Centers for Medicare & Medicaid Services

COVID-19 Medicaid & CHIP All State Call

November 17, 2020

3:00 pm ET

Operator: Greetings and welcome to the CMCS All-State Medicaid and CHIP Call Webinar. During the presentation, all participant lines will be in a listen-only mode. Afterwards, we will conduct a question and answer session. Participants can ask a question in the chat box at the bottom left of their screen. If you have a question on the audio line, please press the one followed by the four on your telephone at any time during the presentation. At that time, your line will briefly be accessed from conference to obtain information. If at any time during the conference you need to reach an operator, please press star zero. As a reminder, today's conference is being recorded Tuesday, November 17, 2020. I would now like to turn the conference over to Jackie Glaze. Please go ahead.

Jackie Glaze: Thank you and good afternoon everyone and welcome to today's all-state call and webinar. I'll now turn to Anne Marie Costello, our acting center director and she will share highlights for today's discussion. Anne Marie.

Anne Marie Costello: Thanks very much Jackie. Welcome everyone and thanks for joining us today. For the first agenda item on today's call, we're going to shift gears just a little bit away from discussing COVID-19 and hear from CMCS staff about our recently released Medicaid and CHIP Managed Care Final Rule. The final rule helps to streamline the Medicaid and CHIP managed care regulatory framework, reduce administrative burden and regulatory barriers to ensure that states are able to work efficiently and effectively to design, develop, and implement Medicaid and CHIP managed care programs that best meet state's local needs.

Anne Marie Costello: John Giles, the Director of our Division of Managed Care Plans in the Disabled and Elderly Health Programs Group will provide an overview of the final rule's major provisions and discuss how these provisions compare with those included in the notice of proposed rulemaking issued two years ago. After John's presentation, we'll take your questions about the managed care rule. Then we'll continue our discussion from the last few weeks regarding the continuous enrollment provisions of the interim final rule.

Anne Marie Costello: Sarah deLone, the Director of the Children and Adults Health Programs Group and our subject matter experts will talk through the answers to a

number of additional state questions on the continuous enrollment provisions under interim final rule that were submitted during the FAQ portion of our last call. After those Qs and As, we will open up the lines for your general questions on any topic. I will note that we will use slides for today's managed care presentation. If you are not logged into the webinar, I recommend that you do so now. The slides will be posted on Medicaid.gov shortly after today's call.

Anne Marie Costello: Before we hear from John, I'm going to turn things over to Ellen-Marie Whalen, our CMCS Chief Population Health Officer to give a quick update on resources that are available to states considering implementing alternative care sites as you continue to respond to the COVID-19 public health emergency. Ellen-Marie.

Ellen-Marie Whelan: Thank you Anne Marie. As we're facing new COVID-19 surges across the country, we wanted to remind you about some of the resources available for states that are considering setting up additional alternate care sites. The term alternate care site or ACS is used to describe any building or structure that is temporarily converted or newly erected for health care uses. These are also sometimes referred to as temporary expansion locations, temporary expansion site field hospitals, or by other names. Most ACSs are established and operated by existing hospitals and health systems and follow our Hospital Without Walls guidance to obtain Medicare and Medicaid payments for covered health services furnished at the ACS.

Ellen-Marie Whelan: The Hospital Without Walls waiver allows already enrolled hospitals and health systems to treat the ACSs at temporary expansions of their existing brick and mortar location. In these circumstances, the local hospital and health systems operate staff and bill for care furnished at the ACS. In contrast, some state and local governments have also established, meaning developed or built, a hospital ACS. While state and local governments may establish the ACS, who and how the ACS is operated will determine if the services delivered at the site can be reimbursed by Medicare and Medicaid.

Ellen-Marie Whelan: During this time of great urgency in the public health emergency, we wanted to let you know that if your state is considering establishing an ACS separate from an existing hospital or health system, please reach out to your CMS state lead as soon as possible to let them know that this is in the works. We understand these sites won't likely provide care only to Medicaid beneficiaries. I want to remind you there are specific rules on how these sites must be operated in order to be paid by CMS for furnishing covered hospital inpatient and outpatient services to enrolled

beneficiaries. CMS with FEMA and ASPR, the Office of the Assistant Secretary for Preparedness and Response, have staff and a wide variety of resources available to help states work through this process.

Ellen-Marie Whelan: There isn't time to review all those details now, but in addition to working one-on-one with states that are interested, we will be setting up a call with states to walk through some of the logistics and answer questions. To say again, if you're aware that your state is considering establishing an ACS separate from an existing hospital or health system, please contact your state lead, and we can start the conversation early in the process to ensure the care delivered at that site can be paid by CMS for the services delivered. With that, I'll pass this over to John Giles.

John Giles: Thanks Ellen-Marie and good afternoon everyone. My name is John Giles, and I'm here to spend a little bit of time with you about the Medicaid and CHIP Managed Care Final Rule. It's been quite a journey for us to get this final rule out, and so we're glad to spend a few minutes with you today talking about some of the major provisions. On the first slide here, we have for you just a couple of reminders about the publication date. As a reminder, we first published the notice of proposed rulemaking back in November of 2018. The final rule officially published in the Federal Register last Friday on November 13th, and we've provided a link here for you to access the full copy of that final rule.

John Giles: I will note for those who have been looking, the final rule is just 91 pages in the Federal Register. It is much shorter than some of our previous rules in the past. As Anne Marie noted for you at the top of the call, CMS had several goals in mind when we were working through the final rule. The final rule was really intended to improve the balance of federal oversight and state flexibility, while maintaining many of those critical beneficiary protections that we have in place. While we had goals of reducing administrative burden on states and supporting state flexibility, that was carefully balanced with several other goals that we've had which is promoting transparency and innovation in the program, fostering accountability, and really maintaining and enhancing program integrity.

John Giles: Now, we're just going to step through the major provisions that are in the final rule and cover it at a high level for you. The first topic is really setting actuarially sound rates, and the way these slides are structured is since it's been a couple of years since some of you may have read through that proposed rule, we wanted to give you an overview of what that proposal was and how we landed in the final rule. That'll be the theme as we walk through these slides. The first topic here is really about rate ranges. In the proposed rule, just as a reminder, CMS had proposed that

states could develop and certify a rate range up to 5% within certain limitation, including that both the upper and lower bounds of the rate range needed to be actuarially sound.

John Giles: In the final rule, we are finalizing this provision with a couple of modifications as detailed here. One of the first things is that we're permitting states to move those rate cells within that 5% rate range within a de minimis amount, or plus or minus 1%. You'll remember in the proposed rule that the certification of point had to be documented prior to the rating period, and that is still true in the final rule, and that no modifications were permitted without a revised rate certification. That is slightly changed here in the final rule to acknowledge that states have natural programmatic changes that they need to make throughout a rate year, and that there needs to be some acknowledgement that even in the use of a rate range, that is still true, and that you can move that plus or minus 1%.

John Giles: I would note that that de minimis range is slightly smaller than the de minimis rate range when you certify to a point, which is maintained at 1.5%, and we'll cover that in a future slide. The second thing that was finalized here with a modification is a transparency requirement on the use of rate ranges, and it does require states to post on their public website certain key information about the rate range prior to executing a managed care contract. You'll see here that includes what the upper and lower bounds of their rate cell was, a description of all of the assumptions that vary between those two bounds, as well as a description of any of the data and methodologies that specifically vary between those two upper and lower bounds.

John Giles: All of that would need to be posted on your public website for transparency purposes. Moving right along, the next slide is also about actuarially sound rates. Many of you will remember that in the proposed rule in 2018, we had specified that any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations must be based on valid rate development standards that represent actual cost differences in providing those covered services, and that any differences in those assumptions, methodologies, or factors cannot vary with the rate of federal financial participation. In the proposed rule, we included a list of prohibited rate development practices that we have proposed along with that provision.

John Giles: In the final rule, we are finalizing the policy about actual cost differences, but removing the list of prohibited rate development practices. That comes though with the ability of CMS to request information from states; written

documentation and justification about any of those differences that are occurring in the assumptions, methodologies, or factors that are used to develop those capitation rates, and to ensure that any of those differences really are based on actual cost differences. You will see as you read through the final rule that we really reference back to those rate development practices that we had originally proposed to prohibit as really the guiding standard that we would use as we review state's proposals.

John Giles: All right. The next slide here is covering a few things from the proposed rule. The first was to maintain the ability of states to utilize a de minimis 1.5 adjustment during the rating period without submitting a revised rate certification for states that are not utilizing the rate range option. This is for states that are certifying to a point. This provision was finalized as proposed with no change. The second area on this slide, we have proposed to codify requirements for CMS to issue annual sub-regulatory guidance to help streamline rate review processes, as well as to address other updates and development in the rate review process. Many of you are already aware that CMS on an annual basis publishes an annual rate development guide.

John Giles: This really codifies that requirement into regulation and ensures that CMS will continue to publish that guidance on an annual basis, and so that was finalized as proposed. The third area here on this slide was to prohibit states from adding or modifying risk sharing mechanisms after the start of a rating period. This was finalized as proposed, and we would note is a slight difference from where we've been as part of the public health emergency, CMS had noted in some FAQs and in some sub-regulatory guidance documents that we would permit these kinds of retroactive or sharing mechanisms because the final rule was not out. We wanted to let you know and draw attention to that because now the final rule is published, and so that would change that guidance.

John Giles: A few things here on pass-through payments and state directed payments. As part of the proposed rule, we had permitted a new transition period, a 3-year transition period for states that are transitioning from managed care to fee-for-service, and that that would allow states to make new pass-through payments that were at an amount that was equal to or less than their existing supplemental payments under fee-for-service. That provision was finalized as proposed, and then we had several provisions related to state directed payments. We have the provision related to not requiring prior approvals if a state was utilizing a state plan approved fee schedule, which means essentially that CMS would no longer require a pre-print for those kinds of payment arrangements.

John Giles: That was finalized as proposed. We had also proposed to allow multi-year payment arrangements for certain state directed payments, such as for value-based purchasing. That was finalized as proposed, and I did want to draw your attention to the last bullet on this slide about a provision that would have allowed us to acknowledge additional types of state directed payments, as well as would have removed the prohibition on specifying amount and frequency of state directed payments. We did not finalize those changes, so that regulatory text would stay intact for states not being able to prohibit the amount or frequency of a state directed payment.

John Giles: On the next slide, we talked about the network adequacy standards. There were two primary proposals here. One was to replace the existing time and distance standard for network adequacy standards and to propose a more flexible requirement for states to establish any quantitative standard. This is particularly important because of the surgence of telehealth. That was finalized as proposed. We had also clarified that states have the authority to define specialists when designing those standards, and that was also finalized as proposed. For appeals and grievances, we had proposed three different things here. The first one was to eliminate the requirement for enrollees to submit a written signed appeal after their oral appeal was submitted.

John Giles: That was seen as reducing some burden on enrollees. That was finalized as proposed. The second provision here was to allow states to really sync up their state fair hearing timelines between managed care and fee-for-service, so allowing for a range of anywhere between 90 calendar days and the existing 120 calendar days, which would allow states to sync up those timelines. That was finalized as proposed. And then we also finalized the definition of an adverse benefit determination to eliminate administrative claim denials, such as a provider didn't put the right NPI number on their claim, and that would also eliminate notices under that provision.

Jackie Glaze: John, this is Jackie. Just want to signal to you, you have three minutes left.

John Giles: Sure. Thank you Jackie.

Jackie Glaze: Great. Thank you John.

John Giles: Okay. A few things on beneficiary information. Several proposals here all being finalized as proposed, replacing the requirement for 18-point font on taglines and adopting the conspicuously visible standard. Eliminating the requirement for taglines to be on all written materials, and instead would only be on those critical to obtaining services. Modifying the updates

needed for the provider directory from monthly to quarterly, as long as the managed care plan is offering a mobile enabled directory. And then modifying the timeline just slightly for notice when a provider has given their termination to a plan. Again, all of those provisions being finalized as proposed. A few things on the quality rating system.

John Giles: We had proposed to add a QRS development process requirement that CMS would develop a minimum set of mandatory performance measures that would apply equally between the federal QRS and the alternative QRS, and that has been finalized as proposed. We're also being more explicit that CMS would consult with states and other stakeholders as we develop the substantially comparable standard for an alternative QRS. Of note here that we did not finalize the requirement. We were proposing to eliminate the requirement that a state received their approval from CMS when they are pursuing an alternative QRS, and that is not being finalized. Quickly, a few things here for CHIP.

John Giles: CHIP is generally aligning with Medicaid when appropriate, really adopting almost all of the provisions related to network adequacy, medical loss ratio, quality, appeals, and grievances, and other provisions where appropriate. There are also a few CHIP technical clarifications in the rule to correct when provisions did not apply to CHIP. You'll see some of those technical amendments in the final rule, and then we have a compliance date slide here that really just specifies the compliance date. All of the provisions of the final rule are effective December 14th of 2020, with a couple of exceptions. The pass-through payment transition period, as well as the rate range provision, those will go into effect July 1 of 2021 for rating periods beginning on or after July 1, 2021.

John Giles: There are also a couple of delays for provisions related to quality strategies that are submitted, as well as external quality review, technical reports, and those provisions also apply for those documents being submitted on or after July 1, 2021. I know that was a lot of material to cover, and we only had 15 minutes to do it. Jackie, am I turning this over to you for a Q&A session?

Jackie Glaze: You are, you are. Thank you so much John, and thank you Ellen-Marie. We're ready now to take your questions on the managed care final rule. We'll begin by taking questions through the chat function, so you begin putting your questions in at this point, and then we'll follow by taking a few questions by the phone. I see a few questions already now.

Ashley Setala: Yes, and the first question that's come in on the managed care rule is, on the 438.6(c) changes, could you give examples of supplemental payments

that trigger CMS approval obligations, and would upper payment limit add-ons to fee-for-service rates to their prior approval obligation?

John Giles: Sure. I can answer that question. I think this is related to the two definitions that we put in the rule, as well as in the 6C section saying that if you are pursuing a state plan approved fee schedule that the prior approval requirement for a pre-print is not triggered. I want to be clear, the supplemental payment I think the example that the commenter gave is an add-on rate related to upper payment limits. We would consider that to fall into the bucket of a supplemental payment, and so therefore would not qualify as being a state plan approved rate. Generally, our understanding of many of those add-ons are calculated retrospectively and then paid in a lump sum, so that would not meet the intent of the definition that we laid forth in the regulation.

John Giles: We're really looking for eliminating the prior approval, that is the pre-print, when it is a specific rate for a specific service that is documented in your state plan, so not related to those supplemental payment requirements such as a UPL arrangement.

Ashley Setala: Okay. Thank you.

Barbara Richards: Great. Thank you John. John, we've got a question about the timing. The next question is, given the majority of sections of the final rule come two weeks before a new annual contracting cycle, will there be delayed enforcement action?

John Giles: I would say this about the provisions of the final rule. We delayed specifically the requirements around the new pass-through payment transition, as well as the rate range provision, to coincide nicely with a rating period, but most of the requirements in this regulation are not necessarily going to be new requirements placed on states. For example, you can think about the network adequacy requirements. If a state is using a time and distance standard today, that certainly is going to meet the spirit of having any quantitative standard. There's not necessarily a change that needs to be made right away. It is an option that states will have in future rating periods.

John Giles: The same could be said for those who may want to take advantage of the range that we're giving for state fair hearing timelines, right? As long as states are utilizing the 120 calendar days per the regulation today, there's not actually an immediate change that they need to make to come into compliance, because the 120 days still lines up. I think what you'll see as states assess these requirements is that many of these things are new

options for states, such as eliminating the 18-point font, or utilizing a different standard for their taglines.

John Giles: I don't necessarily think there's going to be a lot of things in this final rule that will trigger the immediate need to modify their contracts, but as always, states should take a look at their contracts, make sure that there's nothing that they see, and make those determinations. But that really was our thinking as we thought about those compliance dates is that most of these things are new options for states that would not necessarily necessitate an immediate contract action.

Ashley Setala: Okay, and then the next question that has come in is, what is the effective date for the prohibition against adding or modifying risk sharing mechanisms after the start of the rating period?

John Giles: That is one of the provisions that will go into effect, December 14th. I will note that of course, it's driven by performance period under the contract. To the degree that states had implemented a retroactive risk sharing mechanism or had modified the terms of that mechanism prior to the effective date for a previous period of performance, the rule does not go back and retroactively amend that. The prohibition on adding or modifying terms of a risk sharing mechanism would really be moving forward from December 14th on to the performance period of the contract.

Jackie Glaze: Let's transition to the phone lines at this point. Jennifer, can you give instructions to the audience and then open the phone lines please?

Operator: Thank you. If you would like to register a question on the audio lines, please press the one followed by the four on your telephone keypad. You will hear a three-tone prompt to acknowledge your request. Your line will then briefly be accessed from conference to obtain information. If your question has been answered and you would like to withdraw your registration, please press the one followed by the three. Again, if you'd like to register a question on the audio lines, please press one four on your telephone keypad. We do not have any audio questions at this time. I will turn the conference back over to you.

Jackie Glaze: Thank you. Ashley and Barbara, we have time for another question or two and then we can move on to the next presentation.

Barbara Richards: Great. Thanks Jackie. John, we've got another question for you. Could you give a specific situation where a risk sharing mechanism would be prohibited?

John Giles: I don't think that the final rule gives a situation where a risk sharing mechanism would be prohibited, but what it does say is that states can't add or modify the terms of a risk sharing mechanism after the start of the rating period. For example, if a state has an existing risk sharing mechanism in place today after December 14th, which is the effective date of this policy, states would not be able to come in and modify those terms during the rating period. They would need to negotiate those terms ahead of the next rating period, and make sure that it's reflected in contracts and rates for the next rating period to comply with the final rule.

John Giles: What this really begins to foreclose is issues where a state may come in six months into a rating period and adding a brand new risk mitigation that never existed in the contract before, or there were terms for risk mitigation in a contract and the state is coming in maybe six months until rating period and modifying those terms. The rule really changes that to be those things have to be negotiated prior to the start of the rating period for which the risk sharing mechanism would apply.

Ashley Setala: Great, and we have I think one more. We are issuing our 2021 managed care contracts next week. It sounds like we can amend the contracts in say a few months from now to reflect the choices that our state make and have those changes be effective as of a future date, such as July 1, 2021. Can you confirm that that's correct?

John Giles: Yeah, I think that's generally right. For example, you could imagine that those contracts contain many of the provisions that are already codified because of the 2016 final rule, and a state decides that some of the modifications in this rule would be something they would like to take advantage of, there wouldn't necessarily be anything that's out of compliance with the existing contract. I mean states will need to make that assessment, but likely not. Then they could choose to incorporate some of these things into their contracts, or make some revisions for a specific date in the future, so sounds like July 2021 might be a date that the state thinks about, that would certainly be something that a state could do to adopt some of these new options under this final rule.

Jackie Glaze: Great. Thank you John. I know...

Barbara Richards: John, will CMS be updating the state Medicaid managed care guide? Last updated January 2017.

John Giles: Absolutely. We are committed to annually updating the rate development guide. Our goal is generally to update that guide in the spring ahead of the new rating period. I know this past year we were delayed with that update

due to the public health emergency. We apologize for the delay, the delay in our ability to post that. Our goal would be to update the rate development guide hopefully in the spring of 2021 for the July 1, 2021 rating period start date.

Jackie Glaze: Thank you John again, so we'll now transition to Sarah deLone and the other subject matter experts to discuss the FAQs on the maintenance of effort provisions of the IFC. Sarah, I'll turn it over to you.

Sarah deLone: Great. Thanks Jackie, and we have received a number of questions on the continuous coverage requirements for the maintenance of effort in the IFC for states to claim the 6.2 percentage point FMAP increase. These questions relate to a variety of different policy areas including transfers of assets, med petty, medically needy, changes to cost sharing and benefits, among others. In today's call, we are planning to answer questions we have received in two areas. First, Stephanie Bell is going to answer questions we have received on when states can or must move beneficiaries to a different eligibility group. Second, Jessica Stevens is going to answer some questions about the meaning of validly enrolled.

Sarah deLone: We will address questions received in other policy areas on upcoming calls. Stephanie maybe first starting with you, a movement between eligibility groups. Can you just provide a general rule of thumb for when states should move beneficiaries to a different eligibility group under section 433.400 of the interim final rule?

Stephanie Bell: Certainly, so states are required to apply regular, federal, and state Medicaid policies to beneficiaries, unless such policy would violate the requirements described in section 433.400 and the state is claiming the temporary FMAP increase. Recall that 433.400 defines three tiers of coverage. This means that the beneficiary enrolled in tier one or tier two coverage is determined ineligible under one eligibility group or demonstration, but eligible under another group or demonstration. The state must transition that beneficiary to the latter, unless doing so would result in the beneficiary receiving coverage under a less robust year.

Stephanie Bell: In the case of a beneficiary enrolled in tier three coverage, the state cannot transition the beneficiary to the new group or demonstration, unless the beneficiary requests to be transitioned. Beneficiaries can always request to be transitioned to a different eligibility group in any tier for which they are eligible.

Sarah deLone: Thanks. Stephanie when a validly enrolled beneficiary becomes ineligible for Medicaid, so not eligible on any basis, can the state choose the

eligibility group in which to hold that beneficiary provided that it is within the same tier of coverage as the original group? For example, to accommodate eligibility systems limitations, could a woman who is no longer pregnant or in the postpartum period and who does not meet the criteria for any other Medicaid eligibility group, can she be transferred from the pregnant women group to the adult expansion group described at 42 CFR 435.118[1]?

Stephanie Bell: Good question. The answer depends on the coverage provided to the beneficiaries in each eligibility group. For a beneficiary who is determined ineligible for Medicaid on any basis prior to the last day of the month in which the PHE for COVID-19 ends, the regulation at 42 CFR 430.400(c)(2)(i)(4)[2], I hope you got all that, specifies that if states meet the requirement to maintain enrollment by continuing to provide the same coverage that the individual would have received absent the determination of ineligibility.

Stephanie Bell: If a beneficiary enrolled in the pregnant women group is not eligible for any other Medicaid eligibility group at the end of her postpartum period, the state must continue to provide that beneficiary with the coverage that would have been available to her if she remained eligible for the pregnant women's group. Now if the alternative benefit plan available to beneficiaries in the adult group provides the same Medicaid benefits package that is available to beneficiaries in the pregnant women's group, the beneficiary could be maintained in either group, and the state would be in compliance with 433.400(c)(2)(i)(4) through the end of the month in which the PHE ends.

Stephanie Bell: I note that if the beneficiaries move to an eligibility group with a different FMAP, the state will need to ensure that the appropriate FMAP is claimed.

Sarah deLone: Thanks. Does the IFC, does the interim final rule require states to act on known eligibility changes, or does it provide states with the option to act on such changes?

Stephanie Bell: Another good question. If the state has determined that a beneficiary one, is no longer eligible for the group in which he or she is currently enrolled and two, is eligible for another group providing the same tier of coverage, the state must transition the beneficiary to that new eligibility group.

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[1] Please note that this citation was inadvertently incorrect. The correct citation is: 435.119.
[2] Please note that this citation was inadvertently incorrect. The correct citation is: 42 CFR 433.400(c)(2)(iv).

Sarah deLone: With the exception I think that you noted above with the tier three groups that would require beneficiary to agree that they want to be transitioned to a different tier three group. Correct?

Stephanie Bell: Yes, yes. Thank you.

Sarah deLone: Thank you. We've got another question. Before the interim final rule, when a beneficiary was enrolled in the adult group described at 42 CFR 435.118[3], when that beneficiary became eligible for a Medicare savings program eligibility group, we were required to keep the beneficiary enrolled in the adult group and also enroll the beneficiary in the MSP group. Based on the changes made by the interim final rule, please confirm that eligibility in the adult group can now be closed when an individual is enrolled in an MSP group, because both groups provide tier one coverage.

Stephanie Bell: Yes, we can confirm that when a beneficiary becomes ineligible for the adult group and they are eligible for coverage in an MFP group like, for example, the qualified Medicare beneficiaries or QMB group, which is described at section 1902(a)(10)(E)(i) of the act, the state would terminate the beneficiary's coverage in the adult group and transition that beneficiary to the QMB group. Now section 430.400(c)(2)(i)(B) of the interim final rule provides that a state satisfies the requirement to maintain abeneficiary's enrollment in tier one coverage by furnishing the medical assistance available through the Medicare savings program, which is minimum essential coverage.

Stephanie Bell: However, before terminating coverage in the adult group, the state would also need to determine whether the beneficiary is eligible for any other full benefit Medicaid eligibility group in accordance with 42 CFR 435.916(F)(1)[4], because the beneficiary can be enrolled concurrently in the QMB group and another full benefit Medicaid eligibility group.

Sarah deLone: Thanks. Now a slight variation on that last question. If a beneficiary becomes ineligible for Medicaid on any basis, but is eligible for or receiving Medicare, should the beneficiary's Medicaid eligibility be terminated since Medicare is considered minimal essential coverage? For example, an individual in the adult group turns 65 and becomes eligible for Medicare, but is ineligible for any of the Medicare savings program eligibility groups, or any other Medicaid group, can the state terminate this

[3] Please note that this citation was inadvertently incorrect. The correct citation is: 435.119.
[4] Please note that this citation was inadvertently incorrect. The correction citation is: 42 CFR 435.916(f)(1).

individual's Medicaid coverage because he or she has Medicare, which is minimum essential coverage?

Stephanie Bell: In this case, the answer is no. Section 433.400(c)(2) of the interim final rule requires states to maintain the Medicaid enrollment of all Medicaid beneficiaries who were validly enrolled on or after March 18, 2020 through the last day of the month in which the public health emergency for COVID-19 ends as a condition for receiving the temporary FMAP increase. The terminating the Medicaid coverage of a beneficiary enrolled in tier one coverage, when that beneficiary becomes eligible for another form of minimum essential coverage like Medicare, does not comply with that requirement at 433.400(c)(2).

Stephanie Bell: If a beneficiary becomes ineligible for the adult group, and that beneficiary is not eligible for any other Medicaid eligibility group, then again in accordance with 433.400(c)(2)(i)(4), the state would continue to provide that beneficiary with the coverage available to beneficiaries enrolled in the adult group, and they would do so through the last day of the month in which the PHE ends.

Sarah deLone: Similarly, the basic health program, CHIP, and qualified health plans offered through the exchange all provide minimum essential coverage. Can astate terminate the enrollment of a Medicaid beneficiary receiving tier one coverage who becomes ineligible for Medicaid during the public health emergency and is simultaneously determined eligible for the basic health plan or CHIP or enrollment in a qualified health plan?

Stephanie Bell: Again, the answer is no. Section 433.400(c)(2) of the interim final rule requires states to maintain the Medicaid enrollment of all Medicaid beneficiaries who were validly enrolled on or after March 18, 2020 through the last day of the month in which the public health emergency for COVID-19 ends as a condition for receiving the temporary FMAP increase. Their terminating a Medicaid beneficiaries coverage when that beneficiary becomes eligible for a different form of minimum essential coverage, like basic health, like Medicare, like CHIP, or even a qualified health plan offered through the exchange would not be in compliance with 433.400(c)(2), because those other forms are not Medicaid. The three tiers of coverage which are described in 433.400(c)(2) are applicable only to coverage provided by Medicaid.

Sarah deLone: We have one more question in this area, and I'm afraid we're probably not going to get to the questions this week on validly enrolled. We may need to do those next week, but our last question I think that's worth doing here today. When a state conducts a redetermination based on an identified

change in circumstances and the beneficiary does not return documents needed to verify continued eligibility, this is during the PHE, is the state allowed to terminate enrollment, or must the state maintain coverage in the eligibility group in which the beneficiary is currently enrolled?

Stephanie Bell: All right. The requirement at 430.400(c)(2)(i)(4) to maintain the Medicaid coverage provided to a beneficiary who is validly enrolled and becomes ineligible for Medicaid prior to the last day of the month in which the PHE ends, also applies in cases where a state otherwise would terminate a beneficiary's eligibility on a procedural basis. This includes failure to respond to a request for additional information with one exception related to state residency, and that's described at 430.400(c)(3). You may recall that exception relates to a situation in which the PARIS interstate match has identified simultaneous enrollment in benefit programs in different states.

Stephanie Bell: For example, suppose Sam is enrolled in the group for low-income children and the state receives information from quarterly wage data that indicates that Sam's household income exceeds the income standard for the children's group, but the child's family does not respond to a request from the state for additional information. Suppose also that based on the quarterly wage data received, the state cannot determine Sam to be eligible on another basis. Now ordinarily, the state would terminate the child's eligibility on a procedural basis due to the family's failure to return information needed to determine eligibility.

Stephanie Bell: However, in order to comply with section 430.400(c)(2)(i)(4) of the IFC, the state must continue to provide Sam with the same coverage provided to beneficiaries enrolled in the eligibility group for children under age 19, through the end of the month in which the PHE for COVID-19 ends. Then a family is subsequently determined eligible for a different eligibility group that provides the same tier of coverage, which in this case is tier one, the state would then transfer Sam to the new eligibility group.

Sarah deLone: Great. Thanks Stephanie. Jackie, I know we have another minute or two left, but I think it probably doesn't make sense to start in on the questions on validly involved. We'll attend those until next week, and I'll turn it back to you.

Jackie Glaze: Thank you so much Sarah and Stephanie for your remarks. We will now begin taking questions from the audience, and so we'll start with the chat function. You may begin submitting your questions at that point, and then we will follow by taking questions over the phone line. If there's any questions that you may have from today's presentations or any other

general questions that you have, so go ahead and start sending those in now. Thanks.

Ashley Setala: We've gotten a few into the chat already. The first question is, while the PHE and MOE requirements are in effect, can we move individuals to other Medicare savings program groups that offer lower levels of subsidy? For example, moving from the QMB group to the SLMB group.

Sarah deLone: Steph, do you want to answer that or do you want me to?

Stephanie Bell: I would say yes, state could move an individual from the QMB group to the SLMB group because both groups would be tier one benefits that are considered minimum essential coverage.

Sarah deLone: I would say correct.

Stephanie Bell: All right.

Barbara Richards: Great. Thanks Steph, thanks Sarah. We have a question about the Medicare savings program recipients and that being minimal essential, MEC basically. The question is, we have never been told Medicare savings program recipients, QMB only, SLMB, et cetera were minimal essential Medicaid coverage. Why is that changing?

Sarah deLone: I can take this one. It's not changed actually. It's all Medicaid is considered to be minimal essential coverage, unless it is carved out if you will in the IRS regulations that implement section 5000A(f). I think it's (f)(1) is where Medicaid is defined to be minimal essential coverage and in the IRS regulations, certain limited benefits Medicaid eligibility groups, as well as all section 1115 demonstrations was removed from the definition if you will from being minimum essential coverage under 5000A(f) and the IRS regulations, unless CMS designated the coverage to be minimal essential coverage.

Sarah deLone: Any number of you may remember, early on, we developed the state health official letter and some standards for designating whether coverage was NEC or not NEC, and we went through that process in terms of demonstration coverage and coverage for pregnant women. Family planning coverage is not NEC. The MSP groups, that coverage was not carved out of the definition of minimal essential coverage, so it is considered to be minimal essential coverage. No special designation was needed. You didn't need to separately effectuate that because by definition, if somebody has an MSP group coverage, they also have Medicare. They do in fact have the full major benefits that are required.

Sarah deLone: Functionally, they have full robust coverage that meets the standard for minimum potential coverage typically required, but from a legal perspective, because the two go hand in hand, IRS did not and we didn't think IRS needed to at the time, remove the MSP categories from the definition of minimum essential coverage. It always has been and MSP coverage still is considered to be minimum essential coverage under the IRS regulations.

Ashley Setala: Okay, and then we have...

Jackie Glaze: [Crosstalk] can we do one more question, and then we'll move to the phone lines. Thanks.

Ashley Setala: Sure. We've had a couple of questions come in about transferring between CHIP and Medicaid. Can you clarify whether kids can move from CHIP to Medicaid and/or from Medicaid to CHIP?

Stephanie Bell: This is Stephanie. I can take that one, and I can say that a child can move from CHIP to Medicaid because the requirement at 6008(b)(3) only applies to Medicaid, so it wouldn't be applicable to a child who's losing their CHIP coverage, but a child couldn't go the other direction, unless CHIP provided through a Medicaid program which is just essentially Medicaid for this purpose.

Sarah deLone: Right. A kid could go from the Medicaid group that's plain old Medicaid, maybe the low-income children's group to a Medicaid expansion piece of the state's Medicaid program for which it's receiving title 21 match because it's all Medicaid, but not to a separate CHIP.

Jackie Glaze: I think we're ready now to open up the phone lines. Jennifer, could you give instructions, and then we'll take the questions?

Operator: Thank you. If you'd like to register a question on the audio lines, kindly press the one followed by the four on your telephone keypad, and one moment please for the first question.

Jackie Glaze: Jennifer, are there any questions in the queue?

Operator: We do have two questions. We're just gathering their information now.

Jackie Glaze: Okay, all right.

Operator: Our first question comes from the line of Ana Arcs. Please proceed with your question. Miss Arcs, have you perhaps muted your line? Your line is open.

Ana Arcs: Hi, can you hear me?

Ashley Setala: We can hear you Miss Arcs, please go ahead.

Ana Arcs: Okay, thanks. I'm calling from DHS, the Department of Human Services in Pennsylvania and we had a question about EPSDT coverage. In Pennsylvania, we cover children up to age 21 with full children's benefit package which includes EPSDT. We wanted to know if the language in the final rule states need not maintain EPSDT benefits for beneficiaries who turn 21 in order to comply with the terms of 6008(b)(3). Does this mean that a state that has the option to continue EPSDT benefits for those individuals that turned 21 since March of this year until the end of the PHE and continue to receive the 6.2% FFP bump, or must the state and EPSDT benefits with the individual turning 21?

Sarah deLone: This is Sarah, it's a must.

Ana Arcs: It's a must.

Sarah deLone: The normal course of business, yeah, when an individual turns 21, they're no longer entitled to EPSDT benefit, then that's not going to move the individual in and of itself from one share of coverage to another. EPSDT in the ordinary course of business would end. Nothing about doing so would violate the terms of the regulation, and so then you know the state must do that, must end the EPSDT.

Ana Arcs: Okay, great. Thanks.

Sarah deLone: Mm-hmm (affirmative).

Ana Arcs: Thank you very much.

Sarah deLone: Welcome.

Jackie Glaze: We'll take one more question.

Operator: Our next question comes from the line of Eve Lickers. Please proceed with your question.

Eve Lickers: The question about whether or not a state is able to move a child who may be served in a home and community-based service waiver that is for infants and toddlers, are they able to be moved to traditional children's package, so that they can receive early intervention services?

Sarah deLone: Yes. Well, we're running out of time. I'll just say if we don't answer it, you please reach out to your state lead, and so we can get more details, but if something in the child's situation has changed, such that maybe they're no longer eligible for that waiver program but they're eligible under another category, or if something in their situation's changed, they're eligible for something in addition, as long as if you ordinarily would be moving them and they stay in the same tier of coverage. If it's going to be a full state plan benefit package, that's going to be tier one coverage like that, so that should be fine, right? The tier one is the most robust of the three tiers.

Sarah deLone: It sounds like the answer is going to be yes, but it may be worth following up with your state lead to just provide a little bit more particulars about this exact situation you're referencing, so that you don't take the general answer, and you misapply it in your particular situation.

Eve Lickers: Okay. Thank you very much. Generally basically what happens is, is that age three, they age out of that particular waiver, but because of the PHE, they had maintained coverage within the waiver and the children were not able to be moved into the other program. I think you've answered the question. Thank you.

Sarah deLone: Yeah, you're welcome.

Jackie Glaze: Thank you. Now, I'll turn to Anne Marie so she can wrap up today. Anne Marie.

Anne Marie Costello: Thanks. Thanks Jackie and thank you to everyone. I really want to in particular thank Ellen-Marie, John, Sarah and all of our subject matter experts for your excellent presentation and information. There were always more questions than we have time for, so looking forward to planning to host a call next week. The invitation and topics will be forthcoming, but we will continue to answer the questions that we receive through the chat function that we don't get to each meeting. Of course, as questions come up between calls, feel free to reach out to us, your state leads, or bring your questions to our next call. Thanks for joining us today and have a great afternoon. Bye.

Operator: This does conclude today's presentation. We thank you for your participation and ask that you kindly disconnect your lines. Have a good day everyone.