Centers for Medicare & Medicaid Services

COVID-19 Medicaid & CHIP All State Call

December 8, 2020

3:00 pm ET

Operator: Greetings and welcome to the CMCS All State Medicaid and CHIP webinar. During the presentation, all participants will be in the listen only mode. Afterwards, we will conduct a question and answer session. If you have a question 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 the conference to obtain information. You may also submit a question via the chat feature located at the bottom left of your screen. If at any time during the conference you need to reach an operator, please press star zero. As a reminder, this conference is being recorded Tuesday, December 8th, 2020. I would now like to turn the conference over to Jackie Glaze, please go ahead.

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

Anne Marie Costello: Thanks, Jackie. Welcome and thanks to everyone for joining us today. On today's call we have two topics to share with you. The first topic is on renewals and the second is an ongoing discussion of the Continuous Enrollment provisions of the Interim Final Rule. First we'll hear about a Center Informational Bulletin, or CIB, that CMS released this past Friday, outlining federal regulations and expectations for completing redeterminations of eligibility for Medicaid and CHIP beneficiaries. The CIB is intended to assist States with meeting their obligations to make accurate and timely redeterminations of eligibility both during the regular periodic renewals and when state agencies receive information indicating a change in the beneficiary circumstances that may impact eligibility.

Anne Marie Costello: Today's discussion is an important one, because we know that backlogs of pending eligibility and enrollment actions have accrued during the public health emergency as a result of disruptions in state operations due to the pandemic, as well as the continuous enrollment requirements of the Families First Coronavirus Response Act (FFCRA) that requires states to maintain Medicaid enrollment through the public health emergency to qualify for enhanced federal funding. This CIB will also serve as a resource for states on the policies and procedures that will need to be followed when eligibility and enrollment operations eventually return to their routine functioning after the public health emergency concludes.

Anne Marie Costello: To that end, while states won't be required to complete the full redetermination process for beneficiaries until after the PHE ends, to minimize the work required when that day comes, we recommend that all states start initiating renewals and renew coverage for any beneficiaries that you are able to renew on an ex parte basis. This is also an important time for states to be examining your own internal

rules, regulations, and systems to ensure that you use our programs appropriately, and you are ready to start processing for renewals when the PHE ends. Shannon Lovejoy, a Health Insurance Specialist in our Division of Enrollment Policy and Operations, will present on the renewal CIB. After Shannon's presentation, we'll open the lines for your questions on renewals and redeterminations.

Anne Marie Costello: Then we'll continue our discussion from the last couple of weeks regarding the Continuous Enrollment Provisions of the Interim Final Rule. Sarah DeLone, the Director of the Children and Adults Health Programs Group, and subject matter experts will talk through the answers to a number of additional questions on the continuous enrollment positions of the IFC. After those FAQs we'll open up the lines for your general questions. Just as a reminder, the recordings and transcripts for our previous calls are posted on the COVID-19 page of medicaid.gov when they are ready, if you would like to revisit any of our previous calls. With that, I'll turn things over to Shannon to start her presentation. Shannon.

Shannon Lovejoy: Thank you, Anne Marie. Hi everyone, this is Shannon Lovejoy in the Division of Enrollment Policy and Operations, and we appreciate the opportunity to spend some time with you today discussing the CIB that was released on Friday on Medicaid and Children's Health Insurance Program renewal requirements. As Anne Marie mentioned, this CIB reminds states about current federal requirements and expectations for completing redeterminations of eligibility and Medicaid and CHIP, and these requirements are codified in regulation at 42 CFR 435.916, and 457.343. The CIB however does not provide guidance on how states should address backlogs of pending bills and redeterminations that have accumulated during the public health emergency. We know that you all are very eager for that information, and CMS does intend to release more guidance on that in the future. But the information in the CIB will still be important for states in the long-term, since it explains the foundation of redetermination requirements that states will need to reference as they return to routine operations.

Shannon Lovejoy: So the CIB provides a comprehensive review of the renewal process from the point where the states initiate or attempt to initiate renewals by attempting to renew eligibility based on reliable information, as well as the requirements were related to renewal forms when states are not able to renew eligibility based on the available information, as well as the steps they should take when beneficiary is no longer eligible for coverage. The CIB also outlines the requirements to redetermine eligibility in between renewals when a beneficiary experiences a change in circumstances that may impact their eligibility. And there's also a particular section that covers the interactions between redetermination requirements and eligibility periods for pregnant women. And finally the CIB also contains two appendices. Appendix A walks states through the steps to act on changes in circumstances, and Appendix B is a frequently asked questions document that covers some of the more complicated aspects of the renewal process.

Shannon Lovejoy: So for the remainder of today's discussion, I will provide just a high level overview of federal renewal requirements. But we did want to give you a heads-up that in January, we intend to host a webinar that will cover Medicaid and

CHIP renewal and redetermination requirements in much more detail than we will discuss today, and an invitation with registration information will be forthcoming once we've confirmed the specific day and time in January for that. The federal regulations require states to periodically renew eligibility for all Medicaid and CHIP beneficiaries. The renewal process must begin early enough in order to complete the renewal prior to the end of the beneficiaries' eligibility period. If there's sufficient information without requiring information from the individual to determine that eligibility continues, states must renew eligibility for the beneficiary. If the available information is not sufficient to determine eligibility, then states must send a renewal form and request the information that is needed to make the determination.

Shannon Lovejoy: So when we say states must periodically renew eligibility, recomplete the redetermination by the end of the beneficiaries' eligibility period, what we are referring to is the requirement for states to renew eligibility once every 12 months and only once every 12 months for Medicaid and CHIP beneficiaries whose eligibility is based on methodologies using modified adjusted gross income or modified adjusted gross income (MAGI) beneficiaries. For non-MAGI beneficiaries, states must renew eligibility at least once every 12 months, and we refer to the time between renewals as the beneficiary's eligibility period and states must complete the renewals by the end of that eligibility period, which in most cases will be at the end of the 12th month from the effective date of coverage or date of the last renewal. So, to initiate the renewal process, states must, prior to contacting the beneficiary, attempt to renew eligibility for all Medicaid and CHIP beneficiaries based on reliable information that can be contained in the beneficiary's account or other more current information available to the states, and this includes information that states gather from electronic data sources. And this process occurs without requiring information from the beneficiary. At CMS we often refer to this renewal process as an ex parte renewal and we know that many of you may refer to this as an auto renewal or administrative renewal. We want to be clear that this first step in the process is an attempt to renew eligibility based on the available information. And it's a process that doesn't require any beneficiary involvement. If there is sufficient information to renew eligibility then the agency must do so and provide the beneficiary with the notice. And this notice must include the eligibility determination, the information that's used to determine eligibility, and information about the beneficiary's obligation to let the state know if any of the information in that notice is inaccurate or requires changes. Beneficiaries do not need to sign or return the notice if the information in the notice is accurate.

Shannon Lovejoy: So, many renewals can be completed without involving the beneficiary, but there are definitely renewals where the state will need to contact the beneficiary for additional information. When states do not have sufficient information or when they information that the state does have indicates that the individual may be ineligible, then the state must send a renewal form and request the additional information from the individual for MAGI Medicaid and CHIP beneficiaries. This renewal form must be pre-populated with the most recent and relevant information available. And these beneficiaries must be provided with a minimum of 30 days to return the form. For non-MAGI beneficiary, states may pre-

populate the renewal form and must provide a reasonable period of time in order for the beneficiary to return the form and requested information.

Shannon Lovejoy: Renewal forms may only request the information that is necessary to redetermine eligibility, and beneficiaries must be able to sign and return the forms with the same modalities that are available at application. So these are online, by mail, by phone, or in person. So on the next few slides, I'm going to cover some aspects of the process when an individual may be ineligible, and what happens when coverage is terminated. And we just wanted to take a step back to again recognize that states have experienced a lot of disruptions to their eligibility enrollment operations during the public health emergency. So we know that States are delayed at different stages of the renewal process. And we also know that because states are claiming the increase FMAPs, that they are not terminating coverage for most beneficiaries at this time, but we still want it to walk through these basic requirements. When a beneficiary in Medicaid is no longer eligible for the group in which they are enrolled, states must consider eligibility on all other basis prior to determining that the individual is ineligible for Medicaid. If the state identifies that the individual might be eligible for another group, but needs additional information in order to complete that determination, the state must request the additional information and give the beneficiary a reasonable amount of time to provide this information.

Shannon Lovejoy: States may not terminate coverage and benefits must continue to be furnished until the beneficiary is either found ineligible for all groups covered by the state or until the beneficiary doesn't provide this information that was requested timely. So when an individual is determined ineligible for Medicaid or CHIP, the agency must assess potential eligibility for other insurance affordability programs and transfer the accounts, as appropriate. If an individual doesn't return their renewal form or any other documentation necessary, then the state does not need to assess eligibility for other insurance affordability programs and should not transfer accounts to the marketplace, for those who fail to return information.

Shannon Lovejoy: So for MAGI Medicaid and CHIP beneficiaries whose eligibility has been terminated at renewal for failure to return the renewal form or other needed documentation that was requested, states must reconsider the individual's eligibility without requiring the individual to fill out a full new application if the person subsequently returned to renewal form or request information within 90 days after the date of their termination or a longer period, that's selected by the state. And we call this period of time the reconsideration period. But a renewal form or other information is returned during the reconsideration period, it serves as an application, which basically means that the determination of eligibility should be made consistent with the timeliness standards at application, and the effective date of coverage is established the same way that a state would establish the effective date of coverage for a new applicant, but it's based on the date performance returned. A reconsideration period has not provided the authority to reinstate coverage back to the date of termination. Many individuals may be eligible for up to three months of retroactive coverage, if they received Medicaid covered services and were eligible in the month that the services were received. And this period of retroactive coverage might help fill any coverage gaps that the

individual had experienced since their termination of coverage. And for non-MAGI beneficiaries, states may, but are not required to, provide a reconsideration period.

Shannon Lovejoy: As mentioned earlier, states must redetermined eligibility in between renewals as a beneficiary experiences a change in circumstances that may impact eligibility. States must have procedures in place to ensure beneficiaries can make timely and accurate reports of any changes that may impact eligibility. And they must be able to report these changes again online, by phone, by mail, or in person. States must promptly act to redetermine eligibility if there's information indicating a change in circumstances, and this information could be beneficiary-reported or changes that are in the state through means such as periodic data check. When a change is reported, they take only requested additional information related to the change.

Shannon Lovejoy: If a state has information about an anticipated change, and this one includes something, for example, like a beneficiary who's reaching an age milestone for the group in which they're enrolled. Then the state must act on the change in circumstance at the appropriate time based on that change. For individuals who the agency determines continues to be eligible, following a redetermination based on a change in circumstances, a new 12 month renewal period may begin, if there's enough information available to redo eligibility with respect to all other eligibility criteria. Otherwise, they may retain the beneficiary current eligibility period. If an individual is determined to no longer be eligible for the group in which they are enrolled Medicaid or after a redetermination based on the change in circumstances, states follow the same process that we talked about earlier in the presentation.

Shannon Lovejoy: That was a very quick and brief overview of renewal requirements. For additional information, the Medicaid and Children's Health Insurance Programs renewal requirements CIB is posted on medicaid.gov. And as mentioned earlier in the presentation, we will host a more comprehensive webinar in January. So be on the lookout for that invitation and registration information in the near future. And with that, Jackie, I will turn it over to you to open the lines for questions.

Jackie Glaze: Thank you Shannon very much. So we'll begin by taking a few questions through the chat function. So those of you that would like to use that function, you can begin entering your questions now and then we will take a question or two from the phone lines. So you can begin submitting your questions at this time.

Operator: If you would like to register a question on the phone lines, please press the one followed by the four on your telephone. You will hear a three tone prompt to acknowledge your request. Your line will then be accessed from the 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. Once again, to register a phone question, it is the one followed by the four on your telephone.

Jackie Glaze: I'm not seeing any questions in the chat line. So we'll open up the phone lines at this point.

Operator: There are presently no questions on the phone lines at this time either.

Jackie Glaze: Okay. Thank you. So, we certainly have time at the end of the session today to take additional questions. So at this point, we'll now move on to continue the discussion on the FAQs on the maintenance of effort provisions of the IFC. So Sarah DeLone and her team will begin at this point. So Sarah, I'll turn it over to you.

Sarah DeLone: Great. Thanks Jackie and I have with me today some familiar voices, Jessica Stephens, Sarah Lichtman Spector, and Gene Coffey. So last week we left off with explaining the key elements of the Paris match exception which has set forth at section 433.400(d)(1)(ii) of the Interim Final Rule. Under this exception states may treat a beneficiary as not being a state resident for purposes of the continuous coverage requirements in section 6008(b)(3) of FFCRA if specific conditions are met. We want to pick up today with some additional nuanced questions we have received about this provision. Next we'll address questions about who is and is not validly enrolled for purposes of the Interim Final Rule, try to clear up some lingering uncertainty, which seems to be out there about transitioning adult beneficiaries to other eligibility groups, and answer a follow-up question we received on the transfers of assets presentation last week. So Jessica first turning to you and I'll just refer people to the detailed guidance we provided on the PARIS match exception to the transcript or the audio from last week, which isn't out yet, but should be shortly. So, Jessica what proof of residency, if any, may states require of an individual whose coverage has been terminated in accordance with the PARIS match provision and who has subsequently resurfaced as a state resident in the state?

Jessica Stephens: Sure, so these have flexibility under the Medicaid regulations. The verification ones have 42 CFR 435.952(c)(2) and 435.956(c) in how to verify state residency. States may rely on a tested information, electronic data, or if there's no electronic data or an inconsistency between a tested information and electronic data, a reasonable explanation or documentation of state residency. This same state flexibility that I just described exists for individuals terminated following a PARIS match who subsequently resurfaced as a state resident.

Jessica Stephens: So the state is not required to follow its regular residency procedures during the Public Health Emergency for an individual in this situation. For example, even if a state typically requires documentation to resolve an inconsistency with electronic data, such as the PARIS Interstate Match, and that's a station of residency at the time of the individual and resurfaces is sufficient to say that we remind states that any differences in their verification procedures during the PHE should be documented in their Medicaid and CHIP disaster relief verification plan addendum.

Sarah DeLone: Thanks. So what about when an individual resurfaces as a state resident after they've been terminated pursuant to this PARIS match policy. Can the state

require proof of residency back to the date of termination or just for the point in time that the individual resurfaces?

Jessica Stephens: The state cannot require proof of residency back to the date of termination if the individual was terminated because the state couldn't verify that the individual was a resident following a PARIS match, in accordance with the provisions of the Interim Final Rule. The state may only require an attestation or other proof of residency at the point at which the individual resurfaces, as I described in the last question. In other words when an individual, while an individual may be terminated under section 433.400(b)(3)(ii), if the state cannot determine that the individual is a state resident following a PARIS match under the regulation, once the individual has later verified their current state residency, the state must ensure continuous coverage to comply with section 6008(b)(3) of the FFCRA. This requires reinstatement back to the date of termination, and proof of residency for the entire period of time that the individual was temporarily terminated is not required under the rule.

Sarah DeLone: Thanks, Jessica. Are there any other situations in which states claiming the 6.2 percentage point federal medical assistance percentage (FMAP) increase can terminate a beneficiary whose state residence is in question? For example, if the state receives returned mail indicating an out-of-state address could the state terminate the beneficiary if the state has taken other reasonable measures to verify residency but has been unable to do so and the beneficiary does not respond to a request for additional information.

Jessica Stephens: No. And this is important to emphasize that the exception provided in the Interim Final Rule is limited. It's limited to beneficiaries who have been identified through the PARIS Interstate Match as being enrolled in a public benefit program in another state and not in other contexts.

Sarah DeLone: Are there any other situations in which states claiming the 6.2 percentage point increase can terminate a beneficiary who fails to respond to a request for additional information from a state, like after another kind of change in circumstance?

Jessica Stephens: No, again no. States claiming the 6.2 percentage point FMAP increase may not terminate beneficiaries based on their failure to return or renewal form or respond to a request for additional information from the state Medicaid agency. In the case of the PARIS match exception that I just described, the state is not terminating a beneficiary for failure to return requested information, instead the PARIS match exception permits states to treat a beneficiary in very limited circumstances as being a non-resident and then to terminate their coverage on that basis, that is based on no longer being a state resident. The exception in the regulation is narrow and limited to beneficiaries identified through the PARIS match and states claiming the temporary FMAP increase can't terminate beneficiaries for failure to return information requested by the state in any other situation. Doing so would violate the continuous coverage requirement in section 6008(b)(3) of the FFCRA.

Sarah DeLone: Thanks, Jessica. So let's turn now to some questions that we've received on the provision regarding validly enrolled individuals. Can you just remind our listeners the basics, who is considered validly enrolled for purposes of the continuous coverage requirement under the Interim Final Rule?

Jessica Stephens: Sure, most beneficiaries are validly enrolled as I think we've said before. Beneficiaries are not validly enrolled only in two specific circumstances. First, if their eligibility was erroneously granted at an initial application or at the most recent redetermination or renewal prior to March 18, 2020 and that was due to agency error, or secondly, if their eligibility was erroneously granted at initial application or the most recent redetermination or renewal prior to March 18 due to fraud or abuse that's attributed to the beneficiary or the beneficiary's representative. And in that case it's only relevant if the fraud or abuse was material to the incorrect determination of eligibility.

Sarah DeLone: So for anyone who wants a longer description of the basic policy, I think this question Jessica answered earlier in more detail or maybe it was Stephanie Bell on the November 24th call. I think the link to that audio is available, the transcript is not yet available. So following up then on that Jessica with some more detailed questions and examples. So for example, if an eligibility worker uses the wrong income amount to determine eligibility and that results in an incorrect determination of eligibility, would states be correct that the individual would not be considered validly enrolled?

Jessica Stephens: Yes, that's a good example. If a state incorrectly grants eligibility to an applicant based on worker error. So for example the worker enters the incorrect income amount from the application into the eligibility system. The individual is not considered to be validly enrolled for purposes of the continuous coverage requirement under the IFC because the state made a mistake in calculating that income. The state must then redetermine eligibility based on the correct information and determine whether the beneficiary may be eligible on any other basis. If the individual is ineligible on any basis, the state must provide advanced notice of termination and fair hearing rights, but in this circumstance may terminate the beneficiary's coverage.

Sarah DeLone: So what if a state has been implementing a state policy or practice, and CMS has informed the state that the policy or practice violates federal policy. May a state in that case that is seeking the temporary FMAP increase under the FFCRA, may they terminate coverage for beneficiaries whose enrollment is consistent with the state's policy or practice but who would have been denied coverage if the state had applied a federally compliant policy?

Jessica Stephens: No. In such situations the state hasn't made a mistake with respect to a particular applicant rather the state has correctly applied a non-compliant policy or practice which has resulted in the state enrolling some applicants who do not actually meet eligibility requirements. While other applicants to whom the non-compliance policy was applied nonetheless do meet all eligibility requirements. While the state must take steps to come into compliance with federal requirements and maybe subject to payment error rate measurement (PERM)

errors or other findings, it may not terminate individuals correctly enrolled pursuant to the state's policy or practice until the end of the month in which the PHE ends if that state is claiming the temporary FMAP increase. So this is a different answer from the prior question.

Sarah DeLone: Great. So one last question, could you provide an example of that last answer that you gave on the state having a correct determination in accordance with an incorrect state policy or non-compliant state policy or practice?

Jessica Stephens: Sure, suppose that a state has not adopted post enrollment verification. So the state obtained quarterly wage data applications however rather than checking the applicant's income against this data, the state enrolls all applicants who the tested income is at or below the income standard. Then after enrollment, the state compares the tested income to the quarterly wage data collected at that application and if not reasonably compatible takes appropriate steps to resolve the inconsistency.

Jessica Stephens: The process that I just described is not compliant with federal regulations. Going forward the state either needs to adopt and correctly implement a post enrollment verification policy or it needs to compare applicants income to the quarterly wage data and any other electronic information already obtained by the state and determine whether it's reasonably compatible with the attested income and determination of eligibility. However, applicants enrolled based on the tested information in accordance with the state's policy are considered validly enrolled for the purpose of the continuous coverage requirement under the Interim Final Rule. Does that help?

Sarah DeLone: I hope so, I think it will. So I'm going to shift now to a new topic, Sarah Lichtman Spector, to ask some follow-up questions to sort of states seeking clarification on when it is okay to transition individuals losing coverage under the adult group to another eligibility group, specifically most questions have come in around the one of the Medicare savings program groups. So Sarah, on a previous call, CMS said that beneficiaries enrolled in the adult group who become eligible for a Medicare savings program group can be terminated from the adult group and enrolled instead in the MSP group. We mentioned specifically individuals who become eligible for Medicaid coverage of Medicare cost sharing as a Qualified Medicare Beneficiary or QMB. Does this same policy also apply to adult group beneficiaries who become eligible for a different Medicare savings program group, such as the Special Low Income Medicare Beneficiaries (SLMB), Qualified Individuals (QI), and Qualified Disabled and Working Individuals.

Sarah Spector: It does. Adult group beneficiaries who establish eligibility for any Medicare savings program group must be enrolled in the appropriate group for which they're eligible and then terminated from coverage under the adult group. This is required under the Medicaid statute and regulations and does not violate section 433.400 of the Interim Final Rule. You may remember as we explained in some of our previous calls that 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 groups in accordance with 42 CFR 435.916(f)(1). And as a reminder, beneficiary can be enrolled concurrently both in a Medicare Savings Program group and another full benefit Medicaid eligibility group.

Sarah DeLone: How about transitioning a beneficiary from one Medicare Savings Program group to another. For example for somebody who's a QMB becomes eligible for a SLMB or a SLMB to a QI status for example. Is that permitted during the Public Health Emergency under section 433.400 of the Interim Final Rule, if a state is claiming the temporary FMAP increase.

Sarah Spector: Yes it is. So if a beneficiary is enrolled in one of the Medicare Savings Program groups becomes eligible for a different Medicare Savings Program group, the state must then transition the individual to the appropriate group. Also as we've described in some of our other calls under 433.400 of the IFC, the MSP groups are all considered tier one eligibility groups.

Sarah DeLone: Which is why beneficiaries can be transferred from one to the other. Can you remind us, if a beneficiary enrolled in the adult group becomes ineligible for Medicaid on any basis, but is eligible for or receiving Medicare, can the state terminate the met beneficiary's Medicaid eligibility if it is claiming the temporary FMAP increase since Medicare is considered minimum essential coverage?

Sarah Spector: Right, thanks. The answer here is no. Beneficiaries must remain enrolled in Medicaid if the state is claiming the FMAP increase. So in this situation, since the beneficiary no longer meets the requirements for any other tier one eligibility group and in this scenario including a Medicare Savings Program group, the state must continue her enrollment in the adult group in order to claim the temporary FMAP increase.

Sarah DeLone: Right, so here's a question that's not specifically related to adult group beneficiaries. Are states required to provide notice, advanced notice, to beneficiaries who are transferred, transitioned to a new tier one group?

Sarah Spector: So thanks. If there is any change to the beneficiary's coverage, for example a change in the benefit package or a change in premiums or cost sharing check charges, states must provide beneficiaries with appropriate notice. And in the case of an adverse action, for example a loss of benefits or an increase in caution, a minimum of at least 10 days advanced notice must be provided in accordance with regulations at 42 CFR 431.211.

Sarah DeLone: Similarly, are state's required to provide notice to beneficiaries who turned 21 and are no longer eligible for early and periodic screening diagnosis and treatment (EPSDT) benefits as a result?

Sarah Spector: Yes, that's one of the examples that loss of the EPSDT benefits is an adverse action which would require at least 10 days advance notice under 42 CFR 431.211.

Sarah DeLone: Right, thanks Sarah and turning now to Gene Coffey for our final question for today's presentation. A follow-up question Gene on transfers of assets. So we received a question says "CMS has said in the oral guidance that states can impose transfer penalties without violating the conditions to receive the enhanced match. CMS also has acknowledged that this guidance is new but that is unrelated to the Interim Final Rule. CMS has said that transfer penalties that were postponed can now be imposed, however most of the references have been to penalties identified within a look back period that occur at application. What about transfer penalties that arise because enrollees have transferred assets after they have involved in coverage? If the state has postponed the imposition of the penalty period in that case, can the full penalty period now be imposed?"

Gene Coffey: Okay, good. We have another quick question and thanks for this question it's providing us with another opportunity to provide an example. The answer here is yes, a state should impose the full penalty period against the institutionalized individual in this situation, for example, if an institutionalized individual established Medicaid on June 1st, 2020 and the individual transferred an asset for less than fair market value on August 1st, 2020 and the state did not apply a penalty because it believed it could not due to the continuous coverage provision, the state should now apply the penalty info against the institutionalized individuals that it otherwise would have initiated in August.

Sarah DeLone: Great. Thank you, Gene. So I want to just give folks a heads up of that next week. So we have one more topic area of questions on the Interim Final Rule, which we'll cover on next week's call and that relates to the application of the continuous coverage requirement in the context of individuals enrolled in a 1915(c) home and community-based services waiver or who are receiving institutional or other long-term care services and supports. At that point, we believe we will have addressed all of the questions that we have received on the IFC, either through the chat on earlier calls, the email address that was provided last week, or emails that we've received directly from state, although you may not have heard the exact language of the question you submitted, many questions covered similar ground and what we've attempted to do is to distill all of the questions received into the consolidated questions we have presented over the last the last several calls.

Sarah DeLone: If you think we have not addressed your question, or you need additional clarification or have a new question, we plan to set aside time on next week's call, offsite calls for these additional questions during an open mic Q&A session. So please go back to the recordings that have already been posted and take a look at those again and bring your additional questions to next week's call that's it for today. So Jackie I'll turn it back to you I think to open up for Q&A for this call.

Jackie Glaze: Thank you, Sarah. I'd also like to thank Gene, Jessica, and Sarah for the information that you've provided over the last couple of weeks. So we now we'll take questions, so I do see a number of questions already in the chat function. So we, you can ask any questions that you have from the presenters today or anything else. And then we will follow with questions over the phone lines. So we will start reading off the questions that we have in the chat box at this time.

Ashley Setala: Okay so our first question is actually a three part on vaccines. So the first question is, do we need to submit a disaster SPA to pay Medicare rates for vaccine administration when the Medicare rates are higher than our normal vaccine administration rate?

Jeremy: Hey this is Jeremy Silanskis I can take that one, and the answer is yes if the rates are different than your current Medicaid state plan rates, then you would need to submit a state plan to effectuate those changes.

Ashley Setala: Okay, thanks Jeremy and the second part of the question is do states need to submit a disaster SPA to allow mobile vaccination and vaccination in parking lots, if they have approved disaster SPA language that allows this for testing already? Do we have Kirsten Jensen on the line? Go ahead Jeremy, go ahead.

Jeremy: We're just going to start from a payment perspective and I think from our perspective, if your rates are different and you have eligible providers that are providing services in those locations, then the answer is no. That you're being consistent with your payment rates and you have qualified providers, then you wouldn't be doing anything from the payment perspective. As for the coverage, yeah I would have to defer to others who may be on the line.

Sarah DeLone: And it sounds like your coverage already uh, you believe your coverage SPA pages already permit this type of provision. So I think the answer is probably not, but we will make sure that we confirm that with our coverage folks.

Ashley Setala: Okay, great and then the final part of the question is will CMS approve 1115 waivers to add that COVID vaccine to the uninsured COVID-19 testing group benefit package?

Judith Cash: Hi, this Judith Cash, want me to address that Ashley?

Ashley Setala: Sure.

Judith Cash: Hi, this is Judith Cash with the State Demonstrations Group and as I'm sure you've seen in the vaccine toolkit that was issued last week, we did indicate that states could request 1115 authority to cover vaccine administration for those beneficiaries who are in Medicaid coverage programs that are limited in their benefits. And so we would invite states to submit such an application and I suggest that in fact you reach out to your 1115 project officer to discuss that.

Barbara Richards: Terrific thanks, Judith. So our next question is for cap around termination of coverage. And the question is, are you saying that we can only terminate due to a PARIS match or can we also terminate coverage when the beneficiary reports that they have moved out of state?

Jessica Stephens: I think that's for me. This is Jessica and it's a good question. I can clarify that no, I'm not saying that the only circumstance in which a state can terminate is due to PARIS match. The FFCRA requires continuous coverage, but also laid out a

couple of specific exceptions beyond those that are described in more detail in the IFC.

Jessica Stephens: Those include if the beneficiary requests a voluntary termination of eligibility or the state determines that the individual is no longer considered to be a resident of the state and the example that you provide here the state determines that the individual is no longer a resident of the state, and so that is a situation under which coverage can be terminated. I think it was just describing in the context of the PARIS match that as the IFC clarifies that the exception for the PARIS match just provides a situation in which the state can determine that the individual is no longer a resident of the state.

Sarah DeLone: If I can jump in and maybe just try and say it a different way for those whose brains work differently. In the example provided in the question, the state has made a factual determination based on the information provided by the individual that they are no longer a state resident. In the PARIS match exception, there's actually, they're under the regulation, there's uncertainty, the state doesn't actually know whether the individual remains a state resident or not. It just has information from the PARIS match that suggests that they are located in different states because not only maybe are they physically located, but they're actually receiving benefits in another state.

Sarah DeLone: But it hasn't received anything to actually be able to make a factual determination. In that case we've said that that the state can treat that person, consider that person, only for purposes of this continuous coverage requirement as no longer being a state resident, and then therefore they fit under that permissible termination under 6008(b)(3) of terminating for not lack of state residency, again with a requirement to reinstate if the person resurfaces as continuing to be a state resident.

Ashley Setala: Thanks, Sarah. So the next question, and it's also for cap and it says if an individual who meets the citizenship requirements for the pregnant women category, but not the low-income adults or parent caretaker category, does the state need to terminate the mother postpartum?

Shannon Lovejoy: This is Shannon and I can get the answer started just in terms of the general policy under routine normal circumstances outside of the Public Health Emergency. So the end of the postpartum period is a change in circumstances that may impact eligibility that a state would need to act on. If when redetermining eligibility based on this change, the state realizes that the woman may be eligible for another group except for citizenship status, then the woman would remain eligible for treatment of emergency services, if the end of the postpartum period is, before the woman's scheduled renewal date. But the state would also need to assess for potential eligibility for insurance, for the account as appropriate to the marketplace. And I'm not sure if anyone else has anything to add.

Sarah DeLone: I think that captured it Shannon. You've got somebody here who's under the CHIPRA 214 provision, a pregnant woman state is providing full benefits to

lawfully present pregnant women and now this woman is no longer in that category. She doesn't fall under the CHIPRA 214 option cause she's not in her pregnancy period or postpartum period. So then the FSP restriction on coverage for people not in a qualified immigration status kicks in and coverage is limited to emergency services. Sarah, do you have anything else to add?

Sarah Spector: No, I think that captured it.

Sarah DeLone: I see, thanks.

Jackie Glaze: Thanks let's move to the phone lines at this point to see if we have any questions. Operator, can you provide instructions and open up the phone lines please.

Operator: Certainly if you'd like to register a question on the phone lines, please press the one followed by the four on your telephone. One four to register a question. And our first question is from the line of Pat Curtis, please proceed with your question.

Pat Curtis: Yes, this is Pat from Illinois, and we certainly have appreciated the time that you have spent on these calls to answer our questions and we actually have listened to your recorded. However we, it would be so helpful if you could issue these in FAQs. As you know we have to issue guidance to our state staff in writing. We have trainings verbally but we have to give them instructions that are written. And if you could consolidate what you have answered into an FAQ or some guidance it would be extraordinarily helpful because we're consistently left with interpreting over and over again. And although we can listen to the recordings, it isn't as helpful as something in writing. Do you plan to issue this in writing?

Sarah DeLone: Anne Marie do you want to take that or do you want me to take that?

Anne Marie Costello: Sure. Hi Pat, this is Anne Marie Costello. I think we have, we would love to issue these in writing. I think our clearance process takes time so we haven't wanted to slow down getting out the information, so we can look to see about putting something out, but I think you all know that we've got a batch of FAQs in the clearance process for some time now that we haven't yet been able to release. So we're trying to also use this strategy to not slow that down. So Pat we'll try I can't say when we'll get something out though, so that's why we're trying to do them verbally as much as possible.

Pat Curtis: Okay, thank you. Could you do one thing more, we did listen to the recording but would you make it clear again, the dates and where we can access that recording? I know you provided it but could you provide it again, the different dates of the recording and then a link to get to that recording?

Anne Marie Costello: Sure. Why don't we take that back and see if we can figure out maybe we could send out a listserv with the dates and the links or something like that so.

Pat Curtis: That would be helpful, thank you.

Anne Marie Costello: Great.

Operator: Our next question comes from the line of Cassie Porche, please proceed with your question.

Cassie Porche: Hi, good afternoon. This is Cassie from Louisiana. I have to return to the out of state question. I know we've sort of gone back a few times. I have an example where we have some trusted data sources according to the USPS or we might get information about a forwarding address, maybe the person who's out of state, sometimes stuff gets printed on a return mail. Would that be considered actionable by the state or out of state or does it still require verification by the person before action can be taken?

Jessica Stephens: And you, in this case you're referring to during the PHE or in general.

Cassie Porche: Correct. During the PHE yes for enhanced match data, if we're getting the 6.2, sorry, that's another probably good clarification.

Jessica Stephens: Got it. So generally it would in fact always require verification, but for purposes of the PHE, this example again is just limited to the PARIS match. So in the example of return mail that would not be sufficient to...

Cassie Porche: Okay.

Jessica Stephens: Terminate eligibility for an individual. The exception provided is just limited to data to the PARIS Interstate Match data.

Cassie Porche: Or a self-decision, or a confirmation by the individual to what you said.

Jessica Stephens: Correct.

Cassie Porche: No other allowable data source.

Jessica Stephens: That's correct.

Cassie Porche: Okay, thank you.

Operator: Our next question comes from the line of Phyllis Hyman, please proceed with your question.

Phyllis Hyman: Yes hi, thank you. Under the new IFC, if an individual met the spend down in a budget period and we kept the person active even though the person failed to meet the spend down in the new budget period, do we still keep the Medicaid active? In other words, does an individual in an inactive spend down, meaning that the person hasn't incurred sufficient expenses to meet the spend down have MEC.

Sarah DeLone: Gene, do you want to take that?

Gene Coffey: Yeah, I can sure thank you and again this is Gene Coffey. The individual well, first of all we just want to reemphasize that the individual who initially established Medicaid eligibility during the Public Health Emergency by way of a spend-down and who does not have sufficient expenses going into his or her next budget period does have to have his or her Medicaid eligibility maintained. However, for the individual who established Medicaid eligibility through spend-down as a medically needy individual, that person we I think explained in the IFC does not have minimal essential coverage or if we didn't say it in the IFC I think we may have said it in one of our past calls. In any event no, that person who established Medicaid through spend down in a medically needy eligibility group is not, have MEC. So the individual in that particular situation at least has to have I believe pre-cert confirm.

Phyllis Hyman: Tier two.

Gene Coffey: To me that this is correct. That would be tier two, yes thank you. So you do have to find another eligibility group for which the individual is eligible in order to simply maintain the tier two coverage. So if the individual is not eligible for any separate eligibility group the individual would have to be maintained in the medically needy group, but if there is a separate eligibility group for which the individual is eligible only tier two coverage would have to be provided to that individual in the separate eligibility group.

Phyllis Hyman: Okay, thank you and that's in 209(b) states and other states, that's the same?

Gene Coffey: Well, I think we I believe we separated or distinguished the individual who establishes Medicaid through a spend down in a 209(b) states mandatory ABD-related eligibility group that individual does even through the spend-down have MEC. So the individual would have to have preserved tier one coverage if he or she did not have sufficient expenses to meet the spend down in the subsequent budget period, and there happens to be another eligibility group for which the individual meets the eligibility requirements. That an individual again would have to have MEC if the individual was transitioned out of the mandatory 209(b) state group.

Phyllis Hyman: Okay, thank you very much.

Gene Coffey: And let me just make sure that, Sarah did you have anything to add or anything to clarify with what I just said?

Sarah DeLone: No, that was correct. Those 209(b) spend down is MEC. So keeping in that group we're moving to another tier one and if they're eligible definitely.

Jackie Glaze: Thank you for your questions today. I'll now turn the Anne Marie Costello for closing remarks, Anne Marie.

Anne Marie Costello: Great, thanks. I want to thank Shannon, Sarah, and our subject matter experts, Gene, Jessica Stephens, Sarah Spector for their excellent presentations and

information. Looking forward the invitation topic for our next call will be forthcoming. Of course as questions come up between these calls, feel free to reach out to us, your state leads, or bring the questions to our next call. Thanks again for joining us today. Have a great day.

Operator: That does conclude the conference call for today. We thank you for your participation and ask that you please disconnect your lines.