HHS-CMS-CMCS
April 2, 2024
3:00 pm ET

Coordinator: Welcome, and thank you for standing by. At this time, all participants are on listen-only mode. During the Q&A session, if you'd like to ask a question, you may press Star 1 on your phone. Today's call is being recorded. If you have any objections, you may disconnect at this time. I will now turn the call over to Jackie Glaze. Thank you. You may begin.

Jackie Glaze: Thank you and good afternoon and welcome everyone to today's All-State Call and Webinar. I'll now turn to Ann Marie Costello, our Deputy Center Director for opening remarks. Ann Marie.

Anne Marie Costello*:* Thanks, Jackie, and hi, everyone, and welcome to today's All-State Call. On today's call, we'll be discussing two important topics. First, Sheri Gaskins from our Medicaid Benefits and Health programs group will provide a brief verbal update on rural emergency hospital designations and federally qualified health center providers that states should be aware of.

Second, the CMCS team, including Stephanie Bell, (Beth Hines), Meg Barry, (Kristen Pacek), Shakia Singleton, and Sarah Lichtman-Spector, all from the Children and Adult Health Programs Group, will provide an

overview of the Streamlining Enrollment and Renewal Processes and Medicaid and CHIP Final Rule published in the Federal Register on March 27.

The Eligibility Enrollment Final Rule is a significant accomplishment for CMS and will dramatically improve the lives of millions of Medicaid and CHIP enrollees. This rule will make it easier for children and adults across the country to get and keep their coverage by eliminating waiting periods before a child determined eligible is able to receive their coverage, eliminating annual and lifetime limits on children's coverage in CHIP, making it easier to transfer children from Medicaid to CHIP when a family's income rises, ending the practice of locking children out of CHIP coverage of the families unable to pay a premium, requiring states to provide all individuals with at least 15 days to provide any additional information when applying for the first time and 30 days to return documentation when renewing coverage, and prohibiting states from conducting renewals more frequently than every 12 months and requiring in-person interviews for older adults and those with disabilities.

These improvements are especially critical given the backdrop of unwinding. The E&E Final Rule is part of a steadfast commitment to make it easier for eligible individuals, especially children and people with disabilities, to enroll in and keep their Medicaid and CHIP coverage moving forward.

Before we get started, I wanted to let folks know that we'll be using the webinar platform to share slides today. If you are not already logged in, I suggest you do so now so that you can see the slides for today's presentation. You can also submit any questions you have into the chat at any time during our presentation.

With that, I'm pleased to introduce and turn things over to Sheri to provide a brief verbal update on rural hospital designations and FQHC provider changes. Sheri, turning it to you.

Sheri Gaskins: Thank you, Anne Marie. Good afternoon, everyone. I will first start with providing an update on Rural Emergency Hospitals. By way of background, the Consolidated Appropriations Act of 2021 established a new provider type in Medicare called Rural Emergency Hospitals, or REH. CMS issued a regulation in November 2023 establishing conditions of participation and Medicare reimbursement requirements. CMCS is now receiving inquiries from states about how to cover and reimburse for these facilities in Medicaid, even though Medicaid statute was not updated to reflect these provider types.

Beginning January 1st, 2023, certain rural hospitals and critical access hospitals could begin converting to this new provider type. REHs have their own unique conditions of participation or COPs separate from Medicare's hospital COPs and are excluded from the Medicare statutory definition of a hospital. A REH can only furnish emergency and outpatient services with an average patient length of stay of no more than 24 hours. They may not furnish inpatient hospital services, but may have a distinct part skilled nursing facility, otherwise referred to as a SNF.

Because REHs are expressly excluded as hospitals and have separate COPs, they cannot fit under the Medicare - excuse me, the Medicaid benefit for inpatient or outpatient hospital services. The closest benefit in Medicaid to meet this type of facility would be the clinic services benefit, and the nursing facility benefit if the facility includes a distinct part-scale nursing facility.

As the REHs will be classified in the clinic benefit, clinic services provided in these facilities are subject to the Medicaid Clinic Upper Payment Limit,

otherwise known as UPL, consistent with regulations at 42 CFR 447.321. Likewise, services provided in the distinct parts skilled nursing facility are subject to the Medicaid Nursing Facility, UPL, consistent with regulations at 42 CFR 447.272. Excuse me.

States retain considerable flexibility in determining the payment rates for services is provided in these settings under Section 1902(a)(30)(A) of the Social Security Act. But we note that Medicare has established comprehensive prospective payment system rates for these facilities that states are encouraged to use for ease of administration. Medicare has authorized a monthly facility payment to REHs to account for the difference in payment the facility receives as an REH and that which the facility will receive as a CAH, critical access hospital.

Medicaid does not have similar authority to make such payments under the state plan. And as such, will not be including these payments in the Medicaid UPL calculation for clinic or nursing facility services as a monthly facility payment is not a payment for services. As REHs don't provide inpatient hospital services, these facilities will not be eligible for Medicaid DSH payments under the Section 1923 (D)(3) of the Act. States with questions about reflecting REHs in their state plans should contact their state lead to receive technical assistance.

Now, I'll turn over to the Federally Qualified Health Center Update and Rural Health Center Update. CMCS is providing information on recent updates to the Medicare FQHC and RAHC statute that has implications on the Medicaid FQHC and RAHC benefits. The Medicaid statute at 1905(l) for FQHC and RAHC incorporates specific provisions for providers from the Medicare statute. These providers include physicians, nurse practitioners, physician

assistants, nurse-midwives, clinical psychologists, clinical social workers, and visiting nurses in areas with a shortage of home health agencies.

The corresponding Medicare statute of Section 1861(AA) was recently updated by Section 4121 of Division FF of the Consolidated Appropriations Act of 2023 to add marriage and family therapists and mental health counselors. This change was effective for services rendered on or after January 1st, 2024. These new practitioners are now a required component of both the Medicare and Medicaid FQHC and RHC benefits.

As a result of this change, we would like to alert states that to the extent that their coverage page delineates the specific providers of FQHC services, these states must submit a state plan amendment to include these new practitioner types.

Additionally, to the extent that an FQHC, RHC is providing an NSCOPE FQHC, RHC service, which could include the LMFT or MHC services, then that service is eligible to receive the PPS or APM rate as described in the state plan. To the extent that an FQHC, RHC is providing LMFT and MHC services that are currently outside the scope of FQHC and RHC services, then a change in scope of services will need to be conducted to account for the services of these new providers.

To recognize a change in scope of services, states may require that the provider inform the state of the change, or the state itself may want to assume responsibility for identifying an increase or decrease in scope of services. States should review their state plan FQHC and RHC reimbursement pages to identify the currently approved payment rate methodology for FQHCs and RHCs that follow the appropriate PPS or APM methodology as described in

those pages. That concludes my update. I'd like to turn it over now to Stephanie Bell.

Stephanie Bell: Thank you. All right, well, I am Stephanie Bell. I'm a senior policy advisor in the Children and Adult Health Programs Group. And I am so excited to be here. As I hope you all have seen in today's federal register, you can find the official printed version of the final rule entitled, we like to keep things really simple, so we called it, Streamlining the Medicaid Children's Health Insurance Program and Basic Health Program Application Eligibility Determination Enrollment, and Renewal process these final rules.

But seriously, this is a culmination of several years of working with states, hearing from stakeholders and the public, and trying to better understand how the eligibility and - trying to understand how the edibility and enrollment rules for Medicaid, CHIP, and the Basic Health program, or BHP, can really work better for the American people.

This has been a group effort, and I want to give a big thanks not only to all the CMS staff who worked on this rule, but to all the people and the organizations who submitted comments, because they were really invaluable in getting us to where we are today. So, I'm going to start with a brief overview, and then I'm going to turn to some of my colleagues to walk through a few provisions, and we will leave some time at the end for questions.

I encourage you to download the slide deck, it will be posted on Medicaid.gov after today's presentation. There's a lot of slides that we won't be able to cover today, but we wanted to make them available to you all because we've got one for each provision.

So, let's go to the next slide. We published our proposed rule in September of 2022 and finalized it in two parts. In case you missed it, the first part was published in September of 2023, and that was provisions aimed at increasing enrollment and retention in the Medicare Savings program. This final rule is focused on making the enrollment process easier and faster for everyone. And then once people are enrolled, really helping eligible people to stay enrolled.

Next slide. I want to take you back in time for a moment to 2021 and 2022 as we were thinking about what to include in the proposed rule. So, President Biden had issued two executive orders, strengthening Medicaid and the Affordable Care Act and making it easier to enroll in affordable quality health coverage. So, that was definitely on our minds, as well as we had really seen a difference or the difference, really, that the Affordable Care Act related enrollment simplifications could make.

But they were only required for individuals whose eligibility was based on Modified Adjusted Gross Income, or MAGI. And we knew that we wanted to extend those simplifications to MAGI-accepted populations. So, that would largely be older adults and individuals with blindness and disability.

Next slide. At the same time, we recognize that the rate of improper payments in Medicaid and CHIP, particularly related to beneficiary eligibility and enrollment issues were much higher than we'd like. And as we dug into those, we realized that more than half of the errors leading to those improper payments were related to insufficient documentation.

So, it was really also on our minds to bring our record-keeping requirements into the digital age. And last but not least, we can't ignore the impact of the COVID-19 public health emergency, the continuous enrollment condition, and then the unwinding of the continuous enrollment condition.

So, our latest data from December of 2023 showed that over 85 million people were enrolled in Medicaid and CHIP, and that doesn't include the additional folks enrolled in the basic health program. I'm sure you're all familiar with the work states have been doing to address this really unprecedented number of eligibility renewals. And so I'm not going to go into that. But all of this, just to say, was the backdrop for the final rule.

So, let's go to the next slide. Coming up to the present day, this is a balancing act that we were really trying to do with this rule. We removed red tape to help eligible individuals enroll easily and quickly and stay enrolled, so they can access the benefits to which they are entitled. And at the same time, we provide states with clear guidelines and expectations to ensure that ineligible individuals can be properly routed to the appropriate coverage.

Next slide. We received 7,055 comments on this rule, and we've read all of them. Then we used - you can see where the time went, then we used that feedback to craft our proposals into the final rule that's published today. Now, some of the commenters opposed the rule or specific provisions in it, but the support was really overwhelming - overwhelmingly positive support. In particular, we had a lot of support from state agencies, and we also received a lot of comments about things that we could do better. And so a lot of the changes in this final rule are in response to those concerns.

Next slide. One big change in this final rule is that we are phasing in compliance over 36 months. So, recognizing that the provisions in this final rule will require changes to state policies and processes, some of them bigger, some of them smaller, many are going to vary from state to state, some are options, some are not. The rule itself becomes effective on June 3, 2024, and some of the provisions require immediate compliance. Some are options as

they become available immediately and for others states will have up to 36 months to prepare and come into compliance.

Next slide. We organized the rule into four key objectives, or these are basically the four key objectives that we had in mind as we were working on it, streamlining the application and enrollment process, improving retention, removing access barriers for kids, and enhancing program integrity. The rule itself contains 15 distinct provisions, and like I mentioned, each one is summarized in this slide deck, but in the interest of time, we're only going to highlight a few the provisions from each section today.

Let's move ahead to the next slide. Objective 1, Streamlining Application and Enrollment. So, this objective includes several different provisions that are really focused on simplifying the enrollment process, making it easier and faster for eligible people to get coverage.

Next slide. Here you can see the list of provisions that fall under this objective, and they'll be applied for each one of these, kind of, a variety here, but making it easier to get medically needy enrollment, streamlining verification processes, removing unnecessary requirements, et cetera. Let's move ahead to the next slide, and one more, please. All right, Kristen, Can you see up the slide?

(Kristen Pacek): Yes. Hi everyone. Thanks, Steph. This slide is really outlining the requirements for standards when applicants need to provide additional information. And as Anne Marie mentioned earlier, under this final rule, this is the first time that states are going to be required to provide a reasonable period of time of (unintelligible) 15 days to all applicants to provide any additional information that's needed at application. And as part of this, we also established a reconsideration period at application.

And like Steph was saying earlier, we made some changes to our proposal as a result of comments that we received. And so, you'll see in the final rule that the new reconsideration period at application aligns nicely with existing requirements that are applicable for reconsideration periods at renewal, such as requiring a 90-day minimum period and basing the effective date of the eligibility on the date the information was received from the individual. And as you can see here on the slide, this is one of the provisions that has a 36 month timeframe for states to come into compliance.

And but now. I'm going to turn it over to Sarah to talk about changes related to verification and reasonable compatibility of resources. Sarah?

Sarah Lichtman-Spector: Thanks (Kristen). Next slide, and one more, maybe two more. Yes, right here. Great. So, the revisions here to 435.952 simplify enrollment by reducing the need for applicants and beneficiaries to provide documentation of resources when electronic data is available.

So, this provision clarifies that when resource information is obtained from an electronic data source, like an AVS, an asset verification system, and that information is reasonably compatible with the attested information that the applicant provided. For example, both pieces of information are above, at, or below the applicable resource standard. Then the individual cannot be requires to provide additional documentation of resources.

So, of course, this component of resource eligibility would only - review of resource eligibility would only be related to individuals who have their eligibility determined on a basis other than MAGI. And I just want to note that this provision would be effective upon the effective date of the rule. Now I think I'm going to turn it over to Anne.

Anne Marie Costello*:* Thank you. Can you skip to the objective Number two, slide. Great. Thank you. So, the next two provisions that I'll highlight fall under the objective of improving retention rate at and between renewals. Next slide, please. So, the provisions listed here under this objective are intended to reduce the number of eligible individuals who lose coverage and have to enroll again. I will briefly cover the provision related to aligning renewals for non-MAGI beneficiaries, and then I'll hand it to my colleague to cover the provision on facilitating transitions between Medicaid and CHIP.

So, next slide, please. Since the passage of the ACA, like Seth mentioned before, states have been required to apply streamlined application and renewal processes to applicants and beneficiaries whose financial eligibility is based on MAGI, whereas it's been optional for states to implement these simplifications for non-MAGI individuals. We've seen over the years how these simplifications have helped increase enrollment and retention rates for MAGI individuals. So, this rule requires that states adopt many of those streamlined application and renewal procedures for non-MAGI individuals as well in order to align processes for states and promote equity across all populations served by Medicaid.

So, those simplifications now require for both MAGI and non-MAGI populations that eligibility must be renewed once and no more frequently than once every 12 months, states may not require an in-person interview at application and renewal, states must provide all beneficiaries whose eligibility cannot be renewed on an ex-parte basis with a pre-populated renewal form, a minimum of 30 calendar days to return that form, and a minimum 90 calendar day reconsideration period.

And states must allow non-MAGI enrollees to provide requested information via the same modalities as for MAGI individuals, so if MAGI individuals are allowed to submit their information on the phone, via text, over mail or email, the same modalities must be accepted for non-MAGI beneficiaries. And as you can see, for this provision, states will have 36 months to comply. And I will hand it over to Steph.

Stephanie Bell: Thanks, Anne. Next slide, please. Next slide. I think one or two more. This one. Thank you so much. So, through this final rule, we're also instituting requirements for states to seamlessly transition individuals from Medicaid to separate CHIP and from separate CHIP to Medicaid. These new provisions require Medicaid agencies to make determinations of eligibility on behalf of separate CHIP and separate CHIP agencies to make determinations of MAGI-based eligibility for Medicaid. Separate CHIP agencies are also required to make determinations of potential eligibility for non-MAGI Medicaid.

Similarly, Medicaid and separate CHIP agencies must accept determinations of eligibility made by the other program. Medicaid agencies have options for accepting determinations of eligibility based on MAGI that are made by a separate CHIP agency and Medicaid agencies will continue to make final eligibility determinations for Medicaid on a non-MAGI basis. State Medicaid and CHIP agencies must then transition individuals to the program they are determined eligible or potentially eligible for based on available data.

Additionally, Medicaid and separate CHIP agencies must provide one single combined notice to each household with information about all individual household members' eligibility status for the applicable program whenever individuals are transferred between programs. And states must come into compliance with these requirements upon the effective date of the rule by June

6, 2024. And now I'll turn it over to Meg Barry to discuss Objective 3 of the rule.

Meg Barry: Thanks, Beth. Next slide, please. Our third objective was to remove access barriers for children. Next slide. There have been several places where CHIP children continue to face barriers to accessing coverage that didn't exist for Medicaid. We're pleased that we were able to address three of them through this rule, two of which we'll discuss today, and that's lockout periods and waiting periods. In addition, we also eliminated annual and lifetime limits in CHIP, and we also confirmed state authority to adopt optional eligibility groups, serving non-MAGI-based reasonable classifications of children. With that, I'm turning it over to Shakia Singleton.

Shakia Singleton: Thank you, Meg. Next slide, please. To improve access to care and remove coverage gaps for eligible children, we are eliminating the state's option to implement premium lockout periods. Lockout periods, as you may be aware, are a state-specified period of time that a CHIP eligible child who has an unpaid premium or enrollment fee may not enroll in coverage. Prior to issuing our final rule, states have the option to implement up to a 90-day maximum on premium lockout periods.

Our final rule applies to states with a separate CHIP and/or basic health program. Elimination of lockouts and CHIP aligns Medicaid policy, which prohibits lockout periods under state flexibility. We encourage states removing premium lockout periods to consider adopting other mechanisms for addressing timely payments of premiums. Examples include, generating frequent reminder notices, providing multiple and convenient options for paying premiums, and pursuing past these premiums.

Upon effective date of this rule, states may not adopt a new premium lockout period. We recognize that states with existing lockout periods may need to make policy changes to come to compliance. Therefore, upon effective date of this rule, states with existing lockout periods have 12 months from the effective date of this final rule to implement necessary changes. States with biennial legislatures that require legislative action to implement these requirements can request an extension of up to 24 months, following the effective date of this rule. you, and I'll pass to Steph.

Stephanie Bell: Thank Shakia. So, the next provision I will talk through is prohibiting waiting periods. Can you go to the next slide, please? Thank you. So, under prior rules, state-separate CHIP programs were allowed the option to require a waiting period up to 90-days before enrolling individuals into CHIP as a strategy to discourage families from substituting CHIP for coverage under group health plans.

Historically, most states that took up the option to implement a waiting period have already eliminated the waiting period and used other strategies to prevent substitution of coverage. And this rule goes a step further and prohibits waiting periods in CHIP. States that do not currently impose a waiting period are required to comply with this provision upon the effective date of the rule, June 6, 2024, meaning they may not implement new waiting periods after that date.

States with existing waiting periods have up to 12 months after the effective date to sunset them. And similar to the lockout provisions that Shakia discussed, states also have the option to request up to a 24-month extension to account for legislative changes. To do so, states with waiting periods will need to submit a CHIP's file that includes an updated CF-20 form and MMDL to

remove the waiting period and describe one or more monitoring strategies the state will use in place of the waiting period.

So, to meet the requirement that states have reasonable procedures in place to prevent substitution of coverage, states are required to implement monitoring strategies in place of a waiting period. Some examples of monitoring strategies include adding a question about other coverage on the state's health coverage application or conducting database checks to determine if applicants and enrollees have access to other sources of coverage besides CHIP. And now I'm going to turn it over to (Kristen Pacek) to discuss Objective 4 of the rule.

(Kristen Pacek): Thanks. Thank you, Steph. Next slide, please. All right. Keep going. Next slide, one more. All right, perfect. And so this is the last major objective of the rule to enhance program integrity. And we have two more provisions for you all that fall under this objective.

Next slide, please. And as you can see, the two provisions relate to establishing timeframes for timely determinations of eligibility, specifically for renewal and changes in circumstances. And then in addition, we took the opportunity to update our recordkeeping requirements.

Fun fact, the recordkeeping rules were last updated in 1986 and had references to microfiche and many other outdated technologies. And so we took the opportunity to clean those up and help to promote better consistent practices across states to help increase oversight of all the documentation and record-keeping. But before we move to record-keeping, I'm going to talk a little bit more about timely re-determination standards.

So next slide, please. All right, thank you. So, this final rule expands upon existing timeliness standards that application and specifically establishes new timeliness standards for renewal and changes in circumstances. And in certain cases, the standards that are in the final rule provides states with more time to complete a redetermination. But it has this additional information is necessary to complete renewal. And if it's received at the end of an individual's current eligibility period, for example, or if their eligibility needs to be redetermined on another basis.

And if you can move to the next slide. You'll see here that we've included a really helpful chart in the slide deck that is also in the final rule that helps to capture all of the different timeframes for each of the scenarios. While we didn't make - although we want to note that we didn't make any changes, we didn't propose any changes to the determination standards at application, but we included them here so you have everything in one place.

But you'll see in the final rule that we tried to simplify these requirements and pulling in things that were already applicable, such as, for example, if the eligibility determination needs to occur because of - on another basis, basically we are applying the same time limit standards that already exist at application, those states will have, you know, an additional either 45 or 90 days depending on if the determination is on the basis of a disability. I think with that - I think that's our wraps of all of the provisions. So, Steph, I think I turn it over to you.

Stephanie Bell: Thank you. I'm actually going to touch on recordkeeping for one more minute, if you'll go to the next slide. And just say, as (Kristen) mentioned, the prior regulations were very outdated and permitted states to maintain beneficiary enrollment data in paper or on microfiche. So, we are moving into the 21st century, accounting for new technology and

requiring information to be maintained electronically. And this provision will be effective again on June 6th or 4th, I think it was. And then compliance will be required 24 months after the effective date. So, let's move to the next slide, and we can do some questions. Jackie? I'm going to get back to you..

Jackie Glaze: Yes, thank you, Steph and team for your presentation today. So, yes, we are ready to take state questions. And so we will ask that we begin with the chat function. So, if you do have questions, please start submitting them now and then we will follow by taking questions over the phone line. So, I will turn to you, Krista, to start taking the questions to the chat function.

(Krista): Great, thank you so much, Jackie. Right now, I'm not seeing any questions in the chat, so maybe we can just give folks a minute or two to input them. If you have any questions, feel free to put them in the chat.

Coordinator: And then also, if you have questions about today's presentation or any other questions that you may have, please include those.

(Krista): Come on, it's only 99 pages long. I'm sure you've all read it cover to cover already.

Coordinator: All right. One question here. Will there be any written notes provided from the presentation regarding the REH information?

Woman 1: Does anybody know what the REH is, does anybody know? It's the rural emergency hospital, I think, I think the question, yes, based on my point. I believe the question was asking whether we were going to send anything out to states based on what I shared today. And as of now, we are not planning to send anything formally out to states, but that may change.

(Kristen Pacek): And this is (Kristen Pacek). If you have particular questions about what was discussed here today, please contact your state lead and we can provide technical assistance directly to you.

(Krista): I'm getting a few questions just about the slides and where they'll be posted and whether a recording will be available. So, I will just let folks know that all of the slides, even the ones that we skipped over today will be posted on medicaid.gov on the all state calls page, just following this call. And a recording will also be available.

All right, one additional question here. For the 90-day reconsideration period for applications, if whatever caused the denial is cured, would eligibility be established back to the application date?

(Kristen Pacek): Can you repeat the question again?

(Krista): Sure. For the 90-day reconsideration period for applications, if whatever caused the denial is cured, would the eligibility be established back to the application date?

Sarah Lichtman-Spector: (Kristen), I can jump in if you want. This is Sarah, because I just happen to have that particular section of the final rule pulled up.

(Kristen Pacek): Okay. Perfect. Thank you.

Sarah Lichtman-Spector: If you can believe it, everybody, we don't actually have all 99 pages of it memorized either. But what the provision provides, this is in 435.907 in its new paragraph, D as in David, 1, Roman it 3, so triple little I. And if the applicant subsequently submits them, so after the application has been denied and the applicant subsequently submits the additional information

needed within 90 calendar days or longer period, if your state elects a longer period, the state is to treat the additional information as a new application and reconsider eligibility in accordance with application time standards at 435, 912.

So, what that means is the clock resets. The additional information sort of starts as if you just received an application then, and then you get, you know, the 45 days for a MAGI-based application to, you know, to meet the timeliness standards.

Stephanie Bell: This is Stephanie. would just add that we had proposed 30 days, and we changed it to 90 to align with the reconsideration periods for renewals and changes in circumstances, so they all function in relatively the same way.

(Susan): Hi, this is Susan. Maybe I can just add on to that. I think once you treat it as a new application, as Sarah said, you make a determination prospectively, and then you would be able to apply the retro coverage rule. So, if the person meets the retro requirements at 435.915, the state could provide retro for this period before.

(Krista): Thank you both for those clarifications. And I'm seeing a thank you in the chat too, so thank you so much. I'm not seeing any additional questions come through the chat, so I'm not sure, Jackie, maybe you want to open the phone line?

Jackie Glaze: Yes, let's do so. So, Ted, if you could please provide instructions for how to register the questions through the phone line, and if you could open the phone line, please.

Coordinator: Yes, the phone lines are now open for questions. If you would like to ask a question over the phone, please press Star 1 and record your name. To withdraw your question, press Star 2. Thank you.

Stephanie Bell: While we're waiting, I'll just say that we recognize that there is a lot of information in this 99 pages, and as you can see, it's been a team effort on our end, and we don't think this will be the last time will be talking about it.

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

Jackie Glaze: Thank you. And (Krista), I'm not seeing any additional questions through the chat. Are there any additional that you can see?

(Krista): I did just get a question about, sorry, the REH, it was a similar question. It would be helpful to just highlight the REH changes. There was a lot of background. So, I'm not sure if that person can just specify their question in the chat. We can circle back to it. If there's specific questions about REH, we'd be happy to clarify. But I am seeing a few additional questions pop up, so I will just read those. The next one is, was FNS interested in aligning any of their rules to align with Medicaid? For example, 15 days to return verification et cetera.

(Kristen Pacek): Hi, yes. (Unintelligible). Yes, so we have been working with our colleagues and FNS to see what opportunities may exist in the future to align. We know that lots of states have you know integrated eligibility systems and that was one of the key factors that (unintelligible) strong and comment we received, so we are working now to see what may be possible in the future, but I will pause and see if others on the CMS team have anything else to add there?

Sarah Lichtman-Spector: I'll just -- this is Sarah. I'll just add. Thanks (Kristen, that, I mean, it is a challenge, because there are some both regulatory and also some statutory differences that exist. Again, we are doing new regulations, but there's also sort of some statutory differences and also some tensions between sort of some of the goals of our processes.

So, we did take that, and I think there will be some discussion of that in the final rule, to balance that alignment with still achieving our goals as best we could. One place where that tension really popped up was in how long to provide individuals - how long to provide individuals an application who needed to provide additional information.

The FNS SNAP timelines are very much more aggressive, and so we had that tension between our goal of making sure people weren't procedurally denied, if you will, and had the time to receive notice of request for additional information, find your documentation, get it into the agency, and not create sort of an unnecessary denial.

But it was, you know, it's a tension that we acknowledge, and so we hope we struck the best balance that we could, but recognize it's an area that's probably going to require future work, you know, for any number of, you know, months and years to come. And we'll, as always, welcome state feedback and input on what we can do operationally to sort of increase the coordination that's possible.

(Krista): Thanks, Sarah. I see an additional question here about the reconsideration period. For the 90-day reconsideration at application, does it have to be all the required information or at least one of the required information?

Stephanie Bell: You know, I think we ought to take that back and think about it. I'm used - there's always a permutation that you haven't thought of. This one's coming particularly quickly. So, thanks for that question. And we will consult amongst ourselves and circle back as soon as we're able to.

(Krista): Okay. We will take note of that one. I see another question here to confirm periods, individuals have to provide additional information. For applications, it's 15 calendar days. For change in circumstance, it's 30 calendar days. Renewals, it's 30 days. Is that correct?

(Kristen Pacek): Yes. And the 15 days at application is the minimum, you know. They definitely have the flexibility to increase it to 30 days, so the lightning out there consistency across all of the scenarios.

Sarah Lichtman-Spector: And you'll find a handy table in the published rule with all of the timelines in it.

(Krista): All right. Other questions. So, if the agency needs multiple items to determine eligibility, but only one is provided, should the agency consider that the date that information is received as a new date of application? Or would the application remain in denied status until all three items are provided, if provided within the 90-day period?

Stephanie Bell: I think that a little bit is related to the question that I said we'd take back, because here we have items coming in one, two, three, and the question is, does the first item - in this scenario, and I think in the hypothetical in the first question, the way I internalized it was somebody responded with one thing, but not - and didn't necessarily follow up of their own accord, and did the state need to treat that first return of additional information requested as a new application, or could it wait?

And this one, I think, is a variation. Saying this just to make sure we've gotten it right, so the questioner can follow up and clarify. In this case, we're assuming that the person does actually return all of the documentation, and the question is which one, the first one or the last one, piece of documentation that get sent, which date triggers like the new application date for purposes of eligibility. So, I think those are related, and we will take them back and chat and see what we can come back with.

(Krista): Great. One question here on rural emergency hospitals. Can a facility be both RHC and an REH?

Sarah Lichtman-Spector: I think we can take that question back, but are you saying a rural health center, the mandatory benefit in a rural emergency hospital? I know the rural emergency hospital, actually, as well as the RAC, have specific requirements in the Medicare side and the Medicaid side for RACs. And as I stated before, the REH is not represented in the Medicaid statute as of yet. And so I don't think that would be allowable, but I think we need to take that question back.

(Krista): Great. Thank you everyone. I'm not seeing any additional questions in the chat at this time. Jackie, do you want to turn back to the phone line?

Jackie Glaze: Yes. Thank you. So, Ted, could you please provide instructions once again for how to register a phone for the questions to the phones and then open the phone lines, please?

Coordinator: Yes. And as a reminder, if you would like to ask a question over the phone, please press Star 1 and record your name. And then there is a question in the queue from Robin. Your line is open.

(Robin): Oh, good. Hi. Thank you. Can you hear me?

Jackie Glaze: Yes, we can.

(Robin): Oh, can you hear me?

Coordinator: We can hear you.

(Robin): Oh, okay. Thank you. I wanted to do a little bit further on the 90-day reconsideration for a new applicant. What I feel like I'm hearing is they don't need to sign anything new. They don't need to self-attest to anything that was in their original application. We will just pick that up and work with them to give them a prospective grant. And my understanding that right?

Stephanie Bell: That's correct.

(Robin): Great. Thank you.

Stephanie Bell: And then as (Susan) clarified, you would check to see if, you know, if they had received services in the prior three months and, you know, would have been eligible during that prior three months. You would also provide the retroactive eligibility if you're - unless you're a state that has a waiver of retro eligibility.

(Robin): Yes. Okay. Great. Thank you.

Stephanie Bell: Thanks for the questions.

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

Jackie Glaze: Thank you. Thank you, Ted. Krista, any additional questions on your end?

(Krista): Yes. One last question here. So, applications, can a state issue two 10-day requests, an initial request for 10-days, and then, if not provided, an additional 10-day request, for a total of 20 days, or does any request have to be a minimum of 50-days?

Stephanie Bell: This is Stephanie. Go ahead. I was just pulling up the language and it says provide applicants with a reasonable period of time of no less than 15 calendar days measured from the date the agency sends the request to respond and provide any necessary information. I believe, we've always interpreted that in other areas as meaning one chunk of time that's no less than 15 calendars days. In the renewal sphere, we say the current MAGI-based requirements are provided at least 30 calendar days. That means in one chunk, right?

Sarah Lichtman-Spector: Yes.

Stephanie Bell: Thank you. So yes, it would have to be at least one period of 15 calendar days, two separate 10-day periods wouldn't - would not meet the requirement.

Jackie Glaze: I'm seeing one additional question, Krista, do you want to take that, and I think we'll wrap up?

(Krista): That sounds good. The very last question here is, how does the state determine retro when an applicant only provided point in time information? Did you (assume yes) to medical bills in the past three months during the reconciliation period if the person said yes to bills on the original application?

((Crosstalk))

Stephanie Bell: Go ahead.

(Kristen Pacek): Sure. I think it, you know, you would treat retro like you always would. So, either you would include in the notice information on how the person can submit bills and the state could conduct - ask for more information to ensure that the person met all the requirements of retro at that point in time, or states can also collect an attestation that there was no change in the previous period. So, we are happy to talk more - I know, we are almost at time, so happy to talk more about that on a future call, or if you have any questions, please send them to us.

Stephanie Bell: That is just what I was going to say.

Jackie Glaze: Thank you. So, in closing, I do want to thank our team for their presentations today. Looking forward, the topics and invitations for our next call will be forthcoming. So, if you do have questions before we do speak again, please feel free to reach out to us or state leads or bring your questions to our next call. So, again, we do thank you for joining us today and we hope everyone has a great afternoon. Thank you.

Coordinator: This concludes today's. Thank you for your participation. You may disconnect. Speakers, please stand by.

END