Centers for Medicare & Medicaid Services
COVID-19 All State Call
Tuesday, November 24, 2020
3:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode until the question-and-answer session of today's call. At that time, if you would like to ask a question, you may press star 1. Today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the meeting over to Jackie Glaze. You may begin.

(Jackie Glaze): Thank you. And good afternoon everyone. And welcome to today's all state call. I'll now turn to Anne Marie Costello, and she will provide highlights for today's discussion. Anne Marie?

Anne Marie Costello: Thanks, Jackie and welcome to everyone. And thanks for joining us today. On today's call we'll discuss and update to the vaccine toolkit that we released yesterday, and continue our discussion the last few weeks, regarding the continuous enrollment provisions of the Interim Final Rule.

As you'll remember, the vaccine toolkit which we originally released on October 28, provides information on vaccine coverage, payment and administration under Medicaid, CHIP and the Basic Health Program. Yesterday's update includes information on the public readiness and emergency preparedness or the PREP Act authorizations related to COVID-19 vaccinations.

The implications for Medicaid and CHIP coverage and reimbursement and authorization for pharmacies distributing and administering certain coverage countermeasures, including the COVID-19 vaccine. Kirsten Jensen, the

Director of our Division of Benefits and Coverage and the Disabled and Elderly Health Programs Group, will present the toolkit update.

After Kirsten's update, we'll have a short Q&A on the vaccine. Then we'll continue our discussion from the last few weeks regarding the continuous enrollment provisions of the Interim Final Rule. 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 questions on the continuous enrollment provisions of the Interim Final Rule.

So what we didn't get to answer last week, we're going to try to answer today. After those FAQs, we'll open up the lines for your general questions on the IFC, vaccines or any other topic. I do want to note that the recordings and transcripts from our previous calls are posted on the COVID-19 page of Medicaid.gov when they are ready, you will need - you would like to revisit any of the previous calls.

So if you're struggling to write down some of the answers to the questions, you'll have an opportunity to listen to the call again. If you go on our COVID-19 page, scroll all the way down to the bottom to the state calls, and then you'll find the calls by date. With that, I'll turn things over to Kirsten Jensen, to start our vaccine toolkit update. Thank you.

Kirsten Jensen: Thank you, Anne Marie. Hi. This is Kirsten Jensen and I will focus today on the updates to the toolkit that we released yesterday. As you know, this is a very fluid situation, so as we have updates to this toolkit we will update the toolkit over time.

In terms of the update we issued yesterday, in the managed care section, we clarified that during, excuse me, during the course of the public health

emergency, that Medicaid beneficiaries covered through alternative benefit plans in Medicaid and the Basic Health Program, must provide coverage for and must not impose any cost sharing for "qualifying coronavirus preventive services," including a COVID-19 vaccine regardless of whether the vaccine is delivered by an in-network or out-of-network provider.

We also added language to encourage states to set specific network adequacy standards for pharmacy providers who furnish COVID-19 vaccines. And we added language that managed care plans should offer additional network provider agreements to pharmacy providers who can furnish COVID-19 vaccines.

This is to help ensure adequate and timely access to vaccines and this is in addition to our encouragement that states should consider suspending limits on out of network coverage for the vaccines. I think it's safe to say the goal is to make sure that Medicaid beneficiaries and Basic Health Program beneficiaries, have access to vaccines and their administration.

Now turning to the PREP Act which is more of the focus of this particular presentation. A little bit about the PREP Act. The PREP Act authorizes the Secretary of the Department of Health and Human Services to issue a declaration that provides immunity from suit and liability for claims of loss caused by, arising out of, relating to, or resulting from administration or use of covered countermeasures to diseases, health conditions, other threats.

Kind of legalese here, but it's important to set up the context. This immunity extends to entities and individuals involved in the development, manufacturing, testing, distribution, administration, and use of such countermeasures. A PREP Act declaration is not dependent on other emergency declarations.

On March 10, 2020, the Secretary issued a PREP Act declaration, effective February 4, 2020, to provide liability protections for activities related to medical countermeasures against COVID-19. Through various declarations and amendments and additions to establish countermeasures, the Secretary established that qualified state-licensed pharmacists, state-authorized pharmacy interns, and qualified pharmacy technicians are covered persons under the PREP Act when they administer certain COVID-19 tests. But when they administer certain COVID-19 tests, routine childhood vaccinations for individuals aged 3 or over, and COVID-19 vaccinations.

So this presentation will focus on the COVID-19 vaccinations aspect of these - of this establishment of the countermeasure. Pharmacies have also been added as a qualified person when their staff pharmacists order and administer, or their staff pharmacy interns and pharmacy technicians administer countermeasures consistent with the PREP Act declaration and authorizations.

So what does this mean practically, for Medicaid? We'd also - I'm going to start with some information reminding people of the obligations under FFCRA because it's during the period of the public health emergency we need to read FFCRA in relationship to the PREP Act, to understand what the full implications for Medicaid are.

So during the period of the public health emergency, if a state wants to claim the temporary FMAP increase authorized under 6008 of the - of FFCRA, the state must provide coverage for COVID-19 vaccinations and their administration, without cost sharing, during any quarter in which it claims the temporary FMAP increase.

This Medicaid coverage must include reimbursement of a vaccine administration fee or reimbursement for a provider visit during which the

vaccine dose is administered, even if the vaccine dose is furnished to the provider at no cost. So we know that the federal government is purchasing the vaccine and so we would expect that the state is paying for the administration of that vaccine.

While they're in effect, the PREP Act declaration and authorizations essentially make any pharmacy, pharmacist, pharmacy intern, or pharmacy technician who meets the conditions specified in the PREP Act, as qualified providers to administer COVID-19 vaccinations, notwithstanding state law. Now this means that these declarations - if anyone of the providers that were mentioned, are not allowed to perform vaccine administration according to state law, the PREP Act preempts that requirement.

If a licensed pharmacist orders and administers a COVID-19 vaccination or a pharmacy intern or pharmacy technician administers it, consistent with the PREP Act requirements, during the PHE a state may not deny Medicaid coverage or reimbursement for the vaccination administration on the basis that the state law does not authorize these individuals to order and/or administer it.

Accordingly, CMS expects all state Medicaid programs subject to FFCRA, including in states where the state law governing pharmacy, pharmacist, pharmacy intern, or pharmacy technician scope of practice, is preempted by the PREP Act, to identify a pathway to reimbursing pharmacies and/or pharmacists for COVID-19 vaccinations ordered and administered by those providers.

They must still must meet all other applicable federal requirements for covering the applicable benefit, such as reimbursing only those providers that are enrolled in Medicaid - as Medicaid providers and covering vaccinations

only for eligible individuals. And I'll talk about - a little bit more about provider enrollment in just a second.

In terms of the Children's Health Insurance Program and CHIP, states operating separate CHIP programs, generally have flexibility to determine which healthcare providers they would reimburse for providing covered services, including COVID-19 vaccinations. The PREP Act does not require the state's separate CHIP to pay providers or provider types it would not otherwise pay under the state plan.

However, in choosing which healthcare providers to pay for COVID-19 vaccine administrations, states operating separate CHIP should be mindful of their obligation to ensure access to covered services. In terms of provider enrollment, and this has been the hot topic issue that we've heard many questions about and we're happy to finally be able to answer these questions, states that do not already enroll individual pharmacists, techs or interns in their Medicaid program, do not need to do so to provide the COVID-19 vaccine, but will need the pharmacy to enroll as the furnishing provider.

However, in states that do recognize individual pharmacists as an eligible provider type, individual pharmacists would be considered the furnishing provider and must be enrolled to receive reimbursement under the PREP Act.

Some additional provider enrollment updates beyond the PREP Act implications, is that we provided more clarity regarding states' ability to waive the provider agreement requirements using 1135 authority. And with this flexibility, states will be required to maintain documentation regarding each providers' enrollment application, disclosures and screening results. But a signed provider agreement will not be required until after the PHE has ended.

States can reach out to their state lead for more information regarding this flexibility and with any particular questions that you might have.

In terms of reporting and coding, as we mentioned in the first version of the vaccine toolkit, the American Medical Association, in collaboration with CMS, is establishing CPT codes that are manufacturer specific. The AMA announced the first two sets of codes recently. Our vaccine toolkit update has a summary of the initial codes that have been established, along with the links to the AMA's Web site.

We encourage all states to stay abreast as new CPT codes are established for vaccine administration, and to raise awareness amongst your providers, about the appropriate codes to use when submitting claims for payment. CMS expects that these codes will be provided via T-MSIS, on claims and encounters for vaccine administration. We will be doing public reporting about vaccine administration using T-MSIS data.

So with that, I will open for a short question-and-answer period. I'll turn it over to Jackie to kick us off.

(Jackie Glaze): Thank you very much, Kirsten. So yes, as she indicated, we are ready to take your questions. If you have a few questions on the vaccine toolkit, we'll now turn to Valerie, if you could provide a few instructions and then open up the phone lines.

Coordinator: Yes. If you would like to ask a question, please press star 1 and record your name clearly when prompted. To withdraw your question, you may press star 2. One moment please for our first question. Our first question comes from Erin Black. Your line is open.

(Erin Black): Hi there. I'm from the State of Michigan. I had a question regarding if a state that has state plan language prohibiting the coverage of the items and services that are determined to be experimental or investigational, is that state required to complete a DR SPA for the coverage of the EUA status vaccines and treatments, especially in cases where states will not be paying for the product, that that would be 100% federally funded, at least initially? So the question is related to the coverage, not the administration.

Kirsten Jensen: Right. That's a good question. We have been advising states to use the Disaster Relief SPAs to indicate that you will be allowing for the coverage. Given the EUA I think it's kind of a - in this particular circumstance because the vaccine is being federally purchased, we think it's still important given that you would want the vaccine administration to be - well actually administering a vaccine that you would allow in your state.

(Erin Black): Okay. Thank you. And then can I connect it a little bit in a way? Also, we were hoping to maybe try to do an APM related to FQHC (unintelligible) side of the administration of the COVID-19 vaccine. Do - is that something that CMS may consider?

Kirsten Jensen: Do I have anyone from our financial management group on the line?

Rory Howe: Hi Kirsten and hi Erin. Yes, this is Rory Howe. Erin, we can take that question back. There are some flexibilities for vaccine administration payment rates with FQHCs. I think that's something we can follow up with you on if that makes sense, offline.

(Erin Black): Okay. Thank you.

(Jackie Glaze): We'll take one more question.

Coordinator: I show no further questions in queue.

(Jackie Glaze): Okay. Great. Thank you. Okay. So we're ready to move onto Sarah DeLone and her team. And they'll continue the discussion around the FAQs on the maintenance of (unintelligible) provisions of the IFC. So Sarah, I'll turn to you.

Sarah DeLone: Great. Thanks, Jackie. And I'm joined by a couple of our subject matter experts who I'll introduce as we move along through this section of the presentation. So as Anne Marie and Jackie mentioned, we're trying to use these calls to - and today we're going to spend some time answering additional questions we have received, either through the chat on previous calls, as well as questions that you all have been sending directly to us through email.

Another just reminder, as Anne Marie mentioned, these calls are recorded and a transcript is provided. That typically takes a week or two, so be a little bit patient. But those should be there for you to sort of play back or read the transcripts if that's helpful. It's pretty dense material, we recognize.

So there are three sets of questions we're hoping to get through today. First, we want to address questions we have received from a number of states related to acting on changes and circumstances, and what are states required to do in order to comply with the continuous coverage requirements of the Interim Final Rule.

Second, we want to answer some questions we didn't get to last week, related to who is or is not validly enrolled for purposes of the Interim Final Rule. And finally, we've received some questions on application of the continuous coverage requirements to the post eligibility treatment of income rules and also to medically needy individuals who have a spend down.

So those are the three areas we plan to address today. And we will be back next week, with additional areas of questions that you all have sent in. So first, so we have Stephanie Bell, who is a Senior Advisor, Policy Advisor in the Children and Adult Health Program Group, to talk about the changes in circumstances on the compliance with the Interim Final Rule.

So Stephanie, first, can you just sort of level set for us, does Section 433.400 of the Interim Final Rule, that continuous coverage requirement, does that require states to act on changes in circumstances? Is there anything in the IFC that changed the requirement to act on a change in circumstances?

Stephanie Bell: That is a really good question. And the answer is no. So to comply with Section 433.400 of the IFC, states must ensure that with limited exceptions, no beneficiary's eligibility is terminated. And no beneficiary is moved to a less robust care of coverage, prior to the last day of the month in which the PHE for COVID-19 ends.

Now there are exceptions for individuals not validly enrolled or who request to be terminated or, you know, those who are no longer a state resident. But Section 6008 of the FFCRA does not require states to act on changes in circumstances in order to claim the temporary FMAP increase. However, I will say that Title 19 on implementing regulations, do require states to act on known changes in circumstances. They're not Section 6008 of the FFCRA, but other Title 19 requirements.

Sarah DeLone: Okay. So regular Medicaid rules, the general rule is you've got to - not the general rule. The rule is you need to act on changes in circumstances, that's That's not new, with Section 6008(b)(3) or with this new Interim Final Rule.

Stephanie Bell: Yes.

Sarah DeLone: Okay. That's helpful. So are states now then required to act on changes in circumstances identified during the public health emergency, and move individuals to a different eligibility group if they're say no longer eligible for the first group but they are eligible for a different group?

Stephanie Bell: So CMS recognizes that some states have not promptly acted on changes in circumstances, both as a result of the PHE and to prevent inappropriate terminations of coverage under 6008 of the FFCRA. We encourage states to resume processing renewals and redeterminations based on changes in circumstances, to the extent possible during the PHE. This will limit backlog to pending actions that need to be addressed when the PHE ends.

However, the IFC itself, again does not require states to resume acting on changes in circumstances, beginning on the effective date of the rule. Rather, it lifts some of the restrictions states previously faced in processing changes in circumstances. So for example, states can now move beneficiaries in tier 1 or tier 2 coverage, to the appropriate groups for which they are eligible, you know, provided that the new eligibility group is in the same tier or a more robust tier of coverage.

Sarah DeLone: Okay. Thank you. So if a state does not implement changes required as a result of processing a change in circumstance, as is, you know, required under the statute, the Title 19, for example changes to a beneficiary's personal needs allowance or to non-COVID cost sharing obligations or access to EPSDT benefits, will the state - if a state doesn't act on known changes and make those changes to a person's coverage, will the state's access to the temporary FMAP increase be jeopardized?

Stephanie Bell: No. That would not jeopardize access to the temporary FMAP increase. So again, neither Section 6008 of the FFCRA, nor Section 433.400, the new

provisions in the IFC, require states to act on changes in circumstances. Title 19, implementing regulations and your Medicaid state plans, do require you to act on known changes in circumstances.

If a beneficiary has experienced a change in circumstances that the state has determined should result for example, in a decrease in the personal needs allowance, an increase in cost sharing obligations or that loss of access to EPSDT benefits, Title 19 and implementing regulations, do require the state to effectuate the changes.

But again, a state that does not effectuate such changes would be in compliance with the state plan as well as the implementing the Medicaid statute and regulations. But that would not impact the state's ability to claim the temporary FMAP increase.

Sarah DeLone: Okay. Thank you, Stephanie. That's helpful. And we hope that helps to clear up what seems to be some confusion for you all, in that area. So next, we want to turn to the questions about validly enrolled. And for that we have Jessica Stephens, the Director of our Division of Enrollment Policy and Operations.

And so Jessica, can you just sort of remind us the basics of who is considered validly enrolled for purposes of the continuous coverage requirements under the Interim Final Rule?

Jessica Stephens: Sure. I think important to note first, that most beneficiaries are validly enrolled. Beneficiaries are not validly enrolled in only two circumstances - first, if their eligibility was erroneously granted at initial application, or at the most recent redetermination or renewal if that redetermination was conducted prior to March 18, 2020 and was due to agency error.

The second area where beneficiaries may not be validly enrolled is if their eligibility was erroneously granted at initial application or the most recent redetermination prior to March 18th, due to fraud or abuse attributed to the beneficiary or the beneficiary's representative. The fraud or abuse also needs to have been material to the incorrect determination of eligibility. So two exceptions.

Sarah DeLone: And there has to have been a conviction of fraud or a formal finding of abuse, right, by the state agency…

Jessica Stephens: Yes.

Sarah DeLone: After an…

Jessica Stephens: Right.

Sarah DeLone: …investigation? Okay. Thank you. Next question is so are individuals who are receiving benefits during a period of presumptive eligibility, are they considered to be validly enrolled for purposes of the continuous coverage requirement in Section 6008(b)(3) of the FFCRA and the interim regulation 42 CFR 433.400?

Jessica Stephens: No, they are not. Individuals who've been determined presumptively eligible for Medicaid have not received a determination of eligibility under the state plan. And for that reason they're not considered to be enrolled and subject to the requirements of the continuous coverage described under 6008(b)(3) of the FFCRA.

And so that includes individuals determined presumptively eligible by the state Medicaid agency and states that have designated the state agency as a qualified entity for purposes of making presumptive eligibility determinations. You know, that's the flexibility that a number of states have taken up during the public health emergency. Those individuals would not be considered validly enrolled.

Sarah DeLone: Great. So a couple of more questions for you, Jessica. In a state that has elected to enroll individuals based on self-attested information at application, and complete required verification procedures post-enrollment, may the state terminate coverage for the individual if a post-enrollment check completed during the public health emergency, you know, after the person was initially enrolled, if that post-enrollment verification results in determinations that the individual is ineligible for Medicaid? Would those people be considered to be not validly enrolled and therefore the states could terminate them?

Jessica Stephens: No. Those individuals would be validly enrolled. So in a state that has elected the option to enroll an individual into Medicaid based on self-attested information and then to complete the electronic and other verification post-enrollment, the individual is considered to be validly enrolled based on that self-attested information that the state used to enroll the individual for purposes of Section 433.400 of the ISB.

So states will still check required data sources for individual enrolled based on attested information and complete other verification processes consistent with their verification plan following the individual's enrollment into coverage. However, if the state at that point, determines the individual to be ineligible based on post-enrollment verification, or if the beneficiary failed to respond to requests for additional information needed as part of that post-enrollment verification, the state must still keep the individual enrolled in Medicaid in

accordance with Section 433.400 through the end of the month in which the PHE ends.

And that's in order to claim the temporary FMAP increase. So in short, post-enrollment - individuals enrolled based on post-enrollment verification, are considered to be validly enrolled, even if found after the fact that they are not eligible.

Sarah DeLone: Okay. Excuse me. How about can a state terminate eligibility for a beneficiary in cases of suspected fraud or abuse and still receive the temporary FMAP increase authorized under Section 6008 of the FFCRA?

Jessica Stephens: No. We touched on this just a moment ago. For purposes of Section 433.400 of the regulations, states may only consider beneficiaries to be not validly enrolled due to fraud after a fraud conviction or due to abuse after completion of an administrative investigation into suspected abuse. And that's described at 42 CFR 455.15 and 455.16.

In addition, prior to termination of the beneficiary who was not validly enrolled due to fraud or abuse, the state must complete a redetermination consistent with 42 CFR 435.916, so the renewal regulations. And provide the beneficiary with advanced notice and the opportunity for a fair hearing consistent with 42 CFR Part 431 subpart E.

Sarah DeLone: Thanks. And final question Jessica - can states terminate beneficiaries who fail to report a change in circumstances that would have resulted in a determination of ineligibility, prior to March 18, 2020?

Jessica Stephens: Again, I think the answer here is no. If the state is claiming the temporary FMAP increase - so absent a formal finding of abuse following a full

investigation as described at 42 CFR 455.16, a state may not treat beneficiaries in this situation as not validly enrolled, for purposes of Section 433.400.

Sarah DeLone: So this would be just to give an example. If somebody had failed to report a change in circumstances in January of 2020 and the state didn't pick up on that before, you know, being able to process that before March 18th, even if that person would have been terminated if they had been - reported the change back in January they might have been terminated say in February, absent a formal finding of abuse or a conviction for fraud, that person is considered validly enrolled and the state has to continue their coverage in order to comply with a continuous coverage requirement and claim the FMAP increase. Is that - that's correct?

Jessica Stephens: That's right. That's right. That those individuals are considered to be validly enrolled for this purpose.

Sarah DeLone: Thank you. All right. Now turning to our - some questions we have in the non-Magi territory, and we have for that our technical director and subject matter expert, Gene Coffey with the division of Medicaid Eligibility Policy. And first Gene, let's - maybe we could talk about the questions involving post-eligibility treatment of income.

So can states modify their post-eligibility treatment of income, or PETI rules, during the public health emergency, in a way that increases and institutionalized individual's patient liability and still be eligible to claim the temporary FMAP increase? For example, could a state reduce the personal needs allowance or impose a new reasonable limitation on incurred medical expenses, or reduce an existing home maintenance allowance deduction so

that somebody's PETI liability would increase and be in compliance with the continuous coverage requirement as implemented in the Interim Final Rule?

Gene Coffey: Good. Hi all. And again, this is Gene Coffey. The answer is yes. States may consistent with Section 6008(b)(3) of the Families First law in Section 433.400 of our Interim Final Rule, modify their PETI rules, the post-eligibility treatment of income rules, in a way that effectively increases the financial liability of individuals receiving Medicaid coverage for institutional services under the state plan, provided that the modification is otherwise permissible under our PETI rules.

And this includes reductions in personal needs allowances or family allowances, the imposition of a new reasonable limitation on incurred medical expenses, and a reduction in the existing home maintenance allowance. This also includes and this is something we got a number of questions on, making changes to the personal needs allowance that is applied to individuals in the eligibility group, described at 42 CFR 435-217.

Sometimes a frequently referred to as the 217 route while receiving home and community based services through an approved 1915(c) waiver.

Sarah DeLone: Thanks, Gene. So a lot of good examples there. And the basic answer is yes, you can change your PETI rules and not violate the continuous coverage requirement. Of course the changes have to be otherwise permitted under the statute and regulations. But they - changes to PETI don't impact the compliance with the IFC, Interim Final Rule.

So next question, the Section 6008(b)(3) of FCCRA, you know, as implemented in the Interim Final Rule, does that prohibit a state from recalculating an individual's financial responsibility under the PETI rules, to

reflect an increase in the beneficiary's income, a change in setting or other changes in circumstances?

Gene Coffey: No. No. The perspective from the effective date of the IFC, which is November 2nd, Section 433.400 of the regulation, does not bar states that are claiming the temporary FMAP increase from modifying an individual's PETI calculation to reflect a change in circumstance even if the result is that an individual's patient liability increases.

As such, states must process such changes consistent with the PETI regulations and state plan. For example, if an individual moves from receiving home and same day services under a 1915(c) waiver to the 217 group to an institution, Section 6008(b)(3) does not prohibit a state from reducing the individual's personal needs allowance to reflect a change in setting.

This means that a state must recalculate the individual's PETI in this circumstance, under the PETI regulations specific to institutionalized individuals as described in our institution-specific regulation at 42 CFR 435.725 and 733.

Sarah DeLone: Thanks, Gene. So again, just sort of a high level summary, if in the ordinary operation of your, you know, your Medicaid program and the federal regulations and the choices that - the options that you've adopted for your PETI rules, implementing those rules, applying those rules would result in a beneficiary's PETI liability increasing.

You should go ahead and do that. There's nothing in the Interim Final Rule that would preclude you from doing that in order to qualify for the increased FMAP. Would you say Gene, that's a fair high level summary?

Gene Coffey: Yes. That's it. Yes.

Sarah DeLone: Thank you. So let's ask Gene - now Gene, turn to a couple of questions on medically needy beneficiaries and others who have to meet a spend down in order to establish their initial eligibility. So can you just explain - give us an overview on how does the requirement in Section 433.400 of the Interim Final Rule, apply to medically needy individuals who must meet a spend down to establish eligibility?

Gene Coffey: Okay. And let me first level set here with regard to those individuals who qualify for Medicaid through a spend down. There are two groups of individuals who can establish Medicaid eligibility after meeting a spend down. Number one, individuals who are seeking coverage in the state's medically needy group, which is of course the subject of the question.

Number two, in the 209(b) states, individuals seeking coverage in the mandatory eligibility group or individuals who are 65 years old or older or who have (blindness) or disabilities. States seeking to claim the temporary FMAP increase must maintain the eligibility of an individual who attained Medicaid through a spend down in either of those groups, through the last day of the month in which the PHE ends.

This is true even if the individual's budget period ends before the month the PHE ends and the individual does not have sufficient incurred medical or remedial care expenses to meet his or her spend down in the new budget period.

So again, if you retain Medicaid eligibility through a spend down in either your state's medically needed group or in the 209(b) states through the

mandatory ABD group and the individual does not have sufficient incurred expenses to otherwise seamlessly maintain his/her eligibility under normal circumstances, the individual's Medicaid eligibility must be preserved pursuant to 6008(b)(3).

Sarah DeLone: So how about can beneficiaries who initially qualify for Medicaid coverage after meeting a spend down but who do not have sufficient expenses to meet their spend down in a subsequent budget period, can those beneficiaries be transferred to a different eligibility group?

Gene Coffey: Good question. Okay. So again, the individual has to have his/her Medicaid eligibility maintained. But with regard to this question about the potential transition to a separate eligibility group, individuals who initially qualify for Medicaid coverage after meeting a spend down in either of the examples I laid out before, but do not have sufficient expenses to meet their spend down in a subsequent budget period, must be moved to another eligibility group if two conditions are met.

Number one, the individual meets the requirements for that other group. And number two, that the group provides at least the same tiered coverage as the group under which the individual had been originally enrolled, either again, the medically needy group or in 209(b) states the mandatory ABD related group.

For individuals who initially qualified through a spend down in a state's 209(b) mandatory ABD related coverage group, this means that the individual must remain enrolled in tier one coverage, in other words, minimum essential coverage, because of the coverage afforded to individuals in the 209(b) states mandatory ABD related group is in fact minimum essential coverage if it constitutes that.

Medically needy coverage however, for an individual who must meet a spend down in order to qualify for coverage, is not met. And so because states claiming the temporary FMAP increase, are required to cover COVID testing and (unintelligible) services for medically needy beneficiaries in order to comply with the requirement of Section 6008(b)(4), the Families First law, coverage for medically needy individuals who are required to meet a spend down, falls into tier 2 for purposes of Section 433.400 of the Interim Final Rule.

Section 6008(b)(4) of course, generally requires states to cover COVID testing and treatment services. Therefore, for individuals who had initially qualified as medically needy through a spend down and who do not have sufficient expenses to meet the spend down in a subsequent budget period, but established eligibility under another group, for those individuals states must move the individuals to the other group as long as it provide either tier 1 or tier 2 coverage.

And for individuals in either a 209(b) state mandatory ABD related group or medically needy group, who do not have sufficient expenses to meet their spend down in their subsequent budget period and they're not eligible for any other group, again the states must maintain the coverage of the individual in the original group under which they qualify as eligible, if there is no other group for which they qualify.

(Jackie Glaze): Excuse me for just a moment. This is Jackie. Just doing a quick time check. If we could wrap up in the next couple of minutes.

Sarah DeLone: We can. We have just one more question.

(Jackie Glaze): Perfect. Thank you.

Sarah DeLone: And I just so want to - Gene was talking about the - the previous question was specifically related to individuals who have a spend down, have to meet a spend down to establish coverage. And that medically needy coverage as Gene said, is not minimum essential coverage. However, in almost all states, medically needy coverage with no spend own, so somebody doesn't have to meet a spend down, that coverage is minimum essential coverage.

So just - which is tier 1 coverage. So I just wanted to make sure people registered that that answer was very specific to when medically needy coverage is not considered MEC.

The last question for you Gene - is an individual, is a - sort of an example, an individual who is enrolled in Medicaid as of March 18, 2020 under a state's medically needy group, if that individual experiences an increase in income before the individual meets his/her spend down in a subsequent budget period, may the state increase the individual spend down amount consistent with Section 6008(b)(3) of FCCRA and the Interim Final Rule if it seeks to claim the temporary FMAP increase?

Gene Coffey: And the answer is yes. Perspective from the effective date of the Interim Final Rule, which again is November 2nd, a state not only can but must consistent with standard Medicaid rules, recalculate an individual's spend down to account for any change in income, whether or not the recalculation results in an increase or decrease in the individual's spend down liability.

However, because the individual in this example had attained eligibility under the state's medically needy group on or after March 18, 2020 and during the PHE, if the individual does not meet his/her spend down in the subsequent

budget period, the state may not terminate the individual's eligibility until the end of the month in which the PHE ends, and must maintain the individual scope of coverage consistent with Section 433.400 of the Interim Final Rule as described in the previous answer.

I know we repeated that probably three or four times at this point, but again if the individual - yes, they do have to recalculate spend downs, however for an individual who does not have sufficient expenses in the subject budget period, to maintain seamless eligibility in other ordinary circumstances, coverage - eligibility has to be maintained and at the very least, the coverage has to be equal to tier 1 or tier 2 based on the examples we provided in the previous questions.

Sarah DeLone: What I think it comes to is a point that's made that's very sort of clear, I think clearest in the question Gene, which is that the spend down continues to be applied in subsequent budget periods. It's just that if the person doesn't meet that spend down their coverage is still not terminated.

Gene Coffey: Yes.

Sarah DeLone: Great. Okay. Jackie, thanks for bearing with us for a couple of extra minutes. And I turn it back to you.

(Jackie Glaze): Thank you, Sarah…

((Crosstalk))

(Jackie Glaze): Thank you, Sarah for the information you and your team has shared today. So we're ready to open up the phone lines. And so I'll just ask the audience to ask any questions of the speakers that you heard today, or any general questions

you may have. So Valerie, please open up the phone lines at this point. Thank you.

Coordinator: Thank you. If you would like to ask a question, please press star 1 and record your name clearly when prompted. To withdraw your question, you may press star 2. One moment please, for our first question. Our first question comes from (Leah) in Colorado. Your line is open.

(Leah): Hi. I have a question coming from some of my colleagues involved in administering HCBS waivers. The question is that there are individuals who are having continued stay reviews where they are determined to no longer be functionally eligible for the waiver. And we are keeping them enrolled including whatever enrollment group they have been in, in order to provide continuous coverage.

And the question is, when the PHE ends will we be required to perform a reassessment of the functional eligibility or would we just act on the information we already have?

Sarah DeLone: So we have - I mean I think that's a question - this is Sarah DeLone. That's a question that has applicability I think outside the context of the - of the, you know, home and community based services waivers group, which is for people in any eligibility group that have been retained in that group, even they at some point along the way, in the public health emergency, they lost eligibility - they no longer meet all eligibility requirements for the group.

In this case it's because they don't meet the functional needs assessment. And so that, you know that generally is the issue of what states need to do, you know, before acting on those is, you know, those situations is guidance that's upcoming. You know, take an example of where maybe that was - that person

no longer - if you haven't assessed that person in a long time their needs may have changed; may have gone up, may have gone down.

So I think, you know, this - the safer course is definitely going to be to redo that assessment. If it had been very recent, you know, like say, you know, maybe a month before the PHE ends, you know, that might be a different story. But you do, before terminating somebody, regardless of the reason, right, the state needs to sort of have made a decision that it can reasonably still rely on, that the person no longer meets the eligibility requirements for coverage. Is that helpful?

(Leah): Yes. Thank you.

Coordinator: Our next question comes from (Eve Licorice). Your line is open.

(Eve Licorice): Good afternoon. I am calling to or would like to ask for clarification because we want to make sure that we are correct in our understanding. So if we have beneficiaries that are currently receiving EPSDT services such as, I'll just use as an example, pediatric private duty nursing. So that they would receive under our plan, under 21. But when they moved to the adult package based on this Final Rule, they would no longer be eligible to receive those private duty nursing services.

However, would the state be able to continue those services for those individuals because essentially they would still have need for those particular services?

Sarah DeLone: So one, I want to clarify that it's not just moving to the adult group that EPSDT would, you know, no longer becomes available. It's somebody in the adult group who's under 21, still gets EPSDT.

(Eve Licorice): Sure.

Sarah DeLone: Like if you've got somebody who then hits that age 21 mark, under the state plan there's no, you know, you need their - you need to add the benefit or not for, you know, people whose benefits are covered only because they're part of the EPSDT.

I think - I don't know if we have anybody from SDG who is on the call. I think there was some investigation as to whether there was any way -might be waiver authority that's available to do that. But I'm not able to speak to that. I don't know that we have a definitive answer on that either.

(Eve Licorice): That would be our next question is, is that would we be able to then either amend our disaster state plan amendment or through the 1135 authority, be able to then amend the plan so that we could potentially continue that coverage and also still maintain the - well you had said - clarified, we wouldn't be at risk for the enhanced match, it's the other requirements that would be an issue?

Sarah DeLone: You - adding that as a coverage would - certainly wouldn't jeopardize the enhanced match. I think in terms of if there's a vehicle that's available for you to do that it would neither be - and Kirsten Jensen, please jump in if you disagree, but it would neither be the disaster - it wouldn't be a state plan amendment, disaster relief SPA or otherwise, nor 1135. But it would need to be 1115, Section 1115 authority.

But what you might do is reach out to your project officer if you currently have an 1115, or else to your state lead and, you know, raise that question and

we can - then we, you know, we can certainly work with you and work the issue and figure out if that's a possibility or not.

(Eve Licorice): Okay, that - it seems like there would potentially be some difficulty there with an 1115, especially if we're only looking to do this temporarily, until such a time as the public health emergency is over and we can safely transition these individuals.

Because I mean we're - I use the private duty shift nursing, but we're also talking about, you know, individuals that are in residential treatment facilities or receiving particular, you know, behavioral health services that would be only provided to somebody under 21 and now potentially putting them into a package even though it was still within the same tier, where those services would not be available to them.

And, you know, during the PHE, you know, seems to particularly problematic.

Sarah DeLone: Yes. It sounds like it's not a simple - not going to be a simple sort of lift. But I think the best course is going to be for you to reach out and let's start that one on one TA with you to see what can be figured out.

(Eve Licorice): Okay, great. Thank you.

Coordinator: Our next question comes from (Anna Arps). Your line is open.

(Anna Arps): Hi. I was actually just about to try and take away my queue. (Eve Licorice) actually asked my question.

Coordinator: Our next question comes from (Shelly Fox). Your line is open.

(Shelly Fox): Thank you. I am wondering if we could please come back just one more time, to the question about following up on changes in circumstances with the new guidance from the IFC. You had mentioned that 6008 does not require states to take advantage of the flexibilities that are available now, to make changes to eligibility determinations, to cost shares and so forth but that Title 19 does require it.

You had mentioned that 6008 does not require it nor the new CFR provision, but I guess what I'm wondering is Title 19 presumably required it all along but if states were not doing it in order to ensure FMAP eligibility, with the new guidance that allows us to do that are the Title 19 requirements sort of kicking back into place then?

Did the 6 - did the temporary flexibilities sort of temporarily put those on hold for states trying to meet FMAP, and now they can go back to doing - now they must go back to doing them? Or they can go back to doing them? Does this make sense?

Sarah DeLone: Yes, it does. I think Stephanie, let me take - let me take a stab and then please jump in with more. I think maybe the best way to think maybe the best way to think about is to think about Section 6008(b)(3) as, you know, sort of putting up a stop sign when you - when a state would otherwise be processing a change in circumstances that would impact a beneficiary.

And prior to the IFC, right, so the Title 19 and the implementing regulation, nothing in Section 6008 said to do anything different in those - in that space. Right? So…

(Shelly Fox): Right.

Sarah DeLone: …Title 19 still says do renewals, Title 19 says in our regulations they possibly, you know, do changes in circumstances. Does that impact the person's eligibility? Process those changes, give the right notice, you know, etc., and make the change. Think of 6008(b)(3) as like a stop sign that says no, stop, don't do that change, right? You processed it but you can't act on it. Right?

And before 6008(b)(3) was very broad in the time that that stop sign got laid. Going to lose a benefit, stop; going to, you know, going to result in increased cost sharing, stop; you know, going to increase your pay liability, stop. It had a lot of stop signs. Now under the Interim Final Rule there's more time that the state can actually implement and therefore needs to implement, what other - what ordinarily would be required.

Now it's just a stop sign. There's still that stop sign if you're going to terminate somebody altogether. Right? That's…

(Shelly Fox): Right.

Sarah DeLone: …the stop sign. You're going to - you're a stop sign if you're going to move from tier 1 coverage to tier 2 coverage let's say. That's a stop sign. But it's no longer a stop sign if you're going to - somebody's cost share is going to increase or somebody's benefit package is going to shift a little bit but they're still - like they go from state plan coverage to an alternative benefit plan.

Those kinds of coverage, those kinds of changes are okay and so nothing changed in the Title 19 requirements, it's just that the brake for the stop sign that's imposed by 6008(b)(3), has what - has changed with the Internal Final Rule. Is that helpful

(Shelly Fox): That's beautiful. Thank you.

(Jacqulin Glass): Thank you. I'd like to now turn to Anne Marie Costello for closing remarks. Anne Marie?

Anne Marie Costello: I'm sorry if you were in the queue and we didn't get to your question. we'll be back next week to take more questions. So I just want to thank everyone for joining us today.

I also want to thank Kirsten and Sarah, our subject matter experts, Stephanie Bell, Gene Coffey, Jessica Stephens, for their excellent presentations and information.

Looking forward, we will meet again in early December. The call invitation and topic are forthcoming. And of course, if you have questions between calls, please feel free to reach out to us, your state leads, or bring your questions to the next call.

Thanks again for joining us today. And have a Happy Thanksgiving. Bye.

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