new SPA to extend the changes that were made. So you don't have to take any actions, at least on the state plan side, but you probably will need to take actions to notify beneficiaries and stuff like that.

Jackie Glaze: Are there any additional questions through the phone line?

Barbara Richards: So we have one about-

Operator: Not at the moment. Once again, please press one four. No questions on the phone line.

Calder Lynch: I think we can probably open up to more general questions too if folks were holding those back.

Operator: We do have a question on the phone lines. Coming from the line of Eve Lickers. Please go ahead.

Eve Lickers: In the MOE requirements in order to get the enhanced FMAP and our question is whether or not an individual or a beneficiary that is currently in or as of March 18th was in a category of coverage that was excluded from copayment. So say

someone who is under the age of 19 who all copayments are excluded or someone who delivered a child and has now gone past their postpartum period. Can they be moved to a benefit package or which the cost sharing is not across the board excluded? So they would be subject to copayment requirements in that case.

Sarah deLone: So this is Sara deLone. That is also a question that will be addressed in the guidance that Melissa referenced that we hope will be out very soon, and also adding my appreciation to hers for your patience.

Eve Lickers: Thank you.

Barbara Richards: Got a question in the chat for our colleagues in CAHPG. For recipients whose Medicaid eligibility was retained solely due to the emergency, do the states have to re-determine eligibility prior to termination?

Sarah deLone: Generally yes. It may depend, this is Sara deLone again, it depends on when that redetermination was last conducted, but if it wasn't relatively recently, then the state would need to make sure that that person's circumstances have not changed such that they now are eligibility. So the redetermination would need to be redone prior to termination and then a proper advanced notice that is provided.

Calder Lynch: And I think, Sarah, correct me if I'm wrong, but our plan is to try to have some more detailed guidance out to states on ending the continuous coverage requirements at the end of the PHE prior to that time and what steps we think makes sense in terms of returning to more normal eligibility operation.

Sarah deLone: Absolutely. Absolutely, recognizing that many states will have... be in different states in terms of their having been able to continue to process renewals but not act on them. Some are not able to continue to process those renewals. Many states have had to pause processes, changes in circumstances. So states will be in different positions in terms of the extent to which they have a backlog of work to do. So we are thinking very carefully about what kinds of timelines are reasonable for states to catch up, and we'll definitely be providing some detailed guidance on that coming up.

Barbara Richards: Great, thanks Sarah. We have another question in the chat box for our colleagues in CAP regarding tribal consultation. If we do not know that the emergency ends until a few days before the current end date, there will not be enough time for advanced consultation with tribes prior to submission of a permanent state plan amendment. Will CMS wave the consultation timelines for that reason?

Sarah deLone: So CMS cannot waive the... Once the PHE is over, we won't have the 1135 authority available to waive those requirements or to alter those requirements in the case of tribal consultation. If you have an authority, as Calder mentioned

earlier, if there is a state plan authority that you know you will want to continue, you do not need to wait until the PHE is over in order to submit a SPA to extend that. So you could start thinking about that right now. Do your tribal consultation even now or soon so that you're prepared and even submit the SPA. We can work with you on state plan amendments to continue an authority post PHE as early as you're ready to submit your SPA.

Barbara Richards: Great. Thanks, Sarah. We have another one for our colleagues in CAHPG. Many nursing home residents have accrued excessive assets due to an additional period of eligibility for Medicare payment for their cost of care and generally because they are unable to shop and spend money. Are flexibilities available for states to allow additional time for nursing home residents to spend down their excessive assets at the end of the PHE?

Jackie Glaze: Stephanie Kaminsky, do you want to take that?

Stephanie Kaminsky: Sure. So there will not be additional time for nursing home residents to spend down those additional assets, but states can come in with a SPA, a routine SPA and disregard those assets until the next redetermination or until whatever period the state chooses. So we've heard that question a number of times and there are ways to retain such individuals' eligibility, but it would be through a SPA disregard of those assets.

Barbara Richards: Great. Thanks, Stephanie, and I think we should turn it over to the phone lines again because we only have one more question in the chat.

Jackie Glaze: Yes. Operator, can we take a couple more questions and then I'd like to turn to John Giles?

Operator: Sure thing. Once again, please press one four to queue up for a question. We do have a question from the line of Nicole Silks. Please go ahead.

Nicole Silks: Hi, I have a specific question about continuing eligibility, but if somebody is being investigated or prosecuted for fraud, for welfare fraud by like a federal agency or even a state agency, are we able to discontinue their benefits under those instances or do they have to be continued as well?

Sarah deLone: That is also a question that will be addressed or maybe addressed in the upcoming, and we can also work with you offline. Can you give us to make sure we caught your name?

Nicole Silks: I did send the question to my CMS state lead, but I figured since I was on the call I'd just throw it out there to see if you know.

Calder Lynch: No, no, that's come up. That's come up, and we're working through that. I mean part of the issue is we're trying to understand what other statutes may be at play because Congress only provided for very specific exceptions to the continuous coverage requirements in the FFCRA, of which that would not fit neatly under one, although logically you would think that in those cases you would be able to, but ultimately, the statute doesn't provide a lot of room there. So we're working through that, but again I would just point you back to the statute which only really provides for the residency exceptions if someone moves out. But we'll definitely try to follow up on that in our written guidance.

Nicole Silks: Okay, thank you.

Jackie Glaze: Okay, we'll take one more question.

Operator: Over the phone lines, we have a question from the line of Rhonda Workman. Please go ahead.

Rhonda Workman: Hi, this is Rhonda Workman. I just had a question for Melissa. Is there any update on retainer payment flexibilities?

Melissa Harris: Hi. Thanks for that. We hope to be able to have that articulated and publicized as well. Oh dear. I hope my dog is not audible to everyone else as he is to me. So we have a number of guidances that we hope are fairly close to being issued and retainer payments is on that list. We know it is a front runner issue for a lot of people.

Rhonda Workman: Great. Thank you.

Jackie Glaze: And thanks for all of your questions today, but before we wrap up I'd like to turn to John Giles. He would like to provide some information on the directed payment preprint. John?

John Giles: Thank you, Jackie, and good afternoon everyone. As many of you know, we published managed care guidance on May 14th to announce temporary and targeted flexibilities to help states address the public health emergency in their managed care programs, including how states can use state directed payments to temporarily enhance provider payment as part of the states managed care contracts. We wanted to take this opportunity to give states a quick reminder regarding on state directed payment preprint submissions for the current state fiscal year.

Since most states operate on a July to June fiscal year, states must submit any state directed payment preprints for approval before the end of the current contract rating period. Since we are quickly approaching the end of June, states operating on a state fiscal year basis must submit their preprint submissions for

the state fiscal year 2019, 2020 rating period before July 1, 2020. We also want to clarify that state directed payments are only permitted retrospectively to the start of the current contract rating period as laid out in our guidance. CMS will not be able to approve any new state directed payments for rating periods that have ended.

So thank you so much. Then I think I'm turning this to Calder for a wrap up.

Calder Lynch: Yep. Thanks, John. I thought as we were rapidly approaching the end of this, of many of your fiscal years, it'll be worth just a quick reminder on that. So appreciate you doing that, John. Okay. I think with that, we will go ahead and wrap up today's call. I did want to let you all know that the presentation that we did earlier is already up on the website under the Medicaid COVID-19 page on Medicaid.gov under the Medicaid and CHIP resources section. So you can go find that there now as a good reference tool.

I think with that, we will go ahead and wrap up. We will plan to have next week's call on next Tuesday and we'll get information about the topic and invitation out very soon. So thank you all. Have a good afternoon.

Operator: That concludes today's call. We thank you for your participation and ask you to please disconnect your lines. Have a good day.