HHS-CMS-CMCS
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3:00 pm ET

Coordinator: Welcome and thank you, all, for standing by. At this time, I would like to inform all participants that your lines have been placed on a listen-only mode until the question-and-answer session of today's call.

Today's call is also being recorded. If you do have any objections, you may disconnect at this time. And I would now like to turn the call over to Jackie Glaze. Thank you. You may begin.

Jackie Glaze: Thank you. And hi, everyone, and welcome to today's all state call. We will be dedicating today's Medicaid and CHIP all state call to answer states' questions on the three recently released Medicaid and CHIP final rules.

And those are, the first one being the Streamlining the Medicaid, Children's Health Insurance Program, the Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes. The second is ensuring access to Medicaid Services Final Rule. And the third is the Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule.

To start, the CMCS team will answer a few prepared Q&As based on common questions that states have raised then we will open up the floor to states for a

live facilitated Q&A session. Before we get started, I want to let everyone know that today's session will be verbal, so we will not be using any slides. We will not be using the chat function to take your questions, so we'll just be using the phone line so that you'll be able to take yourself off of mute and then ask your question.

So, with that, I'm pleased to introduce and turn things over to Betsy Conklin to get things started today. So, Betsy? Betsy, can you hear me?

Alissa DeBoy: Jackie, this is Alissa. Do you want me to start with our questions and …

Jackie Glaze: Yes, yes, yes, please, Alissa, thank you.

Alissa DeBoy: Okay, great. Hello, everybody. So, we have some common questions that we received on the Home and Community-Based Services provisions of the access rule, and so, we wanted to share them here. I hope that that will be helpful to you.

So, one of the first questions that we have been getting from states is the question of, how will CMS be engaging with states to identify implementation needs for key HCBS provisions, such as system specifications for the 80-20 payment adequacy threshold, incident management requirements, and HCBS quality measure set reporting?

So, in response to that question, we want to first just start by saying that we want to be sure that we are giving states what you need and when you need it. And obviously, because of the rolling applicability dates, we need some time to build our sub-regulatory guidance, and we need to make sure that it's responsive to your needs.

We are very pleased to announce that we will be establishing a workgroup across the Medicaid agencies and HCBS operating agencies. We're working through the state associations to hopefully put that together sometime in the fall. And that will be an opportunity to keep you engaged in a prize as we dig in to guidance development.

We'll also -- we're planning to offering a series of trainings to help states and other stakeholders fully digest the requirements in the rule. And we also plan to start that in the fall as well. And we'll be, of course, collaborating with our data and systems group to ensure that I.T. system builds remain front and center of implementation activities.

The second question that we've been getting quite often is how can the Money Follows the Person, or otherwise known as MFP, demonstration grant be used to assist states in the implementation of the HCBS quality measure set, which is required under the access rule?

So, as we've been sharing with states, MFP programs will be among the first to implement the HCBS quality measure set as part of the grant program ahead of the required reporting as required by the access rule.

And MFP grant recipients can receive grant funding for costs associated with implementation of the measure set. Importantly, the cost associated with implementing the measure set would be considered administrative cost under the MFP demonstration, and as a result, they would be 100% federally funded under the grant with no state share.

So, therefore, we encourage states and territories participating in the MFP program to build these costs into their MFP budgets. And we, of course, are available to provide technical assistance related to the implementation of the

quality measure set under the grant program. And if any states or territories are not currently participating in MFP and would like to do so, you can please contact us for that as well.

The third question that we're getting is, which authorities do the HCBS provisions apply to? Do they -- and also, do they apply to managed care and fee-for-service? So, in response, and as noted in our comment and responses in the rule itself, to promote consistency across Medicaid HCBS authorities, most of the requirements in the HCBS section of the rule apply to the HCBS authorities under 1915(c), (i), (j), and (k), and to Section 1115 demonstrations, and to HCBS delivered under both fee-for-service and managed care.

There are a few exceptions. One key exception is the requirement for states to have a grievance or complaint system in their fee-for-service programs within two years. There are existing grievance systems requirements for managed care programs, but the access rule really filled the gap for fee-for-service programs. So that is only -- those provisions in the access rule are only applicable to fee-for-service.

And this is to ensure that Medicaid beneficiaries receiving HCBS through fee-for-service delivery systems have the same opportunities as people enrolled in managed care to file complaints related to the state's or provider's compliance with person-centered planning and HCBS settings requirements.

Another example is the requirement for states to report annually on waiting lists in their HCBS programs, and this is only applicable to Section 1915(c) waiver programs and 1115 demonstrations. And that is because state authorities, the other state plan authorities are not permitted to have waiting lists, so this reporting requirement would not be applicable.

And then finally, the fourth question that we're getting quite often is when are states expected to meet the HCBS requirements laid out in the access rule? And fortunately, most of the provisions in the rule are not effective immediately.

There are -- most have a three-year applicability date, but there are a few provisions that have different applicability dates. The first one being, what I talked about in the last question, was the requirement for states to implement a grievance system in a fee-for-service HCBS program.

This requirement has a two-year applicability date. It's the first one that's applicable. But beyond that, the others that I'm going to mention have no longer applicability dates in the three years that most of the reporting requirements have.

So, for instance, the requirement for states to report on a percent of Medicaid payments for personal care, homemaker, home health, and rehabilitation services spent on compensation for the direct care workforce, that has a four-year applicability date.

The requirement that at least 80% of those services or Medicaid payments for personal care, homemaker, home health aid be spent on compensation for the direct care workforce, this requirement has a six-year applicability date.

And then the requirement for states to have an electronic incident management system has a five-year applicability date. And then, of course, the HCBS measure set has a four-year effective date. And there's a series of stratification requirements that are phased in over eight years.

So those are the main questions that we've gotten so far on the HCBS provisions of the access rule. So, I think I am turning it over to Jeremy Silanskis to talk about a few more provisions that fall under his purview. Jeremy?

Jeremy Silanskis: Great, thanks, Alissa. My name's Jeremy Silanskis, I'm with the financial management group, and I'm going to talk about some questions that we've gotten on the fee-for-service provision.

First and foremost from states, are states still required to complete the access planning and review plans that were previously in (regulations)? And the good news for states is that, no, as part of the access to care final rule that we issued this year, we rescinded the AMRP process and we replaced it with processes that are focused on transparency, comparisons to Medicare rates for certain services, and a tiered approach to analyzing access to care when states propose to reduce or restructure fee-for-service payment rates through state plan amendments.

The second question that we've received frequently is about the access analysis template that states will complete when they reduce their rates and when that will be issued. The good news there is that we've drafted the template and we're in the process of receiving clearance required to comply with the (people of Reduction Act) processes.

We, in draft form, issued the template on medicaid.gov. You can find it on the main Access to Care page. So, for those pre-production procedures that took effect on July 9th, states are free to use that as an optional tool to complete that process. Once the template is officially cleared, that'll become the form that's required for states to submit that analysis to CMS.

And this -- and I also wanted to know with that, we issued a companion guide for states on the access fee-for-service provisions I believe at the end of June that's also on that Access to Care page. So, if it's helpful for states, we have a lot of good guidance within that guide and I'd encourage you to go check that out as well.

Finally, for fee-for-service, we have states asking which SPAs are considered rate restructuring SPAs that could diminish Medicaid access to care. And I do want to acknowledge that there's some subjectivity there. It's not a "gotcha" question. It really is intended to ensure that states -- and we consider the impact of rate changes on access to care.

I'm going to give a few examples of the types of changes that might be considered restructuring. A state may propose to completely overhaul a fee-for-service payment system and pay using prospective payment rates.

So that would obviously be a restructuring that could diminish access to care and would be a consideration. A state could make a smaller, more targeted change, like changing units of service for a particular benefit category from an hourly to a daily rate. That could cause -- potentially cause access diminish.

An additional state could restructure Medicaid supplemental payments to exclude certain classes of providers that historically received supplemental payments and redistribute the amounts to different providers within an upper payment limit category, basically moving money within the state, but obviously, certain providers could be disaffected by that.

So, in considering those types of examples, I think it's important to go out and just make sure that you have some information when you come into CMS and make those proposed changes around the nature of the change, the policy

associated with it, whether you've heard from -- feedback from providers and what that sort of feedback might be, if you work with providers on those sorts of changes, like all that's very useful to help us understand and you understand the effects of access to care.

Okay, so I'm going to turn it over to Karen Llanos, and she's going to talk about the Medicaid Advisory Committee provisions.

Karen Llanos: Thanks Jeremy. So, as Jeremy said, I am going to talk about the final provision in ensuring access to Medicaid services rule, which is related to the Medicaid Advisory Committee.

The first question that I wanted to talk about are, to clarify the applicability dates and the related percentages for when the Medicaid Advisory Committee members must come from the Beneficiary Advisory Council.

CMS recently issued a technical correction about two weeks ago on July 9th that outlines this change, and I just wanted to reiterate it for folks here on this call as well. So, instead of the 25% minimum threshold seemingly coming into effect right away, our intention was to give states enough time to establish both the Medicaid Advisory Committee and the Beneficiary Advisory Council.

So, the correct dates are that for the period from July 9th, 2025, through July 9th, 2026, 10% of the MAC members must come from the Beneficiary Advisory Council. Next, for the period from July 10th, 2026 through July 9th, 2027, 20% of the MAC members must come from the Beneficiary Advisory Council, and then thereafter, 25% of the MAC members must come from the Beneficiary Advisory Council. So that's a clarification that's re-emphasized in the technical correction as well.

The second question that we are getting quite frequently is can states use existing community groups or advisory councils to satisfy the requirements of the Beneficiary Advisory Council? And we do have this question and response as part of the final rule, but we know there's a lot to sift through. So I just wanted to reiterate on this call that we know that many states already have active Medicaid beneficiary groups that could very easily fill these requirements and function as their Beneficiary Advisory Council.

In these instances, it's not our intention to ask the state to create a second Medicaid beneficiary council to meet these requirements. As we noted in the rule, a state can use an existing group to fill the BAC requirements as long as these committees meet the membership requirements as specified in Section 431.12(e).

They will also need to ensure that the existing committee membership meets the membership requirements of the Beneficiary Advisory Council that I just mentioned in -- under E, and that the existing committee bylaws are developed or updated and published to explain very clearly that this committee functions meet the Beneficiary Advisory Council requirements.

And then finally, a question that we're getting as well is when will the CMS -- when will CMS release the MAC toolkit reference in the final rule? We are targeting a fall release that says September-October release for this toolkit.

And with that, I'm going to turn it over to Ed Dolly from the Data and Systems Group.

Ed Dolly: Well, thank you, Karen. And as Karen said, my name is Ed Dolly. I'm going to cover a couple of questions that we've had come in related to systems configuration and funding.

So the first question being, are the system changes required by the provisions in the E&E access and managed care rules eligible for enhanced match? And the response is, in general, yes, right? State Medicaid agency I.T. system costs may be eligible for enhanced FFP.

Of course, the approval for that FFP comes through the submission of advanced planning document for review, and there's the different levels of match. There's the potential for 90% for the design, development, and implementation of those aspects to support the rule.

And then systems, once they're implemented and approved, can receive 75% match for ongoing maintenance and operations. And then the -- and interested states should refer to the relevant portions of 45 CFR Subpart -- Part 95 Subpart F. And, of course, we'll call out the delineations more clearly in the -- in the written FAQs.

The second question, will CMS provide APD templates to make requested -- requesting funding for these provisions easier? In response, we currently do not have a template for this. However, CMS is reviewing the regulations and processes with our program partners to identify areas where introducing template options may reduce burden on states while still providing all the necessary elements required by regulation for planning documents to be reviewed.

And when we -- and when we evaluate that, we're really looking primarily at such factors of, what is the degree of commonality in the state requirement of

submissions and service level agreements such that a template really fits, right, or is it such that it -- that the state has such -- or we're going to need such a wide degree of variability in the way that they're going to implement, a template really doesn't lend itself to the process. The developing and implementing tools like templates take time and focus, but we are committed to continually reviewing our processes for opportunities to be more efficient.

And then third, what is CMS doing to help reduce the cost each state pays for the system changes required by these provisions? And this is a great question and one that we get often. We -- CMS continues to lean in into and work towards identifying areas of opportunity to reduce overall spend related to the development implementation and ongoing support of all of our systems.

And this work begins with partnering with our program partners to operationalize some provisions in the rules in ways that minimize the cost. This is typically done through providing technical assistance to ensure that in state-specific configuration is minimized to that, which is deemed mission-essential.

A simpler way of saying that potentially is, traditionally, our experience has shown us costs go down when states are willing to make changes to their business processes to use a product as opposed to configure the product to their existing business processes, understanding that some business processes are essential and cannot be changed, but also recognizing some business processes are a result of what's been that way and that's how we keep doing it. Less configuration is cheaper, just bottom-line.

We are also, we, CEMA, we continue to meet routinely with our vendor community and examine other ways to reduce system costs. And, for example, at the upcoming Medicaid Enterprise Systems Conference, in

MESC, we are facilitating an interactive workshop with both state and vendor partners whose whole purpose is to help us understand what more can we do to create opportunities for reuse across the states and territories. And we'll be sharing the results of that -- of that exercise going forward.

And I believe that I'm turning it over to John.

John Giles: Thanks so much. Yes, I am going to cover some common questions for the Medicaid Managed Care Access, Finance, and Quality Final Rule.

All right, our first question is related to the access provisions of the rule. So, in 438.68, which is where our network adequacy rules are, states are required to receive information on errors found in electronic directories by secret shopper surveys within three business days and then forward it to their managed care plans within another three business days. That's a very short turnaround time. Can the secret shopper vendor send the identified errors directly to the managed care plans instead?

So the answer to that question is, yes, states can have their secret shopper vendors send the information on errors found in the provider directory information directly to their managed care plans at the same time that they sent that information to the state.

We do want to clarify that the state must still receive this information on the identified errors as that information is critical to states oversight activities as well as enabling them to ensure that all errors have been corrected timely. You can find information about this on Page 41022 of the Managed Care Final Rule.

Okay. The next question is related to the state-directed payment provisions. The question is, CMS removed the phrase "network provider," from the state-directed payment requirements in 438.6(c), which is where our state-directed payment provisions are found. Does that mean that states are now required to direct plans to pay state-directed payments to both network and non-network providers?

The response is, as part of the final rule, we removed texts in 438.6(c) that limited provider eligibility for fee schedule-type state-directed payments, including uniform increases and minimum and maximum fee schedules to network providers.

However, this change does not require or mandate that states direct state-directed payments to both network and non-network provider, but it does create the option for states to direct state-directed payments to in or out of network providers, depending on the state's goals and objectives for that state-directed payment.

And I just want to check, I believe I'm turning this to Amanda Paige Burns to cover a question on the quality rating system, but I want to check that she's on the speaker line.

Coordinator: I do -- this is the operator. I do not show her on, but if you are on the call, you may press star-0 so we may open your line. And one moment here. Okay, give me one moment and I will open that line for you. Okay, we do have Amanda on.

Amanda Paige Burns: Hi, everybody. This is Amanda Paige Burns, and I am the lead for the Medicaid and CHIP Quality Rating System. So, one question that we've

gotten a couple times so far is the question of, by when the states implement a MAC QRS?

So, the deadline to implement a state MAC QRS is December 31st, 2028, so it's a couple years away. And by then, states need to have their MAC QRS Web site up and available for the public to view, which would include all the requirements that are established under our Web site display section and our regulations.

And then included in that Web site display will be quality ratings for MAC QRS mandatory measures that will include data for services provided in calendar year 2026. And just a flag that states that are unable to fully comply with certain of the MAC QRS requirements, and those include the requirements related to the methodology for calculating quality ratings as well as certain Web site display requirements, will have the option to request a one-time, one-year implementation extension for those specific requirements.

And that flexibility provides an additional year, so that would be until December 31st, 2029, to integrate the requirements for which the extension is granted into a state's existing MAC QRS that was implemented by that December 31, 2028 date. And that's all we have for MAC QRS.

John Giles: Great. I think now, we are turning to the Eligibility and Enrollment Final Rule.

Martin Burian: Thank you, John. This is Martin Burian from the Division of Medicaid Eligibility Policy. We have just a couple of questions. I'm going to go over a question about applications for other benefits, which includes applying for Social Security or unemployment benefits or other cash benefits.

So the question is, with the elimination of the application for other benefits provision at 42 CFR 435.608, applicants and beneficiaries are no longer required to apply for other benefits as a condition of eligibility for Medicaid. Do states have an option to continue this requirement or an obligation to advise individuals about other benefits for which they may be eligible?

And the response is, April 2nd, 2024, Eligibility Final Rule finalized the removal of the requirement at 435.608, and applicants and beneficiaries apply for other benefits as a condition of Medicaid eligibility with an effective date of June 3rd, 2024.

Medicaid agencies have 12 months from the effective date to come into compliance with this provision. States must eliminate the eligibility requirement for applicants and beneficiaries to apply for other benefits no later than 12 months after the June 3rd, 2024, effective date. And there is no optional authority for states to choose to impose such a requirement after states have come into compliance with the elimination of 435.608.

States are not prohibited from advising Medicaid applicants and beneficiaries of other benefits for which they may be entitled. In fact, we encourage states to educate Medicaid applicants and beneficiaries of the other benefits for which they may be eligible in the preamble to the final rule in which we eliminated 435.608.

However, states are not required to provide this information. And as I've just noted, states must no later than 12 months after June 3rd, 2024, eliminate the requirements that Medicaid applicants and beneficiaries apply for other benefits as a condition of their Medicaid eligibility.

And with that, I'm going to turn it over to Stephanie Bell.

Stephanie Bell: Thanks, Martin. Hi, everyone. This is Stephanie Bell, Senior Policy Advisor in the Children and Adult Health Programs Group. And I am going to touch on one of the questions that has been coming in about the different timeframes that were included for different parts of the eligibility determination process.

So, the question is, can you confirm the different timeframes for individuals to provide additional information and application at renewal and following the change in circumstances? And what flexibilities are available for states that have integrated eligibility systems for their Health and Human Services programs?

So, states must provide applicants with a reasonable period of time that can be no less than 15 days to provide additional information needed to determine eligibility. So that's 15 days of application.

At renewal, a state must provide a beneficiary with at least 30 days from the date the renewal form is sent to return additional information needed to renew eligibility. And similarly, following a change in circumstances, states must provide beneficiaries with at least 30 days to respond from the date a request is sent.

These are all measured in calendar days. And the requirements can be found at 435.907 for applications, 435.916 for renewals, and 435.919 for changes in circumstances. And those are all minimum response periods, so they can be extended.

And for states with integrated eligibility systems, I wanted to flag that last month, the Food and Nutrition Service issued a policy memo describing state flexibility for providing households with more time to submit verification

that's required for SNAP eligibility. So if you haven't seen that, I would encourage you to seek it out.

We did collaborate with the Food and Nutrition Service as we worked through the timeframes for Medicaid and CHIP in the Eligibility Final Rule, and then they issued this guidance to provide flexibility to align the timeframes application. So with that, I'm turning back to Jackie.

Jackie Glaze: Thank you, Stephanie, and the rest of the CMCS team for walking through the responses to some of the questions that we received by states. So, now, we're ready to take states' questions. And so, I'll ask, Sue, if you could provide instructions for the states on how to register their questions and if you could open the phone lines please.

Coordinator: Thank you. At this time, if you would like to ask a question, please ensure that your phone is unmuted. Press star-1 and record your name clearly when prompted. If you would need to withdraw your request, please press star-2. Again, to ask a question, that is star-1. And we'll just take a moment for any questions to come in. Please stand by. One moment for the first question.

Our first question is from (Rachel). You may go ahead. (Rachel), your line is open. You might be muted.

(Rachel): I apologize. Will all of these questions and subsequent answers be published, so, if we didn't get all the notes that we needed, we can see the answers?

Krista Hebert: Hi, (Rachel). This is Krista Hebert with CMCS. We will be having a recording of this session posted on medicaid.gov on the All State Call page, will be typically posted following this.

(Rachel): On medicaid.gov, thank you very much.

Coordinator: Thank you. Our next question is from (Elise). You may go ahead.

(Elise): Hi. My question is about the membership on the MAC from the BAC. Is it absolutely necessary that beneficiaries that would like to have their voice on the MAC be from the BAC? What if there's other beneficiaries on other subcommittees that we might have for medical assistance like we have a long-term living subcommittee, could they come from that subcommittee as well?

Karen Llanos: Hi, (Elise), this is Karen. It is a requirement that the beneficiary voice be represented through that system and MAC be represented and pulled through the Beneficiary Advisory Committee.

(Elise): Okay.

Coordinator: Thank you. At this time, there are no further questions. As a reminder, please press star-1 if you would like to ask a question. One moment please to see if there's any further questions. There are no further questions at this time.

Jackie Glaze: Thank you, Sue. So, let's wait a few minutes to see if we do get questions. So if you could just alert me when there is a question, but we'll give it another minute or two to see if we do have questions.

Coordinator: Sure. And again, as a reminder, that is star-1 if you would like to ask a question. One moment, we did just have a question come in. Please stand by.

And our next question is from (Patrick). You may go ahead.

(Patrick): Yes. I'd like to follow up on the last question that was asked regarding the BAC and the MAC, the interaction between those two. If I've got a BAC committee fully established and a MAC committee fully established and all of the BAC members are part of the MAC, if I've got another Medicaid enrollee that doesn't want to be participating in the BAC, why can't they be on the MAC?

Karen Llanos: It's a great question. I mean, the scenarios that we're trying to create is for the state to be able to pull from a Beneficiary Advisory Committee that is connected to the Medicaid Advisory Committee. So that's why we're, in a sense, making space on the -- on the broader committee for the beneficiary voice.

(Patrick): All right.

Karen Llanos: I think the scenario that you're describing could allow for …

(Patrick): I mean, the reason I'm asking is we may have an individual, maybe a former Medicaid recipient or a family member supporting a Medicaid recipient that only wants to be on the MAC. And if they're qualified, I can't see why I would say, "No, you're not allowed to be on the MAC unless you're also on the BAC.

I don't know whether that scenario would present here, but I could imagine it might. I mean, if somebody doesn't want to have to do work on two committees, sort of double the work.

Karen Llanos: Yes, yes, I understand. We certainly consider the additional resources and time commitment of the beneficiaries who would have to potentially sit on two committees. And we do have a question response in the final rule related

to this where we provide different alternatives for the state to potentially rotate out beneficiaries who serve on the larger committee.

But we really do want to retain the membership flop, so to speak, on this broader committee for members of that Beneficiary Advisory Committee.

(Patrick): Okay.

Karen Llanos: Thank you so much though. I -- you're definitely giving us some food for thought.

Coordinator: Thank you. And again, there are no questions at this time. As a reminder, that is star-1 if you would like to ask a question. One moment to see if we have any further questions.

There are no questions at this time.

Jackie Glaze: Okay. Well, let's -- well, we'll wait another minute or two and then I think we'll probably wrap up early today. So, if -- we'll give everyone another minute or two if they can think of a question and then we'll wrap up.

Coordinator: Thank you. And again, that is star-1 if you would like to ask a question.

Jackie Glaze: Are there any questions?

Coordinator: There are no questions coming in at this time.

Jackie Glaze: Great. Okay, well, thank you. So, I do want to thank our team today for the discussion. And our next call will be the third week of August. So, if you do have questions that come up before that time, please feel free to reach out to

us or state leads or bring your questions to the next call. So we do thank you for joining us today and we hope everyone has a great afternoon. Thank you.

Coordinator: Thank you. That does conclude today's conference. Thank you, all, for participating. You may disconnect at this time.

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